Policy/Procedure

TITLE OF POLICY : Clinical Observations and Deteriorating Patient Policy

Changes from last version

- Major rewrite of policy- Archive of nine policies (see notes section for details)

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1. Purpose

The purpose of this policy is to advise all MQ Health staff about the clinical observations and the prevention, recognition and management of deteriorating patients. This document will advise on delivery of resuscitation and available equipment and resources within MQ Health.

This policy empowers all staff, patients and carers to escalate the care of a patient where there is a concern or signs that the patient might be deteriorating.

2. Background

A deteriorating patient is any patient whose condition is worsening; such deterioration will often be accompanied by alterations in clinical observations outside the range that is normal for the patient.

When early or late signs of deterioration are noted, hospital staff can respond promptly utlilising the deteriorating patient model defined in this policy.

MQ Health has a two tiered Deteriorating patient system. For patients with early signs of deterioration, a Clinical Review can be requested. If late deterioration signs are noted, a Code Blue will be initiated. An internal Code Blue can be initiated by any individual who has concern for the condition of another.

The Clinical Excellence Commission, in conjunction with consumer groups, has developed a patient and family-focused model (known as the REACH model). This model has the aim of empowering patients and families to engage with staff if they notice 'something just isn't right' and to call for help if still concerned. MQ Health recognises the need for families and patients to be involved in this process:

Recognise: acknowledge that patients and families can often recognise signs of deterioration before they are clinically evident.

Engage: encourage patients and families to engage with their treating team if they are concerned that 'something is not right'.

Act: enable patients and families to act by requesting a 'clinical review'.

Call: provide patients and families with an independent avenue to call for a rapid response if still concerned and other avenues are exhausted.

Help: Patients and families should be assured that help will be on its way in the form of a clinical review process or code blue response team.

Adult observations are recorded in the patient's electronic medical record (observations form). Parameters are set according to this policy.

Five age-based Paediatric Observation Charts have been implemented as a part of the response and recognition program at MUH. This is set out in Trakcare based on the age-based groups and includes:

1. Under 3 months
2. 3-12 months
3. 1-4 years
4. 5-11 years
5. 12 years and over

All paediatric observation charts have colour coded zones designed to alert the early signs of clinical deterioration and prompt action when a physiological threshold is breached.
The observations are recorded graphically to assist in the user tracking trends visually. The 3 colour coded zones are:

- Blue Zone: represents criteria for increased patient observation and surveillance
- Yellow Zone: represents criteria for which a Clinical Review should be called
- Red Zone: represents criteria for which a Code Blue should be called.

3. Clinical Observations Policy

- All inpatients at MUH must have a full set of core observations recorded at a frequency appropriate to their clinical need, and at a minimum three (3) times per day, at eight (8) hourly intervals.
- Observations must also be conducted on admission to a ward, and prior to and after transfer from one ward to another.
- All clinical areas are to conduct audits of compliance with the use of patient monitoring plans, compliance with measuring the core set of observations, compliance with the minimum frequency and duration of observations and appropriate escalation of care based on clinical observations as defined in this policy.
- Clinical Audit results will be monitored at the Department Manager/ Director of Nursing meeting each month.
- A full set of core observations includes:
    - Temperature
    - Pulse

    - Respiration Rate
    - Blood Pressure
    - Oxygen saturation
    - Level of consciousness
    - Pain score
- Abnormal blood pressure readings that have been measured on an automated machine should be checked manually.
- All observations must be entered into the patient's electronic medical record at the time they are measured.
- AVPU (Alert, Verbal, Pain, Unresponsive) is a tool for rapid assessment of level of consciousness. In the event that a more detailed neurological assessment is required, a Glasgow Coma Scale (GCS) score should be obtained.
- Patients must be woken to assess level of consciousness at the scheduled time for monitoring. Variations to this must be ordered and documented by the patient's Accredited Practitioner.
- Additional observations to be measured as clinically indicated include (but are not limited to) the following: Blood Glucose Level, Neurovascular ob's, Alcohol withdrawal scale,TPN ob's, Graft or flap ob's.

3.1. Minimum Standards for Observation Monitoring in specific circumstances

WARDS

Context	Observations required	Minimum frequency
Pre-operative surgical patients -On admission:	Full set of core observations Height Weight +/- Observations as clinically indicated	On admission every 8 hours until transfer to OT (except for weight and height)
Post-operative patients (inpatient general ward areas):	Full set of core observations +/- Observations as clinically indicated	On return to ward Hourly for 4 hours Every 4 hours for 24 hours (if stable) Every 8 hours until discharge (if stable)
IV Sedation patients only- post operative	Full set of core observations +/- Observations as clinically indicated	On return to Ward Every 8 hours until discharge
ICU patients transferred to a general ward	Full set of core observations +/- Observations as clinically indicated	On admission to the ward Every 4 hours for 24 hours then review
Medical Inpatients	Full set of core observations Height Weight +/- Observations as clinically indicated	On admission every 8 hours (except for weight and height)
Overnight observations	Visual check additional to regular scheduled observations (core and extra as clinically indicated)	Visual check with rise and fall of chest during respiration observed hourly

PERIOPERATIVE

Context	Observations required	Minimum frequency
Post general anaesthetic / sedation patients (PACU, Endo, Angio)	*Full set of core observations +/- Observations as clinically indicated Discharge criteria as per: PACU Admission, Observation and Discharge Criteria Policy Endoscopy Patient Admission and Discharge Policy Angiography Post Procedure Recovery Policy	On admission to the recovery area Every 15 minutes while in recovery area Immediately prior to transfer out of the recovery area.
Post-operative patients (Day Surgery):	Full set of core observations +/- Observations as clinically indicated	On return to Day Surgery Prior to discharge
PAEDIATRIC Post general anaesthetic / sedation patients (PACU, Endo, Angio)	As per Management of the Paediatric Patient in PACU	

MEDICAL DAY ONLY

Context	Observations required	Minimum frequency
Medical inpatients/ day only medical patients	Full set of core observations +/- Observations as clinically indicated	On admission Every 8 hours if stable

ICU

Context	Observations required	Minimum frequency
Intensive Care Patients	Full set of core observations +/- Observations as clinically indicated	On admission to ICU Every hour for 4 hours then review Immediately prior to transfer out of the ICU

3.2. Monitoring Plans

- All inpatients require an individual documented monitoring plan that states:
    - the frequency of observations required
    - extra observations required (in addition to the full core set)

- The monitoring plan is to be initially recorded by nursing staff in the Patient's electronic medical record and then updated as required and at the completion of each shift.
- The monitoring plan and most recent clinical observations are to be verbally handed over when care of the patient is transferred - refer to Clinical Handover Policy.

3.3. Variations to the Frequency and Type of Observations:

- The frequency of observations should be re-assessed whenever there is a change in the patients clinical condition.
- If the patient is unstable, monitoring of observations may need to be attended more frequently or continually until the patient's condition is stabilised.

Increasing:

- Any clinician may initiate an increase in the frequency or type of observations as indicated by the patient's clinical condition.
- This variation and the reason for it must be documented as an update to the patient's monitoring plan.

Decreasing:

- The frequency of clinical observations can only decrease according to policy guidelines or as ordered by the patient's Accredited Practitioner.
- A decrease in the frequency of observations from the minimum (8 hourly intervals) can also only be ordered by the Accredited Practitioner and must be documented in the medical record.

4. Deteriorating Patient and Code Blue Policy

- Where a patient has been deemed at risk for clinical deterioration, the observation frequency will be increased in line with recommendations in this procedure
- Earlier escalation should be considered for patients considered to be at risk, as they are particularly vulnerable to physiological instability, and are therefore, at greater risk of rapid deterioration. The following patient groups are to be considered to be at risk:
    - Patients less than 3 months of age
    - Patients with chronic or complex problems
    - Post-operative patients
    - Patients with pre-existing cardiac or respiratory conditions
    - Patients on opioid infusions
- The plan for ongoing management should be communicated to the patient and carer/s, along with advice for whom to contact with concerns or questions.
- In the event that continued concern exists for a patient's condition (by staff, patients or family members), escalation of concerns to senior clinicians is encouraged. Suggested senior clinicans:
    - Secondary Career Medical Officer (Wards or Intensive Care Unit)
    - Accredited Practitioner
    - Registrar or Fellow
- In the event that a patient's condition deteriorates unexpectedly, the lines of communication shall ensure that the Accredited Practitioner is contacted directly, by the most senior medical officer attending to the patient.
    - If the deterioration has occurred in the first 24 hours post anaesthetic, the Anaesthetist should additionally be contacted
- A debriefing should follow each clinical review or Code Blue. This should involve all staff involved in the incident and the NUM/AHM on duty.

4.1 Orientation of New, Relieving or Agency Nursing Staff to Clinical Observations and Deteriorating Patient Policy

- The Nursing Team Leader (TL) is responsible for orientating new, relieving or agency nursing staff to the Deteriorating Patient policy.
- Orientation will consist of:
    - Provision of a copy of this policy.
    - Allocation of time to read content
    - An introduction to the TL for the shift

- A demonstration regarding how to operate the equipment required to record patient's observations
- A demonstration regarding where to find the documented monitoring plan and how to amend/update it
- Identifying the Clinical Review/Code Blue poster and discussing the calling criteria

5. Special Considerations

5.1. Patients in Critical Care or Perioperative Environments

The following statements apply to patients in Critical Care or Perioperative Departments in the hospital:

- PACU
- Anaesthetics
- Theatres
- Intensive Care Unit
- Angiography
- Endoscopy

- Clinical discretion is required for observations which fall between the deteriorating patient boundaries.
- The decision to escalate is based upon whether observation is 'expected' or 'acceptable'.
- In the event that an abnormal observation is accepted, specific documentation remains a requirement, for example:
  - Patient assessment findings
  - Intervention and treatment plan
  - Resolution or outcome
  - Altered parameters documentation
- For patients being transferred to lower acuity environments an observations review against the deteriorating patient criteria must occur prior to transfer
- Altered parameters must be prescribed prior to transfer and reviewed during clinical handover
  eg a patient being transferred from PACU to Day Surgery or ICU to a Ward

5.2. Paediatric Patients

- For paediatric patients, normal values will vary according to age, and therefore, specific age related observation charts are used for paediatric patients.

- Clinical deterioration may also occur other than when identified by the coloured zones on the paediatric observation chart, and in this case, and also where sound clinical judgement suggests, escalation should occur.
- There is provision on the observation charts for calling criteria and frequency of observations to be altered by a medical officer if required, in order to better reflect the individual patient's usual and/or expected condition.
- If at any stage specialist paediatrician advice is required or retrieval of the paediatric patient is anticipated the NETS team can be contacted on 1300 36 2500.

5.3. Patients with an End-Of-Life Care Plan (Resuscitation Plan)

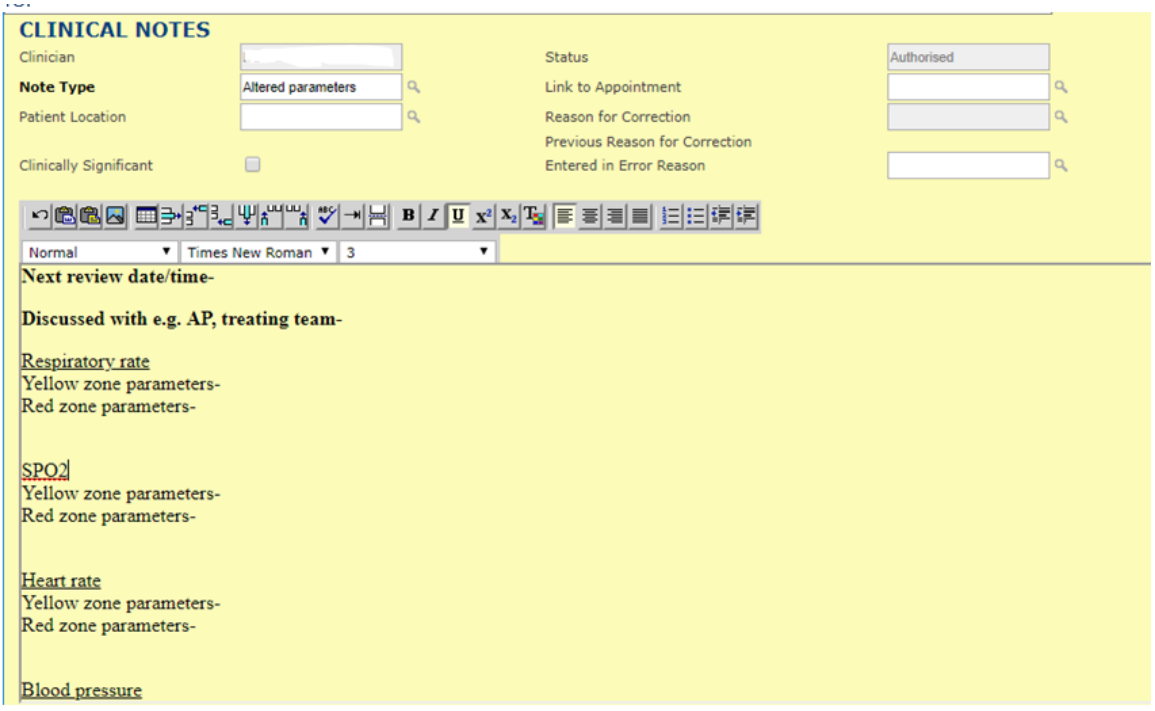
- Patients with a "Resuscitation Plan" order may still require Clinical Review calls to control acute symptoms
- The patient's Resuscitation Plan may contain altered parameters for a clinical review

  Refer to related documents for link to policy

5.4. Alterations to Calling Criteria- "Altered Parameters"

- Standard deteriorating patient calling criteria can be altered for Yellow or Red Zone observations and must be clearly documented by a medical officer, utilising the Altered Parameter Medical Note. The note is accessed via 'clinical notes' with note type 'altered parameters' as shown in Figure 1.

Figure 1: Clinical Notes - Altered Parameters



- Altered calling criteria should be formally reviewed by an Accredited Practitionaer who is responsible for the care of the patient as per the 'Next review date/time' prescribed
- The Altered parameter note set will display in the patient's progress notes and additionally on the 'summary page' of the patient's electronic medical record for reference

5.5. Mental Health Emergency or Aggressive and/or Abusive Patients:

- The Nurse Manager or After Hours Manager (AHM) will arrange for appropriate backup of security or police. Note that security are not to restrain any patient.
- Transfer the patient to a single room and allocate additional staff if required
- Physical contact is to be avoided with maintenance of safe distance between patient and staff where possible:
    - **DO NOT** leave potentially violent/disturbed patients alone.
    - **DO NOT** argue with the patient.
    - **DO NOT** respond to the patient with similar behaviour to them.
    - **DO NOT** approach the patient without back-up.
- In each case, the need for physical restraint must be assessed
- Restraint may be used in circumstances where the person's behaviour presents a risk of harm to themselves or others or a risk of serious damage to property.
- Restraint includes anything that limits an individual's voluntary response or movement. It most commonly involves physical or chemical restraint. Refer to Patient Restraint Management policy
- If the situation continues, contact appropriate personnel to liaise with an Accredited Psychiatrist to discuss arrangement for the transfer of the patient to a more appropriate facility.

Consider consultation with Mental Health Crisis Team phone line on 1800 011 511 for 24 hour support and advice.

6. Clinical Review

6.1. Clinical Review Criteria

Note For Paediatrics: observations are graded Blue Zone on observation chart

Deteriorating Patient Criteria

Clinical Review Criteria

INCREASED VIGILANCE

- **1 Yellow Zone Observation**
- Increase core observation to 15 Minutely
- Consult promptly with TL & consider clinical review
- Does the trend suggest deterioration?
- Are you concerned?

CLINICAL REVIEW

- **2 or more Yellow zone observations**
- Escalate to formalised clinical review
- Increase frequency of observation to 5 Minutely
- Monitor closely

Breathing	**Respiratory Rate** 5 - 10 or 25 - 30 breaths per Minute
O2 Saturation **O2 requirements**	**SpO2** 90 - 95% and/or Increasing oxygen (O2) requirement
Circulation	**Blood Pressure** **Systolic** 90 - 100 systolic or **Diastolic**180 - 200mmHg systolic **Heart Rate** 40 - 50 or 120 - 140 beats per minute Peripheral circulation poor
Neurological	**Level of Consciousness** from alert (A) to rousable by voice (V) in the AVPU or **Confusion or aggression** new onset
Temperature	**Temperature** < 35.5º C or > 38.0º C
Pain	**Pain** Severe (7-10) or Uncontrolled **Chest pain** Post clinical review or coronary procedure
Urine Output	**Urine output** **Low** and persistent for 4hrs ▪ <100mls over 4 hours or ▪ <0.5mL/kg/hr via an IDC **Polyuria**, in the absence of diuretics ▪ > 200 ml/hr for 2 hours
Drains/ **Bleeding**	**Blood loss** excess or increasing **Drain loss** > 200 ml/hr for 2 hours
BGL	**BGL** <4 mmol/L or >20mmol/L if no decrease in level of consciousness
Any rapid change in observations **Any other concern by staff, patient or family member**	

6.2. Clinical Review Policy

- "Clinical Review" is the first stage in the escalation pathway for deteriorating patients
- Yellow (Blue for Paediatrics) coded zones indicate that the observations are abnormal and represent criteria for a Clinical Review
- Clinicans must acknowledge actions taken in response to the observation within the patient's electronic medical record.
- Nursing staff should escalate clinical review criteria to the TL of shift prior to escalating the situation
- Chest pain requires immediate clinical review. If the review is not attended within 10 minutes from onset of symptoms, a Code blue can be initiated
- A Clinical Review can be family-initiated either verbally or through the MQ Health REACH system.
- A Medical Officer must attend the bedside and perform a patient assessment. A phone consultation is not accepted.
- If elevated concern for the patient's condition is held by the clinical team or family, a Code Blue may be initiated at any point.
- If observations deteriorate or clinical review is not done within 30 minutes from request, it should be escalated to a Code Blue Call
- If concern remains after clinical review has been completed, escalation to an appropriate senior clinician is encouraged. Suggested senior clinicans:
    - Secondary Career Medical Officer (Wards or Intensive Care Unit)
    - Accredited Practitioner
    - Registrar or Fellow
- Clinical review time, assessment findings and resulting plan of care must be documented in the patients electronic medical record

6.3. Clinical Review Procedure Roles and Responsibilities

Bedside Nurse in the Clinical Area	1. Initiate appropriate clinical care 2. Repeat and increase the frequency of full set of observations, as indicated by the patient's condition and the number of yellow zone observations noted 3. Perform a patient assessment 4. Contact the CMO and verbalise that a Clinical Review is requested. Perform a brief clinical handover on the phone 5. Prepare to perform a Clinical Handover to the medical officer 6. Ensure that the outcome and plan of care for the clinical review is documented in the Electronic Medical Record

Nursing TL of the Clinical Area	1. Assist in the care of the patient and help determine how much deterioration has occurred from base line. 2. Note the time of call to the Ward CMO. 3. Notify the NUM/AHM of the concerns about the patient and plan to escalate care 4. Confirm that the outcome and plan of care for the clinical review is documented in the Electronic Medical Record
Medical Officer – AP, CMO, Registrar, Junior Medical Officer (phone extension 3067)	1. Attend clinical review request within 30 minutes of request. NOTE: Chest pain and stroke symptom (F.A.S.T.) requires clinical review within 10 minutes 2. Assume Team Leader position in the Clinical Review 3. Receive clinical handover from nursing staff 4. Perform assessment of the patient, initiate investigations, prepare a management plan 5. Communicate the condition and the management plan to the Accredited Practitioner and to the patient and carer/s. 6. Document the assessment findings and the plan of care in the medical record
After Hours manager or NUM (phone extension 3001)	1. Assess resource availablilty/ requirement. 2. Communicate with the appropriate teams if escalation of care is required. 3. Coordinate additional resources as required. 4. Facilitate a debriefing session for staff involved in the Clinical Review (if required). 5. Confirm that the patient and carer/s are informed

7. Code Blue

7.1. Code Blue Criteria

Deteriorating Patient Criteria

MQ Health
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HEALTH SCIENCES CENTRE

Code Blue Criteria

OBSERVATION

- Serious concern by anyone
- Cardiac Arrest // Respiratory Arrest
- Airway obstruction or stridor // Unresponsive or seizures
- Chest pain or stroke symptom which is concerning
- Patient meets Criteria below

CODE BLUE

- Activate the closest EMERGENCY button or Dial 9999 Say "Code Blue"and give your location
- Commence BLS Procedure
- Prepare to handover using ISBAR principles

Observation Criteria – Code Blue

Airway/ Breathing	**Respiratory Rate** < 5 or > 30 breaths per minute
O2 Saturation O2 requirements	**SpO2** < 90% and/or Increasing oxygen (O2) requirements to maintain Oxygen saturation >90%
Circulation	**Systolic Blood Pressure** < 90 or > 200mmHg **Heart Rate** < 40 or > 140 beats per minute
Neurological	**Level of Consciousness** Only responds to pain (P) on the AVPU scale Sudden decrease in Level of Consciousness (a drop of 2 or more points on GCS) **Stroke** symptoms **F**ace.**A**rms.**S**peech.**T**ime
BGL/ Metabolic	Blood Glucose Level < 1 mmol/L
Clinical Review	Deterioration not reversed within 1 hour of Clinical Review Deterioration before or during Clinical Review

7.2 Code Blue Policy

- A Code Blue call can be initiated by any member of staff by pressing the Code Blue EMERGENCY button (in clinical areas) or Dialling '9999' and stating "Code Blue" and giving your location (in other areas).
- Observations which fall into the Red Zone category within this policy necessitate the calling of a Code Blue. Refer to 'Special Considerations' for exemptions
- Documentation during the Code Blue is to be recorded using the Code Blue Scribe Form located on all emergency trolleys and ICU response equipment in all areas of MQ Health.
- The completed form will be scanned into the patient's electronic medical record and attached to the Riskman Incident Report.
- In the event of patient death, the CMO is responsible for confirming death, discussion with the admitting AP and family, and completing death certification or referral to the coroner. Refer to Related documents for policy detail
- All Code Blues must be recorded in the Riskman Incident System. It is the responsibility of the TL on shift to verify that the Riskman is entered promptly.
- Members of the Code Blue Response team will carry a Code Blue phone and respond immediately to an alert to the location indicated on the phone.
- The members of the team are:
    - ICU CMO
    - ICU Code Blue RN who is ALS accredited
    - Ward CMO 1 or 2 depending on shift time
    - Ward Nurse Code Blue phone holder
    - Area NUM/ AHM / Patient Safety and Quality Manager (Non-clinical areas only)
- The Code Blue Response team is to remain in presence until stood down by the Code Blue Team Leader. See team roles in procedure
- At an appropriate time, the patient and their family or carer are to be informed when a Code Blue has been activated and the outcomes of this review

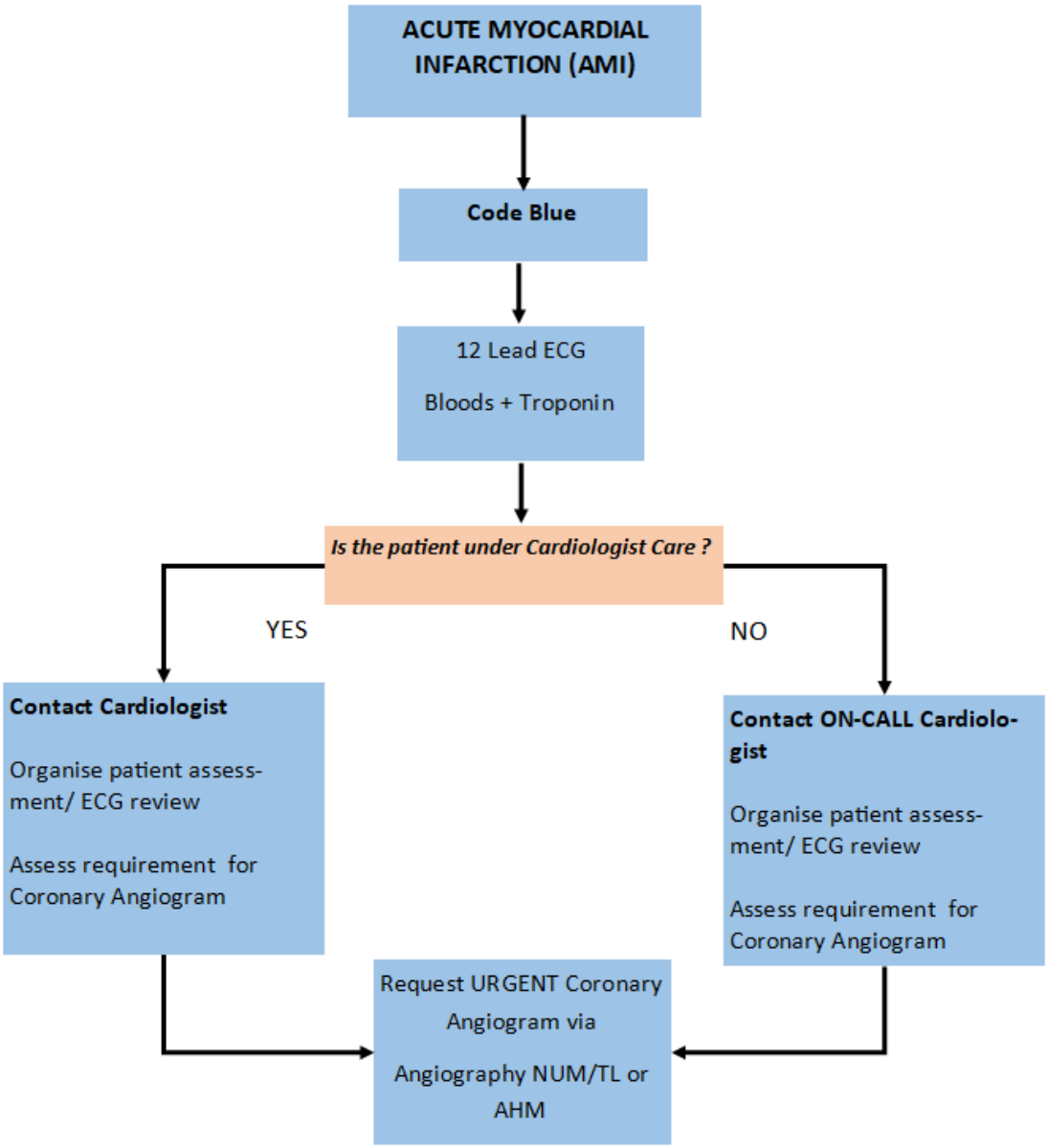
7.3. Code Blue Procedure

7.3.1 To Activate a Code Blue:

1. Press the closest EMERGENCY button or call 9999 and state “Code Blue” when prompted.
2. Provide immediate care such as Basic Life Support (BLS) and oxygen
3. Be prepared to give a Clinical Handover to the Code Blue Response Team upon arrival. The Clinical Handover should use the ISBAR acronym and include:
    a. a history of the patient including what events lead to the arrest
    b. any relevant Alerts (including not for resuscitation orders, precautions, allergies)
    c. reason for hospitalisation
    d. type of surgical procedure they have undergone
    e. current medications, blood results
    f. duration of the event including length of CPR and whether defibrillation has occurred or shock was not advised in AED
4. Take direction from the Code Blue Response team upon arrival. Continue to perform allocated role(s).

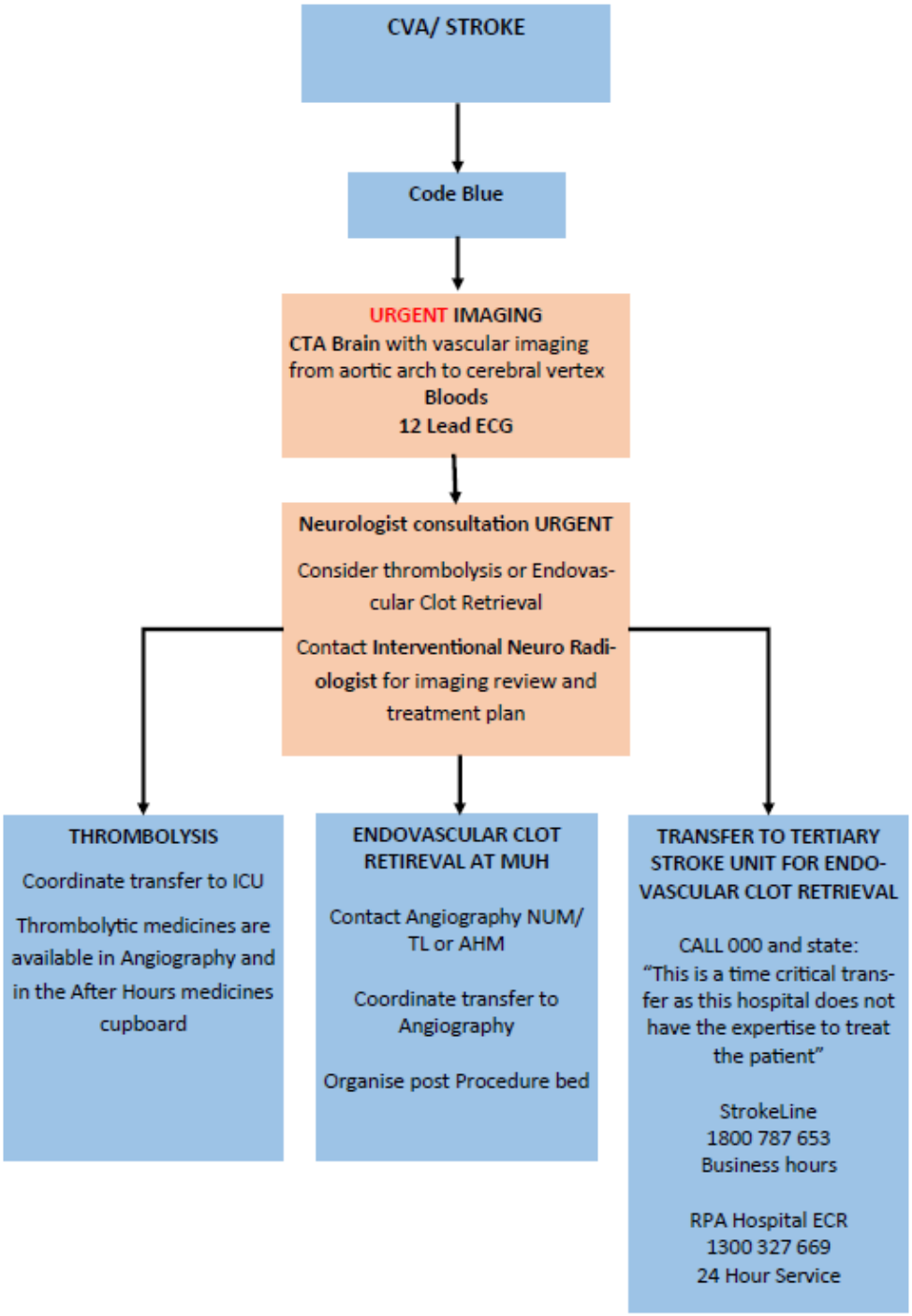
7.4. Acute Myocardial Infarction

In the event of possible Acute Myocardial Infarction consider **immediate treatment** in the Angiography Lab with Interventional Cardiologist.



7.5. Acute Stroke

In the event of a possible Acute Stroke, consider **immediate treatment** in the Angiography Lab with an Interventional Neuroradiologist.

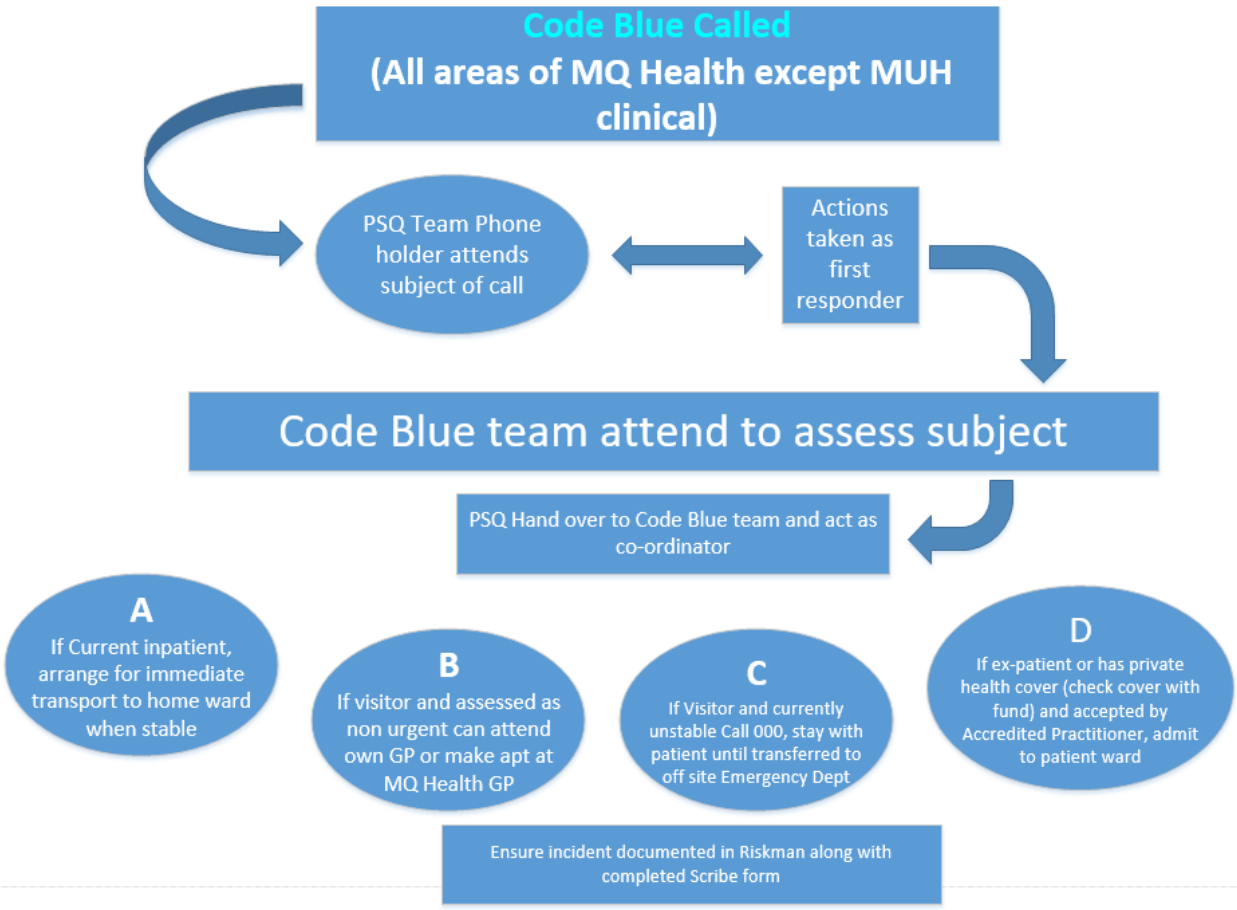


7.7. Turning off the Code Blue alarm

- Upon activation of the Code Blue alarm, the code must only be cancelled if one of the following occurs
    - a false alarm (an accidental pressing of the button by patient/visitors/cleaners).
    - **OR** by the NUM/AHM/Patient Safety and Quality Manager (or delegate) once they have assessed that appropriate resources are on scene to address the clinical situation.

NOTE: Once the code has been cancelled at the bedside, this sends an alert message to the Code Blue responders that the Code Response has been cancelled. This will result in the team standing down and not attending.

7.8. Code Blue in Non-Clinical Areas



- When the situation allows, the Team Leader & Co-ordinator will assess the situation regarding the decision to admit to MUH or transfer via ambulance to the closest Emergency Department.

- The Coordinator will confirm the Health Fund status of the patient while the Team Leader will liaise with an appropriate Accredited Practitioner to arrange acceptance of care and coordinate with the appropriate ward/unit to receive the care of the patient.
- If a patient is uninsured or a suitable Accredited Practitioner is unable to be arranged, the patient is to be stabilised and transferred via ambulance to the nearest Emergency Department.
- For a Code Blue in the clinic, the Riskman Incident Report is to be submitted by the staff member(s) directly involved in the incident.
- For a Code Blue outside the hospital or clinic, the Riskman Incident Report will be submitted by the Patient Safety and Quality Manager/ AHM or delegate.

7.9. Roles of the Code Blue Response Team

First responder and/or nurse allocated to the patient	1. Assess patient's condition utilising Basic Life Support 2. Activate Code blue alarm 3. Commence BLS and or stay with the patient to answer any questions from the Rapid Response (Code Blue) Team 4. Actively participate as directed by the Team 5. Perform clinical handover to the code blue team 6. Follow instructions as delegated by Rapid Response Team
NUM of area/ AHM – (Clinical Areas) **Patient Safety and Quality Manager (or delegate) – Non clinical areas (During Business Hours)**	1. Attend the Code Blue immediately 2. Co-ordinate resources as required 3. Facilitate communication between AP/ CMO and external services 4. Performs the decision to turn off the code blue alarm once adequate resources are on scene to address the clinical situation. 5. If patient transfer is required, Co –ordinate transfer requirements 6. Confirm all documentation is complete and the code blue scribe form is complete including signatures of Medical TL and RN i. Scan to medical record ii. Attach to riskman entry iii. Return form to Patient Safety and Quality 7. Facilitate communication with the patient's family or carer/s 8. Perform debriefing after the event if required 9. Organise restocking of the Emergency Trolley and replacement of Drug Box in trolley.

	If After Hours, the AHM is responsible for retrieving and replacing drug box
Code Blue Team Leader (CMO or ALS RN) **ICU CMO and ward CMO/ Cardiology Registrar**	1. Identify self as 'Team Leader' upon arrival to scene 2. Confirm/Allocate team roles 3. Lead the team and order intervention as per Advanced Life Support guidelines 4. Discuss management with the admitting Accredited Practitioner (AP) 5. Discuss the need for ICU admission with the ICU Consultant 6. Review documentation on the Code Blue Scribe Form including medications given. Print & sign name, date & Designation as the Medical Team Leader 7. Document a summary of events and plan of care in the progress notes
ICU Code Blue RN	1. Take the ICU portable emergency equipment and go immediately to the location of the Code Blue 2. On arrival, introduce self and role to those in attendance 3. If Basic Life Support is underway, assess effectiveness of BLS, listen to Clinical Handover to the team, and follow instructions by the Team Leader of the Code Team 4. Perform primary assessment (ABCD) of patient 5. Confirm that nursing roles are allocated by code blue team leader 6. Apply monitoring equipment if not in place- monitor/defibrillator, automated blood pressure cuff, oxygen probe 7. Ensure initial set of observations are documented by the scribe 8. Assist in Advanced Life Support
Cardiology Registrar **Resident Medical Officer**	1. If first on site, provide BLS 2. When Code Blue Team present, follow instructions and assist. 3. The Cardiology Registrar, once accredited at MQ Health for Advanced Life Support (ALS) may perform the role of Team Leader.
Porter	1. Arrive with a size C Oxygen cylinder 2. Move and position the patient as requested by the Code Blue Response Team. 3. Collect equipment as requested 4. Remain at the code blue until dismissed by the NUM or AHM

	5. If required, may provide cardiac compressions as directed by the Code Blue Team Leader
Ward Nurse (allocated to carry code blue phone)	1. Provide assistance as directed by the team 2. Ensure the patients' medical record is accessible via Trakcare
Scribe	1. A member of the team will be allocated to scribe for the duration of the emergency. Time of the commencement of emergency treatment must be noted, as well as times of the medications that are administered and all other treatment and interventions. 2. The scribe will ensure that the Code blue Form is complete at the completion of the Code Blue

7.10. Duration of CPR

The team should continue cardiopulmonary resuscitation until:

- Patient becomes responsive.
- The Code Blue Response Team arrives (then follow protocol as a member of the team).
- It is impossible to continue (e.g. exhaustion)
- An authorised person pronounces life extinct.

7.11. Post Resuscitation Management

- Conduct a patient assessment
    - Vital signs
    - Neurological observations
    - 12 lead ECG
    - Check chest for defibrillation burns and treat
- Organise bloods (FBC, EUC, Coags, Troponin etc) to be sent to Pathology
- Possible insertion of arterial line and/or CVC, IDC or NGT
- Arrange CXR
- Ensure documentation is complete including; Code blue Scribe Form (uploading to Riskman & Patient Record). Attach rhythm strips, AED data if applicable
- Medical Officer to complete medication chart
- Notify Consultant and Anaesthetist (if applicable)
- Arrange for possible transfer to ICU/other facility
- Clean and restock arrest trolley
- Inform family/ next of kin
- Staff debriefing
- Review procedure and make improvements as identified

8. REACH Patient and Family Activated Clinical Review or Code Blue.

- Information about REACH will be communicated to patients & their families via Pre-Admission Booklet; Patient Compendiums; Screens within MQ Health, posters placed around the hospital / in lifts etc
- Patients are to be encouraged to first seek advice from clinicians involved in their care prior to initiating a REACH call.
- The REACH access telephone will be delegated to a clinican at all times
    - During hours- the Patient Safety and Quality Team answer REACH calls
    - After Hours- the After Hours Manager will answer REACH calls

8.1. REACH Procedure

- Refer to REACH Poster in Appendix of this document

8.2. REACH Evaluation Measures and data collection

- Reach evaluation data will be collected including:
    - number of calls, timing of calls, reason for calls (including identifying calls/referrals outside scope of REACH) that required follow up
    - No. of reach calls that result in clinical review requests over time period
    - Number of calls that result in a Rapid Response call over time period,
    - Local evaluation of every REACH call to look at cause, outcomes and patient and staff feedback.
- The Data will be collected & collated by the AHM group who will provide a report to Patient Safety & Quality team. MQ HEALTH will provide reporting to CEC in line with the agreed program via the Patient Safety & Quality Team. This will be a Standard agenda item for the Critical Care Committee
- Measurement of Outcomes: Awareness of process measures:
    - Call frequency and details of concerns
    - Audit/survey of patient/family/friends/carers' awareness
    - Patient feedback received through MQ Health feedback system
    - Audit/survey of staff awareness
- Other data sources to compare – No. of RCA's / incidents identifying non-recognition of deteriorating patient; Clinical reviews / code blues.

The results of data analysis will be fed back in a timely manner to clinical units, and MQ HealthPatient Safety and Quality Team and committees.

9. Basic Life Support

- Clinical staff members are required to complete the mandatory Basic Life Support theory (ELearning Module) and competency assessment annually.
- Staff members who have direct patient contact will be provided with access to regular resuscitation education appropriate to their expected abilities and roles.
- Clinical Nurse Educators are responsible for the provision of education sessions in resuscitation techniques.

Cardiopulmonary arrest events will be managed according to current Australian Resuscitation Council Guidelines and this policy

9.1. Basic Life Support Procedure

Refer to Australian Resuscitation Council Guidelines https://resus.org.au/guidelines/

10. Advanced Life Support

- Any currently accredited ALS clinician can act as a Code Blue Team Leader.
- The ALS algorithm should not be altered however - it is to serve as a guideline.
- A medical officer can add to the management of the algorithm but the deviation should be clearly documented post-clinical event. Deviations should not detract from the Algorithm.
- In the absence of medical personnel, in an urgent emergency situation, the ALS accredited clinician can initiate any skill which is listed in the ALS algorithm including:
    - Cardiopulmonary resuscitation (CPR)
    - Defibrillation if it is clinically indicated
    - Administration of first line intravenous medications listed within the algorithm. Medications are prepared and labelled in line with safe medication management. These medications are:
        - Adrenaline 1:10000 followed by 0.9% Sodium Chloride flush
        - Amiodarone 300mg as IV push in 20mls 5% glucose followed by pulsatile flush 5% glucaose
- Insertion of artificial airways limited to the Laryngeal Mask Airway (LMA), Guedels Airway and Nasopharyngeal Airway.
- In the event of a Paediatric Cardiopulmonary Arrest ,the Paediatric ALS (PALS) algorithm should be utilised.

10.1. Advanced Life Support Procedure

- Refer to Australian Resuscitation Council Guidelines https://resus.org.au/guidelines/

11. Emergency Trolley

- All staff, irrespective of their position at MQ Health, should know the location of the nearest emergency trolley, defibrillator, oxygen supply and suction apparatus.
- The emergency trolley needs to be cleaned and checked daily
- It is the responsibility of the ward/department manager to ensure that all equipment and supplies are checked at least once every 24 hours
- The task of checking resuscitation equipment should not be allocated to one person, or one specific group of people: all staff should share responsibility.
- Frequent checking of resuscitation equipment by all trained staff will ensure familiarity with equipment.
- The clinic emergency trolley in the Cardiology clinic is to be checked on a weekly basis and sealed by assigned department.
- Following use of equipment, supplies will need to be replaced to ensure that the trolley is ready for the next emergency.
- A list of equipment (including quantities required and the expiry dates of drugs and disposable items) should be attached to the trolley at all times.
- Equipment used for cardiopulmonary resuscitation (including defibrillators and drugs) should have an identical layout across all departments and trolleys.
- It is important that all staff are aware of what can be disposed of and what needs to be kept for sterilisation or cleaning.
    - Disposable items are those that can be used on one patient and disposed of once they are no longer needed.
    - Multiple use items are those that can be used on many patients and are not disposable.
- There are two types of multiple use items:
    - Items that require sterilisation by a SSU department between patients.
    - Items that require minimal cleaning between patients.

11.1. Location of Emergency trolleys & AED – Hospital

Location of Emergency trolleys & AED – Hospital	
Ground Floor	Reception desk (AED only) Endoscopy MMI
Level 1	DOSA PACU Theatre Floor Theatre 10 (Defib only) ICU East Wing ICU West Wing
Level 2	Angiography Lab 14 and Lab 15 Angiography Recovery Area Oncology
Level 3	Ward 1 Ward 2
Level 4	Ward 3 Ward 4

11.2. Location of Emergency trolleys & AED – MQ Health Clinic Building

Clinic Level	Location	Description
Ground Floor	Foyer	In the control panel cupboard on the left when entering the foyer, AED and O2 Cyclinder
Level 2	Suite 203 Cardiology	In the patient change room/store room, emergency trolley with Defibrillator and O2 Cylinder
Level 3	Suite 302 Clinical Care Centre	At the Reception desk, AED and O2 Cylinder
	Suite 305 GP Clinic	AED in corridor and O2 Cylinder in Nurse treatment room
	Suite 302 Plastics Clinic	O2 Cylinder in Nurse procedure room
Level 4	Suite 401 Ophthalmology Clinic	AED and O2

12. Relevant Legislation

Healthcare Identifiers Act

Mental Health Act

Poisons and Therapeutic Goods Act

13. References

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Recognition and Management of Patients who are Clinically Deteriorating. (2013). Retrieved 23 August 2019, from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_049.pdf

Stroke Foundation (2017) Australian Clinical Guidelines for Stroke Management. Retrieved 11 September 2019 from https://informme.org.au/en/Guidelines/Clinical-Guidelines-for-Stroke-Management

14. Related documents

- Angiography Post procedure Recovery Policy
- Blood Management
- Care of a Deceased Patient
- Chest Pain- Patient Management
- Clinical Handover Policy
- Code blue and Code Black Testing
- Epidural/ Paravertebral Infusion Policy
- Endoscopy Admission and Discharge Policy
- Identification of the Patient Policy
- Intraosseous Access Device for Adults and paeds
- Interhospital Transfer Policy
- Management of the Paediatric Patient in PACU
- PACU admission, observation and discharge criteria policy
- Patient Controlled Analgesia policy
- Patient Restraint Management
- Resuscitation plans and End-of-life care
- Sepsis Management policy
- PACU Admission, Observation and Discharge Criteria

Deteriorating Patient Criteria

MQ Health
MACQUARIE UNIVERSITY
HEALTH SCIENCES CENTRE

Clinical Review Criteria

INCREASED VIGILANCE

- **1 Yellow Zone Observation**
- Increase core observation to 15 Minutely
- Consult promptly with TL & consider clinical review
- Does the trend suggest deterioration?
- Are you concerned?

CLINICAL REVIEW

- **2 or more Yellow zone observations**
- Escalate to formalised clinical review
- Increase frequency of observation to 5 Minutely
- Monitor closely

Breathing	**Respiratory Rate** 5 - 10 or 25 - 30 breaths per Minute
O2 Saturation **O2 requirements**	**SpO2** 90 - 95% and/or Increasing oxygen (O2) requirement
Circulation	**Blood Pressure** **Systolic** 90 - 100 systolic or **Diastolic**180 - 200mmHg systolic **Heart Rate** 40 - 50 or 120 - 140 beats per minute Peripheral circulation poor
Neurological	**Level of Consciousness** from alert (A) to rousable by voice (V) in the AVPU or **Confusion or aggression** new onset
Temperature	**Temperature** < 35.5º C or > 38.0º C
Pain	**Pain** Severe (7-10) or Uncontrolled **Chest pain** Post clinical review or coronary procedure
Urine Output	**Urine output** **Low** and persistent for 4hrs ▪ <100mls over 4 hours or ▪ <0.5mL/kg/hr via an IDC **Polyuria**, in the absence of diuretics ▪ > 200 ml/hr for 2 hours
Drains/ **Bleeding**	**Blood loss** excess or increasing **Drain loss** > 200 ml/hr for 2 hours
BGL	**BGL** <4 mmol/L or >20mmol/L if no decrease in level of consciousness
Any rapid change in observations **Any other concern by staff, patient or family member**	

Deteriorating Patient Criteria

Code Blue Criteria

OBSERVATION

- Serious concern by anyone
- Cardiac Arrest // Respiratory Arrest
- Airway obstruction or stridor // Unresponsive or seizures
- Chest pain or stroke symptom which is concerning
- Patient meets Criteria below

CODE BLUE

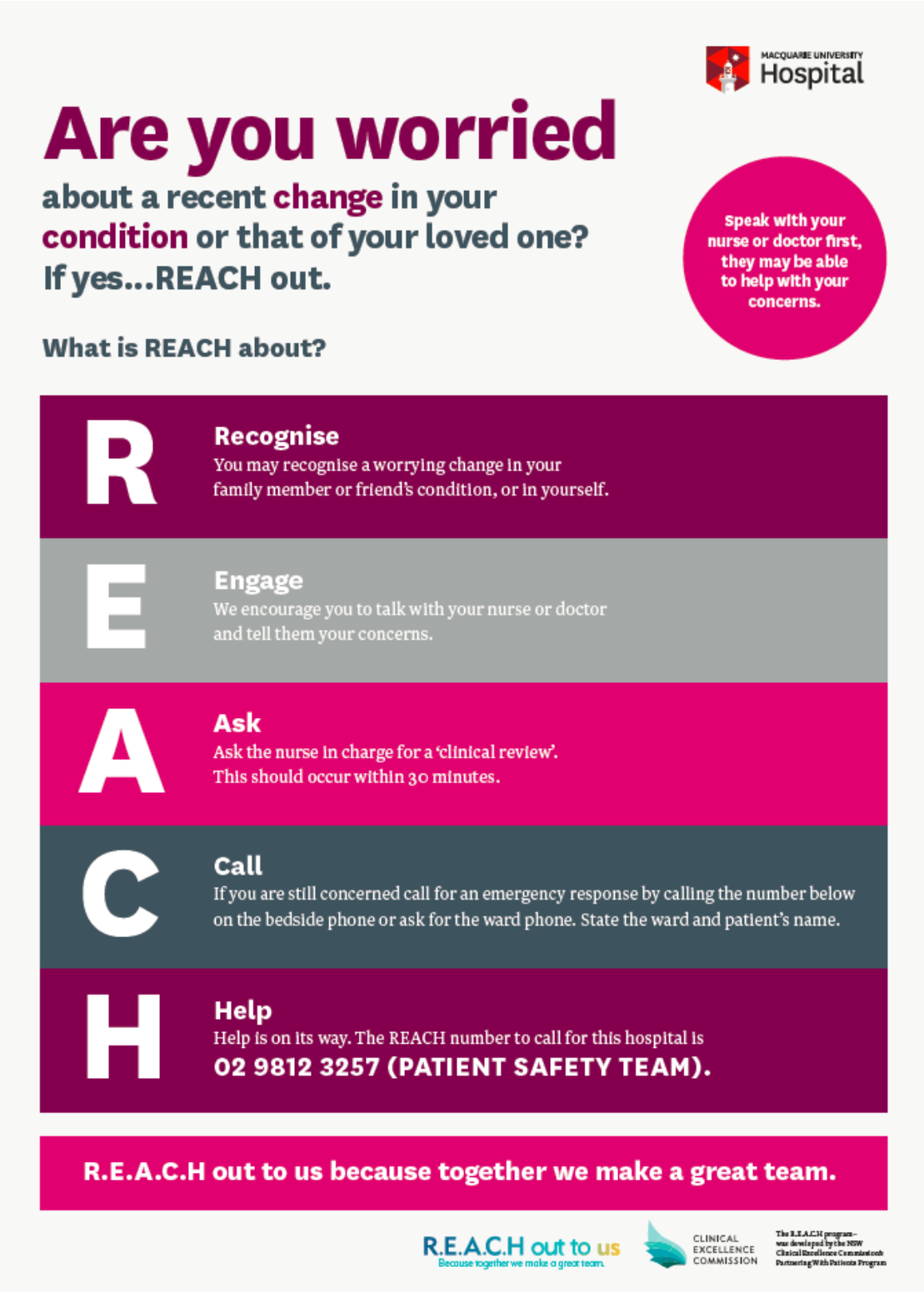
- Activate the closest EMERGENCY button or Dial 9999 Say "Code Blue"and give your location
- Commence BLS Procedure
- Prepare to handover using ISBAR principles

Observation Criteria – Code Blue

Airway/ Breathing	**Respiratory Rate** < 5 or > 30 breaths per minute
O2 Saturation O2 requirements	**SpO2** < 90% and/or Increasing oxygen (O2) requirements to maintain Oxygen saturation >90%
Circulation	**Systolic Blood Pressure** < 90 or > 200mmHg **Heart Rate** < 40 or > 140 beats per minute
Neurological	**Level of Consciousness** Only responds to pain (P) on the AVPU scale Sudden decrease in Level of Consciousness (a drop of 2 or more points on GCS) **Stroke** symptoms **F**ace.**A**rms.**S**peech.**T**ime
BGL/ Metabolic	Blood Glucose Level < 1 mmol/L
Clinical Review	Deterioration not reversed within 1 hour of Clinical Review Deterioration before or during Clinical Review

Appendix 3 Recognise Stroke think F.A.S.T Poster

Appendix 4 REACH Poster



Appendix 5 Link to Basic Life Support Flowchart

Link to Australian Resuscitation Council Flow Chart Page

Appendix 6 Link to Advanced Life Support for Adults Algorithm

Link to Australian Resuscitation Council Flow Chart Page

Appendix 7 Link to Paediatric Advanced Life Support Algorithm

Link to Australian Resuscitation Council Flow Chart Page

Appendix 8 Emergency Trolley Contents list

EMERGENCY TROLLEY CONTENT LIST

MQ Health
MACQUARIE UNIVERSITY
HEALTH SCIENCES CENTRE

TOP OF TROLLEY

- Life Pak 20 with Quick Combo Redi-Pak attached (Adult size)
- ECG Dots attached to 3 leads
- Disposable resuscitator attached to Oxygen cylinder
- Stethoscope
- Scissors
- Trolley contents list and checklist
- Pad of MUH Code Blue scribe forms

1ST DRAWER (INTUBATION SHELF)

- Syringe 10ml
- Lubricant jelly
- White tape
- ETT Tubes sizes 6, 7, 8
- Intubation Stylet
- Yeescope size 3&4
- Y suction catheters size 12
- Yankauer sucker ×1
- McGrill Forceps
- Guedel Airways size 3, 4, 5
- Co-Phenylcaine Forte Spray attached to nozzle
- Spare long and short nozzles ×1 each
- Easy cap CO2 Detector

BROSLOW PAEDIATRIC BAG LOCATIONS
ICU – Level 1
DOSU – Level 1
Ward 1 – Level 3
Ward 3 – Level 4

ICU ONLY

- Non-disposable Laryngoscope handle with MAC Blade 3 attached with plastic wrap to protect
- Spare MAC 4 laryngoscope blade with plastic wrap to protect

2ND DRAWER

- Water for injection 10mls ×5
- Sodium Chloride 0.9% for injection 10mls ×8
- Needles sizes 18, 21, 23, 25 ×5 each
- Chlorhexidine 2% in Alcohol 70% (Tinted Pink) Solution × 2
- 50ml Luer Lock syringe ×1
- Cotton Wool balls ×2 packets
- Large Tegaderm Dressing ×2
- Small Tegaderm Dressing ×2
- Steri Strips ×2 packets
- 20ml syringes ×3
- 1ml, 2ml, 3ml, 5ml, 10ml Syringes ×5 each
- Blood Gas (ABG) Syringes ×2
- IV cannula gauge 18g, 20g, 22g ×3 each
- IV cannula gauge 14g long ×2
- Salbutamol 5mg & Ipratropium 500mcg ×5 ampoules each
- GTN Spray ×1 bottle
- 3-way Taps ×3
- Micropins ×5
- Needless Port ×5
- Red IV Caps ×5
- Prep Pads (2% Alcohol / 70% Chlorhexidine)
- Transpore Tape
- 100mls 5% Glucose X1
- 100mls Sodium Chloride 0.9% ×1

Emergency Trolley Contents List Version 3.0 November 2019

SIDE OF TROLLEY

- Gloves (Small, Medium, Large)
- Tourniquet
- Sharps container
- Oxygen cylinder more than ¾ full
- Twinovac suction attached to tubing & Yankauer sucker
- Intubation Bougie ×2
- BLS/ALS Algorithms (laminated)

DRUG BOX (Second drawer, right-hand side)

- Noradrenaline 2mg ×2
- Adenosine 6mg ×3
- Adrenaline Minijet 1:10,000 ×3
- Atropine Minijet 1mg ×3
- Adrenaline 1:1000 ×5
- Lignocaine Minijet ×2
- Naloxone 400mcg ×5
- Calcium Chloride Minijet ×1
- Glucose 50% Minijet ×1
- Sodium Bicarbonate 8.4% Minijet ×1
- Flumazenil 500mg ×2
- Diazepam 10mg ×5
- Midazolam 5mg ×3
- Propofol 200mg ×2
- Metaraminol 10mg ×5
- Frusemide 20mg ×5
- Hydrocortisone 100mg ×1
- Promethazine 50mg ×1
- Amiodarone 150mg ×3
- Potassium Chloride 10mmol ×3
- Magnesium Sulphate 10mmol ×2
- IV Additive labels ×5

EMERGENCY DRUGS KEPT IN FRIDGE IN LOCKED CLEAN UTILITY ROOM
Suxamethonium 100mg ×2

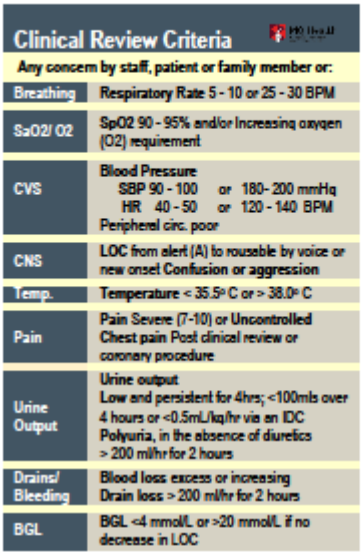
3RD DRAWER

- Nasogastric tube Salem Sump size 14 + Fixing tape
- Anti-Reflux Valve for Salem Sump
- 50ml Catheter Tip Syringe
- Nasopharyngeal Airways size 6 and 7 ×2 each
- ETT Tube sizes 6.5, 7.5, 8.5 & 9
- LMA sizes 3, 4, 5
- Non-rebreather Oxygen Mask
- Hudson Oxygen Mask
- Airway Needles (small and large)
- ECG dots ×6
- Pocket Mask
- Protective Goggles ×2
- Spare Quick-Combo Redi-Paks (Adult and Paediatric sizes) ×1 each
- Pedi-Cap CO2 Detector
- Razor

4TH DRAWER

- J-Loop IV connectors ×3
- Spare rolls printer paper for Life Pak ×3
- Dressing Pack ×1
- 5% Glucose 100mls ×2
- 5% Glucose 500mls ×1
- 0.9% Sodium Chloride 1000mls ×1
- Carefusion Infusion set ×1
- Carefusion Burette set ×1
- Blood Transfusion Pump set ×1
- ICU / Ward 3 / OT Cardiac – Pacing Box Dual Chamber and matching wires

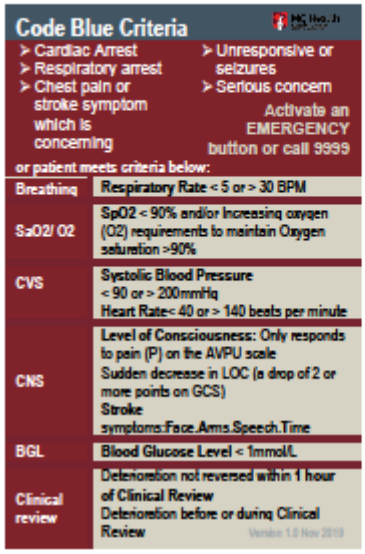
Appendix 9 Lanyard Card



Clinical Review Criteria

Any concern by staff, patient or family member or:

Breathing	Respiratory Rate 5 - 10 or 25 - 30 BPM
SaO2/ O2	SpO2 90 - 95% and/or Increasing oxygen (O2) requirement
CVS	Blood Pressure SBP 90 - 100 or 180 - 200 mmHg HR 40 - 50 or 120 - 140 BPM Peripheral circ. poor
CNS	LOC from alert (A) to rouseble by voice or new onset Confusion or aggression
Temp.	Temperature < 35.5° C or > 38.0° C
Pain	Pain Severe (7-10) or Uncontrolled Chest pain Post clinical review or coronary procedure
Urine Output	Urine output Low and persistent for 4hrs; <100mls over 4 hours or <0.5mL/kg/hr via an IDC Polyuria, in the absence of diuretics > 200 ml/hr for 2 hours
Drains/ Bleeding	Blood loss excess or increasing Drain loss > 200 ml/hr for 2 hours
BGL	BGL <4 mmol/L or >20 mmol/L if no decrease in LOC



Code Blue Criteria

- Cardiac Arrest
- Respiratory arrest
- Chest pain or stroke symptom which is concerning
- Unresponsive or seizures
- Serious concern

Activate an EMERGENCY button or call 9999

or patient meets criteria below:

Breathing	Respiratory Rate < 5 or > 30 BPM
SaO2/ O2	SpO2 < 90% and/or Increasing oxygen (O2) requirements to maintain Oxygen saturation >90%
CVS	Systolic Blood Pressure < 90 or > 200mmHg Heart Rate< 40 or > 140 beats per minute
CNS	Level of Consciousness: Only responds to pain (P) on the AVPU scale Sudden decrease in LOC (a drop of 2 or more points on GCS) Stroke symptoms:Face.Arms.Speech.Time
BGL	Blood Glucose Level < 1mmol/L
Clinical review	Deterioration not reversed within 1 hour of Clinical Review Deterioration before or during Clinical Review

Version 1.0 Nov 2019

15 Notes

1	Contact Officer	Primary point of contact for this policy and any queries relating to it	Zara McCann	
2	Policy Category	Which over-arching category does the policy belong?	Clinical and Operational	
3	Key Words	Include all key words to enable searching for policy – consider *other names* or terms used to describe the content	Observations, clinical, obs, Deteriorating Patient, Clinical Review, Code Blue, Rapid Response, ALS, BLS, Emergency, Airway, Breathing, Circulation, REACH, Mental Health Emergency, Aggressive, Abusive	
4	Relevant to	Please indicate all departments that this policy is relevant to	All Clinical Areas All Areas	

16. Policy and Procedure Committee Endorsement – *Completed by Patient Safety and Quality*

1	Implementation Plan	As nominated by the Policy and Procedure Committee for communication in appropriate areas and implementation of such	1. High Risk Communication 2. L&D Input into Plan 3. For general Document Review Register
2	Approval Authority	Final Sign off	Policy and Procedure Committee
3	Date Approved	As per Policy and Procedure Committee	17 September 2019

4	Review Date	Standard review date is three years unless earlier is required	August 2021

17. Metadata – for upload process

1	Documents superseded by this policy	List of any policy documents or previous authorities superseded by this policy.	Clinic Suites- Medical Emergency response policy Paediatric Deteriorating Patient Policy and Rapid Response (Code Blue) Policy Deteriorating Patient and Rapid Response (Code Blue) Policy Role of the Intensive Care Nurse in the Rapid Response Code blue Advanced Life Support Policy Basic Life Support Policy Checking of the Emergency Trolley Policy Management of Aggressive/Abusive Patient Psychiatric Emergency Procedure Clinical Observations Policy
2	Version History	Version Date (Month/Year)	Clinic Suites- Medical Emergency Response Policy/V2.0/June 2011

			Paediatric Deteriorating Patient Policy and Rapid Response (Code Blue) Policy/V3.0/October 2015 Role of the Intensive Care Nurse in the Rapid Response Code blue/V4.0/September 2016 Advanced Life Support Policy/V3.0/July 2016 Basic Life Support Policy/V4.0/July 2016 Checking of the Emergency Trolley Policy/V5.0/July 2016 Management of Aggressive/Abusive Patient/V2.0/October 2016 Psychiatric Emergency Procedure/V4.0/April 2018 Clinical Observations Policy/V4.0/April 2018 Deteriorating Patient and Rapid Response (Code Blue) Policy/V4.0/June 2018

POLICY REVIEW TOOL

Purpose

This tool is for use by staff members when developing/reviewing policies. Submit a copy of the completed form with the proposed new/revised policy to all members of the applicable committee as a guide for their review.

Title of Policy for Review: _____Clinical Observations and Deteriorating Patient Policy

Date of Review: _____August 2019_____

Criteria	Meets Criteria		Comments/Changes required
	Yes	No	
Reason for the review or new development	yes		Addition of REACH and amalgamation of a number of policies
Does the policy comply with current: • Legislation • NSW Health • Clinical Excellence Commission • ACORN, HICMR, Other	yes		
Does the policy reflect consistency with current practice standards: • Best Practice • Research • Literature Review current reference list and update	yes		
Affected Policies – please identify			As per notes table
Allocated Reviewers • Relevant NUM / Manager • Pharmacist (if relevant) • Medical Directorate • Expert in Field / Educator			As per below
Executive Sponsor Name			Deborah O'Neill

Policy Reviewed by:

Name:	Title:	Signature:
Zara McCann	Patient Safety and Quality Facilitator	author
Jodie Burke	Nursing Unit Manager ICU	Feedback received, content amended
Deborah O'Neill	Director Of Nursing	
David Thompson	Patient Safety and Quality Manager	Feedback received, content amended
Edwina Holmes	Nurse Educator Operating Theatres	Feedback received, content amended
Melanie Webb	Career Medical Officer	Content accepted
Dr Nargis Shaheen	Geriatrician	Content accepted
Myra Tengasantos	Nursing Unit Manager Endoscopy	Content accepted
Wendy Frazer	Nursing Unit Manager Angiography	Feedback received, content amended
Alynne Ledesma	Nursing Unit Manager Ward 4	Content accepted
Abdul Sharma	Manager Security	Content accepted
Geoffrey Matthews	Infection Control Coordinator	Feedback received, content amended
Elizabeth Marshall	Clinical Nurse Specialist/ After Hours Manager	Content accepted
Julie McInnis	Clinical Nurse Educator	Feedback received, content amended
Dr Michael Parr	Director, Intensive Care	Feedback received, content amended
Tania Ruiz	Acting NUM 3 ICU	Feedback received, no changes suggested
Enver Varka	Acting NUM 1 ICU	Feedback received, no changes suggested