FACT SHEET

Implementing recognition and response systems in small, rural and remote health services

Regardless of size or location, all acute healthcare facilities need to have systems in place to ensure that patients who clinically deteriorate receive a timely and appropriate treatment response. Small, rural and remote health services face particular challenges when implementing a recognition and response system. This fact sheet provides specific information and implementation strategies for such services. More comprehensive information about implementing recognition and response systems can be found in the *Guide to Implementation of the National Consensus Statement: Recognising and Responding to Clinical Deterioration* which is available for download from the Commission's web site.

Different escalation policies

Escalation policies should clearly outline when, how and to whom to escalate care. When planning these policies, rural and remote health services should consider what resources are available locally and what level of care can safely be provided. It is important to determine when care should be escalated to external providers. Isolated health services with limited equipment and resources may need to identify and act on clinical deterioration very early because there are often delays associated with referral, review and transfer processes.

Rural and remote facilities may need to develop formal processes for:

- escalation within the facility (e.g. from one nurse to another)
- escalation to an external medical provider (e.g. from a nurse to an on-call general practitioner)
- escalation to a retrieval or transport service (e.g. from a nurse or general practitioner to the Royal Flying Doctors Service or the local ambulance service).

An example of an escalation process in a rural facility

Level of physiological abnormality	Response actions
Low	• Senior nurse review within 30 minutes • Treat pain or distress • Increase frequency of observations to minimum hourly for four hours • On call GP review if you are worried about the patient or if the observations remain abnormal
Moderate	• On call GP review within 30 minutes • Increase frequency of observations to minimum half hourly until the patient has been reviewed • If you are worried about the patient or there is no improvement after initial intervention, then discuss with the consultant emergency physician at the nearest referral hospital
High	• Rapid response call • Commence basic life support as indicated • Mandatory discussion with the consultant emergency physician at the nearest referral hospital

Different rapid response models

Acute care services in rural and remote areas may have only limited access to medically trained staff. Nonetheless, it is expected that patients have timely access to a clinician who can provide advanced life support at all times. Each health facility needs to consider how best to provide a rapid response to clinical deterioration given their particular circumstances.

There are a number of rapid response models in use in Australia. These models range from the medical emergency team systems commonly found in large tertiary hospitals to systems where a nurse trained in advanced life support is supported by local ambulance staff. In some cases an off-site clinician such as the on-call general practitioner may provide the rapid response. In other cases, nurse-led models may need to be developed. For example, in very small remote facilities it might be necessary to ensure that all nurses are trained to provide advanced life support. Or in the case of facilities with an emergency department, senior emergency nurses might provide the rapid response.

FACT SHEET

Implementing recognition and response systems in small, rural and remote health services

Emergency skills

Advanced life support providers may only use their emergency skills a few times a year so it is important that competency is maintained according to the requirements of advanced life support training providers. It is also important to ensure that the clinician calling for help is adequately skilled and resourced to provide basic life support interventions while awaiting the rapid response provider.

Coordinating care: referral and retrieval arrangements

Facilities may like to invite representatives from referral hospitals and local retrieval services to participate in planning and evaluating escalation policies. It is important to consider how to coordinate recognition and response systems because when services are not talking about clinical deterioration in a common language, patients may be put at risk. For example, a hospital's triage code may be quite different from the local ambulance priority code and potentially this could lead to delays in the transfer of seriously unwell patients.

Small rural facilities should consider aligning their recognition and response system with the system in use at referral hospitals. This will help to ensure that clinicians are using common terminology to describe physiological deterioration. Establishing or formalising agreed communication pathways and common communication tools will also assist in ensuring that the referral process is effective.

It may also be worthwhile developing processes to involve retrieval services and referral hospitals in evaluation and peer review processes such as critical incident reviews or morbidity and mortality meetings. This will assist in resolving broader systems issues and fostering improved communication.

Case Study: Plantagenet Hospital, Mount Barker, WA

Plantagenet Hospital rolled out the WA Country Health Service adult observation chart and corresponding escalation processes as part of a program for improving the early recognition and management of clinical deterioration. Plantagenet Hospital is approximately 50km from Albany and has a 14-bed ward, 2-bed emergency department, 38 residential care beds and a palliative care bed. There is one general practice surgery in town which provides 24-hour off-site medical cover for the hospital.

Ruth Godden, the acting Director of Nursing at Plantagenet, is a member of the regional working party for the early recognition and management of the deteriorating patient program. She is heavily involved in leading implementation of the program at Plantagenet. Ruth has made it a priority to embed and sustain the system. This has meant a significant commitment of her time to act as a champion for the system, conduct audits and provide one-to-one feedback to staff, and to identify and escalate broader systems issues to the regional working party.

Ruth used her knowledge of incidents that had previously occurred in the hospital to engage staff. Using real case examples where the new observation and response chart would have prompted earlier detection of deterioration and consequent earlier action helped Ruth to gain buy-in of the nursing staff by illustrating the relevance and usefulness of the system. All nurses attended the COMPASS training program before the roll out of the chart. Ruth suggests that the clarity of the message is lost if education about patient deterioration is embedded into generic orientation or update days. Specific time was dedicated to training nursing staff.

With the Regional Medical Director on board, the system was presented to GPs with an expectation of their active participation. Previously calls for help were often made based on the experience and confidence of individual nurses – some nurses would call very frequently, and some very rarely. GPs have embraced the system as a way to standardise calling criteria and communication about unwell patients, as well as clarifying the response expected from them. As responders, the GPs are all required to have advanced life support certification for both adults and paediatrics.

One of the great benefits of working in a small hospital is the ability to keep track of what is happening with the system on a day to day basis. Audit findings or incidents of delayed action are discussed with nursing staff individually, linking back any identified issues to their training to help them to recognise what could have been done differently. Similarly, if there are delays in response times from the GPs this can quickly be fed back to the senior GP manager so that any problems can be addressed.

Further information

Further information about implementing recognition and response systems can be found in the Australian Commission on Safety and Quality in Health Care publication *A Guide to Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration* (2011).

This can be downloaded from: www.safetyandquality.gov.au

Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney NSW 2001
Telephone: (02) 91263600
Email: mail@safetyandquality.gov.au