Recognising and Responding to Acute Deterioration (RRAD) Procedure

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1. Guiding Principles

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

This procedure outlines 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

2.1 Risk assessment

Baseline documentation of risks identified during admission are completed on:

- CAMHS001 CAMHS Initial Assessment
- CAMHS002 CAMHS Risk Assessment and Management Plan
- CAMHS005 CAMHS Physical Health Assessment
- MR70C Pregnancy Instruction Sheet
- MR75 Newborn Care Plan
- MR80A WACHS Maternity Inpatient Risk Assessment Record
- MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults
- MR111P WACHS Paediatric Nursing Admission / Discharge Assessment
- RC5 WACHS Resident Admission Assessment
- SMHMR902 Mental Health Assessment – Adult
- SMHMR903 Mental Health Physical Examination
- SMHMR905 Mental Health Risk Assessment and Management Plan (RAMP)
- 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
- SMHMR907 Mental Health Treatment, Support and Discharge Plan

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
2.2 Recognising acute deterioration

2.2.1 Observation and response charts (ORCs)

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

- MR140a Adult Observation and Response Chart (AORC)
- MR140c Maternal Observation and Response Chart (M-ORC)
- MR140d Newborn Observation and Response Chart (N-ORC)
- MR 140e-i Paediatric Observation and Response Charts (P-ORC)

2.2.2 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, relevant to the area/location that the patient is in at the time. In larger sites where areas or departments have their own medical teams they are responsible for modifications in those areas/departments; e.g., where a patient transfers from ED to ward – modifications should be made by the ward medical team who are aware of the staffing and parameters suitable for that area in relation to calling criteria rather than the ED doctors.

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

Instructions for modifications are outlined in the ‘Modifications’ section (Page 1) of the Adult, Maternity and Newborn ORCs; and on the ‘Alterations to Calling Criteria’ section (Page 1) of the Paediatric ORC suite.

Where a health service is covered utilising a senior doctor who is remotely on call in a single location or Emergency Telehealth Service, the modification (i.e. written on the front of ORC) may be electronically transmitted via fax, email, or endorsed electronic system, e.g. MyFT, to the doctor’s location for signing and then faxed back for inclusion in the healthcare record in accordance with the WA Health MP0067/17 Information Security Policy.

If electronic transmission occurs, the hard copy document with the doctor’s original signature is to be forwarded to the site for filing in the medical record.

2.2.3 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 develops over a short period of time and 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 at high risk of delirium such as those with dementia, fractured hip or an older person post-surgery or diagnosed with a 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 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.

2.2.4 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”.

Baseline information is an essential component to determining whether deterioration has occurred – this must be established and documented in the healthcare record. Assess for:

- 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.

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

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

2.3.1 Escalation templates

WACHS provides a suite of observation and response escalation and medical emergency response templates:

- templates are available via the intranet for the following areas:
  - Adult and Maternity
  - Paediatric
  - Emergency Department Adult and Maternity
2.3.2 Aishwarya’s CARE Call

The Aishwarya CARE call escalation process comprises three steps:

- **Step 1:** Reminds the patient, family member or carer to talk to the nurse, midwife or doctor caring for them if they have any concerns about the health of themselves or their loved one’s health. Note: there are both paediatric and adult versions of Aishwarya’s CARE Call materials with tailored wording of step one.

- **Step 2:** 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.

- **Step 3:** 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.
2.3.3 Specific clinical area information

2.3.3.1 Mental Health Units
Certain circumstances concerning deterioration may require incidents 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. 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:
- Chief Psychiatrist’s Standards for Clinical Care
- 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.

The Mental Health Inpatient Unit is a specialised area in which the most appropriate responders for mental state deterioration are often present, thus the threshold for escalation may vary from other areas.

2.3.3.2 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.

2.3.3.3 Remote Area Clinics and Nursing Posts
The MR140 series ORCs are to be used at remote area clinics and nursing posts.

Emergency escalation templates are recommended for use (refer to Section 2.3.1). The editable information on the templates can be tailored to suit the location and local agreed processes. This information would be 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.
2.3.3.4 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.

WACHS requires the screening of all patients over the age of 65 (> 50 for Aboriginal people) on presentation to hospital or changes to their medical state using the Delirium risk and cognitive screen (label) which includes the AMT4 tool and Single Question in Delirium. Any abnormal results will require the completion of the MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium as per Cognitive Impairment flowchart to determine if there is a possible delirium.

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.

If a change in the health status occurs in an older person, or changes in vital signs are identified, or if staff are concerned about the person, a senior nurse/midwife must undertake full assessment and a medical officer must review the person.

Escalation of care for an aged care resident will depend on the care type and documented preferences of the resident. 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

2.4.1 MER response

A Code Blue emergency call should be placed for all patients with MER criteria (purple zone observations, or red zone on PORC series), airway threat, respiratory or cardiac arrest, sudden fall in consciousness, oxygen saturations ≤ 84%, seizure, unattended medical review or you or a family member are concerned.

Exception: Advance Health Directives; clearly documented ‘Not for MET call’ or ‘Not for Rapid Response’ instruction (e.g. GoPC form); ‘Not for CPR’ or authorised modified observation parameters (e.g. ORC).

At some sites Medical Review and MER may be via telephone or videoconference; e.g., Emergency Telehealth Service.

If at any time, the escalation process is not progressing in a timely manner, the staff member may contact Exec on Call, the Regional Director Nursing & Midwifery or Medical Director for advice or assistance (as indicated on the top of the escalation template).

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.
2.4.1.1 Resuscitation algorithms

WACHS endorses:

- CAHS Neonatology Resuscitation Algorithm for the Newborn Clinical Guideline for use.
- 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).

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.

2.4.1.2 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).

2.4.1.3 MER record

The senior nurse/midwife 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.

2.4.2 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 (if unclear whether new or the patient’s normal state, it should be assumed to be new until confirmed otherwise) 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. The patient’s management plan, which must include frequency of observations and monitoring, must be documented in the healthcare record.

2.4.2.1 Code Black Personal Threat

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 and requires assistance and may be called for patients actively attempting suicide or engaging in self-harm.

A personal threat is an incident where staff, patients and/or visitors are verbally, physically abused, threatened or assaulted. Personal threats are categorised as unarmed or armed.

Unarmed confrontations may occur when there is a threat to staff, patients and/or visitors by an unarmed person confronting them in a violent or threatening manner. This includes but is not limited to:

- Verbal aggression – threatening or abusive language involving excessive swearing or offensive remarks
- Threatening behaviour
- Physical aggression
- Wilful damage to hospital property.

Refer to:
- Site/Facility specific Emergency Response Procedures
- WACHS Disturbed Behaviour Management – Clinical Practice Standard.

2.4.3 Facility equipment and systems

2.4.3.1 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.
2.4.3.2 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.

2.4.3.3 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 Records Management Policy.

2.4.4 Communication and documentation

Ensure accurate documentation in the patient’s healthcare record and use iSoBAR for all communication including transfer of care to another facility, clinical care coordination team, or with transport providers (e.g. ambulance personnel, RFDS) occurs in accordance with:
- WA Health MP0095 Clinical Handover Policy
- WACHS Assessment and Management of Interhospital Patient Transfers Policy, and
- MR184 WACHS Inter-hospital Clinical Handover Form

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
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- 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. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
</tr>
<tr>
<td>Clinical Incident</td>
<td>A clinical incident is an event or circumstance resulting from health care which could have or did lead to unintended and/or unnecessary harm to a patient/consumer.</td>
</tr>
<tr>
<td>Medical Review</td>
<td>The patient’s admitting doctor, medical team or Emergency Telehealth Service or RFDS reviews the patient or assesses the patient by phone or videoconference within 30 minutes. The most senior nurse/midwife available must be aware the medical review has been requested.</td>
</tr>
<tr>
<td>Code Black</td>
<td>An emergency call for assistance when any individual is at personal threat of harm, violence, self-harm, and suicide or hostage situation within the WACHS Emergency (Disaster) Management Policy consistent with the Australian Standard AS4083-2010 Planning for emergencies – health care facilities.</td>
</tr>
<tr>
<td>Code Blue</td>
<td>The call code (e.g. phone, PA system or pager) made for a Medical Emergency Response (MER) within the WACHS Emergency (Disaster) Management Policy consistent with the Australian Standard AS4083-2010 Planning for emergencies – Health care facilities.</td>
</tr>
<tr>
<td>Loss of function</td>
<td>A reduction in a person’s ability to think clearly, communicate, or engage in regular activities.</td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>Any event in which trained personnel are required to respond to a medical crisis</td>
</tr>
<tr>
<td>Medical Emergency Response</td>
<td>The system for providing emergency assistance to patients whose condition is deteriorating. On the Adult Maternal &amp; Newborn Observation and Response Chart (AORC/MORC/NORC) this is represented by the purple section, and on the Paediatric Observation and Response Charts (PORC) this is represented by the red section</td>
</tr>
<tr>
<td>MER Team</td>
<td>The defined team/personnel required to respond to a medical emergency response as defined on the site escalation procedure.</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>Includes all types of medical officers including District Medical officer (DMO), Health Service Medical Practitioner (HSMP), Senior Medical Practitioner (SMO), Resident Medical Officer</td>
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</tbody>
</table>
(RMO), Registrar, Consultant, Visiting Medical Officer/Practitioner (VMO or VMP), Fellow of the Australasian College of Emergency Medicine (FACEM) or General Practitioner (GP).

### ORC
Observation and Response Chart

<table>
<thead>
<tr>
<th>Senior Nurse/Midwife</th>
<th>Depending on the size of the service, this includes the senior nurse / midwife on duty, e.g. shift coordinator; after hours Nurse Manager; Clinical Nurse Manager (CNM); after hours CNM; DON/HSM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse/Midwife Review</td>
<td>The most senior nurse/midwife available (after hours nurse manager or clinical nurse manager) is to review the patient and, if required contact the medical officer to determine if a clinical review is required.</td>
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### 4. Roles and Responsibilities

<table>
<thead>
<tr>
<th>Staff Member</th>
<th>Responsibilities</th>
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</table>
| Ward Nurse (Enrolled Nurse, Registered Nurse, Midwife) | • Escalate response as per ORC or if concerned  
• Escalate response if family and or carer indicate concern  
• Communicate effectively with Shift Coordinator  
• Document observations and escalation of care appropriately  
• Ensure resuscitation trolley nearby if deterioration identified  
• Ensure patient notes and ORCs 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. |
| Shift Coordinator (may be senior nurse, Remote Area Nurse, nurse practitioner or senior midwife) | • Assess patient  
• Communicate to medical officer if medical review is required  
• 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 |
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- 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.

<table>
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<tr>
<th>Medical Officers</th>
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<tr>
<td>- Provide appropriate medical intervention as required</td>
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<tr>
<td>- Communicate effectively with the other members of the team</td>
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<tr>
<td>- Ensure adequate post MER follow up or appropriate escalation of care</td>
</tr>
<tr>
<td>- 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.</td>
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<table>
<thead>
<tr>
<th>MER Team Leader</th>
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<tr>
<td>This role is to be performed by the most experienced clinical expert available</td>
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<tr>
<td>- 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</td>
</tr>
<tr>
<td>- Be ALS (adult/paediatric/neonatal as required for the situation) competent and experienced staff member</td>
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<tr>
<td>- Communicate effectively with all team members</td>
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<tr>
<td>- Identify the tasks or roles required specific to the emergency</td>
</tr>
<tr>
<td>- Identify and notify all available human resources including ensuring sufficient and suitable medical, nursing/midwifery and support personnel are called</td>
</tr>
<tr>
<td>- Coordinate and delegate roles in accordance with priority of need and in consideration of skill levels/competency/scope of practice of team members</td>
</tr>
<tr>
<td>- Delegate the retrieval of additional equipment/medications to an appropriate nursing/midwifery or other staff member</td>
</tr>
<tr>
<td>- Ensure situational awareness of immediate and surrounding environments including the delegation of care of all other patients to appropriate personnel</td>
</tr>
<tr>
<td>- Maintain a safe working environment</td>
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<tr>
<th>Code BlackResponders</th>
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<tr>
<td>- Respond to a code black emergency call in accordance with local emergency management protocols</td>
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**Note:** If there are perceived issues around the decision to activate a MER, then these are best discussed during debriefing in a safe environment.

### 5. Compliance

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...

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section 26 of the *Health Services Act 2016* (WA) 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.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System in accordance with the WACHS [Records Management Policy](#).

All WACHS clinical records must be managed in accordance with [Health Record Management Policy](#).

7. Evaluation

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
- Senior nurse/midwife is responsible for ensuring by audit, that compliance with checking of resuscitation equipment has been met.

Evaluation of recognition and response systems and MER is addressed in the evaluation section of the WACHS [Recognising and Responding to Acute Deterioration (RRAD) Policy](#).

8. Standards

**National Safety and Quality Health Service Standards**

Clinical Governance Standard: 1.20

Partnering with Consumers Standard: 2.6

Comprehensive Care Standard: 5.5, 5.10 and 5.14

Communicating for Safety Standard: 6.10

Recognising and Responding to Acute Deterioration Standard: 8.1 – 8.13

**Australian Aged Care Quality Agency Accreditation 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. 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)

10. References


7. WACHS Emergency (Disaster) Management Arrangements Policy

8. WA Health MP0122/19 Clinical Incident Management Policy 2019

9. WA Health MP0095 Clinical Handover Policy

10. WACHS Resuscitation, Education and Competency Assessment Policy

11. WA Health MP0086/18 Recognising and Responding to Acute Deterioration Policy


11. Related Forms

CAMHS001 CAMHS Initial Assessment
CAMHS002 CAMHS Risk Assessment and Management Plan
CAMHS005 CAMHS Physical Health Assessment
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 Pregnancy Instruction Sheet
MR75 WACHS Newborn Care Plan
MR75B WACHS Newborn Medical Emergency Response (MER) Record
MR80 WACHS Vaginal birth postnatal Care Plan
MR80A WACHS Maternity Inpatient Risk Assessment Record
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 Observation and Response Chart (P-ORC - Under 3 Months)
MR140F Paediatric Observation and Response Chart (P-ORC - 3 - 12 Months)
MR140G Paediatric Observation and Response Chart (P-ORC - 1 - 4 Years)
MR140H Paediatric Observation and Response Chart (P-ORC - 5 - 11 Years)
MR140I Paediatric Observation and Response Chart (P-ORC - 12+ Years)
MR149 WACHS Neurovascular Observation Chart

Printed or saved electronic copies of this policy document are considered uncontrolled. Always source the current version from WACHS HealthPoint Policies.
12. Related Policy Documents

CAHS Neonatology Resuscitation Algorithm for the Newborn Clinical Guideline
WACHS Assessment and Management of Interhospital Patient Transfers Policy
WACHS Assessment and Management in the Emergency Department - Clinical Practice Standard
WACHS Adult Airway Management Clinical Practice Standard
WACHS Care location for acutely unwell MPS Aged Care Resident Flowchart
WACHS Chest Pain and Acute Coronary Syndrome Clinical Practice Standard
WACHS Clinical Observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance)
WACHS Cognitive Impairment Clinical Practice Standard
WACHS Disturbed Behaviour Management – Clinical Practice Standard
WACHS Maternal and Newborn Care Capability Framework Policy
WACHS Medication Handling and Accountability Policy
WACHS Mental Health Care in Emergency Departments and General Wards Policy
WACHS Oxygen Therapy and Respiratory Devices - Adults Clinical Practice Standard
WACHS Residential Aged Care - Admission to a Residential Facility Flowchart
WACHS Resuscitation, Education and Competency Assessment Policy
WACHS Recognition and Response to Acute Deterioration (RRAD) in the Newborn
WACHS Recognising and Responding to Acute Deterioration Policy
WACHS Use of Advance Care Planning, Advance Health Directives and Goals of Patient Care in Residential Facilities Flowchart

13. Related WA Health System Policies

MP0095 Clinical Handover Policy
MP0122/19 Clinical Incident Management Policy 2019
MP0086/18 Recognising and Responding to Acute Deterioration Policy
MP0067/17 Information Security Policy

14. Policy Framework

Clinical Governance, Safety and Quality

15. Appendices

Appendix 1: BACPAC Mental State Assessment Descriptions
Appendix 2: Recognising and responding to acute mental state deterioration flowchart
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 deterioration flowchart

What is the baseline mental state?

BACPAC Mental State Assessment
Assess for changes in:
- Behaviour
- Appearance
- Conversation
- Perception
- Affect and Mood
- Cognition

Does the patient exhibit any of these indicators?

Enquire with:
- Patient
- Family / Carer / NOK
- Treating team

Are they concerned about the patient’s behaviour?
Is the patient’s care compromised in any way due to their behaviour?

Actions required
- Document mental state in progress notes
- Continue to monitor

Observe escalation triggers

Observe for:
- Threats to self or others
- Physical and verbal aggression
- Expression of self-harm or suicidal behaviour
- Agitation or restlessness
- Bizarre behaviour
- Withdrawn behaviour
- Pessimistic expression
- Ambivalence regarding treatment

Engage with:
- Patient
- Family / Carer / NOK
- Treating team

Does the patient exhibit any of these triggers or are you concerned?

Know what to do and who to escalate to

Management Strategies:
- Implement de-escalation strategies
- Consider 1:1 care
- Assess for withdrawal – AWS
- Address cultural needs / language barriers
- Perform environmental checks – lower stimuli/visible location/single room/remove any potential harm
- Treatment, therapy or medication

Escalation Pathway:
Immediate Risk
- Duress / Code Black / Code Blue

Low to Moderate Risk
- Alert senior staff member
- Inform treating team
- Specialist services
  - Psychiatry
  - MH ETS

Monitor

Be Alert:
- Consider change to medication regimen (PRN)
- Implement / administer change
- Evaluate efficacy of changes and treatment therapies
- Ensure patient/family/career/NOK/ concerns are addressed
- If delirium suspected - complete delirium screen

Stay Alert:
- Consider change to medication regimen (PRN)
- Incorporate into iSoBAR handover
- Safety Huddles
- Document in progress notes

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