Recognising and Responding to Acute Deterioration (RRAD) Policy

1. Background

Serious adverse events, such as unexpected death and cardiac arrest, are often preceded by observable physiological and clinical abnormalities. Other serious events, such as suicide and aggression, are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate deterioration in their mental state.[2]

Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in a health service organisation.[2]

This policy pertains to adult, maternity, newborn and paediatric patients, inclusive of mental health inpatients and aged care residents within WACHS facilities.

It is to be read in conjunction with the WACHS Recognising and Responding to Acute Deterioration (RRAD) Procedure.

2. Policy Statement

WACHS systems that support and promote detection and recognition of acute deterioration and the response to patients whose condition acutely deteriorates are consistent with the:

- Australian Commission on Safety and Quality in Health Care (ACSQHC)'s National Safety and Quality Health Service (NSQHS) Recognising and Responding to Acute Deterioration Standard
- National Consensus Statement: Essential Elements for Recognising and Responding to Acute Physiological Deterioration
- National Consensus Statement: Essential elements for safe and high-quality end-of-life care
- National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state
- National consensus statement: essential elements for safe and high-quality paediatric end-of-life care
- National Standards for Mental Health
- Delirium Clinical Care Standard.

2.1 Governance

The Recognising and Responding to Acute Deterioration (RRAD) Committee provides governance of acute deterioration systems and processes across WACHS, in alignment with the WA Health MP 0086/18 Recognising and Responding to Acute Deterioration Policy and the National Safety and Quality Health Service: Recognition and Response to Acute Deterioration Standard.

The WACHS RRAD Committee works collaboratively with the WACHS Mental Health Safety Quality and Risk Committee and the WACHS Cognitive Impairment Steering Committee for actions within the RRAD Standard, in relation to acute deterioration in mental state including patients at risk of developing delirium (Actions 8.5, 8.9).

The WACHS RRAD Committee is responsible to the WACHS Healthcare Safety and Quality Executive Subcommittee.

Regional governance of RRAD is managed through the Regional Patient Safety and Quality Committees.

2.2 Risk assessment

On admission or presentation, a comprehensive patient assessment should confirm baseline vital signs, mental and cognitive state so that changes can be recognised.

Clinical staff should engage with the patient, their family and carers, where culturally and developmentally appropriate, to identify specific factors that could precipitate deterioration, as well as factors that contribute to the patient's wellbeing. Family and carers' information is essential to clarify if fluctuations in level of alertness, mental state, behaviour or if cognitive functions are different from baseline and ascertain if there has been any decline.[5]

Screening tools are used to assess risks and provide guidance for the management of mental state and mental health deterioration (refer to the WACHS RRAD Procedure section 2.1) for more information related to specific WACHS screening tools).

Timely referrals (as indicated in the risk assessment tools) will ensure further information is available to clinicians to guide and support appropriate management of the patient. All assessments, recommendations and interventions must be documented and filed in the patient's healthcare record.

2.3 Education and training

The WA Health MP 0086/18 Recognising and Responding to Acute Deterioration Policy states that Health Service Providers and relevant Contracted Health Entities must ensure that:

- clinical and non-clinical staff are trained, within their scope, to use the systems in place to manage early recognition of, and response to, acute deterioration
- all staff are to be aware of the local policy, rapid response system and Observation and Response Chart, and know how to activate their local rapid response system.

The NSQHS Recognising and Responding to Acute Deterioration Standard, Action 8.1C outlines that clinicians use the safety and quality systems from the NSQHS Clinical Governance Standard when identifying training requirements for recognising and responding to acute deterioration. WACHS uses our learning management system and Learning and Development governance processes to facilitate:

- Assessment of the competency and training needs of our workforce
- Implementation of a mandatory training program/s to meet the requirements arising from the Recognising and Responding to Acute Deterioration Standard
- Access to training to meet our safety and quality training needs, and
- the ability to monitor our workforce's participation in training.

The following endorsed and standardised education, training and assessment resources are available and can be allocated to relevant staff via our Learning Management System:

- Recognising and Responding to Acute Deterioration:
  - Training courses (eLearning and face to face)
  - Theory Assessment (eLearning) and Practical Assessment (by eLearning declaration)
  - Competency Facilitators & Trainers resources.
- Advanced Life Support:
  - Training courses (eLearning and face to face)
  - Theory Assessment (eLearning) and Practical Assessment
  - Competency Facilitators & Trainers resources.

2.4 Patient, family and carer shared decision-making

Information about observations, deterioration and escalation must be communicated to the patient, family or carer in a timely and ongoing way.

Shared decision making involves discussion and collaboration between the patient and their clinician. It is about bringing together the patient's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, to reach the most appropriate healthcare decisions for that person.

The Australian Charter of Healthcare Rights (second edition) describes the rights that consumers, or someone they care for, can expect when receiving health care.[11]

Patients have the right to involve the people they want in planning and making decisions about their health care and treatment. This could be a family member, carer, friend, or a consumer advocate such as a social worker. Many health services employ different types of liaison officers, such as Aboriginal and Torres Strait Islander liaison officers, who can provide patients with advocacy, information and support.[11]

For sections 2.4.1 and 2.4.2 refer to:

- WACHS Adults with Impaired Decision-Making Capacity Procedure
- WACHS Advance Health Directive and Enduring Power of Guardianship
- WACHS Goals of Patient Care Guideline.

2.4.1 Advance Health Directives (AHD) and Advance Care Plans (ACP)

Clinical staff must discuss the preferences, needs, values and wishes of the patient at admission or as soon as practicable, referring to valid AHD and ACP where accessible. Clinical staff must adhere re to AHDs and ACPs when managing or escalating care of a deteriorating patient.[3]

If the patient does not have decision making capacity clinical staff must refer to the decision-making hierarchy in relation to the guardian, family, or carer.

2.4.2 Goals of Patient Care (GoPC)

All Medical Practitioners (MPs) on the treating team (including interns and resident medical officers) are encouraged to complete Section 1 of the GoPC form (Baseline Information). A senior medical officer is responsible for facilitating the GoPC discussion; listening and responding to the patient, family, or carer's questions; initiating timely discussions around treatment options, treatment-limiting orders and non-beneficial treatments to enable the

patient/the person responsible to make an informed GoPC decision; and accurately reflecting the patient's wishes, values and preferences in the GoPC form.

The GoPC form will guide resuscitation and treatment limitations. They can be extended in their validity for up to a year and clinical staff should check the healthcare record on each admission for a current GoPC form. If a form is valid at the time of the current admission, it should be reviewed to ensure that the goals of care are still current for that admission. If they have changed, then a new form needs to be completed and placed accordingly at the front of the patient's working file (bedside) to ensure prominent placement and easy access.

2.4.3 Aishwarya's CARE Call

Patients, their families or carers are often aware before clinical staff of subtle changes in their or their loved one's health, but may not feel comfortable, or know how to share their concerns with clinical staff. Coronial inquests have identified where concerns raised by family members about their loved one's condition were not fully appreciated by clinical staff, leading to tragic outcomes.

Aishwarya's CARE Call provides patients, their families and carers a way to receive or call for assistance when they feel that the healthcare team has not fully recognised the patient's changing health condition.

It supports established WACHS strategies to improve the recognition and response to clinical deterioration, including the use of WACHS observation and response charts with defined escalation requirements and site-specific clinical escalation processes.

Refer to the WACHS RRAD Procedure (section 2.3.2) for more detailed information on the three steps of Aishwarya's CARE Call and available resource materials.

2.5 Clinical Incident Management

Clinical incidents that are related to a failure or delay to recognise and respond to acute physiological or mental state deterioration must be notified and managed in accordance with the WA Health MP0122/19 Clinical Incident Management Policy 2019.[3,4]

Staff are required to:

- complete a CIMS Datix notification
- document the clinical incident in the patient's healthcare record.

2.6 Recognising acute deterioration

2.6.1 Acute physiological deterioration

Measurable physiological abnormalities occur prior to adverse events such as cardiac arrest, unanticipated admission to intensive care and unexpected death.[1]

These signs can occur both early and late in the acute physiological deterioration process. Regular measurement and documentation of physiological observations is an essential requirement for recognising clinical deterioration.[1]

Observation types, frequency and settings are outlined in the WACHS Clinical Observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance).

WACHS utilises a suite of track-and-trigger observation charts. These charts include:

- the capacity to display documented vital signs graphically
- the capacity to track changes in vital signs over time
- thresholds for each vital sign parameter or combination of parameters that indicate abnormality
- information about the response or action needed when thresholds are reached or physiological deterioration is identified, and
- the potential to document the normal range for the patient.

The WACHS RRAD Procedure (section 2.2.1) specifies the suite of charts that are in use in WACHS.

2.6.2 Acute mental state deterioration

Key factors in recognising deterioration in a person's mental state are observing changes in behaviour, appearance, conversation, perception, affect and mood and/or cognitive function.

While there is a number of typical signs that can indicate deterioration, these can vary significantly and individual changes that are observed or reported by the patient, their family members or carers are critical in recognising deterioration in a person's mental state. Baseline information is an essential component to determining whether deterioration has occurred.

Refer to the WACHS RRAD Procedure (section 2.2.4) for more detail on mental state assessment and escalation of care.

2.6.3 Delirium and cognitive impairment

Cognitive impairment is a broad term which encompasses dementia and delirium, the two most common forms of cognitive impairment. Delirium (also known as acute confusional state) is characterised by an alteration of consciousness with reduced ability to focus, sustain or shift attention, resulting in a cognitive or perceptual disturbance.[16]

Acute deterioration in cognitive state is common in hospitalised patients and may be attributed to physiological compromise or may be a sign of delirium. While delirium can occur in patients of any age, older patients with cognitive impairment, dementia, severe medical illness or a hip fracture are considered at greatest risk during a hospital admission.

Refer to the WACHS RRAD Procedure (section 2.2.3) for more detail on the procedural aspects of screening, assessment and management of cognitive impairment.

2.7 Escalating care

2.7.1 Acute physiological deterioration

The WACHS escalation protocols set out the organisational response required in dealing with different levels of abnormal physiological measurements and observations.

The escalation protocols allow for a graded response commensurate with the level of abnormal physiological measurements, changes in physiological measurements or other identified deterioration. It includes appropriate modifications to nursing care, increased monitoring, review by the attending medical officer or team or calling for emergency assistance.[1]

Escalation and MER process details are to be completed for each WACHS clinical site, and each WACHS site providing an emergency service. This provides clinicians with mechanisms to escalate care and call for emergency assistance appropriately.

The processes are to be documented using the relevant endorsed WACHS templates. Refer to the RRAD Procedure (section 2.3.1) for more detailed information and links to the specific templates.

2.7.2 Acute mental state deterioration

To support staff in identifying and responding to changes in a patient's mental state, WACHS has provided a recognising and responding to acute mental state deterioration flowchart. This is located in Appendix 2 of the RRAD Procedure. The flowchart is designed to enable staff to assess mental state, observe for escalation triggers, know what to do, who to escalate to and what ongoing monitoring is needed.

All WACHS regions are to clearly articulate and document local clinical pathways/clinical procedures for escalation of and response to mental state deterioration in their various sites.

2.8 Responding to acute deterioration

Where acute deterioration occurs, it is important to ensure that the capacity exists to obtain appropriate emergency assistance or advice prior to the occurrence of an adverse event such as a cardiac arrest. The emergency assistance provided as part of a rapid response system is additional to the care provided by the attending medical officer or team.[1]

The clinicians providing emergency assistance as part of the medical emergency response system should:[1]

- be available to respond within agreed timeframes
- be able to assess the patient and provide a provisional diagnosis
- Consider whether a patient is dying and clinical deterioration is likely to be irreversible
- be able to undertake appropriate initial therapeutic intervention
- be able to stabilise and maintain the patient pending definitive disposition
- have authority to make transfer decisions and to access other care providers to deliver definitive care.

Consistent with NSQHSS action 8.11 each site must have a process to ensure access, at all times, to at least one clinician, either on-site or in close proximity, who can practise advanced life support. The WACHS Resuscitation, Education and Competency Assessment Policy outlines requirements for Advance Life Support verification of competency requirements.

Early intervention has been shown to reduce mortality and morbidity in the critically ill patient. The decision to initiate a MER call is made in response to established criteria on the observation and response charts.

The call code (e.g. on a phone, PA system or pager) made for a Medical Emergency Response (MER) is a 'Code Blue' (as defined within the WACHS Emergency (Disaster) Management Policy[10] consistent with the Australian Standard AS4083-2010 Planning for emergencies – Health care facilities).

Refer to the WACHS RRAD Procedure (section 2.4).

2.8.1 Clinical Area Specific Information/Special Considerations

Specific clinical areas have responses contextualised to their needs and are covered in the WACHS RRAD Procedure (section 2.3.3).

Specific areas and special considerations include:

- Mental Health Units
- Theatre, recovery, intensive care and high dependency units
- Remote clinics and nursing posts
- Older person.

3. Definitions

Medical Emergency	Any event in which trained personnel are required to respond to a medical crisis. Includes Acute Myocardial Infarction, Sepsis and Stroke
Medical Emergency Response (MER)	The system for providing emergency assistance to patients whose condition is deteriorating. On the Adult, Maternal & Newborn Observation and Response Chart (AORC/MORC/NORC) and the Paediatric Acute Recognition and Response Observation Tool (PARROT) this is represented by the purple section.
MER Team	The defined team/personnel required to respond to a medical emergency response 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).

4. Roles and Responsibilities

All Staff are required to work within WACHS policies, procedures and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

WACHS Training Reports are available to Managers and the WACHS RRAD Committee to enable monitoring and manage compliance of training and assessment requirements for the RRAD program.

Failure to comply with this policy 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* (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

To evaluate the use of the recognition and response systems, and any failures in these systems, the following investigations are to occur:

- All MERs and cardiac arrests for patients without an advance care directive or an agreed treatment-limiting order (Goals of Patient Care) require a full clinical review
- All missed MERs identified through audit require a full clinical review
- All missed Medical Reviews identified through audit are to be followed up by local investigation

Quarterly review of collated analysis of data from MER record forms are to be presented at multidisciplinary meetings, with a summary of findings escalated to Regional Safety and Quality Governance Groups.

WACHS audit tools and equipment checking compliance is addressed in the evaluation section of the WACHS Recognising and Responding to Acute Deterioration (RRAD) Procedure.

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 3. Personal care and clinical care: 3(d)

National Standards for Mental Health Services

Standard 2. Safety: 2.11

Australian Standard AS4083-2010 Planning for emergencies – health care facilities

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

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3. Government of Western Australia Health Department. MP0086/18 Recognising and Responding to Acute Deterioration Policy. Perth Australia, June 2018 [Accessed: 7 October 2021]
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9. Australian Government. Aged Care Quality and Safety Commission [Internet] 11 June 2021. Standard 3. Personal care and clinical care. [Accessed 7 October 2021]
10. WACHS Emergency (Disaster) Management Arrangements Policy
11. Australian Commission on Safety and Quality in Health Care [Internet] 2020. Australian Charter of Healthcare Rights (second edition). [Accessed 16 December 2021]

11. Related Forms

Nil

12. Related Policy Documents

WACHS Adults with Impaired Decision-Making Capacity Procedure
WACHS Advance Health Directive and Enduring Power of Guardianship
WACHS Clinical Observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance)
WACHS Emergency (Disaster) Management Arrangements Policy
WACHS Goals of Patient Care Guideline
WACHS Recognition and Response to Acute Deterioration (RRAD) in the Newborn
WACHS Resuscitation, Education and Competency Assessment Policy
WACHS Recognising and Responding to Acute Deterioration (RRAD) Procedure

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

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