LOCAL OPERATING PROCEDURE

Approved by Quality & Patient Care Committee
21 June 2018

PATIENT (ADULT) 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 PACE system

2. PATIENT

- Acutely unwell woman, visitor or staff member

3. STAFF

- PACE Tier 1 – Patient's obstetrics/gynaecology registrar or locally agreed deputy
- PACE Tier 2 – 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 PACE call when indicated (Appendix 2) dialling emergency number 777
- Request appropriate rapid response team by stating response required, location and admitting consultant (if known). If PACE called in Delivery Suite, care defers to the on-call obstetric consultant
    - PACE Tier 1: 30 minutes response time
    - PACE Tier 2: 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 777 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 PACE CNC for review and file the original appropriately
- Document the events in the medical record
- Document PACE calls on the SESLHD Adult or Maternity PACE notification form and place in envelope on ward (DO NOT FILE) for data collection by the PACE CNC
- Place completed PACE 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

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

6. DOCUMENTATION

- PACE Notification Form
- PACE 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
- PACE 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 PACE 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
Reviewed and endorsed Maternity Services LOPs 19/6/18
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

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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 PACE	
Red Zone Criteria	
Breathing	RR ≤ 5 or ≥ 30
O^2 Saturations	≤ 90%
O^2 Requirements	Increasing
Systolic BP	≤ 90 or ≥ 200mmHg
Circulation	HR ≤40 or ≥140
Neurological	Decrease in level of consciousness New onset of confusion Seizures
Urine Output	≤ 100mls/4 hours
Blood Glucose Level (BGL)*	≤4 or ≥ 20 mmol/l * Follow local protocol
Any rapid change in observation	
Any other condition you are concerned about	
Concern by patient or family member	

Obstetric PACE	
Red Zone Criteria	
Breathing	RR ≤ 5 or ≥ 30
O^2 Saturations	≤ 90%
O^2 Requirements	Increasing
Systolic BP	≤ 80 or ≥ 170mmHg
Diastolic BP	≤ 40 or ≥ 110mmHg
Circulation	HR ≤40 or ≥140
Neurological	Decrease in level of consciousness New onset of confusion Seizures
Temperature	≤35.5°C or ≥ 38.5°C
Urine Output	≤ 80mls/4 hours
Any rapid change in observation	
Any other condition you are concerned about	
Concern by patient or family member	

Delivery Suite Women	
Tier 1 – Yellow Zone	
Breathing	RR ≤ 5 or ≥ 30
O^2 Saturations	≤ 94%
Urine Output	<100mls/4hrs
Temperature	>38.0°C
BGL	<3 mmols/L
Any rapid change in observations	

Delivery Suite Women	
Tier 2 – Red Zone	
Airway	Threatened
Circulation	HR <45 or >170
Systolic BP	< 85 or >170
Diastolic BP	>110
PPH	>1000mls
You are seriously concerned and require immediate help including: • Cord Prolapse • Seizures/Decrease Consciousness • Fetal Bradycardia >5mins	