## Recognition of the Deteriorating Paediatric Patient

<table>
<thead>
<tr>
<th>Sites where PCP applies</th>
<th>Any areas where paediatric patients are treated within the JHH campus. Excluding NICU &amp; PICU.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This PCP applies to:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Adults</td>
<td>No</td>
</tr>
<tr>
<td>2. Children up to 16 years</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Neonates – less than 29 days</td>
<td>No</td>
</tr>
<tr>
<td><strong>Target audience</strong></td>
<td>All clinical staff providing care to paediatric patients</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>This guideline has been written in response to PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating &amp; describes the essential elements of care staff are to provide.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Keywords</strong></th>
<th>CERS, deterioration, Between the Flags, SPOC, paediatric, children, observations, JHH, JHCH</th>
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<tbody>
<tr>
<td><strong>This PCP relates to NSW Ministry of Health Policy Directive</strong></td>
<td>NSW Health PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating.</td>
</tr>
<tr>
<td><strong>PCP number</strong></td>
<td>JHCH PCP 3.19</td>
</tr>
<tr>
<td><strong>Replaces existing document?</strong></td>
<td>Yes, JHCH 3.19 Guideline/procedure</td>
</tr>
</tbody>
</table>

**Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:**
- NSW Health Policy Directive 2014_036 Clinical Procedure Safety
- NSW Health PD2013_049 Recognition and Management of the Patients who are Clinically Deteriorating.
- Local procedure (JHH_JHCH_BH)0192) Emergency Department: vital sign observations and physical assessment
- NSW Health Policy Directive 2013_043 Medication Handling in NSW Public Health Facilities

**Tier 2 Director responsible for Policy to which the PCP relates. PCP authorised by**
- Pat Marks. General Manager / Director of Nursing CYPFS

**PCP contact person and Network or Service etc. responsible for the PCP**
- Camilla Askie. CYPFS Clinical Practice Improvement Coordinator

**Contact details**
- Camilla.askie@hnehealth.nsw.gov.au

**Date authorised**
- 26th April 2016

**This document contains advice on therapeutics**
- No

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**Review date**
- April 2019
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RISK STATEMENT

This local clinical procedure has been developed to provide direction to staff and to ensure paediatric patients at risk of deterioration are recognised and managed.

Any unplanned event resulting in, or with the potential for, injury, damage or other loss to patients/staff/visitors as a result of this procedure must be reported through the Incident Information Management System and managed in accordance with the Ministry of Health Policy Directive: Incident management PD2007_061. This would include unintended injury that results in disability, death or prolonged hospital stay.

Risk Category: Clinical Care & Patient Safety;

GLOSSARY

<table>
<thead>
<tr>
<th>Acronym or Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMO</td>
<td>Admitting Medical Officer</td>
</tr>
<tr>
<td>AVPU</td>
<td>Alert, Voice, Pain, Unresponsive</td>
</tr>
<tr>
<td>BGL</td>
<td>Blood Glucose Level</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>CERS</td>
<td>Clinical Escalation Response System</td>
</tr>
<tr>
<td>GCS</td>
<td>Glasgow Coma Score</td>
</tr>
<tr>
<td>HR</td>
<td>Heart rate</td>
</tr>
<tr>
<td>HT</td>
<td>Height</td>
</tr>
<tr>
<td>JHCH</td>
<td>John Hunter Children’s Hospital</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of Consciousness</td>
</tr>
</tbody>
</table>
Compliance with this PCP is mandatory.

Clinical Processes

Measurement and recording of observations
It is essential that all paediatric patients receive regular recorded measurement of their physiological observations.

Every child in the acute care setting of John Hunter Children’s Hospital (JHCH) must have observations attended at fourth hourly intervals as a minimum. Patients under the care of a specialist team may have this frequency reduced following clinical assessment by the relevant medical officer AND this must be documented on the front page of the current observation chart. This variation in frequency must be reviewed at least every 48 hours.

Observations and an initial assessment must be undertaken at the time of admission to the ward, and recorded in the medical and nursing admission documentation which forms part of the child’s health care record, and on an age-appropriate Standard Paediatric Observation Chart (SPOC) or Paediatric Emergency Department Observation Chart (PEDOC).

Minimum baseline observations include: temperature (T), heart rate (HR) or pulse (P), respirations (R), Respiratory distress (RD), oxygen saturation, (SpO₂), blood pressure (BP), pain assessment, level of consciousness (LOC) using Glasgow Coma Score (GCS) or Alert, Voice, Pain, Unresponsive (AVPU), urinalysis (UA), weight (WT), and height (HT) must be obtained for each patient as close to admission as is possible.

Observations must be plotted as trended data on an age-appropriate SPOC with the times entered as the observations are completed. Each entry must be signed by the staff member documenting the observations.

The frequency of observations will depend on the clinical situation of the patient which should be described in the health care record. The following guide should be used as a minimum requirement in the varying specific situations, examples are below:
<table>
<thead>
<tr>
<th>Additional Risk of deteriorating</th>
<th>Hourly (or less as stipulated)</th>
<th>4th Hourly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin Infusion</td>
<td>Blood glucose level (BGL), insulin infusion, pain assessment.</td>
<td>T, P, R, B.P., GCS or AVPU</td>
<td>Weight</td>
</tr>
<tr>
<td>Neurological</td>
<td>Neurological assessment, P, R, SpO₂, B.P., pain assessment.</td>
<td>T</td>
<td></td>
</tr>
<tr>
<td>Neurovascular</td>
<td>Neurovascular assessment and pain assessment for 24 hours, then 4/24.</td>
<td>T, P, R, B.P., GCS or AVPU</td>
<td></td>
</tr>
<tr>
<td>Oxygen therapy</td>
<td>P, R, SpO₂, gas flow, RD, pain score, GCS or AVPU</td>
<td>T</td>
<td>B.P</td>
</tr>
<tr>
<td>Post-ICU Transfer</td>
<td>T, P, R, B.P., SpO₂, RD, pain assessment and level of consciousness (LOC) – GCS or AVPU on arrival to ward and hourly for 4 hours, then 2nd hourly for 8 hours unless otherwise documented. An initial falls and Glamorgan pressure injury risk assessment should also be attended.</td>
<td>T, P, R, B.P., SpO₂, pain assessment, GCS or AVPU after 12 hours if stable.</td>
<td>Consider weight, BGL</td>
</tr>
<tr>
<td>Post-Operative on ward</td>
<td>Baseline T, P, R, B.P., RD, SpO₂, sedation assessment, pain assessment, GCS or AVPU and wound assessment initially, then hourly for four hours upon return to ward, then fourth hourly. Tonsillectomy requires hourly P,R, RD, SpO₂ and pain, GCS or AVPU and 4th hourly T, BP, until the patient is 24hrs post-op.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedation</td>
<td>Baseline T, P, R, B.P., RD, SpO₂ and GCS or AVPU, then 5-10 minutely P, R, SpO₂ during sedation and recovery period, then hourly P, R, with continuous SpO₂, and sedation assessment until GCS or AVPU, LOC returns to baseline. Also attend pain assessment with all observations if child is sedated for a painful procedure.</td>
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</tbody>
</table>

**Post Anaesthetic Recovery Unit (PARU)**
A patient is not to be received from the PARU if the observations are in the blue zone unless Altered Calling Criteria have been completed.

**Response to Blue/Yellow and Red zones**
When patient’s observations fall into the blue, yellow or red zones, increase the frequency of observations based on the clinical condition of the patient. Yellow must have at least second hourly, more frequent depending on the individual patient’s condition and red zone hourly.

When the patient falls into a different zone (on the SPOC) than the last set of observations, consider repeating the observations within 30 minutes to determine if there is deterioration or an abnormality. Document repeated observations.
If observations fall into the blue zone on the SPOC, notify the nurse in-charge and increase the frequency of the observations e.g. if on 4th hourly observations, repeat observations in half an hour then determine and document the frequency of further observations. It must be sooner than fourth hourly.

If observations fall into the yellow zone on the SPOC, notify the nurse in-charge who may review the child or call the appropriate resident or registrar to notify the team of the deterioration. The nurse-in-charge review and decisions need to be documented on chart or progress notes especially if a decision not to escalate is made.

When calling the medical officer state you have an URGENT CLINICAL REVIEW. Document the clinical review time called/notified in the intervention section of SPOC and in the patient notes using the Clinical Review sticker. The patient must be reviewed by a medical officer within 30 minutes and a plan documented in the notes & or on sticker by the staff member attending the review. See appendix 1.

If an urgent clinical review or response does not occur within 30 minutes, the deterioration must be escalated to a Rapid Response call.

If observations fall into the red zone on the SPOC, assess the situation. Stay with the patient and initiate the appropriate emergency care (airway, breathing, circulation) if required. Observations must be repeated as indicated by the patient’s condition. One staff member must call for 7700 for help stating that you need a PAEDIATRIC RAPID RESPONSE. WARD XX, BED XX.

The rapid response must be entered into IIMs for review by the NUM on ALL rapid response calls.

The Admitting Medical Officer (AMO) is to be notified by the Paediatric Registrar of all Rapid Response calls as soon as possible.

Minimum baseline observations which should be recorded.

Clinicians may nominate additional observations or investigations as deemed necessary e.g. urinalysis, urine output, biochemistry, venous blood gases (VBG), weight.
Any abnormal observations or investigations and the clinical response to them should be documented in the patient’s record.

For infants aged less than 28 days corrected, consultation with a neonatal consultant is recommended if deterioration is detected.

**Escalation protocol**

A formal documented process of escalating the care of patients in the event of concern or deterioration is available in the form of the JHCH Clinical Escalation Response System (CERS) – see Appendix 2.

**Rapid Response Team (RRT)**

The RRT is triggered by a 7700 phone call to a switchboard operator requesting a PAEDIATRIC Rapid Response. Also tell the operator the LOCATION e.g. ward and bed number or outpatient area.

The criteria for requesting RRT assistance may be any of the following:

- Cardiac arrest
- Respiratory arrest
- Circulatory collapse
- Unresponsive patient
- New onset stridor
- Worried – staff or parents are concerned that the patient may be at risk of serious deterioration.
- Three (3) or more simultaneous observations in the yellow zone
- Failure or inability of medical staff to provide a clinical review within 30 minutes of deterioration into the yellow zone in the absence of altered calling criteria, and ongoing deterioration (Must be reported in IIMS).
- Deterioration not reversed within one (1) hour of Clinical Review
- Observations falling within the red zone on an age-appropriate SPOC in the absence of altered calling criteria
- Significant Bleeding
- Sudden decrease in Level of Consciousness (a drop of 2 or more points in GCS)
- New or prolonged seizures activity
- Floppy
- Blood Glucose Level < 2mmol/L or symptomatic
- Lactate ≥ 4mmol/L
The Rapid Response Team response will:

- Assess the patient and make a provisional diagnosis of the problem, and have a management plan documented in the patient’s health care record,
- Undertake appropriate therapeutic interventions,
- Attempt to stabilise and maintain the patient,
- Have authority to make transfer decisions and access other care providers in order to deliver definitive care
- Stay with the patient for clinical handover to the treating team’s RMO/Registrar, or AMO.

In cases where patients require transfer, clinical staff may be required to assist the RR Team in providing safe supportive care whilst awaiting transfer and also assist during the transfer.

When a RRT call is made, the following is to occur:

- The nurse and/or medical officer is to remain with the patient and call for assistance. Another staff member is to bring the resuscitation trolley to the bedside.
- The nursing or medical staff with the deteriorating patient are to involve and inform the family (if present) that a rapid response has been called and that more staff will be coming to review the patient and assist if required.
- If the medical team is not already present, request the patient’s treating team to attend the RR call. The senior MO must also call the AMO (if not present).
- Remain with the patient and upon arrival of the RR team, give a handover of the current situation. Patient care nurse or delegate from the ward, is to remain with the patient and assist the RRT until further advised.
- The admitting team medical officer is to discuss the patient’s condition and involve the patient/parent or carer in management plan for the patient.
- Documentation is to be completed by members of staff treating the patient and staff must document their component of the RRT call and actions in the patient’s health care record
- An IIMS must be completed on every patient that has a rapid response call made. If there are multiple calls in a shift, only one IIMS is required but it must state how many calls were made and why.

Transfers within the facility

Patients should not be transferred to a lower or equal level of care whilst observations are in the red zone unless the following has occurred:

The senior medical officer from the transferring area is aware of the red zone observation/s, has reviewed the patient, and has notified the receiving paediatric consultant/ AMO that the patient is a candidate for transfer but is in the red zone for particular observations.
If the receiving paediatric consultant/AMO disagrees with the plan to transfer the patient, they must discuss the concerns with the most senior MO in the transferring area. This discussion and outcome MUST be documented in the patient medical record.

If the paediatric Consultant/AMO agrees with the plan to transfer the following needs to occur:

- NUM or Nurse-in-charge (NIC) of receiving unit is to be contacted. The NUM/NIC may need to also contact the Nurse Manager on call or After Hours Manager to discuss the transfer and an agreement reached to ensure patient safety and staffing levels are adequate.

- Altered calling criteria needs to be agreed before transfer and clearly documented on the front of the SPOC and a clear management plan documented in the patient’s health care record.

- A management plan of care including a suitable level of medical monitoring needs to be in place before transfer

- A higher level of escort needs to be provided for the transfer including personnel and equipment

Patients who are being transported with observations in the **yellow zone** in the absence of altered calling criteria must have the following attended PRIOR to transfer:

- A clinical handover of the patient’s condition and situation given by the transferring clinicians and accepted by the receiving clinician for both medical and nursing.

- A clearly documented plan of care in the patient’s health care record including when the next medical review will occur +/- altered calling criteria on the SPOC

- Clinical handover to the nurse in-charge of the receiving unit

- The patient must then be transported with an escort, monitoring and equipment.

The outcomes of all discussions and the resulting decisions must be clearly documented in the patient’s health care record.

**Communication processes**

Effective communication and teamwork amongst clinicians is vital in recognising and responding to clinical deterioration.

The ISBAR communication strategy should be used to effectively convey clinical information. This tool helps people to organise what they need to say so that the communication is clearer and more professional. **See appendix 3.**

Information about possible deterioration from the patient, family, or carer/s should be recognised and valued.

Information about the patient’s deterioration should be communicated to the patient, family, or carer/s in a timely and ongoing way.
Organisational supports
Staff are directed to escalate care if they, or a parent/carer is worried, regardless of the observations. The SPOCs provide a framework to assist in the recognition of deterioration but do not negate clinical judgement or intuition.

Resources used in the emergency response such as equipment and pharmaceuticals must be monitored and maintained daily e.g. arrest trolley contents, medication box intact.

Daily documentation that the equipment has been checked is required and is to be kept for quality assurance and records retained according to General Disposal Authority requirements.

REACH
REACH is a “patient and family” activated escalation process developed by the Clinical Excellence Commission's (CEC) Directorate of Patient Based Care.

REACH empowers patients and/or their families to escalate care if they are concerned about the condition of the patient by first encouraging engagement with the treating clinicians at the bedside.

The letters REACH stand for Recognise, Engage, Act, Call and Help is on its way.

Staff are to enable patients, family and carers to utilise the REACH program by ensuring REACH posters are displayed at the patient’s bedside and by providing an explanation of the system on admission. If the patient, family or carer would like to call for assistance the phone number is 49213620 24/7.

Take the opportunity during the patient admission process, patient rounding, bedside clinical handover, or time at the patient’s care board to discuss the REACH program with the patient, family or carer. It is important for them to know they can engage with staff and call for help if they are concerned.

Evaluation and monitoring
The ICU liaison nurse will keep data on all paediatric rapid response calls which will be sent to NSW Health.

Paediatric facilities within JHCH will monitor and evaluate each rapid response call by requesting that each rapid response is to be recorded as an IIMS under Clinical and using Clinical Management as the Incident Type, “Rapid response” as the Incident Description. The Nurse Unit Managers of each unit will then evaluate each rapid response recorded on IIMS, and ensure the entry of any not recorded on IIMS. Reports should be collated using the PSO report, and any identified concerns from the rapid response evaluation should be escalated through the Clinical Quality and Patient Care Committee (CQ&PCC).

Auditing of the “Between the Flags” program will be undertaken by the NUMS or a delegate in each unit. Results collated by the Clinical Practice Improvement & Innovation Unit (CPI&IU) will be made available to staff through staff forums, grand rounds, summary reports, and at ward meetings. Managers are to complete standard observation chart audits in May and November each year with additional audits to be completed monthly if results under 80%.

Results of the audits will be sent to the CQ&PCC and entered into SMaRTA Viewer twice a year by the Acute Nurse Manager.

Audits should also be attended to review the escalation and outcomes of rapid response calls and arrest calls.

Staff will be responsible for ensuring that they have completed the required mandatory training on HETI online, and keep certificates of completion as part of their professional documentation.
Recognition of the Deteriorating Paediatric Patient JHCH PCP 3.19

Failure to follow the policy NSW PD 2013_049 Recognition and Management of Patients who are Clinically Deteriorating will result in staff being counselled by the NUM.

Implementation and Monitoring Compliance
The implementation of this guideline will be communicated to all staff using the CE news and within the JHCH/JHH, through education boards, educator network and clinical network streams.

Guideline and procedures will all be available through HNE LHD PPG directory and Kaleidoscope site.

Compliance will be monitored with the Standard Observation Audit Tool twice a year and results and an associated action plan where required, will be sent to the JHCH Clinical Quality and Patient Care Committee as well as the JHH/JHCH National Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care committee.

Consultation
JHCH NUMS/NM
JHCH Nurse Educator
JHCH Clinical Nurse Educator
JHH Perioperative Nurse Educator
JHH ICU
JHH ED
JHH/JHCH National Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care committee

Appendices
1. Fact sheet on the clinical review sticker
2. JHCH CERS
3. ISBAR for Rapid Response calls- template

Feedback
Any feedback on this document should be sent to the Contact Officer listed on the front page.

APPROVAL
CPGAG – 18th April 2016
JHCH CQ&PCC – 26th April 2016
GNS Guidelines Committee – 11th May 2016
FACT SHEET

CLINICAL REVIEW RECORD STICKER

When an urgent clinical review has been requested, the below sticker must be placed in the patient’s health care record for completion by medical and nursing/midwifery staff. Additionally, the caller and reviewer/responder must document the patient’s A-G assessment, treatment and outcome.

NURSING/MIDWIFERY STAFF must complete the information in the caller box (highlighted in red), including documenting patient’s name and MRN, and reason for call. When calling for an urgent clinical review, please state the reason of concern.

Also indicate if the patient had one of the listed events in the last 24 hours. If yes, seek senior medical advice.

Medical staff must complete all areas in the reviewer/responder box (grey part of the sticker highlighted in blue). Note: check whether the patient had one of the listed events in the last 24hs and, if so, seek senior medical advice.


AT ALL TIMES IF YOU ARE CONCERNED ABOUT A PATIENT OR A PATIENT DETERIORATES, FOLLOW THE LOCAL PROCEDURE FOR ESCALATION (JHH_JHCH_0019)

All units are expected to commence using this sticker by 1 July 2016 to allow time for education. Any concerns, please contact Marie O’Donnell, Service Manager, Medical & Interventional Services and Chair of John Hunter Resuscitation and Deteriorating Patient Committee.

NB. The Clinical Review Sticker can be ordered through Stream Solutions – ‘Find Product by Search’ (Product Code NH601080)
Appendix 2 JHCH CERS

John Hunter Children’s Hospital

PAEDIATRIC CLINICAL EMERGENCY RESPONSE SYSTEM (CERS)

Patient’s deteriorating condition is identified by clinician on the Standard Paediatric Observation Chart. Notify the Registered Nurse in-charge who is to initiate the appropriate action as guided by the flowchart below using the ISBAR communication tool for the handover of clinical information (see bottom left).

BLUE ZONE or parental concern - Increased Vigilance

- Increase observation of child
- CONSULT promptly with the Registered Nurse In-Charge
- INITIATE appropriate clinical care
- Complete a full set of observations* ("Pulse, BP, O2 sats, Respiration rate, Temp, Cap refill, Pain score, GCS/AAPU)
- INCREASE frequency of observations
- ESCALATE to a Yellow “Clinical Review Response” if you or the parents are worried about the patient

YELLOW ZONE or additional calling criteria – Clinical Review

- INFORM Registered Nurse In-Charge
- Registered Nurse In-Charge to ASSESS the patient
- RN/In-Charge is to DETERMINE and document if a clinical review is or is not required
- Should clinical review be required, the RN/In-Charge/clinician must CALL the treating team Resident or Registrar
- Treating team’s Resident or Registrar to REVIEW the patient in person within 30 minutes

- MUST
- Consult with the Treating team Registrar, Registrar to call Consultant

- CONSIDER
- Calling ICU Liaison Nurse for consult
- On: 55841
- Continuously monitor observations* & record every 30 minutes for the first hour then hourly until patient returns to between the flags

- ESCALATE to a RAPID RESPONSE if the patient has not been reviewed within 30 minutes or the patient’s condition deteriorates at any time.

RED ZONE or Additional calling criteria – Rapid Response

- INFORM Registered Nurse In-Charge
- CALL FOR HELP – Emergency Buzzer
- Initiate appropriate emergency management
- AIRWAY, BREATHING, CIRCULATION

- Registered Nurse In-Charge or detecting clinician to immediately activate a PAEDIATRIC RAPID RESPONSE call by dialing 7100
- Include the location of the patient (ward and bed number)

- Registered Nurse/Clinician to REMAIN with the patient

- MUST
- Senior clinician at rapid response to contact the Consultant by calling switch on 95 & asking to be put through to Paediatric/treating team consultant on call

- Complete an ABCDEFG assessment & document full set of obs* every 5 minutes till the patient arrives, then repeat obs every 15 mins till management plan for the pt is in place.

Document ABCDEFG, treatment plan & inform family

Last reviewed on 24/11/2015
Appendix 3. Rapid Response ISBAR Communication Tool

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIVEN NAME</td>
<td></td>
</tr>
<tr>
<td>□ MALE</td>
<td>□ FEMALE</td>
</tr>
<tr>
<td>D.O.B. /<strong>/</strong></td>
<td>M.O.</td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>LOCATION / WARD</td>
<td></td>
</tr>
</tbody>
</table>

**CLINICAL COMMUNICATION RECORD**

I **Introduction**
- This is: (State your name, designation and location):
- Is that: (Verify the Clinician’s name, designation and location):
- I want to talk to you about: (Patient name, age and location):

S **Situation**
- The situation / problem I am discussing is:

B **Background**
- Diagnosis: on referral / admission to service / unit / ACF
- Relevant clinical history:
- Current Medications:
- Allergies:
- Interventions: Treatments, tests, procedures
- Family/Carer Involvement:
- Resuscitation Status: Resuscitation Plan, ACO, Goals of Care

A **Assessment**
- Look, Listen & Feel
- The patient’s vital signs are: refer to the patient’s standard observation chart
  - Exposure:
  - Breathing: (including sounds, effort)
  - Fluids: (including input / output)
  - Circulation: (including HR, rhythm, warmth, colour)
  - Glucose: (including BSL)
  - Disability: (including AVPU / GCS)
  - Pain Score:
- My Assessment is:
- Treatment Initiated:

R **Recommendation**
- I am recommending / requesting:
- Clinician response:
- Additional actions including any escalations taken:

<table>
<thead>
<tr>
<th>Clinical Review</th>
<th>Rapid Response</th>
</tr>
</thead>
</table>

Signature: ____________________________
Designation: _________________________
Date: _____________________________
Time: _____________________________

**THIS FORM IS TO BE RETAINED IN THE PATIENT’S MEDICAL RECORD**