St Andrew's HOSPITAL - TOOWOOMBA

Nursing Clinical Practice Standards
Escalation of the patient experiencing clinical deterioration

HOSPITAL POLICY NO: **NCPS 166**

Legislation:	Australian Council on Safety and Quality in Health Care, (2011). *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care*

POLICY STATEMENT

St Andrew's Toowoomba Hospital nursing staff effectively evaluate all patient's conditions and escalate care via a MET call when there is evidence of clinical deterioration. At this time the RN or the EN will activate the MET CALL by phoning Extension 4747 or pushing the Code Blue button or pulling the patient call buzzer out of the wall.

[Please note: The 'MET CALL' does not have to be initiated by the After Hours Manager (AHM), although the AHM should be made aware of the initiated MET call immediately].

OUTCOME STATEMENT

Patients who are experiencing a deterioration in their clinical condition are escalated to a higher level of care by the activation of a MET Call.

PROCEDURE

Evidence of clinical deterioration that should trigger a MET Call include:

- Temperature >38.6°C
- Heart Rate <40 or >130 p min
- Respiratory Rate < 9 or > 30 p min
- Blood Pressure Systolic < 90 mmHg
- Oxygen Saturations SpO_2 <90%
- Seizure- prolonged or recurrent
- A sudden decreased level of consciousness
- Any patient the nurse is seriously concerned about that does not fit the above clinical criteria

When evidence of clinical deterioration occurs nursing staff should refer to the Acute Response Plan (See Appendix 1) and escalate care accordingly, either by contacting the patient's Visiting Medical Officer (VMO) or by calling the MET Call.

The decision about whether to initially contact the VMO or make the MET Call is made based on patient's degree of clinical deterioration. **If the patient meets MET Call criteria a MET Call must be made and patient's VMO should be contacted afterwards by ICU Resident Medical Officer (RMO).**

Once the MET Call has been initiated:

The Nursing staff who initiated the MET Call shall:

- Remain with the patient and initiate Basic Life Support until the MET Call Team arrive.
- Retrieve the Emergency Trolley to prepare to assist the MET Call team.
- Prepare to scribe the event through out the MET CALL.
- The Team Leader of the clinical area must notify the After Hours Nurse Manager as soon as able.
- Ensure **ALL** patient records and pathology results/observations and fluid balance charts are with the patient.

The MET Call Team shall:

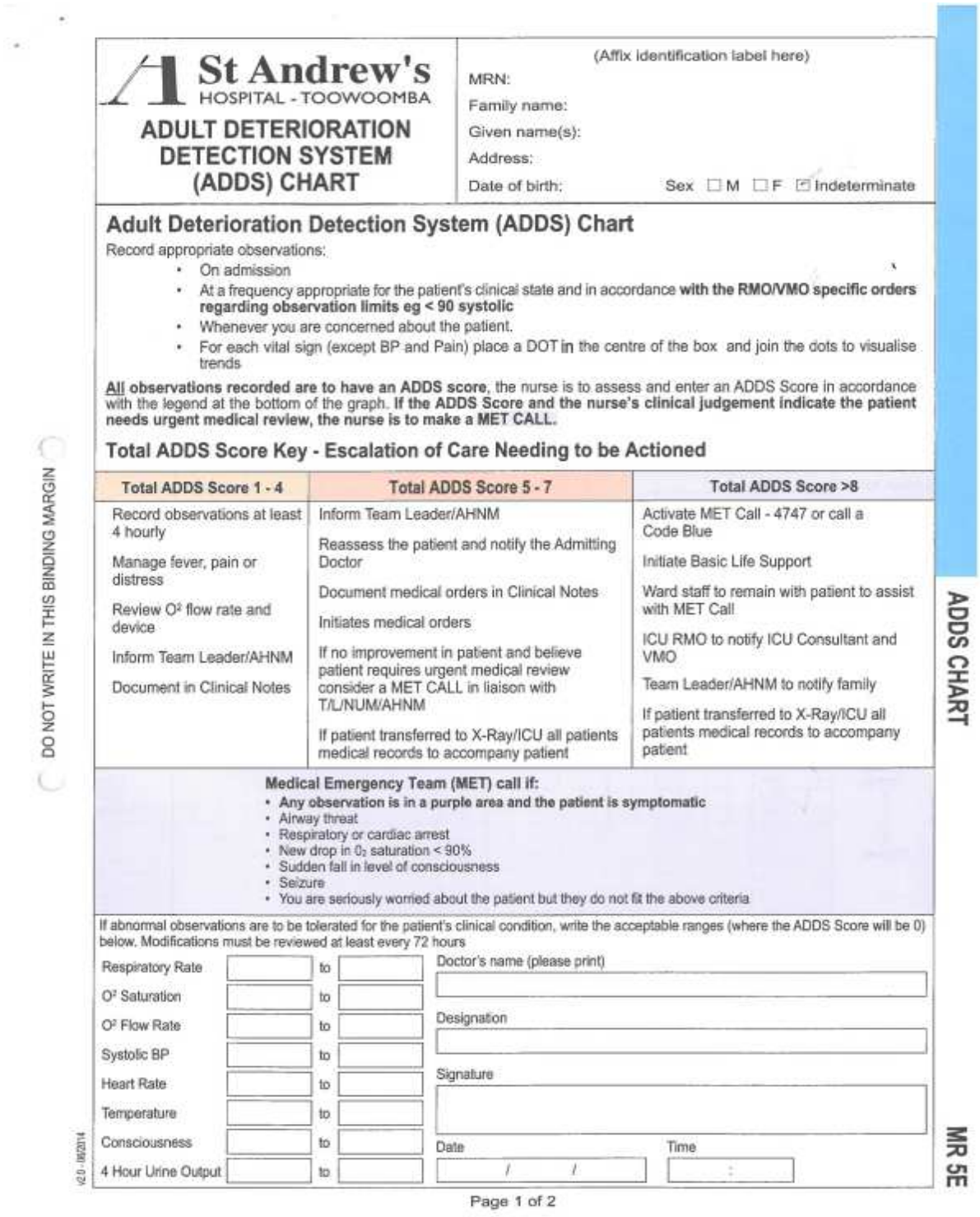
- Respond to all MET Calls without delay. The MET Call team consists of the Resident Medical Officer of the day, a Registered Nurse who has completed an Advanced Life Support Course, the Nurse Manager of the Hospital of the day/ After Hours Nurse Manager and a Wardsperson.
- On arrival of the MET Call Team, the Resident Medical Officer directs the actions to be instigated and determines the degree of escalation required for the patient.
- Ensure the *Medical Emergency Call Sheet* is completed, copied and sent to the ICU Nurse Unit Manager.
- Ensure the patient's next of kin are notified by area Team Leader or AHNM as soon as possible after patient stabilized.

REFERENCES

Australian Commission on Safety and Quality in Healthcare, Standard 9: 'Recognising and Responding to Clinical Deterioration; Use of Observations Chart to Identify Clinical Deterioration (2009)

Ritin Fernandez, RN, MN (Critcare), 2005 A comparison of evidence based regime with the standard protocol for monitoring postoperative.

Appendix 1- ADDS Chart



St Andrew's HOSPITAL - TOOWOOMBA

ADULT DETERIORATION DETECTION SYSTEM (ADDS) CHART

(Affix identification label here)

MRN:
Family name:
Given name(s):
Address:
Date of birth: Sex ☐ M ☐ F ☑ Indeterminate

Adult Deterioration Detection System (ADDS) Chart

Record appropriate observations:

- On admission
- At a frequency appropriate for the patient's clinical state and in accordance **with the RMO/VMO specific orders regarding observation limits eg < 90 systolic**
- Whenever you are concerned about the patient.
- For each vital sign (except BP and Pain) place a DOT in the centre of the box and join the dots to visualise trends

All observations recorded are to have an ADDS score, the nurse is to assess and enter an ADDS Score in accordance with the legend at the bottom of the graph. **If the ADDS Score and the nurse's clinical judgement indicate the patient needs urgent medical review, the nurse is to make a MET CALL.**

Total ADDS Score Key - Escalation of Care Needing to be Actioned

Total ADDS Score 1 - 4	Total ADDS Score 5 - 7	Total ADDS Score >8
Record observations at least 4 hourly Manage fever, pain or distress Review O^2 flow rate and device Inform Team Leader/AHNM Document in Clinical Notes	Inform Team Leader/AHNM Reassess the patient and notify the Admitting Doctor Document medical orders in Clinical Notes Initiates medical orders If no improvement in patient and believe patient requires urgent medical review consider a MET CALL in liaison with T/L/NUM/AHNM If patient transferred to X-Ray/ICU all patients medical records to accompany patient	Activate MET Call - 4747 or call a Code Blue Initiate Basic Life Support Ward staff to remain with patient to assist with MET Call ICU RMO to notify ICU Consultant and VMO Team Leader/AHNM to notify family If patient transferred to X-Ray/ICU all patients medical records to accompany patient

Medical Emergency Team (MET) call if:

- **Any observation is in a purple area and the patient is symptomatic**
- Airway threat
- Respiratory or cardiac arrest
- New drop in O_2 saturation < 90%
- Sudden fall in level of consciousness
- Seizure
- You are seriously worried about the patient but they do not fit the above criteria

If abnormal observations are to be tolerated for the patient's clinical condition, write the acceptable ranges (where the ADDS Score will be 0) below. Modifications must be reviewed at least every 72 hours

Respiratory Rate		to	
O^2 Saturation		to	
O^2 Flow Rate		to	
Systolic BP		to	
Heart Rate		to	
Temperature		to	
Consciousness		to	
4 Hour Urine Output		to	

Doctor's name (please print)

Designation

Signature

Date / /

Time :

DO NOT WRITE IN THIS BINDING MARGIN

ADDS CHART

MR 5E

v2.0 - 06/2014

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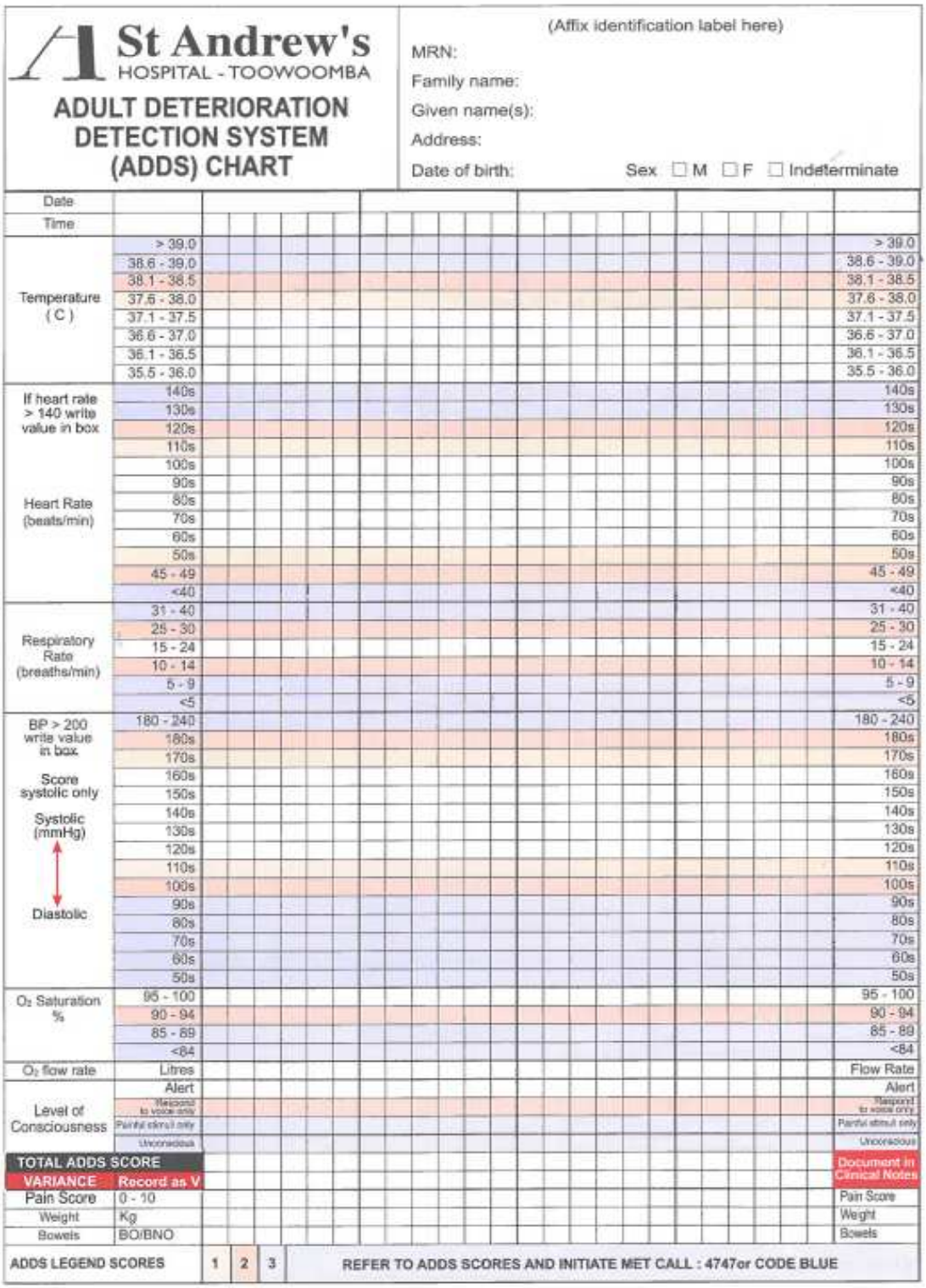

St Andrew's HOSPITAL - TOOWOOMBA

ADULT DETERIORATION DETECTION SYSTEM (ADDS) CHART

(Affix identification label here)

MRN:

Family name:

Given name(s):

Address:

Date of birth: Sex ☐ M ☐ F ☐ Indeterminate

Date								
Time								
Temperature (C)	> 39.0							> 39.0
	38.6 - 39.0							38.6 - 39.0
	38.1 - 38.5							38.1 - 38.5
	37.6 - 38.0							37.6 - 38.0
	37.1 - 37.5							37.1 - 37.5
	36.6 - 37.0							36.6 - 37.0
	36.1 - 36.5							36.1 - 36.5
	35.5 - 36.0							35.5 - 36.0
If heart rate > 140 write value in box	140s							140s
	130s							130s
	120s							120s
	110s							110s
	100s							100s
	90s							90s
Heart Rate (beats/min)	80s							80s
	70s							70s
	60s							60s
	50s							50s
	45 - 49							45 - 49
	<40							<40
Respiratory Rate (breaths/min)	31 - 40							31 - 40
	25 - 30							25 - 30
	15 - 24							15 - 24
	10 - 14							10 - 14
	5 - 9							5 - 9
	<5							<5
BP > 200 write value in box	180 - 240							180 - 240
Score systolic only	180s							180s
	170s							170s
	160s							160s
	150s							150s
Systolic (mmHg)	140s							140s
	130s							130s
	120s							120s
	110s							110s
	100s							100s
Diastolic	90s							90s
	80s							80s
	70s							70s
	60s							60s
	50s							50s
O_2 Saturation %	95 - 100							95 - 100
	90 - 94							90 - 94
	85 - 89							85 - 89
	<84							<84
O_2 flow rate	Litres							Flow Rate
Level of Consciousness	Alert							Alert
	Respond to voice only							Respond to voice only
	Painful stimuli only							Painful stimuli only
	Unconscious							Unconscious
TOTAL ADDS SCORE								Document in Clinical Notes
VARIANCE	Record as V							
Pain Score	0 - 10							Pain Score
Weight	Kg							Weight
Bowels	BO/BNO							Bowels
ADDS LEGEND SCORES	1	2	3	REFER TO ADDS SCORES AND INITIATE MET CALL : 4747or CODE BLUE				

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