SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Management of the Deteriorating ADULT inpatient (excluding maternity)
TYPE OF DOCUMENT	Procedure
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director Clinical Governance and Medical Services
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FUNCTIONAL GROUP	Clinical Governance
KEY TERMS	Clinical deterioration; escalation; clinical emergency response systems; CERS; Between the Flags; deteriorating patient; rapid response; sepsis.
SUMMARY	This procedure outlines the specific measures to be implemented across SESLHD to allow a standardised approach to recognising and managing the deteriorating adult inpatient.

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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 utilise a standardised clinical emergency response system (CERS) to facilitate early recognition and respond to patients with signs of clinical deterioration. The agreed CERS system is the Clinical Excellence Commissions (CEC) Between the Flags program

This procedure shall be read in conjunction with NSW Ministry of Health Policy - PD2020_018 - Recognition and management of patients who are deteriorating.

For Maternity patients (greater than 20 weeks gestation and less than 6 weeks post-natal) refer to the SESLHD Procedure SESLHDPR/705 - Management of the Deteriorating Maternity Woman.

For paediatric patients refer to SESLHD Procedure SESLHDPR/284 - 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 - Management of the Deteriorating NEONATE Inpatient.

2. BACKGROUND

Failure to recognise, respond and appropriately manage patient's deterioration in physical and mental state is a known contributing factor to adverse patient outcomes.

This SESLHD procedure will outline specific measures to be implemented across the district to allow a standardised approach to recognising and managing the deteriorating adult inpatient.

3. RESPONSIBILITIES

Clinical Nurse Consultant's and Educators will:

- Provide leadership and management of recognising and responding to the deteriorating adult via the SESLHD Deteriorating Patient Programs (DPP) Committee
- Provide local guidance and directives on the Clinical Emergency Response System (CERS) to ensure consistency across all local sites
- Provide education guided by the NSW Health Deteriorating Patient Education Strategy

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Clinical staff will:

- Complete mandatory Deteriorating Patient education as per NSW Health Deteriorating Patient Education Strategy
- Adhere to local guidelines and directives

Manager's will:

- Support staff education
- Provide guidance on reporting requirements for each facility

Clinical Governance Units will:

- Communicate with stakeholders, including patients, families, clinicians and the Clinical Excellence Commission (CEC), to provide feedback on the performance and effectiveness of the Deteriorating Patient Safety Net System

4. ASSESSMENT OF DETERIORATION

4.1 Assessment

- A baseline systematic assessment (A-G or agreed equivalent) is to be performed and documented in the patients' health care record and be inclusive of a mental state assessment. Baseline assessment should include patients/families/carers where able, to ascertain a baseline and is inclusive of physical and mental state.

4.2 Standard clinical tools

- In SESLHD general observations for adult patients must be recorded on the NSW Health Standard Adult General Observation (SAGO) chart for all patients over 16 years, women with gestation under 20 weeks and women 6 weeks post-partum. For all other patients, refer to the below SESLHD procedures:
  - SESLHDPR/705 – Deterioration of the Maternity Woman
  - SESLHDPR/284 - Management of the Deteriorating PAEDIATRIC Inpatient
  - SESLHDPR/340 - Management of the Deteriorating NEONATE Inpatient

4.3 Minimum requirement for vital sign monitoring

- Frequency of observation are to be attended as per appendix 2 unless:
  - An individualised monitoring and assessment plan is documented by a Medical Officer (MO) (registrar level or above) in the health care record
- Observations can be increased by both nursing and medical staff. Observation frequency is to be increased when:
  - A patients' observations fall into the coloured zone of Between the Flags (BTF)
  - The patient further deteriorates
  - The patient has a CERS call
- In addition, a full set of vital signs observations must be performed at the time of admission, within one hour of arrival to ward or clinical unit, and within one hour prior to discharge.

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4.4 Individualised monitoring and assessment plans

- Patients who require less monitoring due to clinical situation or diagnosis may have an individualised monitoring and assessment plan as determined by the clinical team and in consultation with the Admitting Medical Officer (AMO). This plan must be documented in the health care record with associated rationale and goals of care.
- All yellow and red zone breaches must be escalated as per local CERS unless an alternative response is documented in the resuscitation plan. Frequency of observations are to be increased following a CERS call and documented in the monitoring and assessment plan.

4.5 Alterations

- Standard calling criteria may be altered by a MO (registrar level or above) following assessment of a patient only in consultation with the AMO / delegated clinician responsible. When altering calling criteria, a rationale must be documented in the health care record. This must include a minimum timeframe for review.

4.5.1 Chronic

Chronic alterations may be set to align with patients altered baseline, and can be set for the duration of the patients' episode of care.

4.5.2 Acute

Acute alterations are to be set for no longer that eight (8) hours and are not to be used for extended periods of time. Regular clinical review of the patient is required.

4.6 Vital sign monitoring for patients in non-hospital/residential care settings

- All non- hospital/residential care setting must develop local protocols for the monitoring and escalation of physiological or mental state deterioration. This must include frequency of assessment and escalation process in line with BTF calling criteria.

4.7 Palliative care and last days of life

- All palliative or end of life patients are to have an individualised monitoring and assessment plan documented in the health care record that aligns with their goals of care. This is to include:
  - Ceiling of care documented on the Resuscitation Plan
  - Consultation with patients' and their families/carers when determining the appropriate plan
  - Initiation of end-of-life care plan
  - The use of the Not for Rapid Response (NRR) function on the BTF observation chart.

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5. CLINICAL EMERGENCY RESPONSE SYSTEMS (CERS)

- All facilities must have a CERS in place. The agreed CERS program for SESLHD is BTF.
- All facilities are to have CERS protocols in place in accordance with the principles outlined in NSW Ministry of Health Policy - PD2020_018 Recognition and management of patients who are deteriorating and address the following:
  - Clearly outline CERS team members and responsibilities
  - Clearly outline the patient carers and family escalation process
  - Clearly define the assessment and management of mental state deterioration
  - All facilities are to use the Clinical Review, Rapid Response and Code Blue process
  - All calls are via 2222
  - All facilities are to have an agreed set of emergency equipment based upon best practice guidelines
  - A Patient and Family Escalation model that enable patients, carers and family's to directly escalate clinical concerns to a clinician who is not routinely involved in the patients care. The clinician is to respond to the call within 30 minutes.

5.1 CERS in specialty areas

- All speciality areas that require a CERS response must have localised protocols in be entered into QARS.

5.2 Clinical review process

- Each facility must have local protocol in place for the clinical review process according to the principles outlined in NSW Ministry of Health Policy - PD2020_018 Recognition and management of patients who are deteriorating and address the following:
  - 2222
  - Additional calling criteria (e.g. low urine output)
  - Clinical review to be documented on the BTF yellow zone form in eMR

5.3 Rapid response process

- Each facility must have local protocol in place for the rapid response process according to the principles outlined in NSW Ministry of Health Policy - PD2020_018 Recognition and management of patients who are deteriorating and address the following:
  - 2222
  - Additional calling criteria (e.g. increasing oxygen requirements)
  - Rapid response to be documented on the BTF red zone form in eMR

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5.4 Code blue process

- Code blue is a medical emergency, immediately or potentially life threatening and includes loss of airway, breathing, circulation or disability (A,B,C,D)
- Each facility must have local protocol in place for the code blue process according to the principles outlined in NSW Ministry of Health Policy - PD2020_018 Recognition and management of patients who are deteriorating and address the following:
    - 2222
    - Additional calling criteria (e.g. patient unresponsive)
    - Code blue to be documented on the Emergency Resuscitation form and/or BTF red zone form in eMR

5.5 Patient transfer processes

- Yellow zone: Patients with observation in the yellow zone may be transferred between clinical areas provided there is a clinical plan in place.
- Red zone: Each facility must have local process in place for the intra-hospital transfer of patients in the red zone.

5.6 Non-hospital / residential care facilities

- Each clinical setting must have local escalation process for yellow zone/ clinical review, red zone / rapid response, and code blue / deterioration. This will include the transfer process to acute facility.

6. EDUCATION

- Education will be provided as per the CEC Deteriorating Patient Education Strategy

7. EVALUATION AND AUDIT

- Evaluation will occur as per SESLHD Evaluation Strategy, in line with the CEC Deteriorating Patient Measurement Strategy Guide.

8. REFERENCES

- NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating
- Clinical Excellence Commission Deteriorating Patient Education Strategy

9. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
December 2020	DRAFT	Initial draft
December 2020	DRAFT	Draft for comment period.
February 2021	DRAFT	Second draft for comment period.
March 2021	DRAFT	Final version approved by Executive Sponsor.

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May 2021	DRAFT	To be tabled at Clinical and Quality Council for approval.
June 2021	0	Endorsed by Clinical and Quality Council.
3 November 2023	1.1	Minor review: responsibilities updated; minor grammatical changes and hyperlinks updated. Approved by SESLHD Deteriorating Patient Committee.

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Appendix 1 – KEY TERMS

Key terms as defined by NSW Ministry of Health Policy Directive - PD2020_018 Recognition and management of patients who are deteriorating

2 KEY TERMS

Acute alterations to calling criteria	Alterations made to calling criteria for a condition where the patient's observations will fall outside the standard parameters for a defined period of time, while treatment is taking effect. Acute alterations to calling criteria are set for a defined period of time (not longer than 8 hours), after which they revert back to standard calling criteria. Patients with acute alterations to calling criteria must have daily medical reviews to ensure their clinical progress aligns with the patient's treatment plan.
Additional criteria	Signs or symptoms of deterioration depicted on the standard observation chart that a patient may exhibit outside of, or in addition to, the standard calling criteria for vital sign observations.
Agreed signs of deterioration	Signs or symptoms of deterioration that a patient may exhibit outside of, or in addition to, the standard calling criteria and additional criteria that are agreed following engagement of the patient, carer and family, and tailored to the patient's specific circumstances.
Altered calling criteria	Changes made to the standard calling criteria by the AMO/delegated clinician responsible, to take account of a patient's unique physiological circumstances and/or medical condition. Alterations may be 'acute' or 'chronic'.
A-G systematic Assessment	A structured approach to physical assessment that considers a patient's Airway, Breathing, Circulation, Disability, Exposure, Fluids, Glucose.
Attending Medical Officer (AMO) / Delegated clinician responsible	Senior medical practitioner who has primary or delegated responsibility and accountability for a patient on a temporary or permanent basis. For an inpatient, this is the named Attending Medical Officer (AMO) or another consultant, staff specialist or visiting medical officer with delegated responsibility. As defined in local guidelines and following a risk assessment, the delegated clinician responsible may also be a senior clinician such as a nurse practitioner. In the non-hospital/residential setting this may be the patient's general practitioner.
Balancing measure/s	A unit of data that measures whether changes to one part of a system have an impact on another part of the system and the size of the effect.
Behaviour change	Changes to the way a patient interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional

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	state, such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.
Blue zone	A coloured zone on the standard clinical tools that requires an increase in the frequency of observation. Staff are to consider calling for an early clinical review.
Clinical Emergency Response System (CERS)	A formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit based responses (clinical review and rapid response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).
CERS Assist	A NSW Ambulance program whereby urgent additional clinical assistance is provided in response to a rapidly deteriorating patient (red zone observations or additional criteria) in a public health care facility.
Chronic alteration to calling criteria	Alterations to calling criteria where a patient has a chronic (lasting >3 months) health condition which causes their normal observations to fall outside standard parameters. Chronic alterations are set for the duration of the patient's episode of care and are reviewed during routine medical review and assessment of the patient.
Clinical Review	A review of a deteriorating patient undertaken within 30 minutes by the clinical team responsible for the patient's care, or designated responder/s, as per the local CERS protocol.
Clinical team responsible for the patient's care	The clinicians, led by the AMO/delegated clinician responsible, who are involved in, and responsible for, the care of the patient on a temporary or permanent basis. In most cases this is the medical team unless otherwise specified.
Clinical service	A health professional or group of professionals who work in co-operation and share common facilities or resources to provide services to patients for the assessment, diagnosis and treatment of a specific set of health-related problems/conditions in a facility or in the community.
Clinical unit	A subset of a facility or service with a special clinical function.
Clinician/s	Medical, nursing, midwifery and allied health professionals who provide direct patient care.
Deterioration in mental state	A negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to

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	several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.[7]
Deteriorating Patient Safety Net System	The NSW Health Deteriorating Patient Safety Net System refers collectively to the various individual programs and frameworks implemented by NSW Health facilities/clinical services or clinical units to support the recognition and appropriate management of patients who deteriorate.
End of life	Refers to the timeframe an individual is clearly approaching the end of their life and is living with and/or impaired by a life-limiting illness. This includes the patient's last weeks or days of life, when deterioration is irreversible and when a patient is likely to die in the next 12 months[10].
Facility	A building or structure where healthcare is provided by a public health organisation, such as a hospital, multi-purpose centre or office-based clinic.
Family of measures	A collection of outcome, process and balancing measures that monitor many facets of the system and provides a framework to understand the impact of changes.
Individualised monitoring and assessment plan	A plan for assessing and monitoring the patient's clinical situation that considers their diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological and behavioural observations to be monitored and the frequency of monitoring[7, 8].
ISBAR	An acronym for **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, a structured communication tool.
Last days of life	Refers to the last 24-72 hours of life when treatment to cure or control the person's disease has stopped and the focus is on physical and emotional comfort and social and spiritual support.
New onset confusion	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days)[11].
Outcome measure/s	A unit of data that measures whether changes to the system have an impact on the intended recipient and the size of the effect.
Palliative care	An approach that aims to prevent and relieve suffering and improve the quality of life of patients and their families who are facing the problems associated with life-threatening illness through early identification and assessment and treatment of pain and other physical, psychosocial and spiritual issues[10].
Process	A unit of data that measures whether the system is performing as it is

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measure/s	intended to and that activities are occurring as planned, and the extent to which that is happening.
Public health organisation (PHO)	Local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.
Rapid response	An urgent review of a deteriorating patient by a rapid response team (RRT), or designated responder/s, as defined in the local CERS protocol.
R.E.A.C.H	An acronym for Recognise, Engage, Act, Call, Help is on its way. R.E.A.C.H is a CEC program for patients, carers and families to directly escalate concerns about deterioration through the local CERS.
Red zone	Coloured zone on the standard clinical tools that represent warning signs of deterioration for which a rapid response call (as defined by the local CERS protocol) is required.
Resuscitation Plans	A medically authorised order to use or withhold resuscitation measures (formerly called 'No CPR Orders'). Resuscitation Plans can also be used to document other time-critical clinical decisions related to end of life. A Resuscitation Plan is made: • With reference to pre-planning by patients (such as Advance Care Directives or plans) • In consultation with patients, carers and families • Taking account of the patient's current clinical status, as well as their wishes and goals of care. Resuscitation Plans are intended for use for patients 29 days and older in all NSW PHOs, including acute facilities; sub-acute facilities; ambulatory and community settings; and by NSW Ambulance [12].
Special Care Nursery	A clinical unit with space designated for the care of neonates who require additional support, or who need additional monitoring and/or observation[13,18].
Standard calling criteria	Signs and symptoms that a patient is deteriorating and may require review of their monitoring plan or escalation of care through the Clinical Emergency Response System to appropriately manage the deterioration. Standard calling criteria are depicted on standard observation charts as blue, yellow and red zones.
Standard clinical tools	A tool or resource that supports clinicians to recognise when a patient is deteriorating and outlines the appropriate response, such as the sepsis pathways; electronic fetal heart rate monitoring algorithm and labels; Comfort Observation and Symptom Assessment chart; and Resuscitation Plan, as well as the NSW Health standard observation

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	charts.
Standard observation chart	Standardised observation chart approved for use by the NSW Ministry of Health. These have been developed for a variety of clinical settings.
Track and trigger tool	A tool, such as the standard observation chart, that records vital sign observations and allows them to be tracked over time to support identification of a change in the patient's condition that requires a review and/or change in management or frequency of observation.
Transfer of care	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Also known as clinical handover.
Yellow zone	Coloured zone on the standard observation charts and standard clinical tools that represent warning signs of deterioration for which a clinical review or other CERS call may be required.

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Appendix 2 – Minimum number and frequency for vital sign observations

Table 2 NSW Ministry of Health Policy Directive - PD2020_018 Recognition and management of patients who are deteriorating

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Adult inpatients	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Including pregnant women greater than twenty (20) weeks gestation and less than six (6) week post-partum admitted for a condition unrelated to pregnancy who are monitored on the Standard Maternity Observation Chart (SMOC).
Mental health acute and subacute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then daily thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Mental state assessment of patients within a mental health inpatient unit are to be completed in line with Engagement and Observation in Mental Health Inpatient Units PD2017_025.
Mental health non-acute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then monthly thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Patients with active comorbid physical health conditions or aged 65 years and over are to have observations no less than weekly and are to have a comprehensive systematic physical assessment completed at least monthly.
Hospital in the Home	At least once during each consultation/visit (17)	To be determined locally based on the models of care and assessment of risk	
Special Care Nursery	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, behaviour change*, pain score	

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Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Newborn	**Before leaving the birthing environment** One (1) full set of vital signs observations and a newborn risk assessment completed If perinatal risk factors are identified and/or observations within the blue, yellow or red zone and/or additional criteria present, further observations must be recorded on a Standard Newborn Observation Chart (SNOC) six (6) times per day at four (4) hourly intervals.	Respiratory rate, oxygen saturations, heart rate and temperature	Newborns with low or no identifiable risk factors are to be monitored/assessed in-line with local protocols.
Paediatric inpatients	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Baseline blood pressure (BP) is required within 24 hours of admission. Additional BPs are to be taken as clinically indicated (PD2010_32)
Maternity/ antenatal inpatient	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*. For fetal heart rate monitoring requirements refer to Maternity – Fetal heart rate monitoring GL2018_025	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Maternity/ postnatal inpatient with no identified risk factors	**Before leaving the birth environment** One (1) full set of vital signs observations and a maternity risk assessment completed.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	If a woman has observations in a coloured zone or identified risk factors, vital sign observations are to be performed four times per day at six hourly intervals. Women receiving midwifery care in the home are to be monitored according to local protocol, refer to section 4.6.

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Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Maternity/ postnatal inpatient with risk factors	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Inpatient sub-acute/ long stay/ rehabilitation	Twice a day at a maximum interval of 12 hours apart	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops an acute medical/ physiological problem the required frequency of observations reverts to a minimum of four (4) times per day at six (6) hourly intervals
Inpatient palliative care	Twice a day at a maximum interval of 12 hours apart	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops acute medical/physiological problems are managed in line with their goals of care and Resuscitation Plan
Residents in long term care facilities, such as a multipurpose service (MPS)	At least once per month	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	The frequency of observations may change depending on the resident's condition and will be determined locally by the AMO/delegated clinician responsible for the resident's care. Additional vital signs may be determined as clinically appropriate for the patient cohort cared for in these settings, such as weight, and monitored on a regular basis.

* Includes an assessment of the patient's behaviour in the context of their developmental age and/or baseline assessment, noting changes in their cognitive function, activity/tone, perception, or emotional state such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.

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