Clinical Emergency Response System (CERS) - Management of the Deteriorating Patient

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.

N.B

For mental health deterioration, please refer to RHW Mental Health Escalation LOPs

For neonates, please refer to CERS- Management of the Deteriorating Neonate LOP

1. AIM

To facilitate the early recognition and management of the deteriorating person utilising the Clinical Emergency Response System (CERS)

2. PATIENT

- Acutely unwell woman, visitor, or staff member

3. STAFF

- All hospital staff

4. EQUIPMENT

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

5. CLINICAL PRACTICE (see Appendix 2)

- Activate a **CERS** call by dialling the emergency number **'2222'** from any phone in the hospital
- Request appropriate level of escalation, stating the exact location and the admitting medical officer (if known). If a CERS call is activated in Delivery Suite, care defers to the on-call obstetric consultant. This activation is determined by deviations from (as below):
  - Standard Maternity Observation Chart (SMOC)
  - Standard Adult Observation Chart (SAGO)

- Activate a **Clinical Review 30-minute response time** for:
  - a woman following consultation with the nurse/midwife in charge when one observation is in the **yellow zone** or
  - a staff member, patient or family/carer is concerned

- Consult with nurse/midwife in charge. If they determine that a clinical review is not required, they should review the woman and consider increasing the frequency of observations as indicated by the woman's condition, with consideration given to any intervention to reverse and/or halt deterioration
- Findings of assessment, nursing intervention and reason for non-escalation should be documented in the woman clinical record using the electronic Medical Record (eMR) Clinical Review form
- Activation of a **Clinical Review MUST** occur if **two or more** observations are in the **yellow zone**

  Medical responders to a Clinical Review will be the admitting medical team Resident.

- Activate a **Rapid Response 5-minute response time** for:
  - a woman who has any observations in the **red zone**, or
  - a woman requires a 30-minute or 60-minute emergency caesarean section

    For 30 and 60 min LSCS criteria please refer to maternal preparation and receiving the Neonate LOP
  - if there has been no response to a Clinical Review call (30 minutes)

- Remain with the woman once a CERS call has been activated. Increase frequency of observations, as indicated by the woman's clinical condition considering any potential signs of sepsis. Initiate any appropriate clinical care within scope of practice
- **Document all clinical reviews and rapid response calls on the eMR electronic form.**

  Medical responders to a Rapid Response will consist of admitting medical team Registrar and anaesthetist (allocated from Theatres to respond to Rapid Response and Code Blue calls at the RHW). At least one of the medical responders will be skilled in Advance life Support.

- Activate a **Code Blue immediate response** for:
  - Woman with any potentially life-threatening condition, such as cardiac/respiratory arrest, airway obstruction, stridor, threatened airway, seizures (new or prolonged), stroke or
  - serious concern by staff member, patient, family and/or carer
  - any non-admitted woman, visitor, or staff member who requires medical assistance

  Medical responders to a Code Blue will consist of admitting team registrar and anaesthetist (allocated from Theatres to respond to Rapid Response and Code Blue calls at the RHW). At least one of the medical responders will be skilled in Advance life Support.

- Escalate to Prince of Wales Hospital (POWH) Code Blue team if extra assistance or support is required. The POWH Code Blue team can be activated by dialling **'2222'** and requesting the **'POW Adult Code Blue Team'** for the exact location. It is advised to have a staff member direct the POWH team in from the lift
- Provide clinical handover to the responder using ISBAR (Introduction, situation, background, Assessment and Recommendation)

- Use maxi lifter located in Macquarie Ward or slide lifter located in the mail room, to lift person from the floor to a bed or trolley
- If an acute stroke is suspected a Rapid Response call must be activated and the patient assessed immediately. If the patient is deemed safe for transfer, the patient must be transferred to **POW Emergency Department (ED)** for urgent assessment by the Neurology team. POW ED must be informed of the immediate transfer on **ext. 28400.** Please refer to the management of patients with suspected or identified acute stroke symptoms at RHW flowchart.
- Documentation of Code Blues must be on the paper based **SESLHD Resuscitation Form** (located on every emergency trolley) and the yellow copy send to the CERS Clinical Nurse Consultant (CNC) for review. The white copy remains in the patients clinical notes.
- Notify the woman, family, or carer that a Clinical Review, Rapid Response or Code Blue was activated and outcomes of the review and/or change of location
- Alter standard calling criteria only if appropriate, following assessment of the woman's condition along with input from woman, carers, or family. A medical officer must consult with the admitting medical officer or delegated clinician prior to altering the standard calling criteria Document alterations to calling criteria on the appropriate electronic observation chart in the electronic medical record. Any alterations to acute calling criteria must be reviewed by a medical officer every 8 hours
- Complete Incident information management system (IIMS) notification if criteria met

6. DOCUMENTATION

- eMR Clinical Response Form
- eMR Rapid Response Form
- SESLHD Resuscitation Form (SEI110.020)
- Medical record
- IIMS
- Standard Maternity Observation Chart (SMOC)
- Standard Adult General Observation (SAGO)

7. EDUCATIONAL NOTES

- Ensure annual Adult Basic Life support (ABLS) assessments are attended by all medical, midwifery, nursing, allied health staff and porters
- Ensure Advanced Life Support assessments completed and renewed as per specific organisation
- In the event that a Rapid Response call is activated, whilst another is still in progress; the team responding to the initial call will conduct a clinical assessment and then negotiate who is the most appropriate person to remain with the patient. The remaining members will attend the second call
- In the absence of an individualised monitoring plan, frequency of observations should occur at a minimum requirement of six hourly intervals

- Following an activation of a clinical review, rapid response or code blue all clinicians (nursing or midwifery and medical staff) should document a systematic A-I assessment (Airway, Breathing, Circulation, Disability, Exposure, Fluids, Glucose, Holistic and Infection) for the woman in the woman medical record
- All nursing and midwifery staff should observe and document daily any changes in a woman's' cognitive function, perception, behaviour, or emotional state. These changes maybe characterised by an acute or gradual change in mental state. Assess and incorporate mental state changes (i.e. cognition, perception, behaviour or emotional state) as part of A-I systematic assessment and escalate any changes from the woman's' baseline using CERS to ensure appropriate investigation, diagnosis and treatment can occur with possible referral to specialist teams

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOPs

- SESLHD PR283 Deteriorating Patient – Clinical Emergency Response System for the Management of Adult and Maternity inpatients November 2019 (Currently under review)
- NSW Ministry of Health Policy Directive. PD2020_015. Recognition & Management of Patients who are Clinically Deteriorating. May 2020.

9. RISK RATING

- High risk

10. NATIONAL STANDARD

- Standard 8 - Recognising and responding to the deteriorating patient

11. REFERENCES

1 SESLHD PR283 Deteriorating Patient – Clinical Emergency Response System for the Management of Adult and Maternity inpatients November 2019

2 NSW Ministry of Health Policy Directive. PD2020_015. Recognition & Management of Patients who are Clinically Deteriorating. May 2020

3 NSW Health Policy Directive PD2001_020 Clinical Handover

Nil

REVISION & APPROVAL HISTORY

Reviewed and endorsed Maternity Services LOPs group November 2019 – previous title Patient (Adult) with acute condition for escalation (Pace) criteria and escalation
Amended August 2019 – change from PACE to CERS
Change 777 to 2222 February 2019
Approved Quality & Patient Care Committee 21/6/18
Reviewed and endorsed Maternity Services LOPs 19/6/18 – previous title Adult Cliical Emergency Response System (CERS) ad Escalation
Approved Quality & Patient Safety Committee 17/7/14
Approved Quality & Patient Safety Committee 18/11/10
Gynaecology Services Management Committee 11/11/10
December 2019 reviewed and approved RHW Safety & Quality Committee

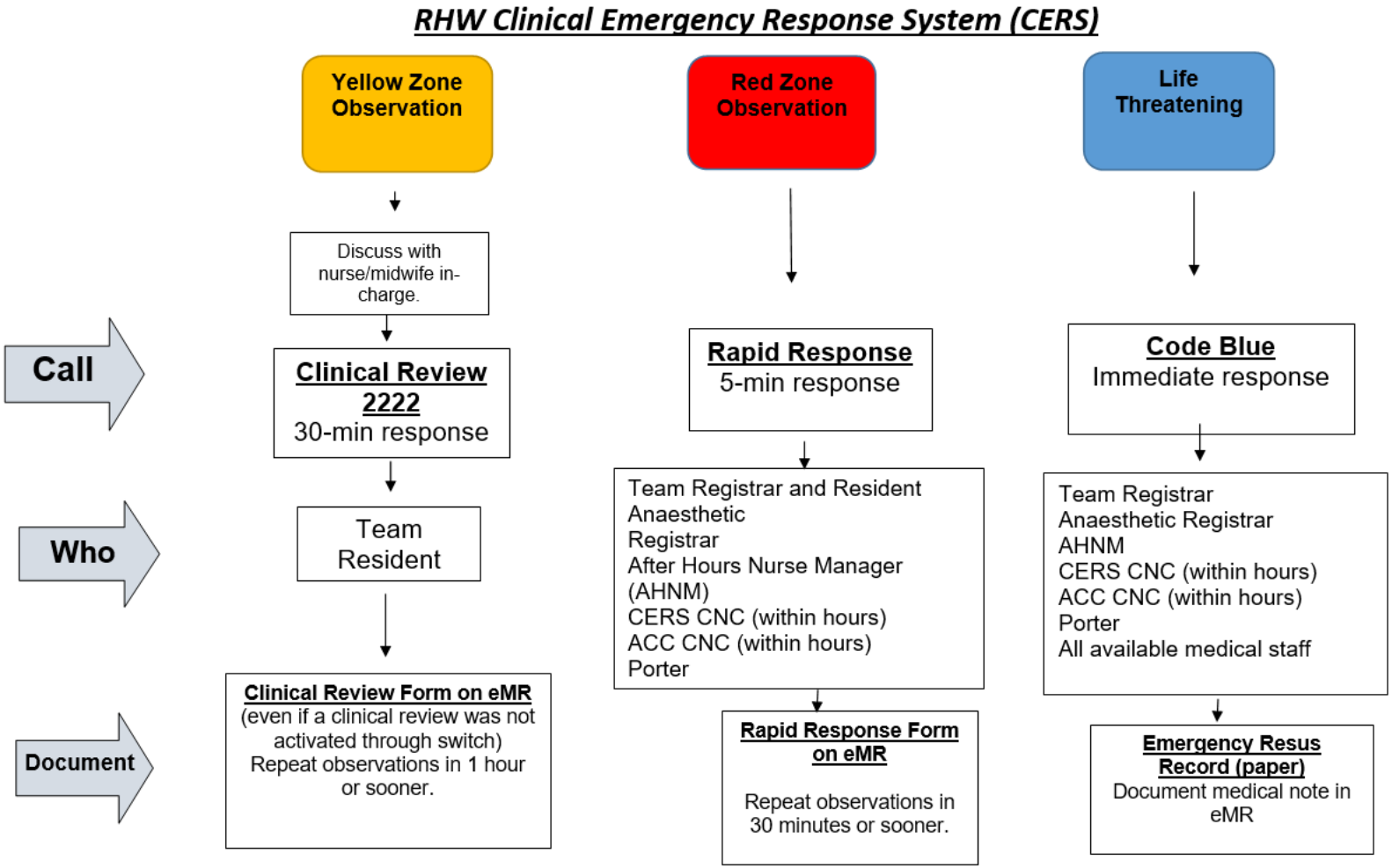
FOR REVIEW: DECMEBER 2022

APPENDIX 1

RHW CARDIAC ARREST TROLLEY/DEFIBRILLATOR LOCATIONS

LEVEL	WARD	DEFIBRILLATOR
Level 4	Acute Care Centre (ACC)	Yes –R 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 – R Series
Ground	Admissions – Behind front desk	Yes – AED
Ground	Reproductive Medicine	No defibrillator – Cardiac arrest trolley only

Appendix 2


RHW Clinical Emergency Response System (CERS)
Yellow Zone Observation
Red Zone Observation
Life Threatening
Call
Who
Document
Discuss with nurse/midwife in-charge.
Clinical Review 2222
30-min response
Team Resident
Clinical Review Form on eMR
(even if a clinical review was not activated through switch)
Repeat observations in 1 hour or sooner.
Rapid Response
5-min response
Team Registrar and Resident Anaesthetic Registrar
After Hours Nurse Manager (AHNM)
CERS CNC (within hours)
ACC CNC (within hours)
Porter
Rapid Response Form on eMR
Repeat observations in 30 minutes or sooner.
Code Blue
Immediate response
Team Registrar
Anaesthetic Registrar
AHNM
CERS CNC (within hours)
ACC CNC (within hours)
Porter
All available medical staff
Emergency Resus Record (paper)
Document medical note in eMR