

### ADULT - PATIENT WITH ACUTE CONDITION FOR ESCALATION (PACE) CRITERIA AND ESCALATION

*This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.*

#### 1. AIM

- Implementation of a local Clinical Emergency Response System (CERS)

#### 2. PATIENT

- Acutely unwell woman, visitor or staff member

#### 3. STAFF

- Clinical Review – Patient's obstetrics/gynaecology registrar or locally agreed deputy
- Rapid Response System – Patient's primary care medical team, , Anesthetic Registrar, Access and Demand Manager (ADM/After Hours Nurse Manager (AHNM), PACE Clinical Nurse Consultant (CNC) (Monday & Tuesday 08.00–16.30) Acute Care CNC (Monday-Tuesday 07.00-15.30) and porter.
- Code Blue – All available medical staff, inside and outside Anaesthetist, ADM/AHNM, Acute Care Centre (ACC) staff member (if available) and porter

#### 4. EQUIPMENT

- Cardiac arrest trolley and defibrillator (See Appendix 1 for locations)

#### 5. CLINICAL PRACTICE

- Activate CERS call when indicated (Appendix 2) dialling emergency number 2222
- Request appropriate rapid response team by stating response required, location and admitting consultant (if known). If CERS called in Delivery Suite, care defers to the on-call obstetric consultant
  - Clinical Review: 30 minutes response time
  - Rapid Response System: 5 minutes response time
  - Adult Code Blue: Immediate response for life threatening conditions
- Escalate to Prince of Wales (POW) to obtain the POW arrest team as appropriate if assistance or support is required. **The POW adult cardiac arrest team can be activated by dialling 2222 and asking for the POW "Adult Code Blue Team" for "The Royal Hospital for Women, stating exact location."** It is advised to have a staff member direct the POW team in from the lift
- Escalate all patients, visitor and staff collapses in non-clinical areas as an Adult Code Blue. Ask the ADM/AHNM to obtain or arrange for the closest cardiac arrest trolley to be brought to the area.
- Use maxi lifter located in Macquarie Ward to lift patients from the floor to a bed or trolley
- Notify the person's family/carer of clinical deterioration and/or change of location
- Complete the adult cardiac arrest resuscitation record at time of cardiac arrest. Send copy to the CERS CNC for review and file the original appropriately
- Document the events in the medical record
- Document CERS calls on the SESLHD Adult or Maternity CERS notification form and place in envelope on ward (DO NOT FILE) for data collection by the CERS CNC
- Place completed CERS sticker in integrated clinical notes for Delivery Suite only
- Alter calling criteria only after consultation with the attending Medical Officer (MO). Document the alterations on appropriate observation charts. Review alterations of criteria for changes by the attending MO within 24 hours

Approved by Quality & Patient Care Committee  
21 June 2018

### PATIENT (ADULT) WITH ACUTE CONDITION FOR ESCALATION (PACE) CRITERIA AND ESCALATION cont'd

#### 6. DOCUMENTATION

- CERS Notification Form
- CERS Sticker (Delivery Suite Only)
- CODE BLUE Resuscitation Record
- Medical record
- IIMS
- Standard Maternity Observation Chart (SMOC)
- Standard Adult General Observation (SAGO) Chart

#### 7. EDUCATIONAL NOTES

- Annual Adult Basic Life Support (ABLS) assessments are required by all medical, midwifery, nursing, and allied health staff and porters
- ACC and Birthing Services have unit specific escalation LOPs for calling additional staff when required
- CERS and escalation procedures are included in RHW staff orientation.
- Advanced Adult Life Support training is recommended for staff likely to be team leading or attending CERS calls

#### 8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOPs

- Acute Care: Admission Criteria, Process and Management
- Escalation for Birthing Services
- Escalation guideline - Acute Care
- Collapse - Maternal
- PACE Management of Deteriorating Adult Patient - SESLHDPR/283
- Emergency Equipment – Checking and Maintenance

#### 9. RISK RATING

- High risk

#### 10. NATIONAL STANDARD

- RR – Recognising and responding to the deteriorating patient

#### 11. REFERENCES

- 1 NSW Health NSW Health PD2013\_049 Recognition and Management of a patient who is Clinically Deteriorating
- 2 NSW Health Policy Directive PD2009\_060 Clinical Handover Standard Key Principles
- 3 SESLHD PR283\_Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating ADULT & MATERNITY Inpatient 2016

#### REVISION & APPROVAL HISTORY

Amended August 2019 – change from PACE to CERS

Change 777 to 2222 February 2019

Reviewed and endorsed Maternity Services LOPs 19/6/18 (previously titled *Adult Clinical Emergency Response System (CERS) and Escalation*)

Approved Quality & Patient Safety Committee 17/7/14

Reviewed and endorsed Maternity Services LOPs group 1/7/14

Approved Quality & Patient Safety Committee 18/11/10

Gynaecology Services Management Committee 11/11/10

**FOR REVIEW : JUNE 2020**

# APPENDIX 1

## RHW CARDIAC ARREST TROLLEY/DEFIBRILLATOR LOCATIONS

LEVEL	WARD	DEFIBRILLATOR
Level 4	Acute Care Centre (ACC)	Yes – M Series
Level 3	Oxford (North)	Yes – Automated External Defibrillator (AED)
Level 3	Paddington (South)	No defibrillator – Cardiac arrest trolley only
Level 2	Day Surgery	No defibrillator – Cardiac arrest trolley only
Level 2	Gynaecology Outpatients	Yes – AED
Level 2	Macquarie Ward	Yes – AED
Level 1	Delivery Suite	Yes – AED
Level 1	Recovery RHW	Yes – M Series
Ground	Admissions – Behind front desk	Yes – AED
Ground	Reproductive Medicine	No defibrillator – Cardiac arrest trolley only

## APPENDIX 2

### PACE CALLING CRITERIA

ADULT CERS		OBSTETRIC CERS	
RED ZONE CRITERIA		RED ZONE CRITERIA	
Breathing	RR $\leq 5$ or $\geq 30$	Breathing	RR $\leq 5$ or $\geq 30$
O <sup>2</sup> Saturations	$\leq 90\%$	O <sup>2</sup> Saturations	$\leq 90\%$
O <sup>2</sup> Requirements	Increasing	O <sup>2</sup> Requirements	Increasing
Systolic BP	$\leq 90$ or $\geq 200\text{mmHg}$	Systolic BP	$\leq 80$ or $\geq 170\text{mmHg}$
Circulation	HR $\leq 40$ or $\geq 140$	Diastolic BP	$\leq 40$ or $\geq 110\text{mmHg}$
Neurological	Decrease in level of consciousness New onset of confusion Seizures	Circulation	HR $\leq 40$ or $\geq 140$
Urine Output	$\leq 100\text{mls}/4$ hours	Neurological	Decrease in level of consciousness New onset of confusion Seizures
Blood Glucose Level (BGL)*	$\leq 4$ or $\geq 20$ mmol/l * Follow local protocol	Temperature	$\leq 35.5^{\circ}\text{C}$ or $\geq 38.5^{\circ}\text{C}$
Any rapid change in observation		Urine Output	$\leq 80\text{mls}/4$ hours
Any other condition you are concerned about		Any rapid change in observation	
Concern by patient or family member		Any other condition you are concerned about	
		Concern by patient or family member	

DELIVERY SUITE WOMEN	
CLINICAL REVIEW – YELLOW ZONE	
Breathing	RR $\leq 5$ or $\geq 30$
O <sup>2</sup> Saturations	$\leq 94\%$
Urine Output	$<100\text{mls}/4\text{hrs}$
Temperature	$>38.0^{\circ}\text{C}$
BGL	$<3$ mmols/L
Any rapid change in observations	

DELIVERY SUITE WOMEN	
RAPID RESPONSE SYSTEM – RED ZONE	
Airway	Threatened
Circulation	HR $<45$ or $>170$
Systolic BP	$< 85$ or $>170$
Diastolic BP	$>110$
PPH	$>1000\text{mls}$
You are seriously concerned and require immediate help including:	
<ul style="list-style-type: none"> <li>• Cord Prolapse</li> <li>• Seizures/Decrease Consciousness</li> <li>• Fetal Bradycardia <math>&gt;5\text{mins}</math></li> </ul>	