EE1 ORC2
FACT SHEET

Modifying the observation and response chart for local use

Once you have selected which observation and response chart (ORC) is appropriate for use in your health service (see fact sheet EE1 ORC1: Introducing an observation and response chart), you will need to make some modifications to the chart so that it reflects the characteristics of your local recognition and response system. The ORCs were created in a program called InDesign and you will need access to this program to make the required modifications.

This fact sheet is one of a series that provides specific information about the process of selecting, implementing and using an observation and response chart. The other fact sheets in this series are:

- EE1 ORC1 Introducing an observation and response chart
- EE1 ORC3 Potential practice changes associated with implementing an observation and response chart
- EE1 ORC4 Training clinicians to use the observation and response charts
- EE1 ORC5 Why is it crucial to test any non-approved ORC modifications?
- EE1 ORC6 How to run a behavioural study to test chart modifications

Required modifications

The only modification that must be made to the observation and response chart you select is to the content of the 'actions required' area. Different health services have different resources available and response actions must reflect local circumstances – a small rural hospital is likely to have very different actions from a large tertiary teaching hospital. It is vital that you undertake a process of matching physiological triggers to the response actions that are appropriate in your organisation. An escalation mapping tool is available to guide you through the process. A worked example and a modifiable template of the escalation mapping tool are available from the link below.

Escalation mapping tools

Allowable optional modifications

Making modifications to the overall design of the ORCs is not endorsed by the Commission.

Any modifications that are made have the potential to reduce the effectiveness of the charts as tools for recognising and responding to clinical deterioration and hence increase patient risk. The table overleaf lists optional changes that may be made to the ORCs and includes brief discussion of the precautions that should be considered if the change is included. **If a change is not specifically listed then it should not be made without further empirical testing of the modified chart to ensure it does not increase patient risk** (see fact sheets EE1 ORC5 and EE1 ORC6).

Further information

Further information about implementing recognition and response systems can be found in the Australian Commission on Safety and Quality in Health Care publication *A Guide to Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration* (2011).

This can be downloaded from: www.safetyandquality.gov.au

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

recognising + responding TO CLINICAL DETERIORATION

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Allowable optional modifications

(note that mapped versions of each of the four ORCs are available on the Commission's web site - these will assist you to identify the chart areas referred to below)

Modification	Precautions
Inserting the name of the health facility in the chart title box.	Formatting should be simple and clear. A coloured logo should not be included as this adds visual clutter and detracts from more important elements of the chart.
Removing the other charts in use area, or substituting the named charts that are listed.	Retain the alphabetical order of named charts. It is acceptable to include up to four blank boxes for writing in the names of less commonly used charts.
Substituting up to three observation parameters to replace the two non-compulsory parameters (O_2 flow rate, pain score) in the observations graphing area. The six compulsory parameters that are prescribed in the National Consensus Statement (respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and consciousness) may not be changed. The maximum number of parameters allowed is nine (assuming these can be fitted on to the chart without changing formatting characteristics such as row height). Note the observations included in the additional observations area on the back of the chart can be substituted freely, although formatting should remain consistent.	Any new parameters that are substituted should be capable of signalling clinical deterioration in a significant proportion of patients independent of other parameters. Examples of parameters that could be substituted include oxygen flow rate, pain, heart rhythm and blood sugar level. The formatting of additional parameters must remain consistent. New parameters should be positioned logically on the chart. For example, heart rhythm should be positioned below the other circulatory parameters. Additional parameters such as blood sugar level or pain should be positioned at the bottom of the chart below consciousness, following the principle that the more safety-critical parameters should be positioned closer to the top of the page. When formatting new parameters, abbreviations should not be used and units of measure should be included in the labelling. While new rows can potentially be added to the observation graphing area if necessary, this must not be done by changing the format of existing rows. Also, the formatting of any new rows must match that of existing rows exactly. Minimum row heights must be 3.6mm for graphed observations, and 4.7mm for written observations.
Adapting the wording of the general instructions for use to reflect local practice.	These must remain succinct, directive and descriptive of what is required from the chart user.
If new parameters are substituted for existing parameters on the observation graphing area of the chart these may also be added to the listed parameters in the modifications area of the chart.	Formatting must remain consistent and the total number of parameters must not exceed nine.
Changing the instruction indicating the frequency with which modifications must be reviewed.	This instruction should reflect local policy.
Adding or subtracting rows to the table for noting interventions.	When changing the number of rows, the formatting of the table should not be changed. For example, row height should not be decreased as this may reduce the legibility of written information.
Changing the designations of who is contacted in the clinical review request area to reflect local policy.	The designations of those who are contacted for clinical review should reflect local policy.
Substituting the AVPU consciousness scale for another simple consciousness scale as long as the alternative scale is selected based on evidence of its clinical efficacy, simplicity and ease of use.	Scales such as the Glasgow Coma Score are too complex to be included on the charts and should be documented on an additional chart if they are required. Alternative consciousness scales must be descriptive and should not require chart users to refer to other materials when making an assessment.
Changing the symbol used to document blood pressure so that it is consistent with all other clinical forms used in the same facility.	It is common for blood pressure to be documented using a double ended arrow with either inward or outward pointing fins. One method should be used consistently across all clinical forms.
Adapting additional response criteria to reflect local conditions.	Instructions must remain succinct, clear, directive and descriptive of what is required form a chart user. Font and font size must not be changed from Arial 11 point. The 'emergency call' prompt can be replaced with a more specific prompt that reflects local policy (for example, 'MET call').