SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Deteriorating Patient – Clinical Emergency Response System for the Management of Adult and Maternity inpatients
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/283
DATE OF PUBLICATION	November 2019
RISK RATING	High
LEVEL OF EVIDENCE	NSQHS Standard 8
REVIEW DATE	November 2021
FORMER REFERENCE(S)	Former PD 208
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KEY TERMS	Clinical deterioration; escalation; clinical emergency response systems, CERS, Sepsis, Between the Flags
SUMMARY	This document outlines the clinical emergency response escalation procedure in use in all SESLHD facilities • Operational components of the rapid response system including criteria for activating a rapid response call • District and hospital responsibilities and accountabilities in relation to the rapid response system

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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1. POLICY STATEMENT

Early recognition of the deteriorating patient and the provision of a prompt and appropriate response are essential components of safe quality patient care.

SESLHD facilities will utilise a standardised rapid response system to facilitate early recognition and respond to patients with signs of clinical deterioration.

In SESLHD general observations for adult patients must be recorded into eMR onto the NSW Health Standard Adult General Observation chart or the NSW Health Standard Maternity Observation chart.

This procedure shall be read in conjunction with NSW Ministry of Health Policy - PD2013_049 Recognition & Management of Patients who are Clinically Deteriorating

For paediatric patients refer to SESLHD Procedure SESLHDPR/284 - Clinical Emergency Response System (CERS): Management of the Deteriorating PAEDIATRIC Inpatient

For neonates in special care nurseries, post-natal wards or within the maternity unit refer to SESLHD Procedure SESLHDPR/340 - Neonate Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating NEONATE Inpatient

NSW Health Incident Management Policy PD2019_034

2. BACKGROUND

Between the Flags (BTF) is the rapid response system activated if a patient's clinical observations or condition meet Between the Flags (BTF) calling criteria. BTF calling criteria aligns with the rapid response criteria documented on the NSW Standard Observation chart or Standard Maternity Observation chart within eMR. The BTF Rapid Response system aims to identify and reverse early signs of deterioration, through early management and treatment. The success of the system relies on the following:

- Observations monitored at a frequency sufficient to detect deterioration or procedural complications
- Recognition of early signs of deterioration by a staff member
- Activation of the system if observations meet calling criteria or other clinical condition of concern
- Timely medical response and management by a senior member of the primary care team
- Built in escalation to specialised emergency care should the patient continue to deteriorate or if the patient's condition is life threatening

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3. DEFINITIONS and ABBREVIATIONS

A-G: Airway; Breathing; Circulation; Disability; Exposure; Fluids; Glucose
AVPU: **A**lert; rousable by **V**oice; rousable only by **P**ain; **U**nresponsive
AMO: Attending Medical Officer / consultant (or on call equivalent)
BTF: Between the flags
BTF DETECT: A mandatory education program based on e-learning and practical scenarios designed to improve clinical assessment skills, recognition and management of clinically deteriorating patients
CERS: Clinical Emergency Response System
Yellow Zone Criteria/ Clinical Review: An observation range that requires the nurse/midwife, to decide based on clinical judgement whether Clinical Review call is activated
Yellow Zone Criteria / Additional Clinical Review: A list of observational conditions, listed on the SAGO/SMOC that require a mandatory escalation
DBP: Diastolic blood pressure
eMR: Electronic medical record
EN: Enrolled Nurse
FONT: Fetal welfare assessment, Obstetric emergencies and Neonatal resuscitation Training
ISBAR: **I**ntroduction / **S**ituation / **B**ackground / **A**ssessment / **R**ecommendations
Observation Monitoring Plan: A plan outlining the minimum observations and assessments that are required, including observation frequency.
Red Zone Criteria / Rapid Response: An abnormal observation range or serious conditions that requires a mandatory Rapid Response or Code Blue call to be made.
Additional Red Zone Criteria: A list of serious conditions, listed on the SAGO/SMOC that require a mandatory escalation
PCT: Primary Care Team (also known as the home team)
REACH: stands for Recognise / Engage / Ask / Call / Help is on its way. REACH is the process a patient or family member can use to independently make an escalation call if they have clinical concern about their relative. Facilities in SESLHD are required to have an independent process that patients/relatives can use to escalate clinical concern should they remain concerned following review by the clinical ward staff
RM: Registered Midwife
RN: Registered Nurse
SAGO: Standard Adult General Observation chart (eMR or paper version)
SMOC: Standard Maternity Observation chart (eMR or paper version)
SNOC: Standard Newborn Observation Chart (eMR or paper version)
SBP: Systolic blood pressure
≥: Greater or equal to
≤: Less than or equal to

4. NSW STANDARD OBSERVATION CHARTS

Vital sign observations are recorded on the Standard Observation charts either on eMR or the paper version.

- NSW Standard General Adult Observation Chart
- NSW Maternity Observation Chart

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Pregnant women admitted at less than 20 weeks gestation have vital signs recorded on the Standard Adult General Observation chart

5. BETWEEN THE FLAGS EDUCATION REQUIREMENTS

Between the Flags - Tier 2 eLearning modules

- Between the Flags - Tier 2: Systematic assessment Course Code 90689601
- Between the Flags - Tier 2: Case Studies (Adult) Course Code 9069035
- Between the Flags - Tier 2: Communication, Teamwork and Documentation Course Code 90689128

Between the Flags – Tier 2 DETECT Workshops

- Between the Flags – Tier 2 DETECT workshop Course Code 91007672

Fetal Welfare Assessment

- FONT (Fetal welfare Obstetric emergency Neonatal resuscitation Training) Course Code CSK903

BTF Orientation

- Overview of the BTF system including when and how to activate a Clinical Review, Rapid response or Code Blue call

6. REACH – Patient and Family Escalation. ACTIVATION BASED ON PATIENT/FAMILY CONCERN

- If a patient or family member / carer raises clinical concern for the patient, the clinician must review the patient and assess whether the patient is deteriorating
- If the patient is breaching the yellow zone criteria a clinical review and appropriate escalation is required
- If the patient is breaching red zone criteria a rapid response call must be made
- If the patient is not deteriorating the clinician must provide the patient or family / carer with a clinical rationale as to the reason not to escalate
- If the patient or family / carer are not satisfied with the rationale or insist on a medical review a Clinical review or Rapid Response call must be made.
- In facilities that have implemented the REACH program, the family member/carer will receive information regarding REACH and how to make an independent REACH call
- The ability to escalate clinical concern by a patient / family member is part of the patient's healthcare rights and responsibilities

7. ALTERATIONS TO CALLING CRITERIA

- Altering criteria should be undertaken with caution as criteria are sensitive signs of deterioration. Calling criteria should only be altered in consultation with the AMO and must be formally reviewed by the AMO. Any alteration to criteria must have a clinical rationale documented in the medical record.

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- Document alterations to calling criteria including the review date/time on the electronic form in eMR. An alert will occur when the review time/date is due.
- Criteria alteration for acute changes should be reviewed by the AMO within 24 hours.
- Alteration of criteria for chronic conditions should be reviewed within 72 hours for general patients and within 36 hours for maternity patients.
- **Palliative patients and patients on an End of Life pathway.** Activation of the Rapid Response system for the management of deranged vital signs may remain appropriate for palliative patients. It is essential that the patient has an individualised patient management plan which clearly documents if and when a Clinical Review or Rapid Response call is to be activated and a Resuscitation Plan that documents resuscitation status and ceiling of care.
- At all times clinicians should use clinical judgement when to activate a Clinical Review or Rapid Response call. Certain situations will require a Clinical Review, Rapid Response or Code Blue activation such as deterioration due to inadvertent misadventure e.g. tracheostomy tube dislodgement

8. RESPONSIBILITIES

8.1 Primary Care Team (PCT) will:

- Attend Orientation and BTF DETECT workshop and/or Fetal Welfare Assessment workshop
- Complete all BTF eLearning modules
- Document a comprehensive medical / obstetric* management plan at the time of admission, including required observations. **for high risk maternity patients*
- Prescribe any required variations to frequency of observations
- **Altering Calling Criteria**: Calling criteria may only be modified in consultation with the AMO. Document any alterations to criteria on the electronic Alterations to Calling Criteria form in eMR. (as above)
  - Any alteration to calling criteria must have a clinical rationale documented in the patient's health care record
  - Review alterations to calling criteria as soon as feasible for any patient transferred from a high acuity area such as Emergency or Intensive Care

8.2 Registrar of the Primary Care Team will:

- Respond to any Rapid Response calls as soon as possible (within 10-15 minutes)
  - If unable to attend a Rapid Response call (i.e. in theatre or attending another Rapid Response, a locally agreed deputy can respond
  - The deputy must discuss the patient with the registrar or AMO (as soon as possible). The discussion and any outcomes should be documented in the medical record
- Document the Rapid Response in the medical record including: clinical findings, treatment and a medical management plan. Ensure this revised plan is communicated to relevant staff.
- Notify the Attending Medical Officer (AMO) of the patient's condition following <u>every</u> Code blue call or following two or more Rapid Response (within a 24 hour period)

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- Notify the patient's next of kin (NOK) as soon as practical following a Rapid Response or Code Blue or following a significant change / deterioration in the patient's condition
- Include any Clinical Review, Rapid Response or Code Blue activations in clinical handover

8.3 Emergency Department (ED) Clinicians will:

- Document observations on the NSW Emergency Standard Observation Chart or for maternity patients ≥ 20 weeks gestation on the NSW Standard Maternity Observation chart via FirstNet (or paper version during down time)
- Escalate any red zone breaches or additional red zone criteria to the senior medical officer on duty in the ED
- For patients being transferred to the ward ensure that on FirstNet the following are completed prior to ward transfer: ED to Ward Form, Medical Admission checklist and ED Safe for Transfer-Nursing and Medical from or ED SAGO Paper version ED to Ward Departure Checklist and Authorisation for Departure from ED to Ward.

8.4 Emergency Department, Critical Care, Intensive Care or High Dependency Unit Clinicians will:

- Ensure that patients are not transferred to the ward breaching red zone criteria or additional red zone criteria without the approval of the transferring senior medical officer and a documented management plan to address
- Ensure that the primary care team, (medical and nursing), are advised prior to transfer of any observations in the yellow or red zone (OR additional yellow zone or additional red zone criteria) and the management plan to address
- Ensure that any **alterations to calling criteria** are documented on the paper SAGO / SMOC or FirstNet Alterations to Criteria form, including a documented review due date and are signed by an ED / ICU senior medical officer before the patient is transferred to the ward. Alterations to calling criteria should be made in liaison with the primary care team. The primary care team must be notified of any alterations to calling criteria before the patient is transferred.
- Attend BTF Orientation and BTF Tier 2 DETECT workshop and/or Fetal Welfare Assessment workshop
- Complete all BTF Tier 2 eLearning modules

8.5 Nurses / Midwives will:

- Attend BTF Orientation and BTF Tier 2 DETECT workshop and/or Fetal Welfare Assessment workshop. Midwives are exempt from the BTF Tier 2 DETECT workshop if they complete FONT training, as the principles of BTF DETECT are incorporated into FONT Training
- Complete all BTF Tier 2 eLearning modules
- Monitor patient's vital signs at a frequency that is appropriate to the clinical condition or treatment being administered.
- Well maternity patients without risk factors (and well new born babies in the postnatal ward) only require one set of core vital sign observations following birth
- Check whether there are appropriate alterations to calling criteria (i.e. signed by the AMO and within the review period)

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- Know when and how to activate the BTF Rapid Response system
- Notify the NUM / MUM or team leader that a Clinical Review, Rapid Response or Code Blue call has been made
- Contemporaneously document the episode in the medical record
- Include any Clinical Review, Rapid Response or Code Blue activations in clinical handover
- Complete an electronic Clinical Review or Rapid Response form
- Discuss the management plan with the reviewing medical officer, seek clarification if required, and instigate treatment as appropriate
- Provide patients/relatives with information regarding the facility's patient/family escalation systems (REACH or Patient and Family Escalation)
- If a patient or family member / carer raises clinical concern for the patient, review the patient (include a complete set of observations) and assess whether the patient is deteriorating. If the patient is deteriorating a Clinical Review or Rapid Response call must be made. If the patient is not deteriorating the nurse/midwife must provide the patient or family / carer with a rationale. If the patient or family / carer insist on a review by a doctor a Clinical Review or Rapid Response call must be made.

8.6 Nursing / Midwife Unit Manager (NUM /MUM)/ Team Leader will:

- Ensure staff receive education and training regarding the BTF Rapid Response system, complete BTF Tier 2 learning modules and attend BTF Tier 2 DETECT workshop
- Review with the bedside nurse/midwife any patient with observations in the clinical review/yellow zone, (following appropriate clinical care being initiated and a repeat set of observations performed) to determine if a clinical review is required
- Review/audit observation charts on a regular basis to ensure that vital signs are recorded completely and at a frequency sufficient to detect clinical deterioration and that any breaches to BTF calling criteria are escalated.
- To ensure continuous quality improvement, remedial action and follow up with staff should occur when deficits are identified.
- The NUM / MUM of the ward/unit is responsible for the provision of sufficient equipment to ensure nursing / midwifery workflow is not delayed due to faulty or insufficient equipment i.e. sphygmomanometers (automatic and manual), BP cuffs, thermometers, oxygen saturation monitors
- Ensure patients and family members receive information regarding the facility's patient/family escalation system
- Notify and /or manage IIMS relating to the management of a deteriorating patient

8.7 Allied Health Professions will:

- Attend BTF Orientation and complete BTF Tier 2 eLearning modules
- Graphically record any vital sign observation measurements on the relevant patient observation chart.
- Notify the nurse / midwife if the patient's observations or clinical condition meet BTF calling criteria.
- Document the deterioration in the medical record

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8.8 Facility CERS / Deterioration Patient Programs Coordinators will:

- Provide ongoing multi-disciplinary education related to the operation of the BTF Rapid Response system
- Maintain a register of all Rapid Response and Code Blue activations. Provide agreed monthly key performance indicators
- Monitor REACH calls
- Audit compliance to the procedure via system reviews and report/feedback any variances to clinical areas, facility Deteriorating Patient Committee and the District Deteriorating Patient Committee.

8.9 District Deteriorating Patient Committee:

- The District Deteriorating Patient Committee is the peak District Committee with overarching responsibility for the SESLHD BTF Rapid Response system
- Any local variance to the District Management of the Deteriorating inpatient policy requires formal approval by this Committee.

8.10 Corporate Services (Telecommunication Managers) will:

- Develop and maintain a Clinical Review, Rapid Response and Code Blue Call Action Card for use by switch operators
- Develop a call log book for operators including:
  - Time of call
  - Type of call being initiated i.e. Clinical Review or Rapid Response or Code Blue Adult, Obstetric, Neonatal or Paediatrics
  - The primary care team being requested
  - The location and bed number of the deteriorating patient
  - Time page initiated
  - Any difficulties encountered in implementing the BTF Rapid Response system
- Monitor adherence to call operator requirements. Report / escalate issues where necessary to facility Clinical Emergency Response Committee.

Telecommunications Operators will:

- Initiate the Clinical Review, Rapid Response, Code Blue call using the hospital emergency paging system (2222)
- Record and document all calls.

9. Escalation PROCEDURE:

9.1.1 Yellow Zone

If observations are charted in the yellow zone:

- Initiate appropriate clinical care and repeat the observations as indicated by the patient's clinical condition
- To determine if a Clinical Review is required the nurse/midwife should consider:
  - ➢ What is usual for the patient? Are there *Alterations to Calling Criteria*?
  - ➢ Does the trend in observations suggest deterioration?
  - ➢ Are you worried about your patient's condition?
  - ➢ Is there more than one Yellow Zone observation charted?

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- If escalation is required, activate calling 2222 (refer to Table 1).
- If observations trend towards the red zone consult with the nurse/midwife in charge to determine if a Rapid Response call is required

If observations meet Yellow Zone criteria and escalation is not required:

- Consider increasing the frequency of observations as indicated by the patient's condition

If observations continue to deteriorate:

- Activate Clinical Review
- Prepare to handover to the responder using ISBAR principles
- Document the reason for escalation / non escalation, any treatment and outcome in the health care record.

Table 1

Clinical Review / Yellow Zone Criteria /: An observation range, recorded in the yellow zone of the SAGO/SMOC. **Additional Yellow Zone Criteria:** A list of serious conditions, listed on the SAGO/SMOC. **Action ➔** consult with the nurse/ midwife in charge to determine whether a Clinical Review call is required When called, the clinical team must respond within 30 minutes **NB For Blood Glucose Level < 4mmol/L or > 20 mmol/L** the clinician should treat the patient as per the local hypoglycaemic protocol. A Clinical Review call is required if the patient does not respond to treatment or if the patient has a symptomatic decrease in level of consciousness.

9.1.2 Red Zone

If a patient's observations meet Red Zone Criteria a Rapid Response or a Code Blue must be activated.

Rapid Response

- Repeat the observation (to clarify if correct)
- Dial the emergency number (2222)
- Request a Rapid Response and team required (Adult, Obstetric or Paediatric or Neonatal)
- Provide the operator with the primary care team required, the ward and bed number of the patient
- Inform the nurse / midwife in charge, instigate treatment within scope of clinical practice. Prepare to handover to the responder using ISBAR principles

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- Review the observation frequency and increase frequency as indicated by the patient's condition
- Document the event as outlined in Nursing /Midwifery Responsibility section of this policy and

- Complete a rapid response electronic form

A senior member of the primary care team will respond to a Rapid Response call within 15 minutes

Table 2

Red Zone Criteria: An abnormal observation range, recorded in the red zone of the SAGO/SMOC. **Additional Red Zone Criteria:** A list of serious conditions, listed on page 4 of the SAGO/SMOC. **Action ➔** activate a <u>mandatory</u> Rapid Response or Code Blue The clinical team should respond within 15 minutes

<u>Code Blue Activation</u>

If the patient's condition becomes immediately life threatening, deteriorates further or the patient is not reviewed within 15 minutes of a Rapid Response call, the clinician MUST activate a Code Blue

Code Blue Criteria
- Cardiac/respiratory arrest
- Airway obstruction, stridor, threatened airway
- Seizures (new or prolonged)

- Dial the emergency number (2222)
- Request a Code Blue an team required (Adult or Obstetric, Paediatric or neonatal)
- Provide the operator with the ward and bed number of the patient
  - At the following sites (RHW, SGH and TSH) also provide the operator with the name of the patient's consultant
- Instigate treatment within scope of clinical practice. Prepare to handover to the team using ISBAR principles

The Code Blue team will respond immediately

9.2 RESPONDING TO A RAPID RESPONSE

The Registrar of the primary care team or locally agreed deputy must respond as soon as possible (within 15 minutes)

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- The Registrar must conduct an urgent systematic review of the patient's condition and commence appropriate management
- The Registrar should initiate further investigations, referrals (consider whether an ICU review is required) or definitive treatment as appropriate
- **If the patient deteriorates further during the review or if the patient's condition becomes immediately life threatening escalate to a Code Blue**
- Notify the AMO if the patient has two or more Rapid Response calls within 24 hours or following a Code Blue call.
- Communicate with nursing staff the outcome of the patient assessment and revised management plan
- The next of kin (NOK) should be notified if the patient has a Rapid Response or Code Blue call made. Notifying the NOK following a Rapid Response should be on the basis of clinical judgement (i.e. substantial change in the patient's condition or management)

9.3 RESPONDING TO A CODE BLUE

- The facility Code Blue team will respond immediately to any code blue calls

10. MONITORING and INCREASING FREQUENCY OF OBSERVATIONS

The RN and EN are accountable for the safety of the patient under his/her care. This includes monitoring the patient's vital signs in accordance with their clinical condition and treatment. In the absence of a clinical pathway, end of life plan or other document specifying frequency of observation measurements, the patient should have a complete set of core vital signs conducted at least once per shift (the interval between observations must be **no greater** than eight hours).

NB As per NSW Ministry of Health Policy - PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating for sub-acute, long stay rehabilitation and palliative care patients the minimum requirement for observations is twice a day. If patients develop an acute medical problem the frequency reverts to a minimum of three times per day.

As per PD2013_049 for Mental Health patients the minimum requirement is three times per day for the first 48 hours then daily thereafter. If patients develop an acute medical problem the required frequency of observations reverts to a minimum of three times per day with additional physical observations and monitoring determined and reviewed by the treating team.
The NSW Guideline 2009_007 Physical Health of Mental Health Consumers is due for revision. Please note the revised guideline with respect to observation frequency will align with the Ministry of Health policy 2011_077

Core vital signs include: respiratory rate, oxygen saturation, blood pressure, heart rate, level of consciousness and temperature. Pain assessment should also be documented.

The RM is accountable for the safety of the mother and baby under his/her care. This includes monitoring the patient's vital signs in accordance with the clinical condition and treatment plan and adhering to local maternity guidelines.

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- Good maternity management includes prompt recognition of severe hypertension including escalation and treatment to stabilise.
- Hypertension in pregnancy is defined a SBP ≥140 and /or DBP ≥ 90.
- The Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) guidelines recommends antihypertensive treatment for all women with systolic blood pressure ≥160 or diastolic blood pressure ≥ 110.
- Severe hypertension is defined as a SBP ≥170 with or without DBP ≥ 110. **NB** This requires urgent assessment and management

For well maternity patients following a normal birth only one set of core vital signs are required, documented on the Standard Maternity Observation Chart.

- See Appendix 1 for when to use the NSW Maternity Observation Chart

Clinical situations that require more frequent observations

Ongoing assessment and monitoring of the patient for signs of clinical deterioration are a core nursing / midwifery function. In considering the need to increase the frequency of observations the nurse / midwife should take into consideration the patient's clinical condition and treatment.
Observations frequency should be increased if:

- Vital signs change or trend away from normal limits
- Vital signs meet yellow zone criteria or /red zone criteria
- A change is evident in the patient's clinical condition or behaviour
- Recently transferred from Critical Care areas or Emergency Department
- Following a general anaesthetic or conscious sedation.

Other clinical situations when vital signs should be monitored:

- On admission or transfer (excludes well maternity patients)
- During / following a change in treatment or management
- Prior /during and following administration of medications that will directly affect the vital signs
- Patient or family member / carer concern re the medical condition of the patient
- Just prior to a patient's discharge from a facility (excludes well maternity patients)
- As per other policies or procedures.

Accuracy of vital sign measurements

The reliability of vital signs measurements is dependent on clinical expertise, proper technique and well maintained equipment. The patient should be settled and at rest for routine observations i.e. following physical activity - allow patient to settle to pre activity levels before measuring vital signs.

- **Respiratory rate** should be assessed over a minute.

- **Oxygen saturation**: The probe should be placed on a warm and well perfused part of the body.

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- **Blood pressure** must be measured with the appropriately sized cuff. Automated blood pressure machines occasionally provide spurious results and questionable values should be confirmed by manual auscultation. If the automated blood pressure reading is outside the patient's usual range, in the yellow or red zone of the standard adult general observation chart, then a manual reading should be obtained.

  NB: Automated blood pressure devices should not be used on maternity patients ≥ 20 weeks gestation.

- **Heart rate** should not be obtained from a pulse oximeter as palpation provides the opportunity to assess regularity and character.

- The heart rate should be counted over sufficient time to ensure an accurate rate is obtained (at least 15 seconds if regular or over a minute if irregular).

- A manual pulse checked by palpation over one minute is to be taken on all patients who breach heart rate calling criteria. If the heart rate is found to be irregular then a manual blood pressure reading should also be obtained.

11. DOCUMENTATION

- NSW Health Standard General Adult Observation Chart
- NSW Health Maternity Observation Chart
- SESLHD Resuscitation record (located on the arrest trolley)
- Electronic rapid response form
- Electronic alterations to calling criteria form
- eMR or eMaternity

12. AUDIT

- District and facility CERS committees will monitor and review key performance indicators, incidents involving the deteriorating patient and system management issues
- Data will be collected on every Rapid Response and Code Blue activation.
- The results of data analysis should be reported to clinical units, facilities and District quality committees, including the SESLHD Deteriorating Patient Committee
- Monthly audits include identification of system failures (i.e. system failures in relation to observations, documentation, escalation of care) for all cardiac arrests and transfers to Critical (Intensive) care *
  - **Excludes transfers from Emergency Department, transfers from sources external to the hospital and patients whose planned postoperative care includes transfer to critical care.*
- Observation chart audits
- IIMS reports

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14. REVISION AND APPROVAL

Date	Revision No.	Author and Approval
Jan 2009	0	Gabby Kilborn CERS CNC POW, Chair Area CERS Sub-committee for SESIAHS Resuscitation Committee (and sub-groups) and Suzanne Schacht for PACE Workshop Committee. Approved by Clinical Council Committee January 2009
Feb 2009	1	Changed calling criteria from "Airway: Threatened/Obstructed" to remove the word "obstructed" at request of G Kilborn. Manager Corporate Governance.
Sept 2009	2	Carolyn Smith RTC SCH. Addition of paediatric information
Jul 2013	3	Converted from old Area Health Service Policy to new District Procedure Document. Aligned with LHD's transition to the NSW Health Standard Observation Charts. Revised by Scarlette Acevedo, District Policy Officer.

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Jul 2013	3	Updated to include Monitoring of Observations; PACE criteria and procedure mapped to align with the NSW Standard observation charts; Paediatric PACE procedure developed as a separate procedure
Nov 2013	4	*Additional yellow zone criteria* updated to mandatory calling criteria as per District Extraordinary CERS Committee; Registrar responsibilities amended as advised by District Clinical Quality Committee. Revised by Suzanne Schacht, District PACE Manager/Intensive Care Program Manager. Re-formatted by Scarlett Acevedo, District Policy Officer.
Dec 2013	4	Updated hyperlink to NSW Ministry of Health 'Recognition and Management of Patients who are Clinically Deteriorating' PD2013_049.
March 2016	4	Bi-annual Review. Revised to include: 1. If unable to attend a PACE tier 1 call (i.e. in theatre or attending another PACE call), a locally agreed deputy can respond. The deputy must discuss the patient with the registrar or AMO (as soon as possible or before the end of the shift if not deemed urgent). 2. Requirement for allied health staff to record observation measurements on the SAGO/ SPOC/SMOC. 3. Other minor changes
July 2016	4	Endorsed by Executive Sponsor
July 2016	4	Approved by Clinical and Quality Council
November 2017	4	Following advice from author Executive Services corrected error on page 14.
July 2018	4	Review conducted and uploaded to draft for comment
September 2018	5	Feedback considered and endorsed by Executive Sponsor.
October 2018	5	Minor review. References and links updated. Processed by Executive Services prior to publication.
November 2019	6	Review conducted to remove PACE and replace with Between The Flags. Approved by Executive Sponsor. Formatted by Executive Services prior to tabling at November Clinical and Quality Council meeting for approval to publish.
November 2019	6	Clinical and Quality Council approved for procedure to be published.

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APPENDIX 1: Information for MATERNITY PATIENTS

The majority of women accessing maternity care are well, healthy young women who have different needs and observation requirements to sick hospital inpatients.
Comprehensive protocols and policies guide clinical practice in the Maternity setting for women who do have risk factors such as hypertension.
There is no evidence to support the practice of routine 8hrly recording of vital signs in well women and well babies. In view of this the following tables provides information regarding the use of the SMOC and Maternity specific calling criteria.

When to use the Standard Maternity Observation Chart (SMOC)
• Irrespective of age or reason for admission SMOC must be used to document observations for ≥ 20 weeks pregnant women/adolescents • This also includes women admitted with a non-obstetric diagnosis who may be on a General ward.
• All antenatal women admitted to hospital.
• SMOC does not replace clinical pathways or the partogram.
• Comprehensive guidelines, local business rules, diagnosis and reason for admission will guide practice and frequency of observations for women admitted to hospital with identified risk factors.
• Maternal risk factors may include (list is not exhaustive): Infection or risk of infection; bleeding or risk of bleeding; hypertension or threatened premature labour.
• Women with pre-existing co-morbidities such as cardiac disease will also need regular observations once admitted and post birth.
• Fetal heart rate is not recorded on the SMOC.
Core Vital Signs of Maternity Patients • Core vital signs: RR, BP, HR, Level of consciousness, Temperature • Oxygen saturations as per local guidelines

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APPENDIX 2: Recognition of Prior Learning (RPL)

Clinicians who have completed courses which meet the learning requirement of DETECT adult / junior may apply for recognition of prior learning (RPL). There is no RPL options for e-DETECT.

Applications for RPL for the face to face component of DETECT should be forwarded via the staff member's line manager to the facility CERS Committee or other facility body for approval.