

Royal Hospital for Women (RHW)
NEONATAL BUSINESS RULE
COVER SHEET



Health
 South Eastern Sydney
 Local Health District

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EXECUTIVE SPONSOR	Sally Wise, Nursing Co- Director Neonatal Services Srinivas Bolisetty, Medical Co- Director Neonatal Services
AUTHOR	N Ford (CMC Quality and Innovation), J Mossman (CERS CNC), R Jackson (NE NCC)
SUMMARY	To identify and respond to neonates who are clinically deteriorating and to follow the CERS process for these neonates.
Key Words	Deteriorating, CERS, Clinical Review, Rapid Response, Code Blue, Neonate



**Recognition and Management of the Neonate who is
Clinically Deteriorating outside of the Newborn Care Centre**

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Recognition and Management of the Neonate who is Clinically Deteriorating outside of the Newborn Care Centre

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This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges from this Clinical Business Rule. Using this document outside RHW or its reproduction in whole or part, is subject to acknowledgement that it is the property of RHW and is valid and applicable for use at the time of publication. RHW is not responsible for consequences that may develop from the use of this document outside RHW.

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The aim of this CBR is facilitate the early recognition and management of the deteriorating neonate outside Newborn Care Centre (NCC). These areas include but are not limited:

- Close Observation Unit
- Antenatal Ward
- Birthing Services
- Postnatal Ward

2 RESPONSIBILITIES

2.1 Medical Staff

- Recognise and respond to acute deterioration.
- Initiate a Code Blue call for any admitted neonate.
- Respond within required time frame to Clinical Emergency Response System (CERS) calls.
- Conduct an A-I (Airway, Breathing, Circulation, Disability, Exposure, Fluids, Glucose, Holistic and Infection) assessment on the neonate.
- Implement appropriate care within Scope of Practice, including Basic Life Support (BLS) or Advanced Life Support (ALS) (if skilled) as clinically indicated.
- Alter the calling criteria as appropriate for the neonate's baseline condition.
- Escalate the response at any time if the condition continues to worsen (e.g. escalate to Senior Consultant/ Fellow/ Neonatal Nurse Practitioner [NNP]).
- Document assessment, intervention, management plan and outcome in eMR.
- Notify the parent/carer of the CERS activation, the outcome of the review, and/or change of location.
- If an issue is identified around recognition and response to deterioration, or processes outlined in this CBR, complete an Incident Management System (IMS+) notification and document in eMR notes.

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- Complete mandatory training yearly, including Neonatal Basic Life Support Assessment.

2.2 Midwifery and Nursing Staff

- Recognise and respond to acute deterioration in accordance with the Standard Neonatal Observation Chart (SNOC)
- Conduct an A-I assessment on the neonate. Continue to reassess the patient as clinically indicated.
- Make an appropriate CERS call (Clinical Review/Rapid Response/Code Blue) based on the assessment of the neonate
- Implement appropriate care within Scope of Practice, including Basic BLS where clinically indicated.
- Increase frequency of observations, as indication by the clinical condition.
- Check and maintain Emergency equipment, and be aware of nearest Neonatal Emergency Trolley and Defibrillator
- Escalate response at any time if the neonate's condition deteriorates.
- Document all Clinical Review and Rapid Response calls on the appropriate electronic medical records (eMR) form or on the Emergency Resuscitation Record (paper).
- Notify the parent/carer of the CERS activation, the outcome of the review, and/or change of location.
- If an issue is identified around recognition and response to deterioration, or processes outlined in this CBR, complete an Incident Management System (IMS+) notification and document in eMR notes.
- Complete Mandatory Training (DETECT, eLearning for Basic Life Support, and yearly Basic Life Support Assessment)

3 PROCEDURE

3.1 Clinical Practice

- Perform a baseline assessment:
 - **At birth:**
 - Apgar assessment and identification of other perinatal risk factors
 - **Before leaving birthing environment:**
 - One full set of observations:
 - Respiratory rate (RR)
 - Oxygen saturations (SPO₂ sats)
 - Heart rate (HR)
 - Temperature, and
 - Any additional observations e.g. blood sugar, scalp examination (for subgaleal haemorrhage) as determined by neonatal and perinatal risk factors

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- **Within one hour of admission to postnatal ward:**
 - One full set of observations as outlined above using SNOC and neonatal risk assessment for any identifiable perinatal risk factors
- **Within one hour prior to discharge or transfer:**
 - One full set of observations as outlined above
- Recommended frequency of observations as outlined in RHW [Neonatal Observations outside of Newborn Care Centre](#) CBR

SEPSIS

- Sepsis is **infection** with organ **dysfunction** and is a '**medical emergency.**' Conduct an A-I assessment for the deteriorating neonate and if there are signs of sepsis, commence the Neonatal sepsis pathway (see Appendix 3).
- All sepsis resources can be accessed through the [Clinical Excellence Commission \(CEC\) website.](#)

NOTE

All sepsis pathways are in paper form and sourced from individual wards.

3.2 Standard Neonatal Observation Chart: White and Blue Zone

- Escalate care for neonate outside of NCC environment as follows:
 - WHITE ZONE
 - Continue observations as per standard frequency for neonate with observations within normal parameters unless clinical change is noted in the neonate
 - BLUE ZONE
 - Inform and review the neonate with the team leader and nurse/midwife if the neonate has any observations in the blue zone to determine whether:
 - there is any adverse trend in the observations
 - there are any alterations to calling criteria for the neonate, and
 - the abnormal observations reflect deterioration
 - Perform the following if YES to the above:
 - Initiate appropriate clinical care
 - Increase the frequency of observations
 - Reassess the neonate within one hour
 - Escalate care if there is any concern about the neonate's condition

3.3 Activating a CERS call

- Dial '2222' from any phone in the hospital
- Request appropriate level of escalation (Clinical Review, Rapid Response, Code Blue)
- State 'Neonatal' for any review
- State exact location

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- This activation is determined by deviations from:
 - SNOC

3.4 Clinical Review (Review within 30 minutes): YELLOW ZONE

- Inform and review the neonate promptly with the team leader and nurse/midwife if a neonate has one or more observations documented in the yellow zone or has additional yellow zone criteria including:
 - Blood gas results outside acceptable parameters
 - Poor peripheral perfusion
 - Irritability, poor handling or feeding, possible pain or excessive sleeping
 - Bilious green vomit or coffee ground vomit
 - Temperature instability OR
 - Concern by any staff or family, follow-up as per REACH program
- Consider:
 - Are the observation changes already addressed within the altered calling criteria? (e.g. stable neonate with self-reverting supraventricular tachycardia that is medicated and has a low heart rate)
 - Does the trend in observations suggest deterioration?
 - Is there more than one yellow zone observation or additional criteria?
- Activate a clinical review if criteria met, by calling 2222 and state that you are requesting a neonatal clinical review (see appendix 1)
- Initiate appropriate clinical care and document on electronic clinical review form
- Repeat observations and reassess the neonate within 30 minutes
- Continue 30 minutely observations until the neonate's clinical condition stabilises or as advised by neonatal team
- Reassess the neonate and escalate to a Rapid Response if the neonate has not been reviewed by a medical officer or NNP from the NCC within 30 minutes
- **Activate a neonatal Rapid Response** if the neonate's observations enter the **RED zone** while you are awaiting a response from them the clinical review
- Inform the neonatal fellow/consultant on-call of the review by paediatric medical officer or NNP who assessed and managed the neonate
- Document the assessment in the neonate's medical record by paediatric medical officer or NNP

3.5 Rapid Response (Review within 5 minutes): RED ZONE

- Initiate a **rapid response** by calling 2222 and stating **Neonatal Rapid Response Review**. Rapid Responses require attendance **within 5 minutes**, if a neonate has **any Red Zone** observation or additional Red Zone criteria present (see appendix 1) including:
 - Clinical suspicion of sepsis
 - Apnoea – responds to stimulation
 - White extremity/s
 - Three or more simultaneous “yellow zone” observations

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- Generalised scalp swelling with laxity of the scalp crossing the suture line suggestive of subgaleal haemorrhage
- Deterioration not reversed within one hour of a clinical review OR
- Serious concern by any staff or family member
- Initiate appropriate clinical care and document on the electronic rapid response form
- Repeat and increase the frequency of observations as indicated by the neonate's condition
- Document the assessment in the neonate's medical record by paediatric medical officer or NNP
- Commence BLS as per Australia and New Zealand Committee on Resuscitation (ANZCOR) Neonatal Resuscitation Guidelines ([ANZCOR guidelines](#), see appendix 2) and escalate to a Neonatal **CODE BLUE** if neonate **further deteriorates** and basic life support is required
- Escalate to a neonatal **CODE BLUE** if **further assistance is required** during a Rapid Response
- Inform the neonatal fellow/consultant on call as soon as practicable by the experienced paediatric medical officer who assessed and managed the neonate

3.6 CODE BLUE (Immediate Response)

- Activate a CODE BLUE urgently by calling 2222 and stating NEONATAL CODE BLUE with your exact location if a neonate has any of the following:
 - Respiratory arrest
 - Cardiac arrest or circulatory collapse
 - Prolonged and/or profound desaturation
 - Apnoea not responsive to stimulation
 - New or prolonged seizure or suspected seizure activity
 - Cyanosis – particularly around the mouth
 - Bleeding from mouth or nose, suggestive of pulmonary haemorrhage
 - Haemorrhage from rectum/significant volume of frank blood
 - Is floppy and unresponsive or not rousable
- Take neonate to resuscitaire and ensure neonatal red resuscitation trolley is with the resuscitaire.
- Commence BLS and/or ALS as per [ANZCOR Guidelines](#) (Appendix 2).
- Document on the Neonatal Resuscitation chart.
- Request additional members of the neonatal team to assist with the resuscitation if further assistance is required after the neonatal code blue activated, by making an urgent call to the NCC NUM/team leader.
- Admit any neonate who has received chest compressions or extensive resuscitation to NCC for ongoing observation and post resuscitation care

3.7 Alteration to the calling criteria

- Alter standard calling criteria for yellow or red zone observations in consultation with the on-call fellow/consultant if required. This **MUST** be clearly documented by a medical officer or NNP.

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- Document if the on-call fellow/consultant is unavailable to counter sign the order at the time of consultation. This should be noted in the neonate's medical record by the medical officer and attended to as soon as practical
- Document the rationale for altering the calling criteria in the neonate's medical record
- Review all alterations within 8 hours for acute and 24 hours for chronic or earlier if clinically indicated.

3.8 REACH Program

- If a parent/carer/family member feels there has been a clinical deterioration in their neonate or is concerned about their neonate, they can escalate their concerns through the REACH program.
- Register concern about patient by following REACH poster (Appendix 4)
- Activate a REACH Call by dialling:
 - **2222** from bedside telephone or
 - **02 9382 6111** from a mobile telephone
- Once activated, the switch operator will page NUM (in hours) of where the patient is located, or After-Hours Nurse Manager (AHNM) (out of hours) to review the patient within 30 minutes
- If the family members or carers remain worried or concerns are not met, page the medical registrar/NNP/fellow/consultant of the patient. This is carried out by the NUM or AHNM. The medical team must review the patient within 30 minutes.
- Discuss assessment findings, treatment plan and actions with the patient, their family member or carer in addition to documentation in medical record.

3.9 Documentation

- Medical record
- Neonatal resuscitation record
- eRIC
- eMR

3.10 Education Notes

- Neonatal Resuscitaires located in birth unit, postnatal ward, antenatal ward, outpatients and operating theatre are equipped to provide Basic life support and include a Neopuff® or T-piece, Ambu-SPUR II ®, oxygen saturation monitor and radiant heat.
- Neonatal red emergency trolleys are located in all ward areas.
 - Two red advanced life support trolleys are located in birth unit and operating theatre
 - One red advanced life support trolley is located in postnatal ward, antenatal ward and outpatients
- Medical responders for CERS calls listed as below:
 - Clinical review will be NCC resident medical officer (RMO)

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- Rapid response will be the NCC RMO and registrar skilled in advanced life support
- Code blue will be NCC fellow, registrar/NNP, and senior neonatal nurse (in hours), Neonatal fellow, senior neonatal nurse (after hours)
- The NCC consultant should be called by phone if required in hours and after hours.
- When calling a code blue for a deteriorating neonate, it is essential to state it is a NEONATAL code blue.

3.11 Abbreviations

CERS	Clinical Emergency Response System	A-I	Airway, Breathing, Circulation, Disability, Exposure, Fluids, Glucose, Holistic and Infection
BLS	Basic Life Support	ALS	Advanced Life Support
NNP	Neonatal Nurse Practitioner	IMS+	Incident Management System
SNOG	Standard Neonatal Observation Chart	RR	Respiratory Rate
SpO ₂	Oxygen Saturations	HR	Heart Rate
CEC	Clinical Excellence Commission	REACH	Recognise, Engage, Act, Call, Help
ANZCOR	Australia and New Zealand Committee on Resuscitation	RMO	Resident Medical Officer
REACH	Recognise, Engage, Act, Call, Help		

3.12 Implementation, communication and education plan

This revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

3.13 Related Policies/procedures

- SESLHD Procedure - [Management of the Deteriorating NEONATAL inpatient SESLHD/340](#)

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- NSW Health - [Policy Directive- Recognition and management of patients who are deteriorating PD2020_018](#)
- RHW CBR - [Neonatal Resuscitation at Delivery](#)
- RHW CBR - [Admission of a neonate to Postnatal Services](#)
- RHW CBR - [Neonatal Observations outside Newborn Care Centre](#)

3.14 References

1. Australian and New Zealand Committee on Resuscitation Guideline 13.2 – Planning for Neonatal Resuscitation and Identification of the Newborn at Risk. 2021. Cited 1.10.2024 <https://www.anzcor.org/home/neonatal-resuscitation/guideline-13-2-planning-for-newborn-resuscitation-and-identification-of-the-newborn-at-risk/>
2. Australian and New Zealand Committee on Resuscitation Guideline 13.3 – Assessment of the Newborn Infant. 2021. Cited 1.10.2024 <https://www.anzcor.org/home/neonatal-resuscitation/guideline-13-3-assessment-of-the-newborn/>
3. Australian and New Zealand Committee on Resuscitation Guideline 13.4 – Airway Management and Mask Ventilation of the Newborn Infant. 2021. Cited 1.10.2024 <https://www.anzcor.org/home/neonatal-resuscitation/guideline-13-4-airway-management-and-mask-ventilation-of-the-newborn/>
4. Wycoff, M., Wyllie, J., Aziz, K. et al. 2020. Neonatal Life Support: 2020 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. Circulation. 2020;142: S185-221. <https://www.ahajournals.org/doi/10.1161/CIR.0000000000000895>
5. NSW Government. Recognition and Management of Neonatal Patients who are Clinically Deteriorating PD2020_018. 2020. Cited 1.10.2024 https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_018.pdf
6. Clinical Excellence Commission (CEC) website, 2024

4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services



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5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

6 NATIONAL STANDARDS

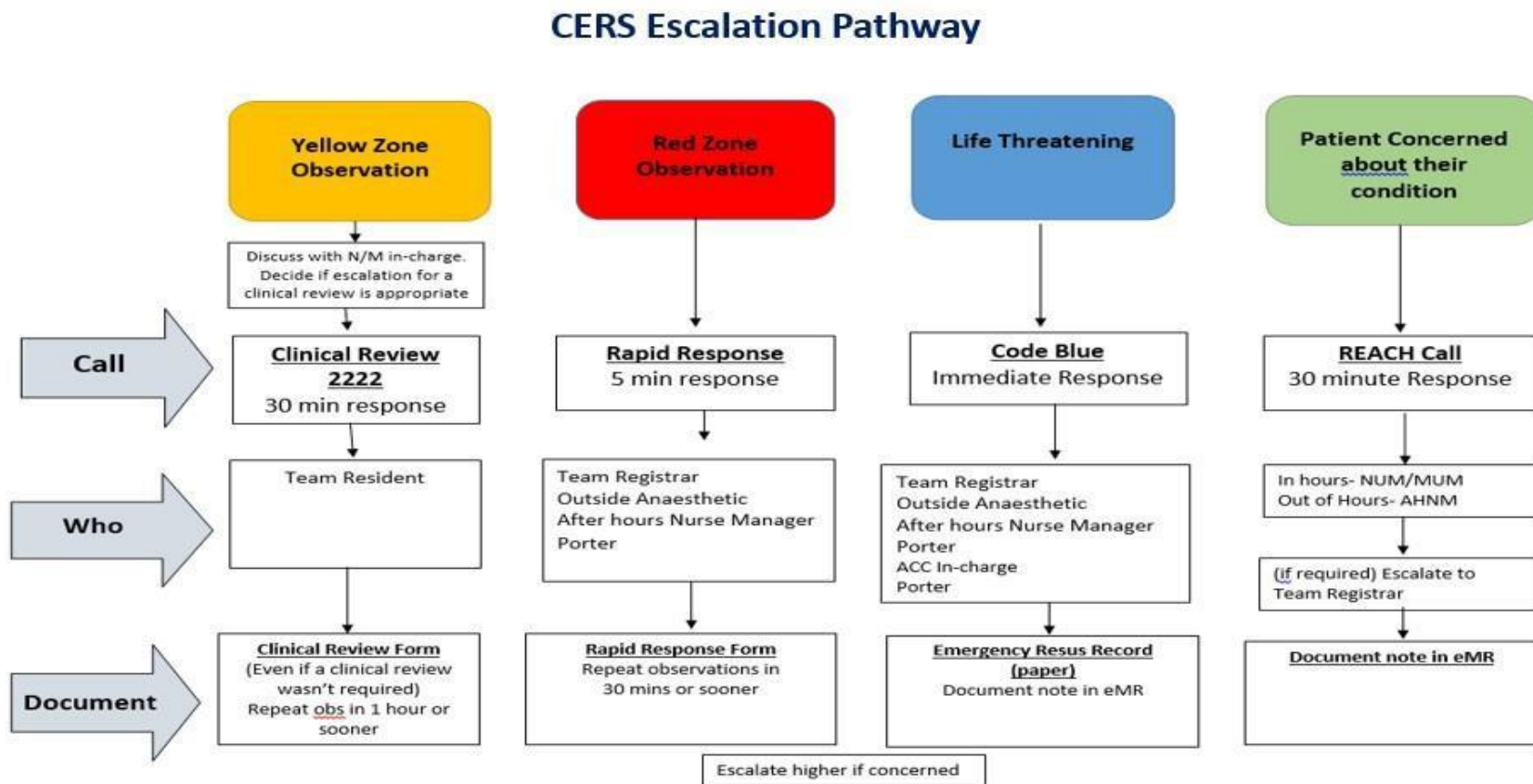
- Standard 1 – Clinical Governance
- Standard 2 – Partnering with Consumers
- Standard 5 - Comprehensive Care
- Standard 6 – Communicating for Safety
- Standard 8 – Recognising and Responding to Acute Deterioration

7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
1.10.2024 7.11.2024	3	N Ford (CMC Quality and Innovation), J Mossman (CERS CNC), R Jackson (NE NCC) Endorsed by NCC CBR Committee
Primary	2020	Srinivas Bolisetty, Charlotte Walter (ANE)
Revised	2021	Cheryl Johnson (CME), Annette Taylor (CME), Rochelle Phillips (CNC,) NCC LOP Committee
Endorsed Maternity Services LOPs group 24/8/21 (+ Neonatal Services input)		

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Appendix 1 CERS Escalation Pathway

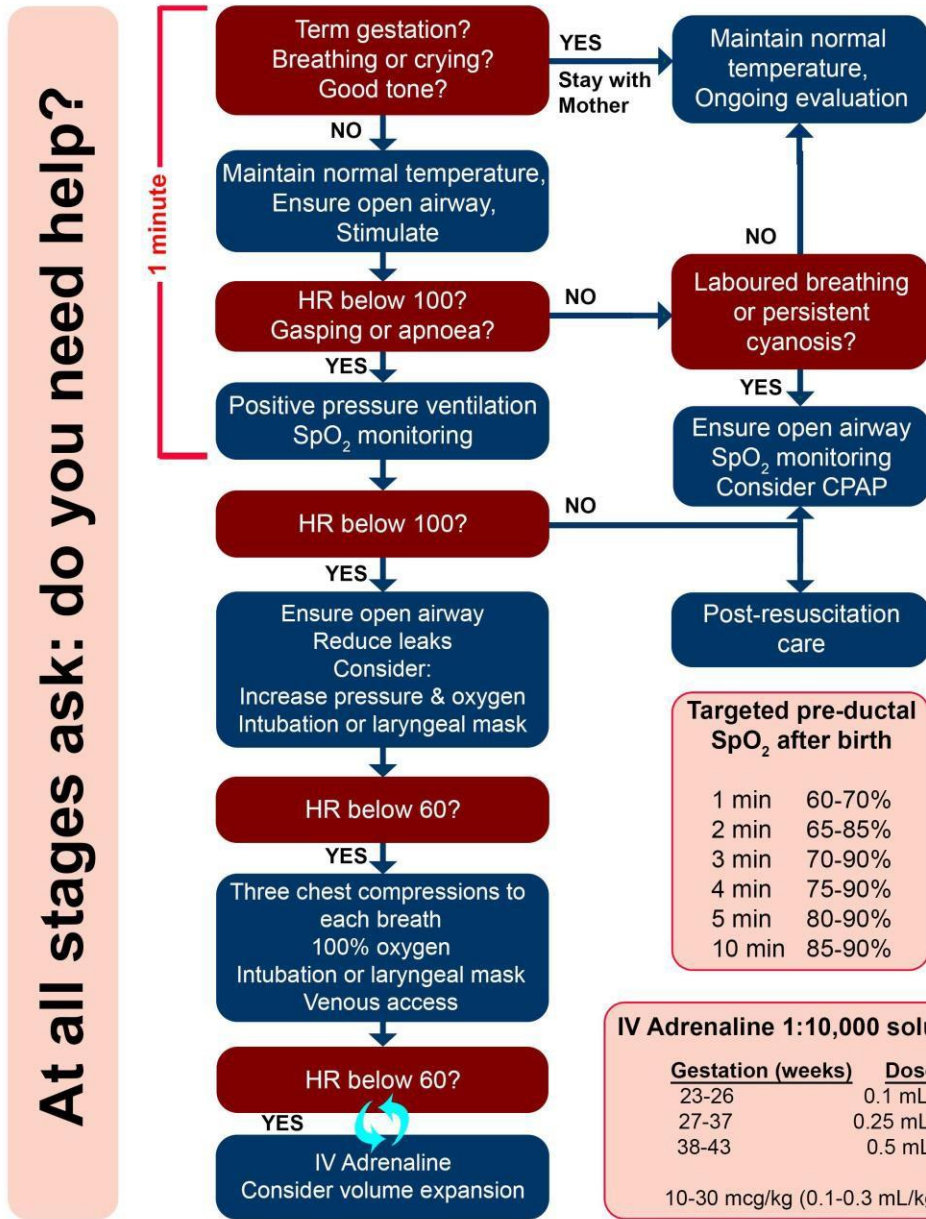


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Appendix 2- ANZCOR Newborn Life Support Guideline

Newborn Life Support



Reviewed August 2023




NEW ZEALAND
Resuscitation Council
WHAKAHAUORA AOTEAROA

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Appendix 3: Neonatal Sepsis Pathway



SMR060403

Holes Punched as per AS2288.1:2019
BINDING MARGIN - NO WRITING

14/10/18 01/02/4

 <p>NSW Health</p> <p>Facility:</p> <p style="font-weight: bold; font-size: 1.2em;">NEONATAL SEPSIS PATHWAY</p>	FAMILY NAME	MRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. ____/____/____	M.O.
	ADDRESS	
	LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Use for neonates (babies up to 28 days corrected age) in any clinical setting to support recognition and management of sepsis

COULD IT BE SEPSIS?


Sepsis is infection with organ dysfunction and is a **medical emergency**

Does the baby have any of the following:

<p>Signs or symptoms of INFECTION?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever, hyperthermia, temperature instability <input type="checkbox"/> Pale, mottled, central cyanosis <input type="checkbox"/> Lethargy, poor feeding, floppy / poor tone <input type="checkbox"/> Apnoea(s) <input type="checkbox"/> New or worsening signs of respiratory distress <p>Maternal risk factors?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prolonged rupture of membranes > 18 hours <input type="checkbox"/> Maternal pyrexia $\geq 38^{\circ}\text{C}$ <input type="checkbox"/> Maternal infection <input type="checkbox"/> Group B streptococcus (GBS) <input type="checkbox"/> Bacterial growth on placental swab <input type="checkbox"/> Increased sepsis probability on Neonatal Early-Onset Sepsis Calculator* 	<ul style="list-style-type: none"> <input type="checkbox"/> New rash, red umbilicus, cellulitis, joint swelling <input type="checkbox"/> Seizure(s), abnormal movements, high pitched cry, irritability, increased tone, jitteriness <input type="checkbox"/> Abdominal distension / tenderness, vomiting, diarrhoea, blood in stool <p>Other risk factors?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Family, carer or clinician concern the baby is sick <input type="checkbox"/> Unwell family members <input type="checkbox"/> Re-presentation for ongoing condition or concern <input type="checkbox"/> Known or suspected infection - not improving <input type="checkbox"/> Indwelling line(s) with signs of infection <input type="checkbox"/> Prematurity (immunocompromised) <input type="checkbox"/> Aboriginal and Torres Strait Islander people
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***Neonatal Early-Onset Sepsis Calculator**

ONLY for babies < 24 hours old AND ≥ 34 weeks gestation
Entered details must be exact
Set incidence to 0.4/1000 births
Note: Does not replace the senior clinician decision to commence treatment



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Commence A-G systematic assessment and document a full set of vital sign observations including blood pressure

Does the baby have ANY features of SEVERE ILLNESS?

Laboratory features of *severe illness / organ dysfunction* include acidosis, lactate ≥ 4 mmol/L, neutropenia, thrombocytopenia, elevated CRP

<input type="checkbox"/> ANY RED ZONE observation OR additional criteria	<input type="checkbox"/> ANY YELLOW ZONE observation OR additional criteria
Call a RAPID RESPONSE (as per local CERS) and consult with SENIOR CLINICIAN	Call for a CLINICAL REVIEW (as per local CERS) and SENIOR CLINICIAN review within 30 minutes
Consider other causes (e.g. postnatal transition, respiratory distress syndrome, congenital heart disease, hypovolaemia or metabolic disease)	
Does the senior clinician consider the baby has POSSIBLE SEPSIS?	
YES COMMENCE SEPSIS TREATMENT (over page)	NO Consider other causes of deterioration and increase frequency of vital sign observations Reconsider sepsis if the baby deteriorates

RECOGNISE

RESPOND & ESCALATE

NEONATAL SEPSIS PATHWAY

SMR060403

NO WRITING

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<p>NSW Health</p>	FAMILY NAME	MRN	
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
	D.O.B. ____/____/____	M.O.	
	ADDRESS		
Facility:	LOCATION / WARD		
NEONATAL SEPSIS PATHWAY			
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
RESUSCITATE	Complete actions 1 to 5 within 60 minutes with ongoing A-G systematic assessment		
	1. Get help	<ul style="list-style-type: none"> Consult with Paediatrician / Neonatologist / Emergency Physician / NETS 	WITHIN
	2. Monitor Airway, Breathing, Circulation	<ul style="list-style-type: none"> Commence respiratory support if required Give supplemental oxygen to maintain SpO₂ <ul style="list-style-type: none"> 90 – 94% (babies < 48 hours) ≥ 95% (babies > 48 hours) Continually monitor the baby and assess vital sign observations including blood pressure Assess for signs of shock (e.g. delayed capillary refill, poor perfusion, tachycardia, hypotension, acidosis) Provide thermal environment to achieve normothermia 	WITHIN
	3. Obtain access and collect pathology	<ul style="list-style-type: none"> Gain access: IV / umbilical / intraosseous (if baby > 2 kg) Call for expert assistance after 2 failed attempts at cannulation Prioritise blood culture collection (0.5 - 1 mL) prior to antibiotics Collect relevant screening samples (e.g. lumbar puncture, urine) according to suspected source if haemodynamically stable <p>Do not delay antibiotic administration for sample collection or test results</p>	WITHIN
	<input type="checkbox"/> Vascular access <input type="checkbox"/> Blood culture <input type="checkbox"/> Blood gas <input type="checkbox"/> Lactate <input type="checkbox"/> Blood glucose level (BGL)	<p>Prescribe and administer antibiotics according to the Australasian Neonatal Medicines Formulary (ANMF)</p> <p>BENZYLPENICILLIN OR AMPICILLIN plus GENTAMICIN</p> <p>If baby is severely unwell or deteriorating, discuss other infective sources and additional antimicrobials with appropriate expert clinician or NETS (e.g. CEFOTAXIME if suspected meningitis, ACICLOVIR, VANCOMYCIN)</p>	WITHIN
<input type="checkbox"/> Antibiotics commenced <input type="checkbox"/> Consulted with appropriate expert clinician or NETS	5. Consider fluid resuscitation	<ul style="list-style-type: none"> If signs of shock, administer 10 mL/kg sodium chloride 0.9% bolus Give 2 mL/kg glucose 10% plus maintenance fluids if: <ul style="list-style-type: none"> BGL < 2.6 mmol/L (babies < 48 hours) BGL < 3.0 mmol/L (babies > 48 hours) 	
REASSESS & REFER	6. Reassess	<ul style="list-style-type: none"> If signs of shock persist, discuss ongoing management including additional fluid bolus and/or vasopressors e.g. adrenaline (epinephrine) with a Neonatologist / NETS Continue to monitor vital sign observations at a minimum frequency every 30 minutes for 2 hours, then hourly for 4 hours Actively seek microbiology and other investigation results Review treatment plan and consider viral screening 	
	7. Refer	<ul style="list-style-type: none"> If no improvement or further deterioration occurs, escalate to higher level of care (e.g. Intensive Care / NETS) Discuss management plan with the family / carers 	
NETS 1300 36 25 00			
Print Name: _____	Signature: _____		
Designation: _____	Date: ____/____/____		

Holes Punched as per AS2829.1:2019
BINDING MARGIN - NO WRITING



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Appendix 4 REACH Call



Are you worried
about a recent **change** in your **condition**
or that of your loved one?
If yes... REACH out.

WHAT IS REACH ABOUT?

- R** You may recognise a worrying change in your condition or in the person you care for.
- E** **1** Engage (talk) with the nurse or doctor. Tell them your concerns.
- A** **2** Ask the nurse in charge for a "Clinical Review". This should occur within 30 minutes.
- C** **3** If you are still worried call REACH. You can use your bedside phone or ask for a ward phone.
- H** Call REACH on **2222**. Help is on its way.

Speak to your nurse or doctor first.
They may be able to help with your concerns.



R.E.A.C.H out to us
Because together we make a great team.

The R.E.A.C.H program was developed by the NSW Clinical Excellence Commission.