Frequently Asked Questions

1. Q: Why is a standardised observation chart important and how do we know if it works?
   A: Bedside observation charts play a critical role in detecting clinical deterioration in ward patients. Research clearly shows that system design changes such as standardisation, combined with a strong patient safety culture, can improve the recognition and response to unexpected clinical deterioration.

2. Q: We already use observation charts. Why should we use this one?
   A: While observation charts already exist in your hospital, recognition and response to clinical deterioration is of national and international health care concern. The SA Health Rapid Detection and Response (RDR) Chart, is based on a chart recommended by the Australian Commission on Safety and Quality in Health Care (ACSQHC) that has been through a national pilot and human factors evaluation. Having a standard set of charts ensures a consistent approach within and across health care services in order to reduce error associated with variation. The benefits of such an approach have been realised with the national introduction of standardised medication charts.

3. Q: I work on a ward where other observations, such as the Glasgow Coma Scale or Wound Chart are really important to monitor alongside other vital signs. Why can’t these be included on the Rapid Detection and Response Observation Chart?
   A: This tool is a general observation chart that has been designed to monitor the core physiological vital signs of specific patient populations, namely adult, maternity and paediatric (see ACSQHC Standards/Consensus statement). A neonatal chart will be developed in addition to these charts. Any additional specialty observations should be monitored on a separate chart.

4. Q: Why is there a bold line every 3rd column when it doesn’t align with 4 hourly or QID observations?
   A: The bold line every 3rd column prevents ‘column shift’ or error of recording observations in the wrong column. It is a human factor consideration that improves accuracy of documentation.

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6. Q: I want to be accurate when I’m recording patient observations. Why do I have to use dots and ranges in the graphing area instead of numbers?
   A: Empirical human factors research indicates that the use of dots, colour coding and separate graphing areas is much more effective in recognising clinical deterioration than the use of numbers, tables / legends and overlapping areas.

7. Q: What if I think the observations are OK for that patient even though the chart indicates they are parameters that need action? Do I need to act?
   A: Yes, unless a modification has been clearly documented on the chart or an Advance Care Directive or decision of a substitute decision maker has been made, or a medical order directs not to act.

8. Q: How often do I have to do observations?
   A: Measuring and documenting physiological observations regularly is essential to recognising clinical deterioration, and for those patients admitted to an acute care facility, observations should be recorded at a minimum of eight hourly, unless clearly documented otherwise. Each patient should have a documented monitoring plan.

9. Q: Can I let my patient sleep overnight and not do observations?
   A: No, it is recommended that all patients admitted to an acute care facility have a set of physiological observations at least every 8 hours unless documented otherwise. If observations are due in accordance with the patient monitoring plan, the patient must be woken for observations.

10. Q: What do you mean by physiological observations and which ones should we be taking?
    A: The term ‘physiological observations’ is the same as vital signs and should include respiratory rate, oxygen saturations, blood pressure, heart rate, temperature, pain and level of consciousness/sedation.
**Modification**

11. Q: What if the patient has an illness/chronic condition that will always result in parameters that fulfil current emergency response criteria?
   A: The chart contains a Modifications area where a Medical Officer can indicate if abnormal observations are to be tolerated for the patient's clinical condition.

12. Q: Can modifications to the frequency of observations be made?
   A: Modifications to frequency of observations can be made. A Registered Medical Officer may determine that the frequency of observations should be increased in certain patient conditions, or decreased in certain patient conditions for example patients receiving palliative care. However, all patients must have a clearly documented and relevant monitoring plan.

13. Q: What is the minimum designation required for a doctor to document a Modification?
   A: Modifications can be made by a Registered Medical Officer.

14. Q: Why does a nurse need to co-sign the Modifications area?
   A: A Registered Nurse/Registered Midwife (RN/RM) is required to co-sign the Modifications so that confirmation of this important aspect of the patient's plan of care is shared with the direct care team.

15. Q: I have further questions not covered by the FAQ can I speak to someone?
   A: You can get further information by emailing SafetyQualityfeedback@health.sa.gov.au

**Response**

16. Q: What do I do if an RN/RM or Doctor can’t be contacted or won’t come?
   A: If a RN/RM and / or Doctor does not respond to your concerns within 30 minutes please escalate to the next tiered response indicated on the chart.

17. Q: Is there a minimum designation required for a doctor to participate in Multi-Disciplinary Team (MDT) Review?
   A: Each Health Service will need to consider their available resources to help avert clinical deterioration. Each site will need to determine the most appropriate level of experience in a doctor to perform this important role. Timely interventions with experienced clinicians reduce the need for unnecessary procedures and the subsequent effect this has on the patient experience and outcome.

18. Q: What is a MDT Review?
   A: A MDT Review values multiple perspectives on a clinical situation. The minimum requirement is that a RN/RM and a Registered Medical Doctor assess the patient. The patient / family / carer may provide valuable perspectives in this assessment.

**Resuscitation orders**

19. Q: Who can transcribe Resuscitation Orders?
   A: Transcription is vulnerable to human error. Safeguards should be implemented to ensure accuracy in transcription. The delegation of this task should consider the appropriate level of accountability and responsibility for the documentation of Resuscitation Orders.

**Exclusion areas**

20. Q: Is every area required to use the RDR chart?
   A: Intensive Care Units, ED Resuscitation Rooms, Labour Wards (intrapartum), Operating Theatres and selected High Dependency Units are not required to use the SA Health RDR chart at this time.

**References**


**Contact details:**

SA Health
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