Recognising and Responding to Acute Deterioration Policy Review Discussion paper

Why are we consulting?

The current MP86 'Recognising and Responding to Acute Deterioration Policy' is being reviewed by the Patient Safety and Clinical Quality Directorate, and a revised draft policy (RRAD Policy) is available for review.

The Department of Health is seeking the perspectives of clinical and non-clinical WA Health staff to understand how the Department can responsively assist Health Service Providers (HSPs) to meet patient safety and clinical quality obligations through the RRAD Policy.

Your participation in the policy review may inform:

- Review of the RRAD policy to ensure consistent state-wide clinical guidance; with consideration given to additional mandatory requirements for certain issues
- Exploration of potential supporting programs to promote patient safety and reduce unwarranted clinical variation for both acute deterioration and related areas of comprehensive care.

What is the Recognising and Responding to Acute Deterioration (RRAD) policy?

The revised draft WA Health Recognising and Responding to Acute Deterioration Policy (RRAD Policy) sets the minimum requirements to be implemented by HSPs through the development of local evidence-based policies and systems, to facilitate early recognition and response to acute deterioration in WA Health.

The policy enforces clinical guidance in the *National Safety and Quality Health Service Standards* (Standard 8: Recognising and Responding to Acute Deterioration), mandated in WA through the National Safety and Quality Health Service Standards Accreditation Policy - MP 0134/20.

The RRAD policy supports the use of clinician, patient, and carer judgement in addition to mandatory elements to escalate care; and stipulates that acute deterioration includes physiological and mental state deterioration.

What are the issues being considered and why are reviewing these?

Acute deterioration accounted for the highest number of incidents which reported a patient outcome of death (n=47).[1] The RRAD Policy provides state-wide mandatory guidance to HSPs to support early recognition and timely responses to worsening clinical conditions, which minimise the need for more intensive and complex stabilising interventions in healthcare.

Since the existing RRAD policy was last revised, developments in the clinical governance and legislative landscape for RRAD include:

- The introduction of *National Safety and Quality Health Service Standards* version 2 and NSQHSS *Advisory AS 19/01* 'Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state'
- Changes to WA's advanced care planning, end-of-life care guidance, and voluntary assisted dying legislation
- High-profile clinical incidents relating to acute deterioration; and reported variation in HSP compliance with NSQHS Standard 8 during accreditation
- Updates to clinical best-practice: definitions and terminology, the inclusion of new clinical areas (including sepsis and mental state deterioration), and emerging technological advancements to support RRAD).

[1] Department of Health (2020), 'Your Safety in our Hands in Hospital: An Integrated Approach to Patient Safety Surveillance by WA Health Service Providers, Hospitals and the Community' *Delivering Safer Care Series Report 9* v.1 (Perth: Patient Safety Surveillance Unit, Department of Health), 88.

There are several issues for consideration as part of review of the proposed RRAD Policy:

Mental state deterioration

The inclusion of mental state deterioration within RRAD systems is mandated by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in *NSQHS v.2* 'Standard 8: Recognising and Responding to Acute Deterioration' and *Advisory AS 19/01* 'Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state', with a timeframe for service-wide implementation by December 2021.

This directive is unique to the Australian context. In 2017, the ACSQHC consulted with each Australian jurisdiction to develop a national consensus statement for acute deterioration of mental state.[2] A 2018 review commissioned by the ACSQHC identified 28 clusters of signs arranged into five indicators of deterioration in a person's mental state.

- Reported change
- Distress
- Loss of touch with reality of consequence of behaviours
- Loss of function
- Elevated risk to self, others, or property[3]

This review found that an ideal assessment tool for mental state deterioration would facilitate individualised assessments, incorporate a broad set of behaviours, enable repeat assessment over time and draw on multiple sources of information (clinical observations, reports of people experiencing deterioration and those who know them well); with observations relating to any one of the five indicators proposed being enough or enough to prompt an escalation of care.[4]

While the previous RRAD Policy refers to mental state deterioration, no Australian jurisdiction currently mandates the use of specific mental state indicators as part of standard state-wide RRAD systems and tools.[5] A validation study of the mental state deterioration criteria outlined in the Gaskin and Dagley review is underway at St Vincent's, Melbourne; and one WA health service already refers to mental state indicators and response pathways in their current RRAD procedure. This policy review provides an opportunity to explore the mandatory inclusion of mental state deterioration in all WA RRAD systems.

Universal applicability: Emergency settings

Clinical incidents involving acute deterioration in emergency departments create an imperative to examine existing policies and systems to ensure they are comprehensive, relevant, and current for all WA Health settings, with a focus on enhancing family/carer escalation pathways in paediatric, maternal, and neonate settings.

The previous RRAD Policy applies only to inpatients of WA Health facilities, with observations commencing generally upon admission (with provision to commence at initial assessment). The use of RRAD systems within emergency settings are increasing worldwide, and many WA facilities have already adopted RRAD and escalation protocols (including family/carer escalation) within emergency settings **(Attachment 2)**.

Issues with RRAD systems in emergency settings raised in international research literature include:

- Poor completion rates by emergency department staff (resulting from high patient turnover in emergency departments, no opportunity for longitudinal observation, and co-morbid physiological and psychological presentations)
- Interference with, or duplication of, triage processes
- Variable reliability of RRAD tools in validation studies specific to emergency or acute settings

Many of these issues may be overcome through effective implementation and systematic review of emergency department processes; and this policy review offers the opportunity to consider a mandated universal requirement for RRAD in all settings (including acute settings) across WA Health.

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[2] Australian Commission on Safety and Quality in Health Care, *National Consensus Statement: essential elements for recognising and responding to deterioration in a person's mental state* (Sydney: 2017).

[3] Gaskin, C, Dagley G, *Recognising Signs of Deterioration in a Person's Mental State: Final Report* (Sydney: 2018): i.

[4] The 2018 *User Guide for Health Services Providing Care for People with Mental Health Issues* includes the assessment criteria as a 'practice resource' to support RRAD. ACSQHC. (Sydney: ACSQHC; 2018).

[5] Gaskin, C, Dagley G, *Recognising Signs of Deterioration in a Person's Mental State: Final Report* (Sydney: 2018): 6.

Inclusion of sepsis pathways in RRAD systems

Like consideration for universal applicability of RRAD systems across all WA Health settings, recent clinical incidents have highlighted the need to include sepsis recognition prompts and management pathways as part of RRAD systems **(Attachment 1).**

In 2021, the Child and Adolescent Health Service introduced a Paediatric Acute Recognition and Response Observation Tool at Perth Children's Hospital which includes a sepsis recognition pathway. Further consideration is underway across Health Services regarding the use of this tool across WA Health services and consideration of opportunities to introduce or expand sepsis recognition pathways for adult patients.

Interface of RRAD and Comprehensive Care Standards

With the introduction of NSQHSS v.2., guidance pertaining to clinical areas within Standard 8 interfaces closely with guidance pertaining to clinical issues within *Standard 5: Comprehensive Care*.

This guidance relates to the following clinical areas:

- Goals of care, End-of-life, and advanced care planning
- Delirium and cognitive impairment
- Psychological and behavioural disturbance (suicide risk, violence and aggression, mental state)

This policy review provides an opportunity to understand how HSPs manage the interface between Standard 8 and Standard 5, and whether issues relating to the clinical areas above may be best supported through co-ordinated state-wide planning.

Roles of HSPs and DoH in implementing, monitoring, and evaluating the RRAD policy

The RRAD policy is a mandatory requirement under the *Clinical Governance, Safety and Quality Policy Framework*. The current governance and assurance arrangements for RRAD require HSPs to ensure their own compliance with the RRAD policy; with provision for the System Manager to audit Health Service Provider compliance with the Policy and evaluate the effectiveness of the Policy.

The System Manager currently monitors compliance with the policy through accreditation, clinical incident management, and an annual policy assurance process.

Supporting information for the previous RRAD Policy included:

- *The WA Health Recognising and Responding to Acute Deterioration Guideline*
- *A Model of an Acute Deterioration Policy Compliance Assessment and Action Form*
- *Suggested Roles and Responsibilities for a Rapid Response Team*

This review seeks to understand the relevance of this clinical guidance and possibility for rescindment; given that HSPs are responsible for implementation through the development of local RRAD policies and systems.

Considerations for implementation of a revised RRAD policy

Any recommended changes to the RRAD policy will require support for implementation within each Health Service Provider – this may involve the delivery of workforce training and changes to supporting HSP local policies, governance, processes and systems, incident reporting, and quality improvement activities.

The ACSQHC offer an extensive suite of complementary materials to support implementation and evaluation of RRAD by HSPs; including sample staff knowledge and satisfaction surveys; rapid response system case report forms; medical record audit tools; evaluation agreement tools; escalation mapping tools: and rapid response system self-assessment tools.

Several of these tools have been adapted for assessment of mental state deterioration.

Attachment 1: WA Health system performance for acute deterioration clinical incidents

Acute clinical deterioration incidents are captured using the following criteria in Datix CIMS:

- SAC 1 categories of "Delay in recognising/responding to physical clinical deterioration"
- SAC 1 categories "Clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual), or death or serious harm to staff, other patients or other persons"
- Datix CIMS classification Tier 3[6]

In 2019/20, there were 1,516 notified acute deterioration clinical incidents. The number of acute deterioration events across WA Health peaked at 1857 events in 2017 **(Figure 1)**; which might be explained by the addition of cognitive and mental state deterioration to the Standard in NSQHSS v.2.[7]

The number of events has shown a declining trend since this time, which may demonstrate gradual implementation of supporting processes, procedures, and policies to support NSQHS v.2 recognition and response to acute deterioration in WA Health services.

Acute clinical deterioration incidents accounted for 4.6% of all clinical incidents notified in 2019-2020. This Standard contained the highest number of incidents that reported a patient outcome of death (n=47) in 2019/20.

In 2019/20 obstetrics reported the highest number of acute clinical deterioration incidents (n=206; 14.3%), followed by General Medicine (n=164; 11.4%), and General Surgery (n=101; 7.0%). Of the acute deterioration clinical incidents in 2019/20 that reported a patient outcome of death, five cases related to clinical deterioration associated with sepsis.[8]

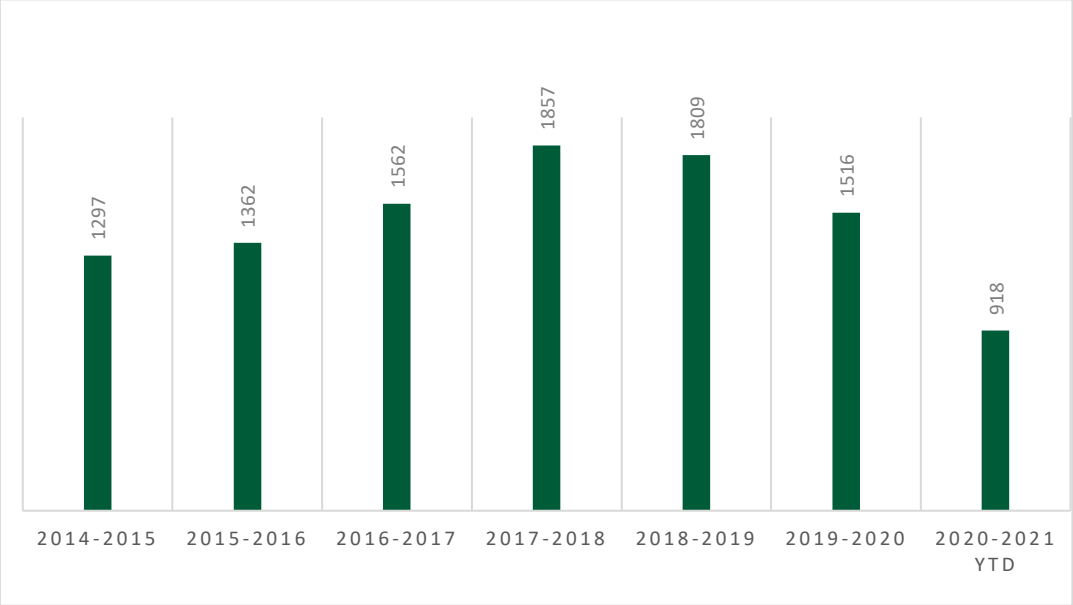

Figure 1: WA Health Recognising and Responding to Acute Deterioration SAC Events by Year 2014-2021

[6] i.e. 'Unplanned elevation of care to intensive care setting'; 'Failure/insufficient response to significant change in patient status'; 'Failure/insufficient recognition of significant change in patient status'; 'Failure to activate rapid response/resuscitation team'; Unplanned return to surgery': Department of Health/Health Support Services, 'Recognising and Responding to Acute Deterioration (Standard 8)' *NSQHS Standards 2nd edition CCS2 tagging*, Accessed Nov 2021.

[7] Department of Health (2021), *Clinical Incident Management Dashboard* (Perth: Patient Safety and Surveillance Unit, Department of Health). Accessed May 2021.

[8] Department of Health (2020), 'Your Safety in our Hands in Hospital: An Integrated Approach to Patient Safety Surveillance by WA Health Service Providers, Hospitals and the Community' *Delivering Safer Care Series Report 9* v.1 (Perth: Patient Safety Surveillance Unit, Department of Health).

Attachment 1: WA Health system performance for acute deterioration clinical incidents

In 2019/20, failure to monitor or incomplete or insufficient monitoring of the patient during or after treatments or procedures was the most frequent of the Top Five Tier Three category of acute clinical deterioration incident reported (n=661).[9]

In these cases, Communication between staff, documentation, and issues in implementing policy, procedure or guidelines were the top contributory or causative factors (**Figure 2)**.[10]

Communication issues between staff were identified as the major contributory factor (n=364) of closed acute clinical deterioration clinical incidents in 2019/20 (Figure 3).[11] Documentation, and issues in applying policies, procedures and guidelines, were also leading contributory factors for acute deterioration, which are both directly relevant to the implementation and application of the RRAD policy.

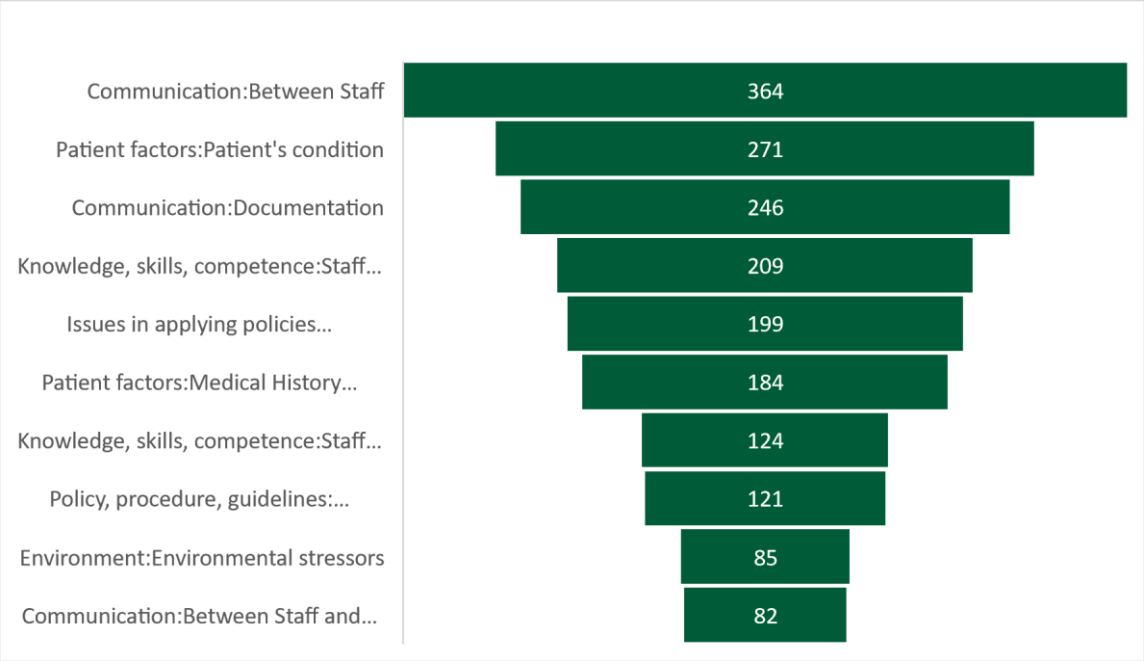

Figure 2: Causative/contributory factors to All SAC events for 2019-2020 FY

[9] Department of Health (2020), 'Your Safety in our Hands in Hospital: An Integrated Approach to Patient Safety Surveillance by WA Health Service Providers, Hospitals and the Community' *Delivering Safer Care Series Report 9* v.1 (Perth: Patient Safety Surveillance Unit, Department of Health), 90.

[10] Department of Health (2021), *Clinical Incident Management Dashboard* (Perth: Patient Safety and Surveillance Unit, Department of Health). Accessed May 2021.

[11] Department of Health (2021), *Clinical Incident Management Dashboard* (Perth: Patient Safety and Surveillance Unit, Department of Health). Accessed May 2021.

Attachment 2: WA Health Service Provider local policies for acute deterioration (not exhaustive)

Health Service Provider**	Hospital-level inpatient service	Dedicated webpage/Hub	Policy/ guideline/ procedure documentation	Relevant Committee
Child & Adolescent Health Service	Perth Children's Hospital and CAMHS	Recognising and Responding to Acute Deterioration (Feb 2020)	Recognising and Responding to Acute Deterioration Policy (Sept 2020)	CAHS Clinical Deterioration Committee
	Community Health	-	Recognising and Responding to Acute Deterioration Policy (July 2020)	
East Metropolitan Health Service				
	Armadale Kalamunda Group		Recognition and Response Acute Deterioration (June 2017)	
	Royal Perth Bentley Group		Recognising and Responding to Acute Deterioration Policy (Dec 2020)	
	Midland	-	-	
North Metropolitan Health Service			Recognising and Responding to Acute Deterioration (refers directly to DoH policy, Jun 2018)	
	Sir Charles Gairdner and Osborne Park Group	Standard 8 webpage (Jul 2019)	Recognising and Responding to Acute Deterioration Policy (Aug 2019)	SCGH RRAD Committee
	Osborne Park Hospital		Recognising and Responding to Acute Deterioration Hospital Procedure (Aug 2019)	
	WNHS (King Edward Hospital)	Recognising and Responding to Acute Deterioration (Feb 2021)	Recognising and Responding to Acute Physiological (Clinical) Deterioration (Nov 2019)	Recognising and Responding to Acute Deterioration Committee
	Mental Health, Public Health, and Dental Services	Standard 8: Recognising and Responding to Acute Deterioration (Feb 2021)	Recognising and managing acute mental state deterioration (Nov 2019)	
	Joondalup	-	-	
South Metropolitan Health Service			Recognition and Response to Acute Deterioration (RRAD) Policy (July 2019)	
	Fiona Stanley Fremantle Group	Recognising and Responding to Acute Deterioration (Mar 2021)	Recognising and Responding to Acute Deterioration (Nov 2020)	FSH Recognising & Responding to Acute Deterioration Committee
	Rockingham Peel Group	Recognising and Responding to Acute Deterioration web page (Apr 2019)	-	
WA Country Health Service	Most services have individualised content	Acute Physiological Deterioration (May 2020) Acute Deterioration - Audit Tools and Resources	Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy (Nov 2020)	Recognising and Responding to Acute Deterioration Committee