Q-ADDS Fact Sheet - The Queensland Adult Deterioration Detection System (Q-ADDS)

The Q-ADDS (HITH) chart is the vital sign chart to be used within the Community and Oral Health Directorate. The Q-ADDS charts serve as an early warning system in detecting patient deterioration and incorporates trending and scoring for each vital sign measured. It does not replace good clinical judgement and using visualisation skills. If it is clear, or if you have concerns a patient is deteriorating, call for help early rather than waiting for the patient to reach a specific score.

The General Instruction Section provides the reader with the basic tools to use the form.

The modifications section on the Q-ADDS chart should be completed to individualise appropriate action plans and reduce unnecessary escalation to medical staff.

When modifications have been prescribed for a client, vital signs plotted within the modified reference range will not score. If a client's observations move outside of the modified range their observations are scored as per QADDS.

The intervention section is provided to allow clinicians to document when an intervention to the patient has taken place.

When using the Q-ADDS form clinicians need to assess pain by asking the patient a question such as: "On a scale of 1 to 10, can you please state your current pain level with 10 being the worst pain you can imagine and zero being no pain at all?"

If the patient reports having any pain, the clinician needs to assess a Functional Activity Score. This involves asking the patient to perform an activity appropriate to their pain.

The Additional Observations Section provides a small amount of space to record items.

The other charts section allows record of other documentation used.
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Plotting vital signs on the Q-ADDS chart shows trending of the client's vital sign data

- Vital sign assessment for adult patients must include (but is not limited to):
  - Respiratory rate
  - Oxygen saturations
  - Oxygen flow rate (record as L/min if on RA)
  - Pulse/heart rate
  - Blood pressure
  - Temperature
  - Level of consciousness/sedation
  - Pain score

The letter "M" must be documented in the row above the Total Q-ADDS Score to indicate modifications to the scoring system are in use

- Nursing staff must calculate a Total Q-ADDS Score for each set of observations and record it in the Total Q-ADDS Score box even if the score is zero.

Ensure intervention is put in place according to total score. Document on page 1 what the intervention is.

Actions required are grouped according to severity of variation in physiological parameters:
- A total score of "4" or higher will initiate further actions
- It is the clinician's responsibility to follow the actions required as stated on the QADDS to escalate care

These actions are designed to decrease adverse events associated with patient deterioration and include:
- Increasing vital signs and observation frequency
- Notifying senior staff
- Escalation
- Safe transfer of patients and escorts required

Emergency call (dial 000) if:
- Any observation to is in a purple area
- Respiratory or cardiac arrest
- Blood pressure <90/<60 mmHg
- Oxygen saturation <90%
- Sudden loss of consciousness
- You are concerned about the patient but not present in the above criteria