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

Sarah Imray
CNS PAR service
CCDHB
A personal story
### PAR Protocol

<table>
<thead>
<tr>
<th>Score</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ramp Rate (bpm)</td>
<td>Less than 8</td>
<td>9 – 14</td>
<td>15 – 19</td>
<td>20 – 29</td>
<td>≥ 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conscious Level</td>
<td>Somnolent</td>
<td>Alert</td>
<td>Responds only to voice</td>
<td>Responds only to pain</td>
<td>Unresponsive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Rate (bpm)</td>
<td>90 – 120</td>
<td>121 – 140</td>
<td>141 – 160</td>
<td>≥ 160</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SBP</td>
<td>≤ 70</td>
<td>71 – 80</td>
<td>81 – 100</td>
<td>101 – 119</td>
<td>≥ 120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine Output over 1 hour</td>
<td>≤ 60 ml</td>
<td>61 – 240 ml</td>
<td>≥ 250 ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Considerations:
- Increase the frequency of observations.
- Consider a fluid bolus.
- Check blood glucose levels.
- Management plan in place.
- Plan for review documented.
- Plan for action, involving abnormal observations documented.

#### Is the total score for your patient 3 or more?
- If YES, immediately discuss with the nurse in charge.
  - If this is an emergency, ring 777 and state “Medical Emergency”.
  - Page PAR Nurse (0785).

#### If PAR score is 3 or more, discuss with nurse in charge.
- Page PAR Nurse (0785).

#### If PAR score is 5 or more, page the House Surgeon.
- Page PAR Nurse (0785).
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#### Hardwire the patient’s condition using ”TISBAR” reporting mechanism.
- Document as per TISBAR form in ICU on page 1 and the original in nurses station.

#### Management of critical care admissions:
- Potential critical care admissions must be discussed at Consultant level (Primary Team and Intensive Care).

#### If the Primary Team requires assistance, consider consulting ICU on phone 0735 for telephone advice.
- If the patient deteriorates at any point call 777 and state “Medical Emergency”.

#### Availability:
- 0800 – 2130 PAR Teams page ETBS 2130 – 2209 First on House Surgeon or Registrar (now reduced) 2209 – 0809 Night House Surgeon or Registrar.
# CCDHB adult vital signs chart

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resp rate (breaths/min)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2 flow rate (L/min)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2 sat (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure (mmHg)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score systolic only (if &lt;200 or &gt;40 write value in box)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate (beats/min)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature (°C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 hour urine output (mL)</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

### Medical staff: modification to EWS

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Respiratory rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic BP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 hour urine output</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of consciousness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### Nursing action required for patients triggering EWS

- **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 patients: referral mechanism

ICU follow up: 58%
Ward/other staff: 40%
777 call: 2%
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)
### Vital Signs Chart

<table>
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<tr>
<th>Name</th>
<th>Time (hr)</th>
<th>Time (min)</th>
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<tbody>
<tr>
<td>Respiratory Rate</td>
<td>09:04</td>
<td>09:00</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>09:03</td>
<td>09:00</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>110/70</td>
<td>110/70</td>
</tr>
<tr>
<td>Diastolic BP</td>
<td>70/50</td>
<td>70/50</td>
</tr>
<tr>
<td>Pulse oximetry</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Temperature</td>
<td>98.6°</td>
<td>98.6°</td>
</tr>
<tr>
<td>Weight</td>
<td>150 lbs</td>
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<tr>
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</tr>
<tr>
<td>11:00</td>
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### EWS 1.5
- Manage pain, fear or distress
- Increase frequency of vital signs monitoring

### EWS 6.7
- Inform nurse in charge
- Refer to Physician if ARDS (Pulmonary injury) or significant chronic disease

### EWS 8.9
- Register review within 20 minutes and suggest ICU referral

### EWS 10+
- Call 777
- State ‘Medical Emergency Team’ then give your location
- Support Airway, Breathing & Circulation

### Modification to Early Warning Score (EWS) Triggers
- These triggers must be recorded in the patient’s clinical record. All modifications must be made in line with hospital policy and regularly reviewed by the primary team.

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### Modified EWS Triggers

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<tr>
<th>Vital sign</th>
<th>Trigger level</th>
<th>Action</th>
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<tbody>
<tr>
<td>Respiratory Rate</td>
<td>20/min</td>
<td>Increase monitoring</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>100/min</td>
<td>Increase monitoring</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>120/80mmHg</td>
<td>Refer to Physician</td>
</tr>
<tr>
<td>Diastolic BP</td>
<td>80/50mmHg</td>
<td>Refer to Physician</td>
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### Treatment Options

- If treatment options are required, they 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 clinical team.
23/09/04 12:30
Patient ‘A’
Admitted to ED with “asthma”

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

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

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

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

25/09/04 6am
Patient ‘A’
Unresponsive
Died