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Subject: WA Health Clinical Deterioration Policy

This policy is intended for use by all clinicians working within Western Australian Department of Health Services and applies to all in-patients within WA Health acute care facilities having an acute or subacute (or residential in WACHS) episode of care. It provides the minimum requirements to ensure that clinical deterioration is recognised and acted upon promptly.

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Contents

1 Executive Summary 1
  1.1 Purpose 1
  1.2 Scope 1
  1.3 Relevant Standards and Guidelines 1
  1.4 Review 1
  1.5 Policy exceptions 2

2 Policy 3
  2.1 Observations 3
    2.1.1 Measurement and documentation 3
    2.1.2 Frequency of observations 3
    2.1.3 Minimum physiological observations 3
    2.1.4 Observation and Response Chart 4
    2.1.5 Monitoring plan 4
  2.2 Escalation of care 4
    2.2.1 Escalation protocol 4
    2.2.2 Escalation response 4
    2.2.3 Modifications 4
    2.2.4 Not for resuscitation 5
  2.3 Roles and responsibilities 5
  2.4 Rapid response systems 6
    2.4.1 Rapid response system – organisational requirements 6
    2.4.2 Medical Emergency escalation criteria 6
    2.4.3 Rapid response team – staffing 6
    2.4.4 Rapid response processes 7
  2.5 Clinical communication 7
    2.5.1 Clinical handover 7
    2.5.2 Communication with the patient, family and/or carer 7
  2.6 Organisational requirements 8
    2.6.1 Local clinical deterioration policies 8
    2.6.2 Governance 8
  2.7 Education 8
    2.7.1 Education program 8
  2.8 Evaluation, audit and feedback 9
1 Executive Summary

The Western Australian (WA) Health Clinical Deterioration Policy details the core principles that must be followed within WA Health Services.

The failure to recognise and respond to clinical deterioration has been highlighted as a significant factor in a number of adverse events within WA. This policy provides an overarching framework about the minimum requirements to ensure that clinical deterioration is recognised and acted upon promptly.

The observation and response charts in use within WA, incorporate a ‘track and trigger’ system to identify changes in physiological parameters over time and the required action when these physiological parameters become abnormal.

1.1 Purpose

The purpose of this policy is to:

- describe the elements essential for the timely recognition and response to clinical deterioration of patients in acute healthcare facilities
- enhance patient safety by improving the recognition of abnormal vital signs and potential clinical deterioration
- ensure a timely response when abnormal vital signs are detected
- ensure a consistent approach to the recognition and response to clinical deterioration across WA Health.

1.2 Scope

This policy applies to:

- all in-patients within WA Health acute care facilities having an acute or subacute (or residential in WACHS) episode of care
- nursing and midwifery, medical and allied health staff unless otherwise specified.

1.3 Relevant Standards and Guidelines

The policy should be read in conjunction with:

- The National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration developed by the Australian Commission on Safety and Quality in Health Care, 2010
- National Safety and Quality Health Service Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care
- WA Clinical Handover Policy, 2013.

1.4 Review

This policy will as a minimum be reviewed by the Performance Activity and Quality Division, Department of Health WA, 18 months from initial release, and every 3 years thereafter.
1.5 Policy exceptions

The WA Clinical Deterioration Policy aligns with the Australian Commission on Safety and Quality’s Consensus Statement¹. WA Health acknowledges that exceptions to the WA Clinical Deterioration Policy may be required.

Prior to implementation of any organisation-wide exceptions, hospitals must assess potential risks using a risk management approach as detailed by the Australian Commission on Safety and Quality in Healthcare⁴. Refer to the WA Health Clinical Risk Management resources for additional guidance⁵,⁶.

It is also acknowledged that there will be case-by-case circumstances where exceptions to this policy will be necessary for best patient care. Clinicians must justify and document these exceptions within the medical record.
2 Policy
The following **minimum** requirements apply.

2.1 Observations

2.1.1 Measurement and documentation
Regular measurement and documentation of physiological observations is an essential requirement for recognising and responding to clinical deterioration.

Observations **must** be taken:
- on all in-patients experiencing an acute episode within a WA Health hospital
- on patients at the time of admission (or initial assessment)
- prior to inter and intra hospital transfer.

2.1.2 Frequency of observations
Observations should be taken at least every eight hours (three times a day).

Unless otherwise stated in the monitoring plan, the frequency of observations should be consistent with (and reconsidered and monitored based on) the clinical situation of the patient (see Appendix 2).

2.1.3 Minimum physiological observations
At a **minimum** the following physiological observations must be performed:
- respiratory rate
- oxygen saturation
- heart rate
- blood pressure
- temperature
- level of consciousness (Alert, Voice, Pain, Unresponsive – AVPU).

For paediatric patients (including newborn infants) one or several physiological observations may not be routinely performed and/or other paediatric-specific measures may be included. Any changes to the minimum set of physiological observations must be recorded in the monitoring plan (see 2.1.5).

All paediatric patients (including newborn infants) must have a full set of physiological observations taken:
- on admission to ward
- prior to or following transfers between wards/clinical areas where the child as undergone a procedure including surgery
- when the observations performed trigger an escalation of care response
- if a child is critically unwell.
2.1.4 Observation and Response Chart
Observations should be documented on a Health Service endorsed observation and response chart. Sites wishing to use alternative observation and response charts must raise it with their appropriate Health Service Committee, who will present it for endorsement at the Clinical Deterioration Executive Steering Committee.

The endorsement of speciality specific charts (e.g. neurosurgery observation charts) must be approved via site and Health Service governance.

To better visually identify trends, all observations must be recorded in a graph format, unless otherwise stated on the observation and response chart.

2.1.5 Monitoring plan
A personalised monitoring plan, that includes the plan for physiological observations (as listed in 2.1.3), monitoring and recording, must be developed at the time of admission. The monitoring plan must include the frequency of observations and take into account the patient’s diagnosis, presence of comorbidities, treatment and protocol requirements (i.e. oxygen therapy) and any restrictions to intervention associated with Advance Health Directives. The monitoring plan must be reviewed and modified every eight hours (if clinically appropriate). Clinical areas need to determine which member(s) of the team will document the monitoring plan.

2.2 Escalation of care
2.2.1 Escalation protocol
The escalation protocol refers to the response criteria and the actions required indicated on the observation and response chart (see Appendix 3). This applies to the care of all patients at all times.

2.2.2 Escalation response
Each hospital must have a formal documented escalation procedure that sets out actions required to respond to different levels of abnormal physiological observations.

The ‘actions’ described on the escalation response section of the observation and response chart must be aligned with local escalation procedures. Sites have the ability to change the ‘actions’ outlined within the escalation protocol to meet local needs but must not change the clinical escalation criteria (response criteria) on the observation and response chart.

2.2.3 Modifications
Modifications to the response criteria can only be made in exceptional circumstances and following a review of the patient and their monitoring plan. There must be sound clinical justification for the modification.

If a modification is initiated, a detailed clinical management plan must be documented in the patient’s medical record along with a clinical justification for the modification. The management plan must include:

1. a monitoring plan
2. an escalation plan that includes actions required for the altered response criteria
3. time frame for which the modification is valid (not more than 72 hours).
Modifications should only be made by consultants or in WACHS sites by the most senior doctor available. Modifications must be reviewed at least every 72 hours on patients experiencing an acute episode.

### 2.2.4 Not for resuscitation

A NFR order is the responsibility of senior clinicians and should be made early in the patient’s admission and documented in the medical record. Documentation must include the rationale for the decision and communication about the decision with the patient, family and/or carer.

A Not for Resuscitation (NFR) decision does not imply withdrawal of all treatment. In these situations, patients must still be monitored using an observation and response chart. Medical Emergency Response must continue to be activated for criteria other than cardiopulmonary arrest. Refer to site/health service guidelines for additional information regarding NFR decisions (including those relating to palliative patients).

### 2.3 Roles and responsibilities

All doctors, nurses and midwives must:
- evaluate the patient’s condition when taking observations
- review vital signs outside of normal range
- initiate appropriate early interventions for patients who are deteriorating and document the intervention/s on the observation and response chart and in the medical record
- respond with life-sustaining measures in the event of severe or rapid deterioration, pending the arrival of emergency assistance, and where appropriate contribute to the ongoing acute management of the patient
- document in the medical record all vital signs outside of normal range (along with appropriate interpretation and a treatment plan)
- immediately communicate all vital signs outside of normal range to other clinicians involved in the care of the patient as outlined within the escalation protocol
- communicate information about clinical deterioration using a structured communication tool (refer to the WA Clinical Handover Policy, 2013)
- inform patients, families and carers about the observation monitoring and escalation process
- understand the importance of and discuss end-of-life care planning with the patient, family and/or carer
- undertake tasks required to properly care for patients who are deteriorating, such as developing a clinical management plan, adjusting escalation criteria (modifications) based on appropriate clinical justification and documenting clinical deterioration and the response to it.
All allied health staff must be able to:
- systematically assess a patient appropriate to their professional practice and training
- call for assistance for patients who are deteriorating/appear to be deteriorating
- initiate appropriate early interventions for patients who are deteriorating and document the intervention/s on the observation and response chart
- respond with life-sustaining measures in the event of severe or rapid deterioration, pending the arrival of emergency assistance and, where appropriate, contribute to ongoing acute management of the patient
- communicate information about clinical deterioration using a structured communication tool (refer to the WA Clinical Handover Policy, 2013) to clinicians, patients, families and carers where appropriate.

All non-clinical staff must be able to:
- know how to call for emergency assistance if they have any concerns about a patient, and know that they should call under these circumstances.

2.4 Rapid response systems

2.4.1 Rapid response system – organisational requirements
Every hospital must have a rapid response system that is appropriate to the size, role and staffing mix of the hospital (see Appendix 4).

2.4.2 Medical Emergency escalation criteria
Criteria for calling for a Medical Emergency Response must be included in the escalation protocol and includes:
- the patient’s observations falling into the medical emergency trigger zone of the observation chart or when the cumulative score for medical emergency is reached (see Appendix 1 for the Medical Emergency Response Adult Calling Criteria)
- staff and/or family/carer concern – ‘worried criterion’
- failure to respond to medical review request within a specified time frame.

2.4.3 Rapid response team – staffing
The rapid response system must include access to, at all times, one clinician (on site or in close proximity) who can practise advanced life support.

Clinicians providing emergency assistance as part of the rapid response team must:
- be available to respond within agreed timeframes
- be able to assess the patient and provide a provisional diagnosis
- be able to undertake appropriate initial therapeutic intervention
- be able to stabilise and maintain the patient
- have authority to make transfer decisions and to access other care providers to deliver definitive care
- seek clinical advice from senior/speciality staff in a timely manner
- have access to a staff member of sufficient seniority who can provide treatment-limiting decisions.
2.4.4 Rapid response processes
A patient meeting Medical Emergency Response criteria should not be transferred between hospitals or within the hospital unless they are assessed, accompanied and monitored by a clinician with advanced life support skills.

When a medical emergency call has been made, the doctor with primary responsibility for the care of the patient must be notified.

Clinicians providing emergency assistance must communicate in an appropriate, detailed and structured way with the attending medical officer or team.

Events surrounding the medical emergency call and the actions resulting from the call must be documented in the patient’s medical record.

2.5 Clinical communication
Effective communication and teamwork among clinicians is essential in recognising and responding to clinical deterioration.

2.5.1 Clinical handover
Standard handover processes, including documentation of handovers, must be used for all patients. All handover procedures must conform to the WA Clinical Handover Policy, 2013.

Handover must include identification of patients who are, or are at particular risk of, deteriorating and communication of information relevant to their management.

Handover must include information about the most recent observations and clinical assessment particularly vital signs outside of normal range.

2.5.2 Communication with the patient, family and/or carer
Clinicians must consider the value of information about potential deterioration from the patient, family or carer.

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

Clinicians must discuss the wishes of the patient (e.g. Advance Health Directives) at admission (or as soon as practicable) in accordance with WA Health guidelines. If the patient does not have decision making capacity refer to the Consent to Treatment Policy regarding the decision making hierarchy in relation to the guardian, family, or carer.
2.6 Organisational requirements

2.6.1 Local clinical deterioration policies
Each health service must ensure that they have formal clinical deterioration procedures to support this policy which includes:
  ■ governance
  ■ roles and responsibilities
  ■ communication processes
  ■ resources for the rapid response system (e.g. staff and equipment)
  ■ training requirements
  ■ evaluation, audit and feedback process
  ■ rapid response system arrangements made with external organisations.

2.6.2 Governance
The Recognising and Responding to Clinical Deterioration Statewide Executive Steering Committee (Executive Steering Committee) oversees the development, implementation and ongoing review of clinical deterioration activities across WA Health.

Each Health Service and WA Health site must ensure they have appropriate governance arrangements in place to oversee the implementation and ongoing review of clinical deterioration activities at a site level.

The Health Service/Site Clinical Deterioration Committee must:
  ■ have appropriate responsibilities delegated to it and be accountable for its decisions and actions
  ■ monitor data collected
  ■ provide advice about the allocation of resources
  ■ review education resources
  ■ include consumers, clinicians, managers and executives.

Each hospital is expected to report any issues/risks to their health service who will provide a report to the Executive Steering Committee on a quarterly basis. All issues and risks will be recorded on a statewide issues register and regularly reviewed by the Executive Steering Committee and Subcommittees.

2.7 Education

2.7.1 Education program
All WA Health sites must have an education program in place. All clinical staff must be trained and proficient in basic life support.

All clinical and non-clinical staff must receive education about:
  ■ their local escalation protocol relevant to their position
  ■ how to call for emergency assistance if they have any concerns about a patient.
Clinical deterioration education must be provided at the commencement of employment. Each hospital will ensure relevant elements related to the recognition and response to clinical deterioration are included in regular refresher training. Education provided must be relevant to each occupation.

2.8 Evaluation, audit and feedback

All WA Health facilities must collect and review data locally to assess performance.

Recognition and response systems must be evaluated to determine whether they are operating effectively. This must include seeking feedback from the clinical workforce about the responsiveness of the recognition and response systems and using feedback to make improvements.

As a minimum, sites must ensure the following is monitored and reviewed:

- the circumstances and outcome of calls for emergency assistance
- the following measures as outlined within ‘A Guide to Support Implementation of the National Consensus Statement’:
  - documentation of core physiological observations
  - compliance with monitoring plans and policies
  - escalation of care
  - unexpected cardiopulmonary arrests.
Appendix 1. Medical Emergency Response (MER) Calling Criteria

Criteria for calling a Medical Emergency Team (MET) for adult patients has been developed to assist clinicians to identify patients at risk. The criteria indicated is the minimum calling criteria. Sites may choose to apply more stringent calling criteria or choose to employ additional MER calling criteria (i.e., a score on some Adult Deterioration Detection System (ADDS) charts will trigger a MER).

**Calling Criteria – Adults**

<table>
<thead>
<tr>
<th>Acute changes in any one or more:</th>
<th>Physiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway</td>
<td>Threatened</td>
</tr>
<tr>
<td>Breathing</td>
<td>Respiratory rate ≤ 4</td>
</tr>
<tr>
<td></td>
<td>Respiratory rate ≥ 36</td>
</tr>
<tr>
<td></td>
<td>O2 Saturation ≤ 84</td>
</tr>
<tr>
<td>Circulation</td>
<td>Pulse rate ≤ 30</td>
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<tr>
<td></td>
<td>Pulse rate ≥ 140</td>
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<tr>
<td></td>
<td>Systolic blood pressure &lt; 90</td>
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<tr>
<td></td>
<td>Systolic blood pressure &lt; 70 for maternity patients</td>
</tr>
<tr>
<td>Neurology</td>
<td>Sudden fall in level of consciousness</td>
</tr>
<tr>
<td></td>
<td>(Fall in Glasgow Coma Scale (GCS) of &gt; 2 points)</td>
</tr>
<tr>
<td></td>
<td>Repeated or prolonged seizures</td>
</tr>
<tr>
<td>Other</td>
<td>Any patient who you (or a family member/carer) are seriously concerned about that does not fit the above criteria</td>
</tr>
</tbody>
</table>

**Paediatrics**

All paediatric (including newborn infants) patients must have their observations documented on a Health Service endorsed observation and response chart which must include criteria for calling a MER.
Appendix 2. Observations

Frequency of observations

The minimum frequency of observations (eight hourly) can be modified based on changes to clinical circumstances.

Based on an assessment of the patient, the minimum frequency of observations (eight hourly) should be:

- **decreased** with the approval of a medical officer (following consultation with the attending medical officer)
  
  Such patients requiring less frequent observations may include, but are not limited to, patients awaiting permanent residential care and permanent aged care residents in multi purpose services and small rural hospitals

- **increased** by nursing or other clinical staff based on clinical judgement of a patient’s condition.

At an absolute minimum observations must be taken at least:

- daily for subacute adult patients
- monthly for aged care residents who reside in a WACHS multipurpose service or co-located residential aged care facility.

Changes to the frequency of observations must be clearly documented on the monitoring plan and in the patient’s medical record.

Newborns not deemed at risk will have temperature, heart rate and respiratory rate attended hourly for three hours, and if remain ‘normal’ will cease, as per King Edward Memorial Hospital guidelines.

Postnatal women following vaginal delivery with uncomplicated pregnancy, and admission observations within normal limits, who have no co-morbidities, and remain stable should have observations as per King Edward Memorial Hospital’s clinical guidelines for routine post-partum care.

**Additional physiological observations**

Clinicians may nominate additional observations as required (i.e. pain, fluid balance) to be documented on the monitoring plan.
Appendix 3. Local escalation protocol and guidelines

Each site must have an escalation protocol that defines what should occur when abnormal physiological parameters are met and should include timeframes by which the patient must be reviewed/attended to. This should be supported by local escalation guidelines.

The escalation protocol should:

- authorise the clinician to escalate care until they are satisfied an appropriate response has been made. If the delegated clinical staff member is unable to respond to a clinical review request, the calling clinician should escalate to the next escalation level
- be tailored to the characteristics of the hospital (size, role, location, available resources, potential need for transfer to another hospital)
- highlight the inclusion of the ‘worried’ criterion which allows all clinicians to escalate care in the absence of other abnormal physiological measurements
- take into consideration the concerns of the patient, family or carers. Hospitals should have a process by which the patient, family or carer can request a clinical review if they are concerned
- include consideration of the needs and wishes of patients with an Advance Health Directive or other treatment limiting decisions
- be accessible, distributed widely and included in staff education.

The escalation protocol should specify:

- the abnormal physiological parameters (coloured zones)
- the response required for a particular abnormal physiological parameter or cumulative score
- how the care of the patient is escalated
- the personnel that the care of the patient is escalated to
- who has primary responsibility for care of the patient
- who else is to be contacted when the care of the patient is escalated
- the timeframe in which a requested response should be provided
- backup options to obtaining a response.
Appendix 4. Organisational requirements

Rapid response system – organisational requirements
The rapid response system needs to be appropriate to the size, role and staffing mix of the hospital. At some remote sites the rapid response system may consist of a nurse/midwife accredited in advanced life support, local ambulance service or general practitioner.

Rapid response calls – learning opportunities
The clinicians providing emergency assistance should, where practical, use the Medical Emergency Response call (and events leading up to it) as an educational opportunity for ward staff and students.

The clinicians providing emergency assistance should provide feedback to the attending medical officer and team about the outcome of the call including information to be documented in patient’s medical record.

Local clinical deterioration policies
A local clinical deterioration policy should apply across the acute health care hospital. This policy should identify the planned variations in the escalation protocol and responses that might exist in different circumstances (e.g. different times of the day).

Each site must have a system in place to ensure resources used in emergency response are available and operational. All equipment should be checked daily and after use. On orientation all clinical staff should be given training on how to use equipment.

Policies and documentation regarding Advance Health Directives, treatment-limiting decisions and end of life decision making should be available and included in clinician education.
Appendix 5. Evaluation, audit and feedback

Rapid response system
Systems should be evaluated to determine whether they are improving the recognition and response to clinical deterioration. Sites should refer to the Australian Commission’s A Guide to Support Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration\(^9\).

Where possible, sites should collect and review the following measures:
- number of rapid response calls
- rate of deaths
- cardiopulmonary arrests
- unexpected mortality
- clinical documentation after rapid response system calls
- activation of patient, family and carer escalation
- awareness of patient, family and carer escalation
- unplanned admission into ICU
- completion rates of observation charts
- proportion of staff that have completed clinical deterioration training.

Medical emergency response call
Sites should collect data for each call for emergency assistance that is made. Where possible, as a minimum, sites should collect, document and review the following:
- patient demographics
- date and time of call and response time
- reason for the call
- treatment or intervention provided
- outcomes of the call.

Sites should conduct regular audits of triggers and outcomes for patients who have received medical emergency assistance calls. Consider looking at longer-term outcomes such as 30, 60-day mortality.

Consider other information such as incident reports, root cause analyses, cardiac arrest calls and death reviews. Identify whether the escalation criteria for the medical emergency response call were met and whether care was escalated appropriately.

Staff perceptions
Staff perception surveys should be used to obtain information about the barriers and enablers of change and implementation issues.
Feedback loop
Information collected as part of evaluation and audit should be:
- fed back to ward staff and home team regarding their calls for emergency assistance
- fed back to the clinicians providing the emergency assistance
- reviewed to identify lessons that can improve clinical and organisational systems
- used in education and training programs
- used to track outcomes and changes in performance over time.

Senior executives at hospital and health service level should regularly review data relating to the implementation and effectiveness of recognition systems. Any significant issues should be provided to the statewide Executive Steering Committee for review.
Appendix 6. Technological systems and solutions

Electronic systems can be used to automatically monitor vital signs and alert clinicians. The introduction of technological systems and solutions should be introduced with the approval of the Executive Steering Committee via the site’s Health Service Clinical Deterioration Committee. Prior to the introduction of technological systems the following should be considered (and presented to the Health Service Clinical Deterioration Committee).

- The introduction of technological solutions must be based on evidence of efficacy and cost as well as potential safety and quality risks. Prior to implementation the education and technical support requirements must be considered along with an explicit study of adverse events.
- Technological solutions should not place a barrier between the clinician and the patient and must conform to the elements specified in the National Consensus Statement.
Glossary

**Acute care**: Acute care is (admitted patient) care in which the clinical intent or treatment goal is to:
- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

**Advance Health Directive**: instructions that consent to, or refuse, the future use of specified medical treatments (also known as healthcare directive, advance plan or other similar terms).

**Advanced life support (ALS)**: Nationally accredited or hospital based training that gives the provider skills to apply the Australian Resuscitation Council ALS Algorithm, manage peri arrest situations, provide and instruct others in CPR as well as safe defibrillation techniques and manage an airway on the compromised patient.

**Attending medical officer**: The treating doctor or team with primary responsibility for caring for the patient.

**Audit**: a systematic review against a predetermined set of criteria.

**Carer**: a carer is a person who (without being paid) provides ongoing care or assistance to another person who has a disability, a chronic illness or a mental illness, or who is frail.

**Clinician**: A health care provider, trained in a health profession. This term encompasses medical practitioners, nurses, midwives, dentists, paramedics and allied health professionals such as physiotherapists, occupational therapists, speech pathologists, dieticians, radiographers, social workers, psychologists, pharmacists and all others in active clinical practice, but excludes clinicians-in-training and junior practitioners who must work under supervision.

**Escalation criteria**: Alternatively called ‘calling’ criteria. Escalation criteria identifies when care needs to be escalated. Trigger zones are coded to draw attention when the escalation criteria are met.

**Escalation protocol**: The protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to care of all patients at all times.

**Health service**: Grouping of public health services and hospitals that are operated and managed collectively. For the purposes of this policy, Health Service refers to all WA Department of Health funded health services, specifically, North Metropolitan, South Metropolitan, Child and Adolescent and WA Country Health Services.
Medical emergency response: Emergency clinical advice or assistance provided when the patient’s condition has deteriorated. This assistance is provided as part of the rapid response system and is additional to the care provided by the attending medical officer or team.

Monitoring plan: A monitoring plan identifies and ensures:
- appropriate observations and assessments for a patient’s clinical condition and proposed treatment plan
- frequency of observations and assessments
- monitoring requirements for each patient are clearly communicated to all members of the health care team.

Rapid response system: The system for providing emergency assistance to patients whose condition is deteriorating. The system will include the clinical team or individual providing emergency assistance, and may include on-site and off-site personnel.

Subacute care: Subacute care is time limited, goal-oriented, individualised, multidisciplinary care that aims to help people who are disabled, frail, chronically ill or recovering from traumatic injury to regain and/or maintain optimal function to allow as many people as possible to maximise their independence and return to (or remain in) their usual place of residence.

Track and trigger: A track and trigger tool refers to an observation chart that allows observations to be recorded graphically and allows for trends to be visually ‘tracked’. It also incorporates a criteria/threshold ‘trigger’ which requires action.
References


