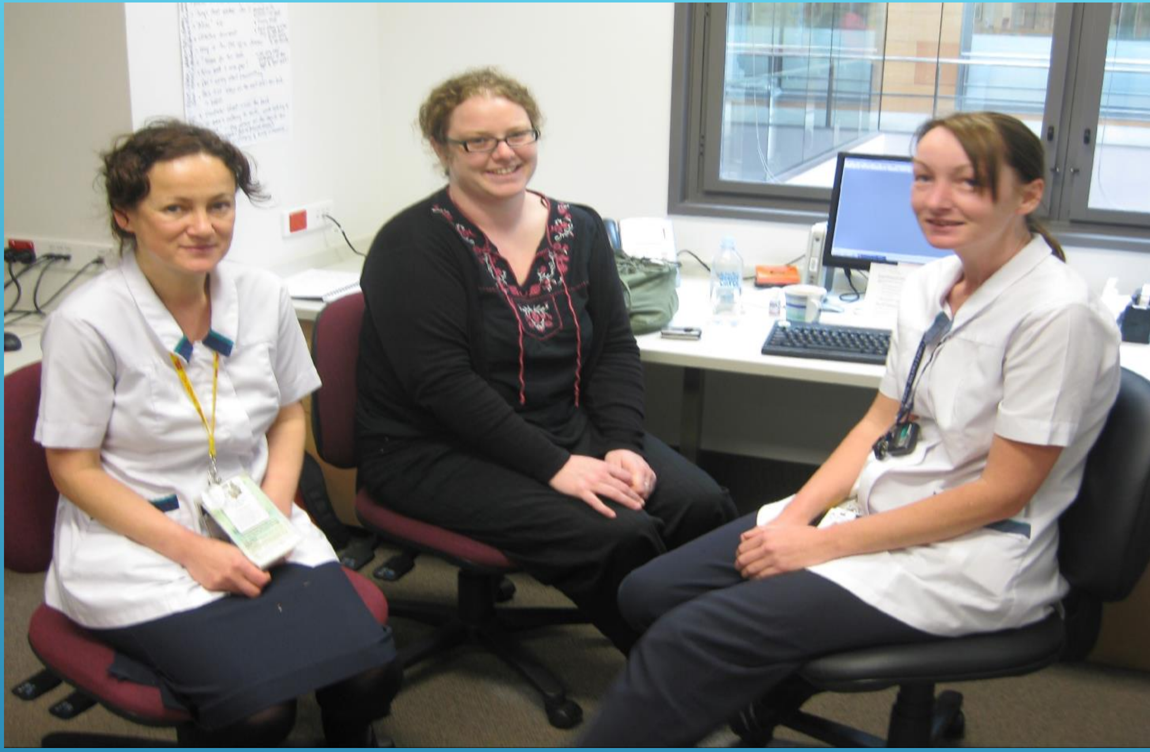
PAR – ONE SMALL STEP FOR CCDHB; ONE GIANT LEAP FOR PATIENT SAFETY

Sarah Imray

CNS PAR service

CCDHB

A personal story



Ventilation

Patient Label	Current PAR Team patient?	Y / N	ADULT patient observation chart	Patient label	Current PAR Team patient?	Y / N

MONTH:
DAY:
TIME:

TEMP °C: 40, 38, 36, 34

Heart rate = x
Blood Pressure = ^ v

220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Resp Rate: ≥30, 20 to 29, 15 to 19, 9 to 14, 0-8

SpO2 Sats
O2 Flow rate

LOC: Alert, Voice, Agitation, Pain, Unresp'

RR
HR
Systolic BP
LOC
Urine
Total Score
Referred? Y/N/NA

Score	3	2	1	0	1	2	3
RespRate		< or = 8		9 to 14	15 to 19	20 to 29	> or = 30
LOC		Agitated		ALERT	Voice	Pain	Unresp'
Heart rate		< or = 40	41 to 50	51-100	101 to 110	111 to 129	> or = 130
Systolic BP	< or = 70	71 to 80	81 to 100	101 to 179		> or = 180	
Urine / 4 hrs	< or = 80mL	80 to 120mL					

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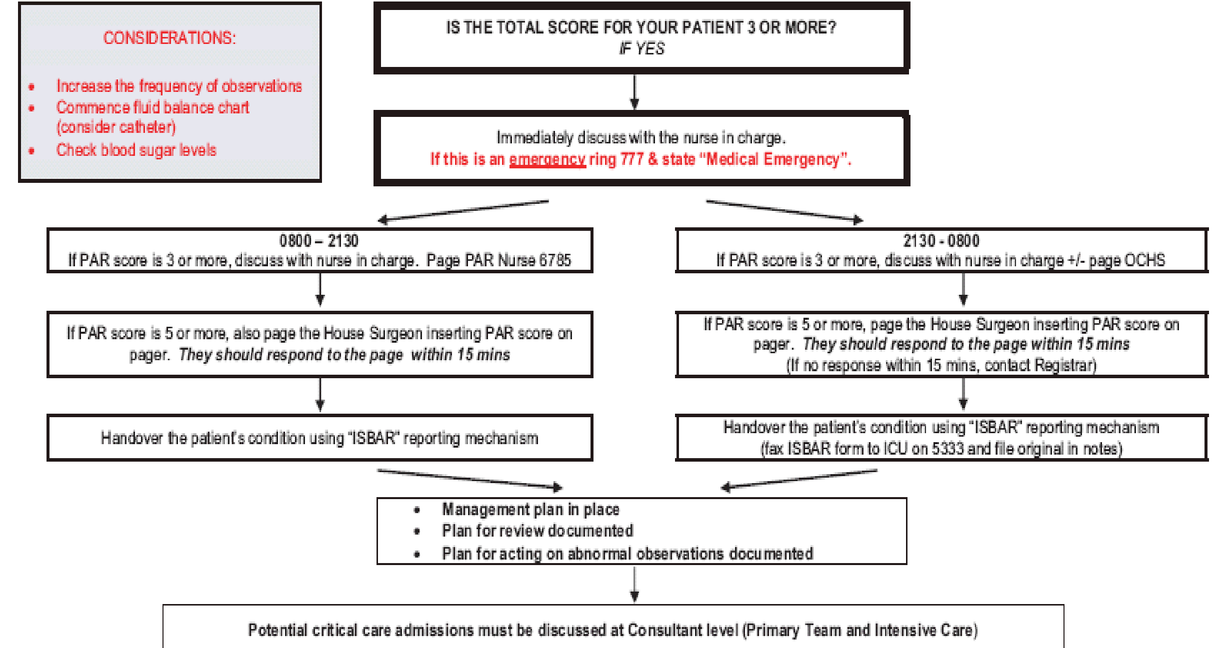
Urine / 4 hrs	< or = 80mL	80 to 120mL					

PAR PROTOCOL

Score	3	2	1	0	1	2	3	AVAILABILITY
Resp Rate per min		Less than 8		9 – 14	15 – 19	20 – 29	≥ 30	0800 – 2130 PAR Team page 6785 2130 – 2230 First on House Surgeon or Registrar (see roster) 2230 – 0800 Night House Surgeon or Registrar
Conscious Level		New onset confusion		ALERT	Responds only to voice	Responds only to pain	Unresponsive	
Heart Rate per min		≤40	41 – 50	51 – 100	101 – 110	111 - 129	≥ 130	
BP Systolic	≤ 70	71 – 80	81 – 100	101 – 179		≥180		
Urine Output over 4 hrs	≤ 80 ml	80 – 120 ml						



If the Primary Team requires assistance consider contacting ICU on 5533 for telephone advice

If the patient deteriorates at any point call 777 and state "Medical Emergency"

CCDHB adult vital signs chart	Date		Date
	Time		Time
Resp rate (breaths/min)	≥36		≥36
	31 - 35		31 - 35
	21 - 30		21 - 30
	9 - 20		9 - 20
	4 - 8		4 - 8
	≤4		≤4
O2 flow rate (L/min)	7 to 15		7 to 15
	3 to 6		3 to 6
	≤2		≤2
O2 sat (%)	≥93		≥93
	90 - 92		90 - 92
	85 - 89		85 - 89
	≤84		≤84
Blood Pressure (mmHg)	Write ≥ 200		Write ≥ 200
	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
Score systolic only	60		60
	50		50
(If >200 or <40 write value in box)	Write ≤ 40		Write ≤ 40
Heart rate (beats/min)	Write ≥140		Write ≥140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
(If heart rate >150 or <40 write value in box)	50		50
	40		40
	Write ≤30		Write ≤30
Temperature (C)	≥ 38.6		≥ 38.6
	38 - 38.5		38 - 38.5
	35.6 - 37.9		35.6 - 37.9
	35.1 - 35.5		35.1 - 35.5
(write value in box)	34.1 - 35		34.1 - 35
	≤34		≤34
4 hour urine output (mL)	≥ 800		≥ 800
	120 - 799		120 - 799
	80 - 119		80 - 119
	≤79		≤79
L.O.C.	Alert		Alert
	Voice		Voice
	Agitation/confusion		Agit/Conf
	Pain		Pain
	Unresponsive		Unresp'
Pain score (0 to 10)	Rest		Pain rest
	Movement		Pain mvmt
EWS	Respiratory rate		RR
	Systolic BP		SBP
	Heart rate		HR
	4 hour urine output		Urine
	Consciousness		LOC
	TOTAL EWS		TOTAL

777 MET

EWS 3

EWS 2

EWS 1

Patient label here

Medical staff: modification to EWS

Alterations to EWS should be reviewed by the primary team at least daily. Alterations must be made by a doctor.

If abnormal observations are to be tolerated for the patient's clinical condition, write the acceptable ranges (where EWS will be 0) below.

Respiratory rate		to	
Systolic BP		to	
Heart rate		to	
4 hour urine output		to	
Level of consciousness		to	

Doctor's name

Doctor's designation

Date and time

If patient not for MET calls please document in clinical record and on admission to discharge planner

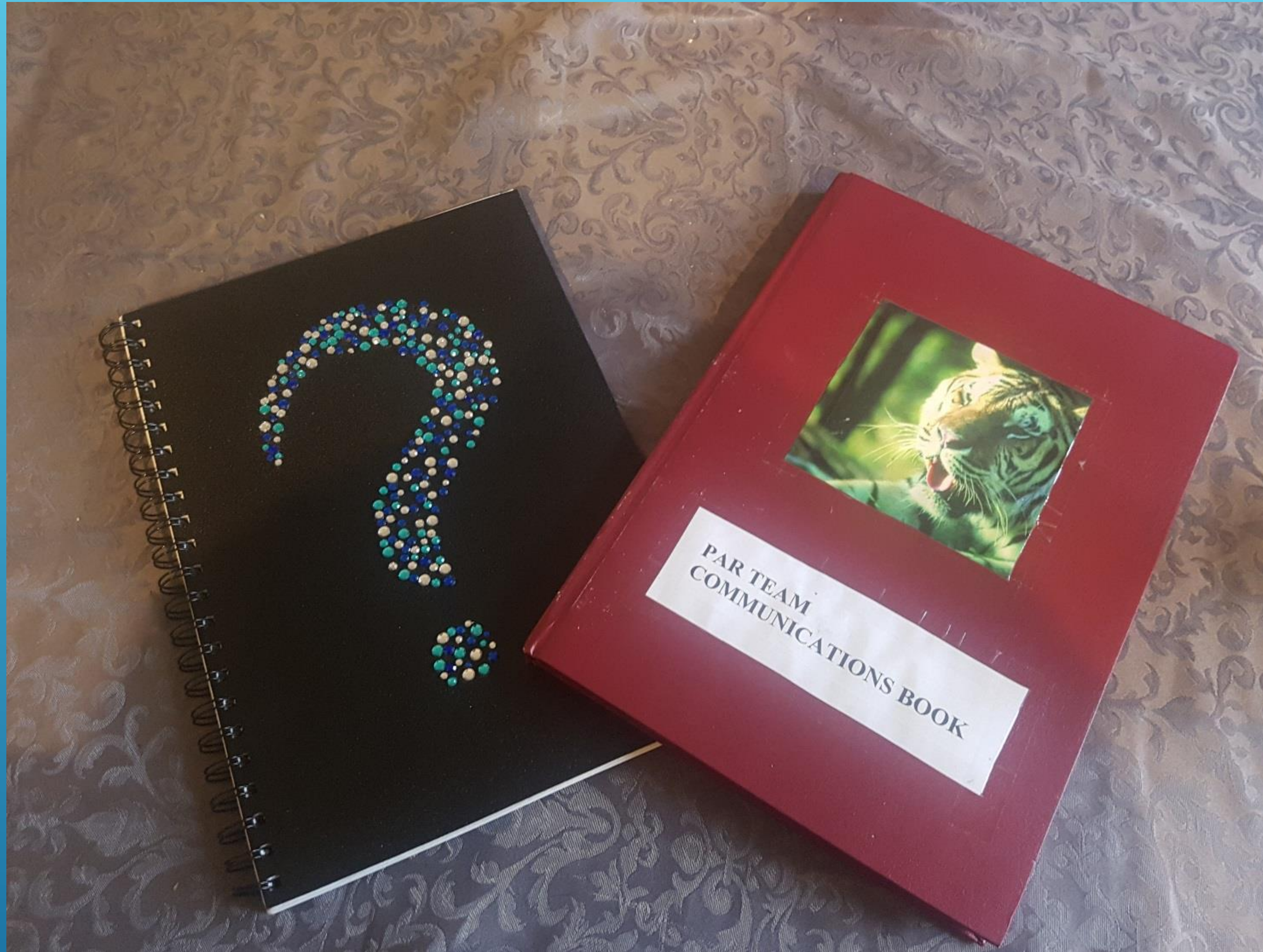
Nursing action required for patients triggering EWS

Trigger	Action
Any vital sign in the pink zone or total score 8 or more	777 Medical Emergency Team call: stay with the patient
Any vital sign in the orange zone or total score 6-7	Registrar review within 20 minutes, inform PAR nurse and nurse in charge
Any vital sign in the gold zone or total score 3-5	Discuss with nurse in charge +/- refer to House Officer +/- PAR nurse
Any vital sign in the yellow zone or total score 1-2	Manage pain, fever or distress, consider increasing frequency of vital sign observations

ALWAYS INFORM THE NURSE IN CHARGE ABOUT DETERIORATING PATIENTS

EWS should be calculated when any vital sign falls into a coloured zone. Vital signs should be recorded minimum 4 hourly unless rationale for reduced frequency is documented in the patient's clinical record.

When referring to a House Officer, Registrar or PAR nurse please complete ISBAR sticker and place in patient record


PAR TEAM
COMMUNICATIONS BOOK

PAR patients: referral mechanism
777 call
2%
Ward/other staff
40%
ICU follow up
58%

We are a nurse-led team which applies critical care skills to the management of deteriorating and acutely unwell ward patients. We support patients, their families, and healthcare professionals by: responding to clinical emergencies and acute referrals; monitoring patients recently discharged from ICU; and, providing education and advice in the management of acutely unwell ward patients.

(PAR Team, Dec 2011).

Adult Vital Signs Chart side 1

Family Name:
Given Name:
Gender:
AFFIX PATIENT LABEL HERE
NHI#:
Date of Birth:

Vital Signs	Date / Time (24 hour)	EWS	Date / Time (24 hour)
Respiratory Rate (breaths/min) *write RR value in box*	≥ 36	MET	≥ 36
	25-35	3	25-35
	21-24	2	21-24
	12-20	0	12-20
	9-11	1	9-11
	5-8	3	5-8
	≤ 4	MET	≤ 4
Oxygen (L/min)	Room air ✓	0	✓ Room air
	Supplement (L/min)	2	Supplement (L/min)
Oxygen Saturation (%) *write SpO_2 value in box*	≥ 96	0	≥ 96
	94-95	1	94-95
	92-93	2	92-93
	≤ 91	3	≤ 91
Heart Rate (bpm) *mark HR with X, write value if off scale*	Write if ≥ 140	MET	Write if ≥ 140
	130s	3	130s
	120s	2	120s
	110s		110s
	100s	1	100s
	90s		90s
	80s	0	80s
	70s		70s
	60s		60s
	50s		50s
	40s	2	40s
	30s	MET	30s
Blood Pressure (mmHg) *score systolic BP value only*	Write if ≥ 220	3	Write if ≥ 220
	210s	0	210s
	200s		200s
	190s		190s
	180s		180s
	170s		170s
	160s		160s
	150s		150s
	140s		140s
	130s		130s
	120s		120s
	110s		110s
	100s	1	100s
	90s	2	90s
	80s	3	80s
	70s		70s
	60s	MET	60s
	50s		50s
Temperature (°C) *mark Temp with X, write value if off scale*	≥ 39s	2	≥ 39s
	38s	1	38s
	37s	0	37s
	36s		36s
	35s	1	35s
	≤ 34s	2	≤ 34s
Level Of Consciousness mark LOC with ✓	Alert	0	Alert
	Voice	3	Voice
	Pain		Pain
	Unresponsive	MET	Unresponsive
EARLY WARNING SCORE TOTAL			**EWS TOTAL**
Pain *write score (0-10)*	Move / Rest		Move / Rest
Urine Output — Catheter	> 100mls / 4h		> 100mls / 4h
	< 100mls / 4h		< 100mls / 4h
Urine Output — No catheter ✓	PU last 8h		PU last 8h
	Not PU last 8h		Not PU last 8h

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Capital & Coast District Health Board

Family Name:
Given Name: Gender:
AFFIX PATIENT LABEL HERE
Date of Birth: NHI#:

ESCALATE CARE FOR ANY PATIENT YOU, THEY OR THEIR FAMILY ARE WORRIED ABOUT, REGARDLESS OF VITAL SIGNS OR EWS

Mandatory escalation pathway

Total Early Warning Score (EWS)	Action	
EWS 1-5	• Manage pain, fever or distress • Increase frequency of vital sign monitoring	
EWS 6-7 Acute illness or unstable chronic disease	House officer review within 60 minutes	• Inform nurse in charge • Refer to Patient At Risk (PAR) nurse #6785 • Increase frequency of vital signs • Document plan including intervention, escalation & review timeframe
EWS 8-9 *or any vital sign in red zone* Likely to deteriorate rapidly	Registrar review within 20 minutes & suggest ICU referral	
EWS 10+ *or any vital sign in blue zone* Immediately life threatening critical illness	• Dial 777 • State '*Medical Emergency Team*' then give your location • Support Airway, Breathing & Circulation	

Modification to Early Warning Score (EWS) Triggers

The EWS can be changed to prevent chronic disease incorrectly triggering escalation. All modifications must be made in line with hospital policy and regularly reviewed by the primary team.
Ignore any modification that is not signed and dated.

Vital sign (use abbreviation)	Accepted values and modified EWS	Date and time	Duration (hours)	Name and contact details
		/ / :		
Reason:				
		/ / :		
Reason:				
		/ / :		
Reason:				
NOT FOR CPR ☐	NOT FOR MET ☐	/ / :		

Any treatment limitations must be documented in the patient's clinical record.

A full set of vital signs with corresponding EWS must be taken and calculated each time at a frequency stated in hospital policy. If there is no timely response to your request for review, escalate to the next coloured zone.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

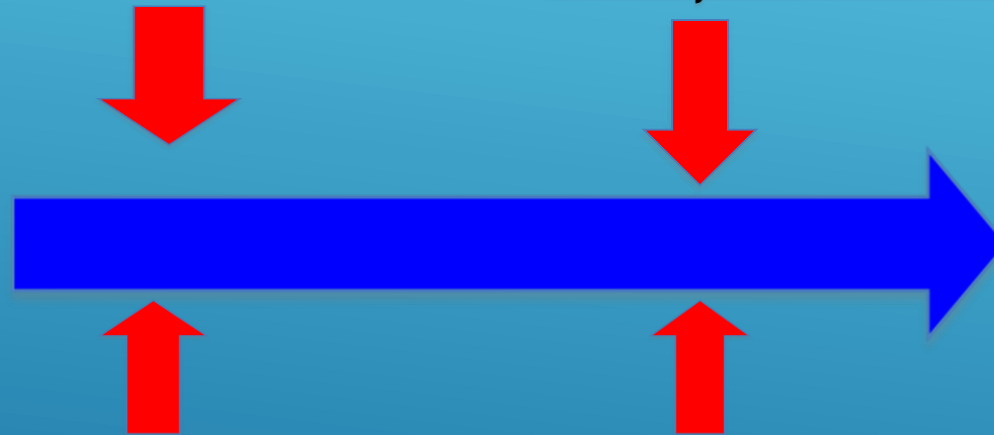
Kupu Taurangi Hauora o Aotearoa

PATIENT A 2018

(1) 23/09/04
Overnight: **EWS 8.**
REG & PAR reviews

(3) 24/09/04
Overnight: RN concerned re: pt
EWS 777: MET call for any patient you are seriously concerned about

23/09/04 12:30
Patient 'A'
Admitted to ED with "asthma"



25/09/04 6am
Patient 'A'
Unresponsive
Died

(2) 24/09/04
Daytime: **EWS 9**
PAR & REG review

(4) 24/09/04
RR >60. **EWS 777:**
EWS trigger mandates 777 MET call