Recognising and Responding to Acute Deterioration Procedure

1. Purpose

The purpose of this procedure is to outline the systems and processes in place for recognising and responding to acute deterioration for adult, maternity, newborn and paediatric patients, and is inclusive of mental health inpatients and aged care residents within WACHS healthcare facilities and residential aged facilities.

Where a Medical Emergency Response (MER) is required outside the health facility location, ambulance assistance is to be sought by dialling '000' (WACHS staff may be first responders).

2. Procedure

This procedure is to be read in conjunction with the WACHS Recognising and Responding to Acute Deterioration Policy.

2.1 Risk assessment

Baseline documentation of risks identified during admission are completed on:

- Child and Adolescent Mental Health Service Initial Assessment (CAMHS001)
- Child and Adolescent Mental Health Service Risk Assessment and Management Plan (CAMHS002)
- Child and Adolescent Mental Health Service Physical Examination (CAMHS005)
- MR70C WACHS Pregnancy Instruction Sheet
- MR75 WACHS Newborn Care Plan
- MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis
- MR80A.2 WACHS Postnatal Risk Assessment for VTE Prophylaxis
- MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults
- MR111P WACHS Paediatric Nursing Admission / Discharge Assessment
- RC5 WACHS Resident Admission Assessment
- Adult Mental Health Assessment (SMHMR902)
- Adult Mental Health Physical Examination (SMHMR903)
- Adult Mental Health Risk Assessment and Management Plan (SMHMR905)
- WACHS Residential Aged Care - Admission to a Residential Facility Flowchart.

Several of the forms above have inbuilt mechanisms for referral to more comprehensive assessments or specialist staff as indicated by the initial risk assessments.

Ongoing assessment and management plans are outlined on:

- MR120 WACHS Adult Nursing Care Plan
- MR120P WACHS Paediatric Nursing Care Plan
- MR115 WACHS Paediatric Short Stay Medical Admission
- MR80 WACHS Vaginal birth postnatal Care Plan
- MR81 WACHS Caesarean Postnatal Care Plan
- MR70A WACHS Antenatal Inpatient Care Plan
- RC7 WACHS Resident Care Plan

- Mental Health Treatment, Support and Discharge Plan (SMHMR907).

For non-admitted patients in the Emergency Department the BACPAC assessment (Appendix 1) and MR46 WACHS Suicide Risk Assessment and Safety Plan is to be used. Refer to the WACHS Assessment and Management in the Emergency Department Clinical Practice Standard.

2.2 Recognising acute deterioration

Observation and response charts (ORCs)

The following observation and response charts are endorsed for use in WACHS:

- MR140a Adult Observation and Response Chart (A-ORC)
- MR140c Maternal Observation and Response Chart (M-ORC)
- MR140d Newborn Observation and Response Chart (N-ORC)
- MR 140e-i Paediatric Acute Recognition & Response Observation Tool (PARROT)

Age limits for the PARROT

- The upper age limit for the 12 years and above PARROT chart is 15 years +364 days. Note: children admitted to a dedicated WACHS Paediatric Ward / Unit between 16 years and 17 years +364 days can remain on a 12 years and above paediatric chart.
- Any infant presenting to a WACHS site should have their observations recorded on the age-appropriate PARROT chart, including babies less than 28 days who have been discharged from newborn care and who then represent and / or are admitted. For example, a baby who is discharged on day 3 of life, and is then readmitted on day 5 of life will be placed on the <3month PARROT chart.

Modifications

In keeping with the WA Health MP 0086/18 Recognising and Responding to Acute Deterioration Policy, modifications to the response criteria can only be made in exceptional circumstances and should only be made by consultants, or by the most senior doctor available in smaller sites, depending upon the area / location in which the patient is at the time.

Larger sites, where areas or departments have their own medical teams, are responsible for modifications in those areas / departments, e.g., where a patient transfers from ED to a ward – modifications to the response criteria should be made by the ward medical team familiar with the staffing levels and parameters appropriate to that area rather than the ED doctors.

Any such modification requires careful consideration, balancing the risk of reduced sensitivity of the escalation activation system, with the benefit of altered criteria.[16] Modifications can only be made following a full review of the patient, and with sound clinical rationale being documented.

Instructions for modifications are outlined in the ‘Modifications’ section (page 1) of the Adult, Maternity and Newborn ORCs.

For the PARROT where a health service utilises a senior doctor, who is remotely on call or Emergency Telehealth Service, modification may be authorised by verbal order from a Senior Medical Officer (SMO) to the on-site Nursing staff. The Nursing staff (two nurses - if

available) are to repeat the modification order for clarification before entering the directions onto the PARROT chart and confirming in the 'events section' that a verbal order for the modifications has been taken (see example below). Modification advice is also to be

Modification to Early Warning Score (EWS)

- Acceptable parameters can be modified based on the patient's specific clinical, treatment and/or pre-existing conditions.
- All modifications must adhere to local process and be reviewed frequently by the treating consultant.
- **Modifications must NEVER be used to normalise a clinically unstable patient.**

Observations	Accepted parameters and modified EWS	Date and time	Duration (hrs)	Name and signature
SaO_2	80-92% = EWS of 0	16/4/20	72	Name Dr. George (ETS FACEM)
Reason:	Cyanotic Heart Disease			Signature Brown
		/ / :		Name
Reason:				Signature
		/ / :		Name
Reason:				Signature

Events – record event details, including interventions, and concerns from clinician or family

	Intervention/comment	Initials
A	Verbal order for modifications taken by Sarah Plummer RN + Will Price RN	SP/WP
B		

Figure 1: documentation of modifications given by phone order

recorded in the medical notes by the SMO and sent to site as soon as practicable.

Delirium and cognitive impairment

Prevention is the most effective strategy, but outcomes for patients with delirium can also be improved by early recognition and intervention.

Staff should be alert for changes such as disturbance of consciousness, attention, cognition and perception that develop over a short period of time and should acknowledge concerns raised by family members and carers, asking them, "Do you think (name of person) is thinking differently or behaving differently over the last few hours or days?".

All patients who are identified as being at high risk of delirium, such as those with dementia, fractured hip or an older person post-surgery or previously diagnosed with delirium, are to be provided the WACHS Delirium Patient / Family information brochure to support consumer engagement to prevent and treat delirium.

Refer to the WACHS Cognitive Impairment flowchart for screening and assessment procedures (including the AMT4 tool and Single Question in Delirium), and prevention and management strategies (P.I.T.C.H.E.D).

Prompt medical escalation is required for all patients scoring 4 or above on the MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium and a medical assessment for Delirium must be completed, documenting outcomes and interventions.

Further guidance in recognising and managing cognitive impairment and delirium can be found in the WACHS Cognitive Impairment Clinical Practice Standard and the WACHS Cognitive Impairment intranet page.

Mental state deterioration

Defined as “Change in a person’s perception, cognitive function or mood which negatively influences their capacity to function as they would typically choose”.[16]

Baseline information is essential to determining whether deterioration has occurred – this must be established and documented in the healthcare record. Assess for:[19,20]

- Behaviour
- Appearance
- Conversation
- Perception
- Affect and Mood
- Cognition

Refer to Appendix 1: BACPAC Mental State Assessment Descriptions for further information on each of the above assessment areas.

Enquire with the patient, as well as their family, carer and/or Next of Kin (NOK) to determine whether they have observed changes in behaviour consistent with deterioration in the patient’s mental state. Families and close friends have a central role in identifying early stages of deterioration in a person's mental state.[19,20]

If the patient does not exhibit any of the features described above, document their baseline mental state in the healthcare record.[19,20]

If the patient displays any of the indicators listed above, or the patient, family, carer or NOK report the potential for deterioration, commence safety planning and use the WACHS Recognising and responding to acute mental state deterioration flowchart (Appendix 2).

2.3 Escalating care

Escalation templates

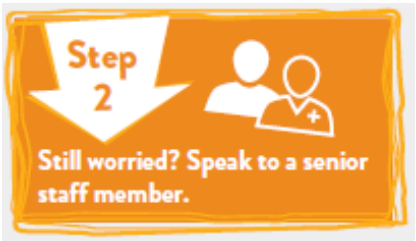
A suite of observation and response escalation and medical emergency response templates exists inside WACHS:

- templates are available via the intranet for the following areas:
  - Adult and Maternity (Ward)
  - Adult and Maternity (Emergency Department)
  - Paediatric ward / unit
  - Paediatric Emergency Department
  - Newborn
- each site is to identify the internal and external relevant site / regional contacts who would assist with escalation
- the templates are to be reviewed annually for currency, or sooner if essential information changes
- a copy of the completed and signed template is to be maintained in accordance with the WACHS Corporate Recordkeeping Compliance Policy.

Aishwarya's CARE Call

The Aishwarya CARE call escalation process comprises three steps:

Reminds the patient, family member or carer to talk to the nurse, midwife or doctor caring for them if they have any concerns about their own health or that of their loved one's health. Note: there are both paediatric and adult versions of Aishwarya's CARE Call materials with tailored wording of this step.



Encourages the patient, family member or carer to ask to speak to the shift coordinator, nurse or midwife in charge if they still have concerns and feel that these have not been addressed by their primary carer.

Provides the ability for the patient, family member or carer to make a CARE call and speak to a senior staff member if they still have concerns that they don't feel have been adequately addressed.

When an Aishwarya CARE Call is made, a senior staff member should listen to the concerns of the caller, and make a full assessment of the patient's situation, liaising with the treating medical team and other health care providers as required.

A decision support flowchart is available to assist staff in managing the Aishwarya's CARE Calls they receive. This includes the use of the MR141 WACHS CARE Call Clinical Review Record and a regional log of Aishwarya's CARE Calls.

Materials to promote Aishwarya's CARE Call are available from the WACHS Safety and Quality CARE Call resources intranet page. Posters are to be laminated to meet infection control guidelines for environmental cleaning.

Specific clinical area information

- Mental Health Units
  - Certain incidents involving physiological deterioration may need to be reported via CIMS Datix or to the Chief Psychiatrist – refer to the Policy for Reporting of Notifiable Incidents to the Chief Psychiatrist - Public Mental Health Services 2018.
  - Physiological Deterioration of a Mental Health Patient: there is overwhelming evidence indicating poor physical health outcomes for people with mental illness.[12] It is important to minimise delays in recognising and escalating a mental health patient's physiological deterioration.
    Relevant standards and guidance from the Chief Psychiatrist include the Chief Psychiatrist's Standards for Clinical Care and Clinical Guidelines for the Physical Care of Mental Health Consumers (UWA)

Where a patient's physiological deterioration requires ongoing complex medical care beyond the capacity of a mental health unit, transfer to an appropriate unit or hospital will be considered in accordance with hospital procedures.
    - Mental State Deterioration of a Mental Health Patient: in an authorised mental health unit, all treatment in the management of mental state deterioration is to be in accordance with the *Mental Health Act 2014* (WA). This includes the use of emergency psychiatric treatment, restraint and seclusion.

- Theatre, Recovery, Intensive Care Units and High Dependency Units
    - These are specialised areas in which the most appropriate responders to clinical deterioration are often present, thus it may not always be appropriate to call the MER team. Local escalation plans for the area are to be followed.

- Remote Area Clinics and Nursing Posts
    - The MR140 series charts are to be used at remote area clinics and nursing posts.
    - Emergency escalation templates a are recommended for use (refer to Section 2.3.1). The editable information on the templates can be tailored to suit the location and agreed local processes. Access to this information is essential for staff rotating / relieving at these locations.
    - Some regions may also have local regional / site procedures in place relating to clinical escalation - these should be included as part of the orientation process to those relevant sites / locations.

- Older Person
    - Recognising acute deterioration in older people may be challenging due to complex underlying health issues - vague and nonspecific complaints are not to be dismissed as they may be signs of acute deterioration.
    - An acute deterioration of mental state can be an early marker of a serious condition. Early recognition and escalation can improve the older person's health outcomes and reduce rates of comorbidities for treatable geriatric syndromes.
    - Escalation of care for an aged care resident will depend on the care type and documented preferences of the resident (check for RC00H.1 WACHS Residential Goals of Care form). Those whose care type moves to acute – escalation will follow the site escalation template. For those who do not move to acute, refer to the WACHS Care location for acutely unwell MPS Aged Care Resident Flowchart or as relevant, the WACHS Use of Advance Care Planning, Advance Health Directives and Goals of Patient Care in Residential Facilities Flowchart.

2.4 Responding to deterioration

MER response

A Code Blue emergency call should be placed as indicated in the escalation criteria and actions on the ORC / PARROT charts.
Exceptions:

- Advance Health Directives that preclude resuscitation,
- Clearly documented 'Not for Rapid Response' instruction (e.g. GoPC form), or
- Authorised modified observation parameters (e.g. ORC / PARROT).

At some sites Medical Review and MER may be via telephone or videoconference e.g. Emergency Telehealth Service (ETS).

It must be clear to all team members who the MER team leader is at the beginning of the medical emergency response and thereafter when the leadership role changes.

- Resuscitation algorithms
  WACHS endorses:
  - CAHS Neonatology Resuscitation: Neonatal (Newborn Life Support Algorithm).
  - Australian and New Zealand Committee on Resuscitation (ANZCOR) guidelines and flowcharts for:
    - Basic Life Support Flowchart
    - Adult Cardiorespiratory Arrest Flowchart (Advanced Life Support for Adults)
    - Paediatric Cardiorespiratory Arrest Flowchart (Advanced Life Support for Infants and Children)
    - Advanced Paediatric Life Support (APLS) Paediatric Basic Life Support Flowchart
  - When applied, the information contained in these guidelines must take account of the context and scope of practice, level of service delivery and facility capacity.

- Resuscitation during the COVID-19 Pandemic
  The Australian Resuscitation Council provides the following resources:
  - Resuscitation during the COVID-19 pandemic (Australian and New Zealand Committee on Resuscitation [ANZCOR])
  - Flowchart 7 Preparedness for CPR (National COVID-19 Clinical Evidence Taskforce)
  - Flowchart 6 CPR In Hospital (National COVID-19 Clinical Evidence Taskforce).

- **MER record**

  The shift coordinator[21] is to ensure a MER record form is completed for every MER.

  All MER calls are to be documented on either the:
  - MR140 WACHS Medical Emergency Response (MER) / Code Blue Record; or
  - MR75B WACHS Newborn Medical Emergency Response (MER) Record.
  - All MER events recorded on a MER record form require a regional process for clinical review by a senior nurse / midwife or medical officer.

  The clinical review should assess:
  - events preceding the MER
  - MER process
  - outcome of the MER
  - whether a clinical incident has occurred and if investigation has occurred through the Datix Clinical Incident Management System (CIMS).

  Results and actions from MER record clinical reviews are to be tabled at appropriate site / regional committees.

Mental state deterioration

Refer to Appendix 2: Recognising and responding to acute mental state deterioration flowchart for management strategies and escalation.

If new confusion or altered mental state is identified or suspected, this must be documented and escalated to the Shift Coordinator / Team Leader and Treating Team without delay.

It is the responsibility of the treating MO to undertake a comprehensive assessment of the patient and to escalate to colleagues with appropriate expertise to manage physical or psychological conditions related to changes in mental state.

The effectiveness of the response must be continuously assessed and adapted to current need. Assess the patient's mental state variation from baseline each shift.[19]
The patient's management plan, which must include frequency of observations and monitoring, must be documented in the healthcare record.

- Personal Threat (Code Black)
  - Where deterioration in mental state (resulting in personal threat, to self or others), an emergency response is activated. Early response to escalating violence and aggression is an opportunity to better support staff and patients.
  - A Code Black Personal Threat activation can be made by any staff member who feels the situation is an emergency including patients actively attempting suicide or engaging in self-harm.
  - Refer to site / facility specific Emergency Response Procedures and the WACHS De-escalation Techniques Information Resource.

- Facility equipment and systems
  - Code Blue Alarm System Testing: it is a requirement for each region to ensure they have a process for testing of code blue alarm systems at all their facilities on **a minimum annual basis**, with scheduling of the testing and maintenance to be documented within the Agility Maintenance Database coordinated by Facilities Management.
  - Resuscitation Medications: resuscitation medications that require refrigeration are to be stored in an appropriate area that is easily accessible in the event of a MER. The team leader is to ensure that these medications accompany the MER team to the patient. Storage requirements of restricted medicines within a resuscitation trolley must be in line with the requirements set out in the WACHS Medication Handling and Accountability Policy.

- Resuscitation Equipment
  - WACHS Resuscitation trolley recommended minimum equipment lists provide the recommended minimum content for MER at all sites. The standardised lists ensure provision in all clinical areas for access to resuscitation equipment and drugs consistent with the ANZCOR Standards for Resuscitation: Clinical Practice and Education 2014, recommendations and suggested equipment.[4]
  - All clinical staff are to be familiar with the location and appropriate use of resuscitation equipment including competency requirements. This information is to be provided to staff during orientation.
  - Portable oxygen and suction must be available, and in good working order
  - Resuscitation equipment including defibrillator is to be checked by the nurse / midwife who has the delegated clinical responsibility for the area.
    Frequency of checking:
    - As a minimum of daily or after use (except Nursing Posts where checking is to be once per week)
    - Every shift where an area / bay is designated for emergency services or critical care, and staff are rostered on a shift by shift basis in the area
    - Checking of all defibrillators is to occur as per the manufacturer's guidelines. Checklists for the standard defibrillators used in WACHS (for checking defibrillator equipment and functionality) include the Zoll R series and Zoll X series
    - Where a problem is identified, the problem and the actions taken are to be documented

  - The records of checking and audit of checking should be managed in accordance with the WACHS Corporate Recordkeeping Compliance Policy.

- Communication and documentation
  Ensure accurate documentation in the patient's healthcare record and use iSoBAR for **all** communication including transfer of care within / to another facility, clinical care coordination team, or with transport providers (e.g. ambulance personnel, RFDS) occurs in accordance with:
  - WA Health MP0095/18 Clinical Handover Policy
  - WACHS Assessment and Management of Interhospital Patient Transfers Policy,
  - MR184 WACHS Inter-hospital Clinical Handover Form
  - MR184A WACHS Resident Handover
  - MR184B WACHS Intra-hospital Clinical Handover Form
  - MR184C WACHS Interhospital Transfer Maternal Form
  - MR184P WACHS Interhospital Transfer Neonatal Paediatric

  Medical and nursing / midwifery staff must document the plan for monitoring observations, treatment and escalation of the deteriorating patient at the time of admission. The management plan must include the frequency of observations, taking into consideration:[15,16]
  - the patient's diagnosis
  - presence of comorbidities
  - treatment and protocol requirements
  - restrictions to intervention associated with any Advance Health Directive, Advance Care Plan, GoPC forms or Care Plan for the Dying Person.

  The plan must be reviewed and modified based on the patient's clinical status and / or treatment as clinically appropriate, and the outcomes of this treatment documented in the patient's medical record.

3. Roles and Responsibilities

Medical Officers

- Provide appropriate medical intervention as required
- Communicate effectively with the other members of the team and document review in the health care record
- Ensure adequate post MER follow up or appropriate escalation of care
- In the case of mental state deterioration, assess the patient and situation, consider escalation to mental health treatment team as appropriate and / or consider calling a code black in case of immediate risk of harm.

MER Team Leader

This role is to be performed by the most experienced clinical expert available.

- Ensure that it is clear to all team members who the MER team leader is at the beginning of the medical emergency response and thereafter when this leadership role changes
- Be ALS (adult / paediatric / neonatal as required for the situation) competent and experienced staff member
- Communicate effectively with all team members
- Identify the tasks or roles required specific to the emergency

- Identify and notify all available human resources including ensuring sufficient and suitable medical, nursing / midwifery and support personnel are called
- Coordinate and delegate roles in accordance with priority of need and in consideration of skill levels / competency / scope of practice of team members
- Delegate the retrieval of additional equipment / medications to an appropriate nursing / midwifery or other staff member
- Ensure situational awareness of immediate and surrounding environments including the delegation of care of all other patients to appropriate personnel
- Maintain a safe working environment.

Shift Coordinator

- Provide senior nurse / midwife review and documentation (in the health care record) of assessment and plan for all patients who meet the senior nurse / midwife review criteria[21]
- Communicate to medical officer if medical review is required and document review in intervention / event section of ORC / PARROT chart
- Initiate MER if need identified and if other staff have not already done so
- Contact other medical staff as requested by MER leader (e.g. second MO, obstetrician, anaesthetist, surgeon)
- Contact radiology, pathology and theatre team on call as required / available
- Initiate BLS and ALS (where competent) until MER Team arrives
- Communicate patient's condition, history and progress to MER Team
- Complete and submit MR140 or MR75B (Newborn) Medical Emergency Response Record
- In the case of mental state deterioration, assess the patient and situation, consider escalation to medical officer as appropriate and / or consider calling a code black in case of immediate risk of harm.
- Ensure that compliance with checking of resuscitation equipment has been met.

Ward Nurse / Midwife

- Escalate response as per ORC / PARROT or if concerned
- Escalate response if family and or carer indicate concern
- Communicate effectively with Shift Coordinator
- Document observations appropriately
- Document escalation of care in the interventions (ORC) or events (PARROT) section
- Ensure resuscitation trolley nearby if deterioration identified
- Ensure patient notes and ORCs / PARROTs are available at bedside
- Follow instruction by MER leader and deliver appropriate care within their scope of practice
- Check and re-stock MER equipment daily (weekly for Nursing Posts) and immediately following use
- Report equipment issues to nursing/midwifery manager
- In the case of mental state deterioration, assess the patient and situation, consider escalation to shift coordinator and/or consider calling a code black in case of immediate risk of harm.

Code Black Responders

- Respond to a code black emergency call in accordance with local emergency management protocols

4. Monitoring and Evaluation

4.1 Monitoring

Data collection and interpretation at a site, regional and area level includes:

- Audit using the agreed WACHS audit tools available on the WACHS Clinical Audit intranet page to assess the:
  - documentation of recorded observations, as specified in the patient's care plan
  - appropriate recognition and escalation when observations fall into one of the shaded zones on the observation and response charts
- Nursing / Midwifery Managers are responsible for ensuring by audit, that compliance with checking of resuscitation equipment has been met.

4.2 Evaluation

Evaluation of recognition and response systems and MER is addressed in the evaluation section of the WACHS Recognising and Responding to Acute Deterioration Policy.

Review of this document will be facilitated by the Clinical Nurse Consultant Recognising and Responding to Acute Deterioration (RRAD) 5 yearly unless required earlier.

5. Compliance

This policy is a mandatory requirement under the WA Health Recognising and Responding to Acute Deterioration Mandatory Policy – MP 0717/22.

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

6. References

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20. Government of Western Australia WA Country Health Service. Mental Health Care in Emergency Departments and General Wards Policy. Perth Australia: 2018 [Accessed: 18 May 2023]
21. Government of Western Australia (WA), Department of Health. Shift Coordinator Procedure. Perth, Australia: WA Country Health Service; 2022 [Accessed: 18 May 2023]

7. Definitions

Term	Definition
Medical review	The clinical assessment of a patient by the admitting doctor, another member of the medical team, a member of the Emergency Telehealth Service or of the RFDS - in person, by phone or by videoconference.
Medical emergency response (MER)	The system for providing emergency assistance to patients whose condition is deteriorating. On the Observation and Response Charts (Adult, Maternal, Newborn and PARROT) this is represented by the purple zone.
MER team	The defined team / personnel required to respond to a MER as defined on the site escalation procedure.
Medical officer	Includes all types of medical officers including District Medical officer (DMO), Health Service Medical Practitioner (HSMP), Senior Medical Practitioner (SMO), Resident Medical Officer (RMO), Registrar, Consultant, Visiting Medical Officer / Practitioner (VMO or VMP), Fellow of the Australasian College of Emergency Medicine (FACEM) or General Practitioner (GP).
Shift coordinator	The Senior Nurse / Midwife of the respective rostered shift.

8. Document Summary

Coverage	WACHS wide
Audience	Medical Officers, Nurses, Midwives, Allied Health and Operations Managers
Records Management	Non Clinical: Corporate Recordkeeping Compliance Policy Clinical: Health Record Management Policy
Related Legislation	*Aged Care Act 1997 (Commonwealth)* *Health Services Act 2016* (WA) *Carers Recognition Act 2004* (WA) *Disability Services Act 1993* (WA) *Guardianship and Administration Act 1990* (WA) *Health Practitioner Regulation National Law (WA) Act 2010* *Mental Health Act 2014* (WA) *Medicines and Poisons Act 2014* (WA) Medicines and Poisons Regulations 2016 (WA) *State Records Act 2000* (WA)
Related Mandatory Policies / Frameworks	MP 0095/18 Clinical Handover Policy MP 0122/19 Clinical Incident Management Policy 2019 MP 0171/22 Recognising and Responding to Acute Deterioration Policy MP0067/17 Information Security Policy Clinical Governance, Safety and Quality Framework
Related WACHS Policy Documents	Assessment and Management of Interhospital Patient Transfers Policy Assessment and Management in the Emergency Department - Clinical Practice Standard Adult Airway Management Clinical Practice Standard Clinical Observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance) Cognitive Impairment Clinical Practice Standard Ethical Decision Making for Clinical or Patient Care Issues Guideline Maternal and Newborn Care Capability Framework Policy Maternity Care Conflict Escalation Pathway Policy. Medication Handling and Accountability Policy Mental Health Care in Emergency Departments and General Wards Policy Oxygen Therapy and Respiratory Devices - Adults Clinical Practice Standard Resuscitation, Education and Competency Assessment Policy

Related WACHS Policy Documents	Recognition and Response to Acute Deterioration in the Newborn Recognising and Responding to Acute Deterioration Policy Shift Coordinator Procedure
Other Related Documents	Care location for acutely unwell MPS Aged Care Resident Flowchart Residential Aged Care - Admission Flowchart Use of Advance Care Planning, Advance Health Directives and Goals of Patient Care in Residential Facilities Flowchart CAHS Neonatology Resuscitation: Neonatal (Newborn Life Support Algorithm)
Related Forms	Child and Adolescent Mental Health Service Initial Assessment (CAMHS001) Child and Adolescent Mental Health Service Physical Examination (CAMHS005) Child and Adolescent Mental Health Service Risk Assessment and Management Plan (CAMHS002) Adult Mental Health Assessment (SMHMR902) Adult Mental Health Physical Examination (SMHMR903) Adult Mental Health Risk Assessment and Management Plan (SMHMR905) Mental Health Treatment, Support and Discharge Plan (SMHMR907) MR46 WACHS Suicide Risk Assessment and Safety Plan MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium MR70A WACHS Antenatal Inpatient Care Plan MR70C WACHS Pregnancy Instruction Sheet MR75 WACHS Newborn Care Plan MR75B WACHS Newborn Medical Emergency Response (MER) Record MR80 WACHS Vaginal birth postnatal Care Plan MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis MR80A.2 WACHS Postnatal Risk Assessment for VTE Prophylaxis MR81 WACHS Caesarean Postnatal Care Plan MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults MR111P WACHS Paediatric Nursing Admission / Discharge Assessment MR115 WACHS Paediatric Short Stay Medical Admission MR120 WACHS Adult Nursing Care Plan MR120P WACHS Paediatric Nursing Care Plan MR140 WACHS Medical Emergency Response / Code Blue Record MR140A Adult Observation & Response Chart AORC

	MR140B Maternal Observation and Response Chart (M-ORC) MR140D Newborn Observation & Response Chart (N-ORC) MR140E Paediatric Acute Recognition and Response Observation Tool (PARROT <3 M) MR140F Paediatric Acute Recognition and Response Observation Tool (PARROT 3-12 M) MR140G Paediatric Acute Recognition and Response Observation Tool (PARROT 1-4 Yr) MR140H Paediatric Acute Recognition and Response Observation Tool (PARROT 5-11 Yr) MR140i Paediatric Acute Recognition and Response Observation Tool (PARROT 12+ Yr) MR149 WACHS Neurovascular Observation Chart MR184 WACHS Inter-hospital Clinical Handover Form MR184A WACHS Resident Handover MR184B WACHS Intra-hospital Clinical Handover Form MR184C WACHS Interhospital Transfer Maternal Form MR184P WACHS Interhospital Transfer Neonatal Paediatric RC00H.1 WACHS Residential Goals of Care RC5 WACHS Resident Admission Assessment RC7 WACHS Resident Care Plan
Related Training Packages	RRAD: Recognising and Responding to Acute Deterioration eLearning (RRAD EL1) via MyLearning LMS
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2281
National Safety and Quality Health Service (NSQHS) Standards	1.20, 2.06, 5.05, 5.10, 5.14, 6.10, 8.01 – 8.13
Aged Care Quality Standards	Standard 1. Dignity and Choice Standard 3. Personal care and clinical care: 3(d)
National Standards for Mental Health Services	Standard 2. Safety: 2.11

9. Document Control

Version	Published date	Current from	Summary of changes
3.00	07/09/2023	07/09/2023	Update to new policy document template; title updated to remove (RRAD); update of broken links; update of Resuscitation + COVID - confirmed as remaining in document and links updated; medical officer – documentation of reviews in the health care record; shift coordinator to provide senior nurse/midwife review and document in health care record assessment and plans, document review in intervention/event section of ORC/PARROT chart, and ensure compliance with checking or resuscitation equipment has been met; ward nurse/midwife – document escalation of care in the interventions /events section of the ORC/PARROT; shift coordinator definition updated.
3.01	02/11/2023	07/09/2023	Mental Health forms hyperlinked to the Statewide Standardised Clinical Documentation (SSCD) - Resources HealthPoint page.
3.02	14 October 2024	07/09/2023	Minor amendment: forms

10. Approval

Policy Owner	Executive Director Clinical Excellence
Co-approver	Executive Director Nursing and Midwifery Services
Contact	Program Officer Clinical Practice Standards
Business Unit	Medical Services
EDRMS #	ED-CO-21-491005

This document can be made available in alternative formats on request.

Appendix 1: BACPAC Mental State Assessment Descriptions

Behaviour

Describe the person's behaviour:

- abnormal responses to environment
- overt responses to internal stimuli (e.g. apparent responding to 'voices')
- attitude towards interviewer, others and surrounding
- repetitive movements, gestures, mannerisms
- akathisia (restlessness), tremor, rigidity and abnormal involuntary movements.

A person experiencing a deterioration in mental state may become more escalated in their behaviour or more subdued. Escalated behaviours can include: yelling, pacing, wandering, unusual bodily movements, repetitive movements (e.g. wringing hands), violence, responding to unseen stimuli. Diminished behaviours can include: withdrawal, lying in bed, not engaging with staff, mute, refusing treatment, hiding.

Appearance

- general appearance, personal hygiene and grooming
- appropriateness of clothing and make up (e.g. clothing and make-up not appropriate to context, or removing clothing)
- eye contact (increases e.g. intense stares or decreases e.g. closes eyes), facial expression (not matching behaviour, mood or affect), posture, etc.

There may be no or minimal changes in appearance.

Conversation

- speech prosody, rate, flow and form
- predominant content – appropriate to topic, unusual ideas, delusions
- congruence of speech content to affect
- abnormal or bizarre thoughts.

The way a person engages with you can indicate a subtle or overt deterioration in mental state. Escalated conversation: speech is rapid; ideas and thoughts are difficult to follow; words are nonsensical; topics change rapidly; voice is raised; speech is persistent, unable to interrupt; talking to unseen stimuli. Diminished conversation: speech is slow; partial sentences; softly spoken; long pauses before responding; no responses or single word responses; distracted conversation.

Perception

- illusions: distorted sensory perceptions
- hallucinations – auditory, visual, tactile, gustatory, olfactory
- general feelings of unreality.

A change in a person's understanding and interaction with reality can indicate a deterioration in mental state. This can present as: the person reports or you observe them hearing, seeing, smelling, feeling or tasting something you are unable to see, hear, smell, taste or feel; the person describes not feeling in touch with reality; the person describes

things that are not congruent with reality; e.g. they are Jesus and here to heal everyone; their mother is really a wolf.

Affect and Mood

- patients expressed internal emotions and feelings (mood)
- clinicians observed expression of emotion and feeling (affect)
- as inferred by facial expression, body posture, overall presentation.

Mood is how the person describes their emotions and feelings and affect is what you as the clinician observe the persons feelings and emotions to be. Early deterioration of mental state can be incongruent mood and affect - what you observe no longer matches what they describe ("I am fine" but is crying or pacing their room); or the person describing a sudden change in mood or you observe a sudden change in affect.

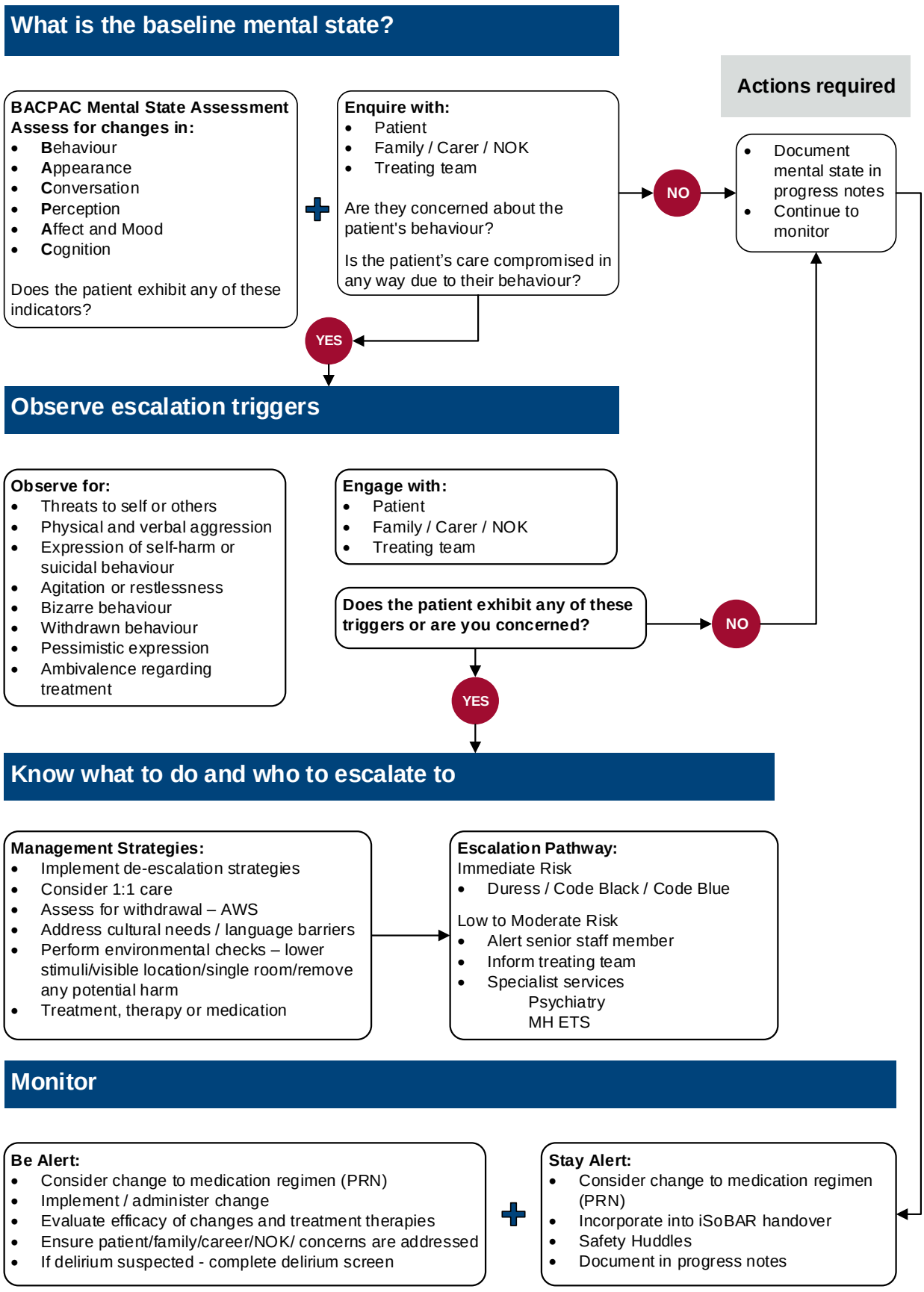
Cognition

- intellectual level of functioning
- memory, concentration, attention span
- judgement and insight
- ability to interpret actions and surroundings.

Examples may include: increased sedation or increased arousal; confusion, inability to concentrate, unable to recall information you have provided, repetitive questioning, disorientated to time, person and / or place; denial of any issues with health or mental health when there are issues.

Appendix 2: Recognising and responding to acute mental state

Use this link to access a printable version of this flowchart.



Adapted from the Fiona Stanley Hospital Mental State Deterioration and Escalation of Care Pathway (Sept 2021)