KEY POINTS OF RECOGNISING AND RESPONDING TO CLINICAL DETERORATION (STANDARD 9) FOR MEDICAL STAFF

Observation and Response Chart (ORC):

There a **5** different ORC used at BHS for different patient groups:

- Adult Observation and Response Chart **= ORC**
- Maternity Observation and Response Chart **= MORC**
- Statewide Paediatric Observation and Response Chart **= SPORC**
- Emergency Observation and Response Chart
- Post Anaesthetic Recovery Management Chart

It is the responsibility of Nurses /Midwifes at BHS to:

- Attend to and record physiological observations in the expected manner on the appropriate ORC
- Recognise clinical deterioration based on the track and trigger system within the appropriate ORC
- Escalate care in an appropriate and timely manner to the appropriate medical staff or the Medical Emergency Team (MET)

It is the responsibility of Medical Staff at BHS to:

- Review physiological observations routinely to determine trends or more subtle deterioration that may not fall into escalation criteria
- Respond to calls for clinical review in the appropriate and expected time frame (**15 minutes**)
- Document modifications for patients who have abnormal observations that are to be tolerated due to the patients acute or chronic clinical condition
- Review these modifications in the expected time frame (**72 hours**) to ensure appropriateness and currency

❖ **PLEASE** do **not** ask nursing staff to write numbers on the ORC, for example specific blood pressure readings, as this is asking them to do something that they are instructed not to do.
The ORC relies on the trending of observations, not specific numbers

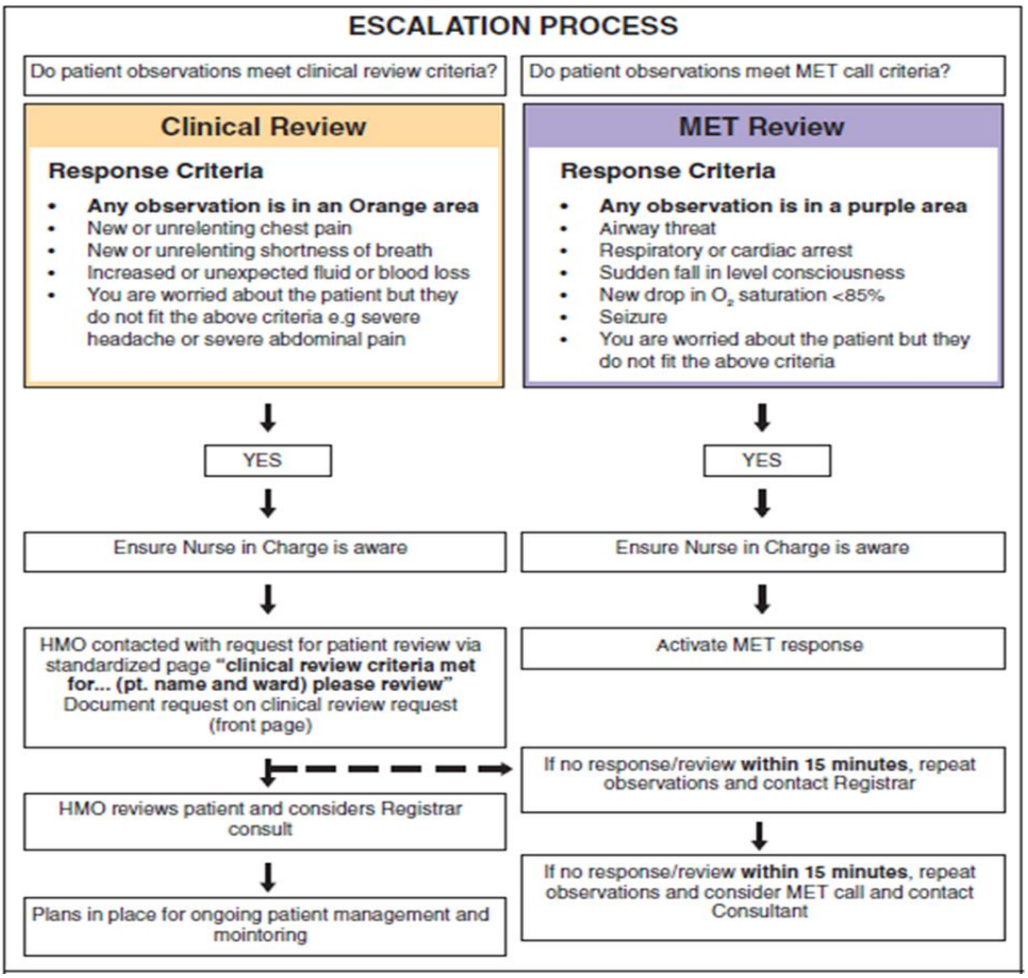
Modifications:
Modifications allow the parent medical unit to communicate to all clinicians involved in the care of a particular patient, a set of individualised, acceptable clinical parameters for each patient that may otherwise trigger the need for escalation to Clinical Review or MET Review.

Modifications may be documented by junior medical officers (HMO) **only** following consultation with the registrar and/or consultant responsible for the patient.
The Nurse /Midwife may take a phone order for a modification **only** from the registrar or consultant responsible for the patient.

Competencies:

It is an expectation within BHS that **ALL** medical staff are competent in at least Basic Life Support (**BLS**). Some medical staff are expected to be competent in Advanced Life Support (**ALS**) depending on your role and the department in which you work.

Clinical Review / MET Review:



If you do not respond to a pager message for Clinical Review in the allocated time frame (15 minutes), nursing staff are instructed to escalate and continue to escalate until they receive assistance and the patient is safe. This may result in consultants being called and MET responses activated when they do not necessarily need to be. Response via phone is acceptable if you are unable to attend the ward area in the 15 minute timeframe to ascertain the issues and plan a course of action.

Policies and Protocols:

In the Governance Documentation System (accessed via the intranet), type "Standard 9" into the Keyword search and you will see all polices and protocols that relate to Recognising and Responding to Clinical Deterioration at BHS.