



Between the Flags

Keeping patients safe

A statewide initiative of the Clinical Excellence Commission



NSW Health Standard Observation Charts

January 2014



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- Launched in Jan 2010
- 1,000 less cardiac arrests since BTF started
- The BTF charts are being used around Australia
- We wouldn't be here today without the hard work of many clinicians and the leadership from:



Deborah Picone
Director General and Ministry Sponsor who
said this program must be implemented



Professor Ken Hillman
Founder of the Medical Emergency Team
and MET criteria



Professor Cliff Hughes
CEC Chief Executive



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News Entertainment Life & Style Business Sport Travel Tech Other Sections

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How system fatally failed Vanessa

January 24, 2008 - 1:27PM

Page 1 of 2 | Single page

✉ 📄 A A

NSW Premier Morris Iemma today announced a Special Commission of Inquiry into the NSW health system following an inquest into the death of a girl who was hit by a golf ball in 2005.

Deputy State Coroner Carl Milovanovich was scathing of the NSW Government in his findings into the death of Sydney teenager Vanessa Anderson at Royal North Shore Hospital.

She died from respiratory arrest due to the depressant effects of opiate medication after a doctor misread her chart.

The coroner said "almost every conceivable error or omission" had occurred in her treatment before her death and called for a wide-ranging inquiry into the NSW health system.

Mr Iemma stopped short of ordering a royal commission, instead announcing a statewide inquiry into the troubled health system.

"We will be establishing a special commission of inquiry to act on that recommendation of the coroner," Mr Iemma said.

He indicated he would seek to appoint a high-profile lawyer such as Bret Walker, SC, to oversee the inquiry and has told his Health Minister, Reba Meagher, and the Director-General of Premier and Cabinet, Robyn Kruk, to finalise details within the

"I have never seen a case such as Vanessa's in which almost every conceivable error or omission was detected and those errors continued to build one on top of the other"



Golf ball victim Vanessa Anderson.

Latest related coverage

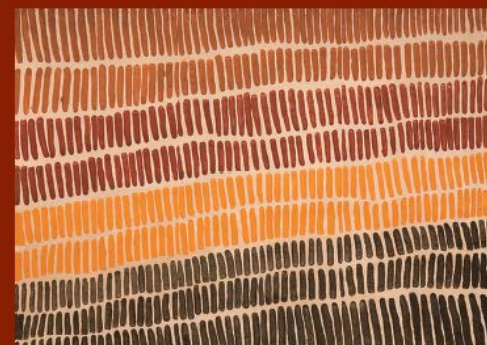
- Iemma orders special inquiry into health system



Special Commission of Inquiry
Acute Care Services in NSW Public Hospitals

Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals

Overview



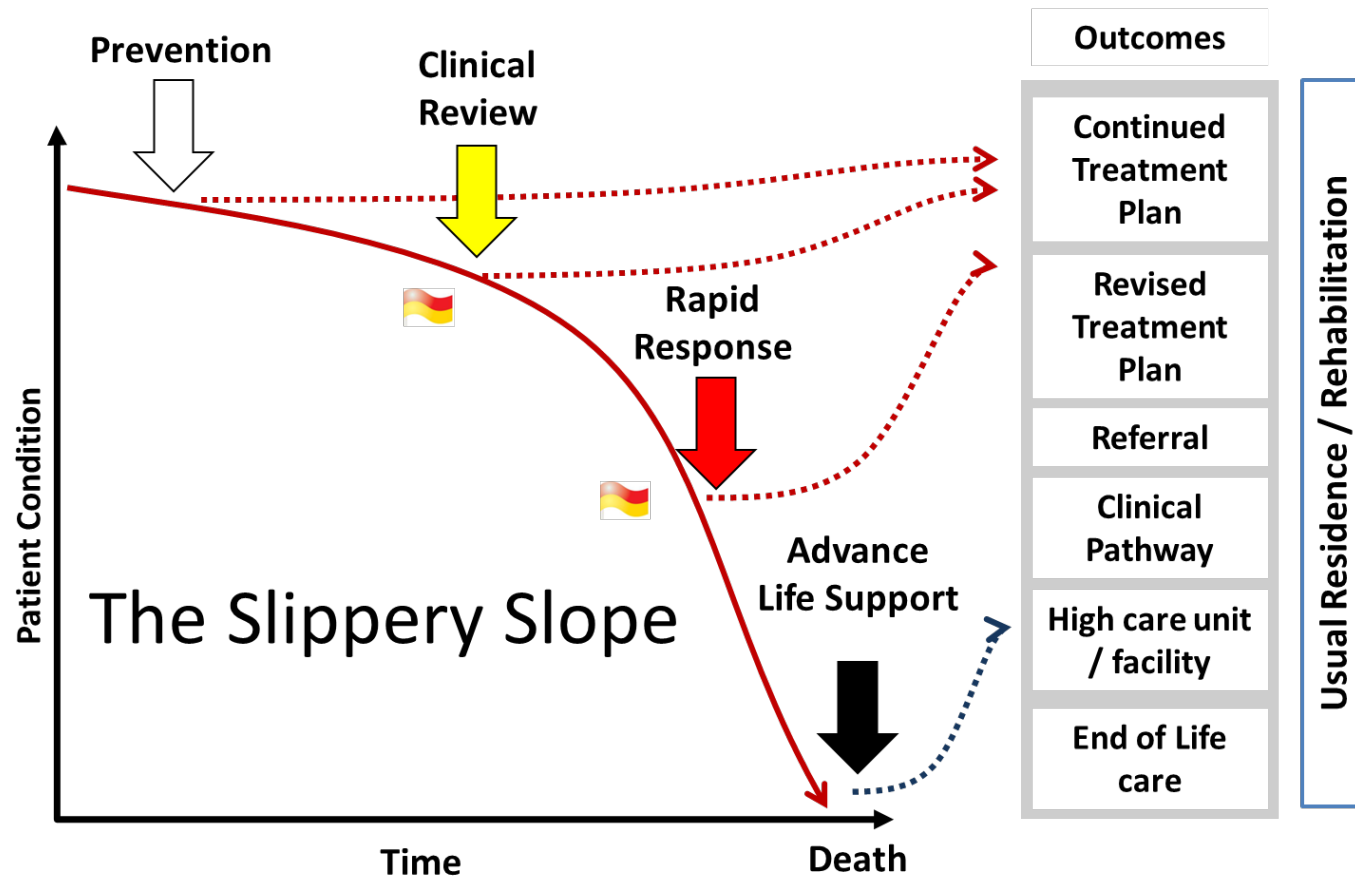
Peter Garling SC
27 November 2008



CLINICAL
EXCELLENCE
COMMISSION



'Slippery Slope'



 'Between the Flags' intervention on the 'Slippery Slope' of patient deterioration.



NSW Standard Observation Charts

- *A sick patient is a sick patient, wherever they are*
- Standardisation
- Calling criteria
- ‘Track and trigger’
- CERS in every hospital



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Striking the right balance

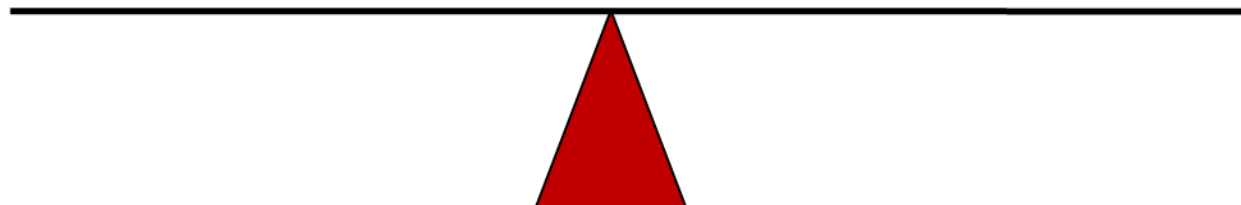
DETECT

Discretion in
Yellow Zone

No discretion in
Red Zone

Clinical
judgement

Rule-based
approach





REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF YOUR PATIENT

Yellow Zone Response

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU **MUST**

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by your patient's condition
3. Consult promptly with the **NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criterion?
- Are you concerned about your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
3. Inform the Attending Medical Officer that a call was made as soon as it is practicable

*Additional YELLOW ZONE Criteria

- Increasing oxygen requirement
- Poor peripheral circulation
- Excess or increasing blood loss
- Decrease in Level of Consciousness or new onset of confusion
- Low urine output persistent for 4 hours (< 100mls over 4 hours or < 0.5mL/kg/hr via an IDC)
- Polyuria, in the absence of diuretics (urine output > 200mL/hr for 2 hours)
- Greater than expected fluid loss from a drain
- New, increasing or uncontrolled pain (including chest pain)
- Blood Glucose Level <4mmol/L or > 20mmol/L with no decrease in Level of Consciousness
- Ketonaemia > 1.5mmol/L or Ketonuria 2+ or more
- Concern by patient or family member
- Concern by you or any staff member

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, A NEW ARRHYTHMIA, HYPOVOLAEMIA/HAEMORRHAGE, PULMONARY EMBOLUS/DVT, PNEUMONIA/ATELECTASIS, AN AMI, STROKE, OR AN OVERDOSE/OVER SEDATION

Red Zone Response

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU **MUST** CALL FOR A RAPID RESPONSE (as per local CERS) **AND**

1. Initiate appropriate clinical care
2. Inform the **NURSE IN CHARGE** that you have called for a RAPID RESPONSE
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

#Additional RED ZONE Criteria

- Cardiac or respiratory arrest
- Airway obstruction or stridor
- Patient unresponsive
- Deterioration not reversed within 1 hour of Clinical Review
- Increasing oxygen requirements to maintain oxygen saturation > 90%
- Arterial Blood Gas: $\text{PaO}_2 < 80$ or $\text{PaCO}_2 > 80$ or $\text{pH} < 7.2$ or $\text{BE} < -5$
- Venous Blood Gas: $\text{PvCO}_2 > 85$ or $\text{pH} < 7.2$
- Only responds to Pain (P) on the AVPU scale
- Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS)
- Seizures
- Low urine output persistent for 8 hours (< 200mls over 8 hours or < 0.5mL/kg/hr via an IDC)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with a decreased Level of Consciousness
- Lactate $\geq 4\text{mmol/L}$
- Serious concern by any patient or family member
- Serious concern by you or any staff member

Page 4 of the SAGO and SPOCs have been redesigned

The intended message remains the same and aims to 'Strike the right Balance'





If you or any other staff member is
concerned about your patient
activate your local
'Clinical Emergency Response
System'

Clinical Review

or

Rapid Response



The Yellow Zone

The ***DISCRETIONARY ZONE***

- Activation of the facility's CERS based on Yellow Zone observations or additional criteria is ***discretionary*** and based on your ***Clinical Judgement*** of the patient's condition.

Decision to escalate or not to escalate **MUST** be done in consultation with the **NURSE IN CHARGE.**



The Yellow Zone

To determine if a Clinical Review is required you and the **NURSE IN CHARGE** should consider:

- What is usual for the patient?
- Are there documented ***ALTERATIONS TO CALLING CRITERIA?***
- Does the trend in observations reflect deterioration?
- Is there more than one Yellow Zone observation or additional criteria?
- ARE YOU CONCERNED ABOUT YOUR PATIENT?

‘Use your Clinical Judgement’



The Yellow Zone

If escalation is not required you ***MUST***:

- Initiate appropriate clinical care
- Repeat and increase the frequency of observations as indicated by the patient's condition. The frequency should be *above the minimum requirement of 8 hourly*
- Document relevant information including actions taken and the rationale for not escalating in the patient's health care record.



The Yellow Zone

- If a Clinical Review is CALLED you ***MUST***:
 - Initiate appropriate clinical care
 - Repeat your patient's observations
 - Increase the frequency of observations as indicated by the patient's condition
 - Document an A-G assessment, reason for escalation, treatment and outcome in the Health Care Record
 - Inform the AMO as soon as practicable



CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO

- SEPSIS,
- A NEW ARRHYTHMIA,
- HYPOVOLAEMIA / HAEMORRHAGE,
- PULMONARY EMBOLUS/DVT,
- PNEUMONIA / ATELECTASIS,
- AN AMI,
- STROKE,
- OVERDOSE / OVER SEDATION



The Yellow Zone

- If you become more concerned or if the call is NOT attended within 30 minutes:
 - Reassess your patient and escalate according to your local CERS

PLEASE NOTE:

Any Red Zone Observation or additional criteria = **Rapid Response**

Deterioration not reversed within 1 hour of Clinical Review = **Rapid Response**

Serious Concern = **Rapid Response**

The Red Zone

MANDATORY escalation

If your patient has any RED Zone observations or additional criteria you ***MUST***

- Call for a Rapid Response
- Initiate appropriate clinical care
- Inform the ***NURSE IN CHARGE*** that you have called for a Rapid Response
- Repeat and increase the frequency of observations

‘Remain with your patient’

The Red Zone

MANDATORY escalation (continued)

- Document an A-G assessment, treatment, escalation process and outcome in the Health Care Record
- Inform the AMO as soon as it is practicable

Note: Refer to your local Clinical Emergency Response System protocol for instructions on how to make a call

The Worried Criterion

If at any stage you or any other staff member are concerned about your patient activate your local 'Clinical Emergency Response System'

Clinical Review

or

Rapid Response



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The NSW Standard Observation Charts have
been improved.....




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 NSW Health STANDARD ADULT GENERAL OBSERVATION CHART	FAMILY NAME		MRN	
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
	D.O.B. ____/____/____		M.O.	
	ADDRESS			
	LOCATION			
<input type="checkbox"/> Altered Calling Criteria	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
ALL OBSERVATIONS MUST BE GRAPHED				
OTHER CHARTS IN USE <input type="checkbox"/> Neurological Observation <input type="checkbox"/> Insulin Infusion <input type="checkbox"/> Alcohol Withdrawal <input type="checkbox"/> Fluid Balance <input type="checkbox"/> Pain / Epidural / Patient Control Analgesia <input type="checkbox"/> Resuscitation Plan <input type="checkbox"/> Anticoagulant <input type="checkbox"/> Neurovascular <input type="checkbox"/> Other _____				
PRESCRIBED FREQUENCY OF OBSERVATIONS <i>Observations must be performed routinely at least 8th hourly, unless advised below</i>				
DATE:	dd/MM/yy			
Time:	hh:mm			
Frequency Required	Twice daily			
Medical Officer Name (BLOCK letters)	P. SMITH			
Medical Officer Signature	P. SMITH			
Attending Medical Officer Signature	P. Bloggs			
ALTERATIONS TO CALLING CRITERIA MUST BE REVIEWED WITHIN 72 HOURS OR EARLIER IF CLINICALLY INDICATED Any alterations MUST be signed by a Medical Officer and confirmed by Attending Medical Officer Document rationale for altering CALLING CRITERIA in the patient's health care record				
DATE:	dd/MM/yy			
TIME:	hh:mm			
Next review due Date & Time	dd/MM/yy hh:mm			
Respiratory Rate	Yellow Zone	30-34		
	Red Zone	≥ 35		
SpO ₂	Yellow Zone			
	Red Zone			
Heart Rate	Yellow Zone			
	Red Zone			
Blood Pressure	Yellow Zone			
	Red Zone			
Other	Yellow Zone			
	Red Zone			
Medical Officer Name (BLOCK letters)		P. SMITH		
Medical Officer Signature		P. SMITH		
Attending Medical Officer Signature		P. Bloggs		
INTERVENTIONS / COMMENTS / ACTIONS				
	Date	Time		
1.				
2.				
3.				
4.				

SAGO – Page 1

Change:

Tick box added for Altered Calling Criteria

Tick box added for Resuscitation Plan

Change:

Guide for minimum frequency of observation and example of how to complete documentation

Change:

Next review date/time added. Alterations to Calling Criteria divided into Yellow Zone and Red Zone with an example of how to complete documentation

Change:

Provision for MO to sign off Alteration to Calling Criteria until AMO can provided a signature

Change:

Date/time columns added. Intervention rows reduced to 4



NSW Health		FAMILY NAME		MRN
STANDARD ADULT GENERAL OBSERVATION CHART		GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/> Altered Calling Criteria		D.O.B. ____/____/____ M.O.		
		ADDRESS		
		LOCATION		
ALL OBSERVATIONS MUST BE GRAPHED		COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		
AIRWAY/BREATHING	Date Time			Date Time
	Respiratory Rate	35 30 25 20 15 10 5		35 30 25 20 15 10 5
	SpO ₂ %	100 95 90 85		100 95 90 85
CIRCULATION	Oxygen Device / Mode			O ₂ Lpm Device / Mode
	Key: RA = Room Air, NP = Nasal Prongs, FM = Simple facemask, NRB = Non Re-breather, VM = Venturi Mask			
	Blood Pressure (mmHg)	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40		230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40
DISABILITY	Rhythm			Rhythm
	Heart Rate	160 150 140 130 120 110 100 90 80 70 60 50 40		160 150 140 130 120 110 100 90 80 70 60 50 40
	Neurological	A V P U		A V P U
Enter appropriate letter. A= Alert, V= Rousable by voice (conduct GCS). P= Rousable only by pain (conduct GCS). U= Unresponsive				
Initials		Initials		

SAGO – Page 2

Change:

Tick box added for Altered Calling Criteria

Change:

Number of columns reduced from 24 to 21

Change:

Oxygen device/mode row added as well as key for documentation

Change:

SBP scale stops at 230

Change:

HR scale stops at 160
Rhythm row added

Change:

Row added for initials
Red and Yellow reference boxes removed

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF YOUR PATIENT

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*Additional YELLOW ZONE Criteria

- Increasing oxygen requirement
- Poor peripheral circulation
- Excess or increasing blood loss
- Decrease in Level of Consciousness or new onset of confusion
- Low urine output persistent for 4 hours (< 100mLs over 4 hours or < 0.5mL/kg/hr via an IDC)
- Polyuria, in the absence of diuretics (urine output > 200mL/hr for 2 hours)
- Greater than expected fluid loss from a drain
- New, increasing or uncontrolled pain (including chest pain)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with no decrease in Level of Consciousness
- Ketonaemia > 1.5mmol/L or Ketonuria 2+ or more
- Concern by patient or family member
- Concern by you or any staff member

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, A NEW ARRHYTHMIA, HYPOVOLAEMIA/HAEMORRHAGE, PULMONARY EMBOLUS/DVT, PNEUMONIA/ATELECTASIS, AN AMI, STROKE, OR AN OVERDOSE/OVER SEDATION

Red Zone Response

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1. Initiate appropriate clinical care
2. Inform the **NURSE IN CHARGE** that you have called for a **RAPID RESPONSE**
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

#Additional RED ZONE Criteria

- Cardiac or respiratory arrest
- Airway obstruction or stridor
- Patient unresponsive
- Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS)
- Seizures
- Deterioration not reversed within 1 hour of Clinical Review
- Increasing oxygen requirements to maintain oxygen saturation > 90%
- Arterial Blood Gas: $\text{PaO}_2 < 60$ or $\text{PaCO}_2 > 60$ or $\text{pH} < 7.2$ or $\text{BE} < -5$
- Venous Blood Gas: $\text{PvCO}_2 > 65$ or $\text{pH} < 7.2$
- Only responds to Pain (P) on the AVPU scale
- Low urine output persistent for 8 hours (< 200mLs over 8 hours or < 0.5mL/kg/hr via an IDC)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with a decreased Level of Consciousness
- Lactate $\geq 4\text{mmol/L}$
- Serious concern by any patient or family member
- Serious concern by you or any staff member

SAGO – Page 4

Change:

Wording of 'Advance care directives' changed to 'End of life care plan'

Change:

Title change 'Yellow Zone Response'

Clarification of the decision making process when calling for a Clinical Review.

Emphasis placed on using clinical judgement and consulting the **NURSE IN CHARGE**.

Change:

Updated BGL and U/O criteria in both the Yellow and Red Zones

The importance of family or staff member concern is highlighted in both Yellow and Red Zones.

Change:

Title change 'Red Zone Response'

Emphasis placed on notifying the **NURSE IN CHARGE** when a call is made, increasing the frequency of observations, informing the AMO and documentation.

Change:

Lactate added to Red Zone additional criteria

Holes punched as per AS2928.1:2012
BINDING MARGIN - NO WRITING



NSW GOVERNMENT Health		FAMILY NAME		MRN	
STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)		GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
1 - 4 Years		D.O.B. ____/____/____		M.O. ____	
<input type="checkbox"/> Altered Calling Criteria		ADDRESS			
ALL OBSERVATIONS MUST BE GRAPHED		COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
OTHER CHARTS IN USE					
<input type="checkbox"/> Fluid Balance <input type="checkbox"/> Insulin Infusion <input type="checkbox"/> Other _____ <input type="checkbox"/> Neurological Observation <input type="checkbox"/> Pain / Epidural / Patient Control Analgesia <input type="checkbox"/> Other _____ <input type="checkbox"/> Neurovascular <input type="checkbox"/> Resuscitation Plan <input type="checkbox"/> Other _____					
PRESCRIBED FREQUENCY OF OBSERVATIONS					
Observations must be performed routinely at least 4th hourly, unless advised below					
DATE:		dd/MM/yy			
TIME:		hh:mm			
Frequency Required		Twice daily			
Medical Officer Name (BLOCK letters)		P. SMITH			
Medical Officer Signature		P. SMITH			
Attending Medical Officer Signature		R. Blagge			
ALTERATIONS TO CALLING CRITERIA					
MUST BE REVIEWED WITHIN 48 HOURS OR EARLIER IF CLINICALLY INDICATED					
Any alterations MUST be signed by a Medical Officer and confirmed by Attending Medical Officer					
Document rationale for altering CALLING CRITERIA in the patient's health care record					
DATE:		dd/MM/yy			
TIME:		hh:mm			
Next review due Date & Time		dd/MM/yy hh:mm			
Vital Sign	Zone	Standard Thresholds			
Respiratory Rate	Yellow Zone	15 - 20 50 - 60			
	Red Zone	<15 >60			
SpO ₂	Yellow Zone	90 - 95			
	Red Zone	<90			
Heart Rate	Yellow Zone	70 - 80 150 - 170	xxx-xxx		
	Red Zone	<70 >170	≤ or ≥ xxx		
Other	Yellow Zone				
	Red Zone				
Medical Officer Name (BLOCK letters)		P. SMITH			
Medical Officer Signature		P. SMITH			
Attending Medical Officer Signature		R. Blagge			
Date	Time	INTERVENTIONS / COMMENTS / ACTIONS			
1.					
2.					
3.					
4.					

SPOC – Page 1

Change:

Facility line removed

Text added “all observations must be graphed”

Tick box added for Altered Calling Criteria

Tick box added for Resuscitation Plan

Change:

Added - guide for minimum frequency of observations and an example of how to complete documentation.

Change:

Text added to highlight the requirement to document the rationale for Altering to Calling Criteria.

Altered Calling Criteria divided into Yellow and Red Zones with an example of how to complete documentation.


Standard thresholds added as a guide for each age group.

Change:

Provision for MO to sign off Altered Calling Criteria until AMO provides signature

Change:

Intervention rows reduced from 9 to 4

 Health	FAMILY NAME		MRN											
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE											
	D.O.B. ____/____/____	M.O. ____/____/____												
	ADDRESS													
STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)														
1 - 4 Years														
<input type="checkbox"/> Altered Calling Criteria														
ALL OBSERVATIONS MUST BE GRAPHED		COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE												
DISABILITY	Date													Date
	Time													Time
	Level of Consciousness													Level of Consciousness
	Alert													Alert
	Verbal													Verbal
EXPOSURE	Pain													Pain
	Unresponsive													Unresponsive
	Enter appropriate letter. A= Alert, V= Rousable only by voice (consider GCS). P= Rousable only by central pain (conduct GCS). U=Unresponsive													
	Severe (7-10)													Severe (7-10)
	Moderate (4-6)													Moderate (4-6)
TEMPERATURE (°C) <small>(Check unit policy)</small>	Mild (1-3)													Mild (1-3)
	Nil													Nil
	41													41
	40.5													40.5
	40													40
	39.5													39.5
	39													39
	38.5													38.5
	38													38
	37.5													37.5
37													37	
36.5													36.5	
36													36	
35.5													35.5	
35													35	
34.5													34.5	
34													34	
BGL														BGL
Weight														Weight
Initials														Initials

SPOC – Page 3

Change:

Facility line removed

Tick box for Altered Calling Criteria enhanced

Text added “all observations must be graphed”

Change:

Dashed line added to 37 degrees.

Change:

Row for initials enhanced

CONSIDER EARLIER ESCALATION OF PATIENTS WITH

- Chronic or complex conditions
- Post-operative
- Pre-Existing cardiac or respiratory conditions
- Opioid Infusions

ADDITIONAL CRITERIA FOR ESCALATION ON BACK PAGE

ASSESSMENT OF RESPIRATORY DISTRESS

	MILD	MODERATE	SEVERE
Airway	• Stridor on exertion	• Stridor at rest • Partial airway obstruction	• New onset of stridor • Imminent airway obstruction
Behaviour & Feeding	• Normal • Talks in sentences	• Some / intermittent irritability • Difficulty talking or crying • Difficulty feeding or eating	• Agitated / confused • Drowsy • Unable to talk or cry • Unable to feed or eat
Respiratory Rate	• Mildly increased	• Respiratory rate in the Yellow Zone	• Respiratory rate in the Red Zone • Decreasing (exhaustion)
Accessory Muscle Use	• None / minimal	• Moderate recession • Tracheal tug • Nasal flaring	• Severe recession • Gasping • Grunting • Extreme pallor • Cyanosis • Absent breath sounds
Apnoeic Episodes	• None	• Abnormal pauses in breathing	• Apnoeic episodes
Oxygen	• No oxygen requirement	• Mild hypoxaemia, corrected by oxygen • Increasing oxygen requirement	• Hypoxaemia, may not be corrected by oxygen



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Blue Zone Response

IF YOUR PATIENT HAS ANY BLUE ZONE OBSERVATIONS YOU **MUST**

1. Initiate appropriate clinical care
2. Increase the frequency of observations, as indicated by your patient's condition
3. Manage anxiety, pain and review oxygenation in consultation with the **NURSE IN CHARGE**
4. You can make a call to escalate the care of your patient at any time if you are worried or unsure whether to call

Consider the following:

1. What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
2. Does the abnormal observation reflect deterioration in your patient?
3. Is there an adverse trend in observations?

Yellow Zone Response

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU **MUST**

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by your patient's condition
3. Consult promptly with the **NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criteria?
- Are you concerned about your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
3. Inform the Attending Medical Officer that a call has been made

Change:

Box added with common causes of clinical deterioration

*Additional YELLOW ZONE Criteria

- Increasing oxygen requirement
- Poor peripheral circulation
- Greater than expected fluid loss
- Reduced urine output or anuria (< 1mL/kg/hr)

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, DEHYDRATION / HYPOVOLAEMIA / HAEMORRHAGE, OR AN OVERDOSE / OVER SEDATION

Red Zone Response

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU **MUST** CALL FOR A RAPID RESPONSE (as per local CERS) **AND**

1. Initiate appropriate clinical care
2. Inform the **NURSE IN CHARGE** that you have called for a Rapid Response
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call has been made

Change:

Immediately 'life threatening' additional criteria are highlighted.

#Additional RED ZONE Criteria

- Cardiac or respiratory arrest
- Circulatory collapse
- Patient unresponsive
- New onset of stridor

- Deterioration not reversed within 1 hour of Clinical Review
- 3 or more simultaneous 'Yellow Zone' observations

- Lactate $\geq 4\text{mmol/L}$
- Serious concern by you or any staff or family member

SPOC – Page 4

Change:

Wording of 'Advance care directives' changed to 'End of life care plan'

Title change 'Blue Zone Response'

Change:

Title change 'Yellow Zone Response'

Clarification of the decision making process when calling for a Clinical Review.

Emphasis placed on using clinical judgement and consulting the **NURSE IN CHARGE**.

Change:

The importance of family or staff member concern is highlighted in both Yellow and Red Zones.

Change:

Title change 'Red Zone Response'

Emphasis placed on notifying the **NURSE IN CHARGE** when a call is made, increasing the frequency of observations, informing the AMO and documentation.

Change:

Lactate added to additional criteria to align with the SEPSIS Kills program.

CLINICAL REVIEW - NO REVIEW

SMART 10017

Future directions

- Standard Maternity and Newborn Observation Charts (SMOC/SNOC) under review in 2014
- Trial of the Community SAGO and Care of the Dying charts will be evaluated in early 2014
- Scoping has begun on potential new charts
 - HDU/CCU flowchart
 - Dialysis observation chart
 - Ante-natal observation chart



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We gratefully acknowledge



Remember “Always swim between the red and yellow flags”





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For further information

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