Between the Flags

Keeping patients safe

GUIDELINES AND IMPLEMENTATION TOOLKIT

2010

CLINICAL EXCELLENCE COMMISSION

NSW HEALTH

INTRODUCTION

The purpose of this document is to provide those responsible for implementing the Between the Flags Program the tools and guidance they need to do this.

This toolkit is not exhaustive and will grow over time, as new tools are developed to meet the needs of the Program, as it evolves and passes through different phases.

We hope that Executive Sponsors and Clinical Leads will find this toolkit useful and that those, at all levels of the public health system who are involved in implementing the Program will benefit from it.

We would welcome any contributions or additions to this Toolkit. If tools that are developed to meet the needs of those who daily overcome the challenges of implementation are shared among us, this Toolkit will grow rapidly and become more and more relevant to the people who need it.

BACKGROUND

Rationale

The Between the Flags Program addresses a key clinical risk that has been demonstrated by data derived from the NSW Patient Safety and Clinical Quality Program and which was the subject of a key recommendation in the Garling Commission Report. This is the failure to recognise and manage deteriorating patients within acute care facilities. This problem affects health systems around the world.

Diagnostic Project

The Between the Flags Diagnostic Project was designed to obtain evidence from the NSW public health system regarding the factors that influence recognition and management of clinical deterioration and was undertaken between November 2007 and July 2008. The Project used both qualitative and quantitative research methods to explore and test possible solutions.

Working with clinicians and managers in five representative facilities across NSW, the diagnostic phase of the project identified a number of issues that are relevant to recognising and managing patient deterioration. These included:

- work practice issues, such as a strong reliance on automated observation equipment;
- environmental issues, including access to equipment and supplies, and general ward organisation;
- cultural issues around communication, including handover practices and a lack of clear escalation protocols.
- and awareness and education issues, including staff describing a limited understanding of the signs of a deteriorating patient.

The Project also involved a review of the literature and consultation with industry experts, which confirmed the view that this is a complex problem which requires a multifaceted approach and a series of solutions.

Incident data from the Incident Information Management System (IIMS) was reviewed and an analysis of RCA reports and recommendations was conducted as well as focus groups with clinicians and observational studies about how they worked on the wards. Results from the QSA (Quality Systems Analysis) survey identified that concerns relating to the recognition and management of the deteriorating patient are not limited to medical and surgical wards. These concerns extend to subspecialty groups including maternity and paediatrics and beyond. It was clear that there are many variables which may have an impact on the ability of clinical staff to both identify and manage such patients whose condition deteriorates, often unexpectedly.

Some solutions to the problem were trialled, including the "Productive Ward" approach which has been used successfully by the NHS in the UK to increase time for patient contact and direct patient care. As well, a colour coded observation chart with Modified Early Warning Scores (MEWS) score overlaid was trialled as a means of focussing attention on observations and consequent action to be taken. An education package supporting this was also trialled. Escalation protocols were developed in consultation with the clinical staff who would use them and respond to them and communication techniques were taught to enable clinicians to communicate more effectively with each other.

The project identified many issues and potential barriers to a wider roll out of the concepts as well as success factors and it has informed the development of a state-wide plan for implementation of the 5 elements of the Between the Flags Program.

This Toolkit presents a range of tools and resources to assist AHS in implementing the Between the Flags Program, to improve the early recognition and management of the deteriorating patient.

Key Findings

1. Observation of Vital Signs is the key to identifying patient deterioration

Observation of v assists in the recognition of the deteriorating patient. They are sensitive enough to detect early signs of physiological dysfunction which if treated early may improve patient outcomes. For vital signs to provide meaningful and timely information there needs to be good understanding of the purpose of vital sign monitoring, observations should be taken with appropriate frequency and all elements of vital signs should be recorded. Variations in vital signs should prompt consideration of remedial treatment. Lack of or incomplete observations can compromise clinical care and care planning processes and may delay access to appropriate assessment and timely treatment in the deteriorating patient. Recording observations in one location improves the likelihood of identifying that a patient is deteriorating. Evidence suggests that clinical staff lack judgement in determining the frequency with which observations should be taken and in some instances what type of observations are indicated.

2. Staff require appropriate training to recognise and manage deteriorating patients

Staff need a sound understanding of physiology to recognise the early signs of patient deterioration. Recognising the need for increasing observations and acting on clinical findings can improve patient outcomes. All staff need training in Basic Life Support and staff with Advance Life Support skills should always be available. The lack of skill and knowledge of staff in recognising the deteriorating patient has been recognised as a factor that contributes to adverse patient outcomes.

3. Escalation processes are needed to safeguard the deteriorating patient

Clear track and trigger and clinical escalation policies are needed to help staff identify the clinical deterioration of a patient and provide the means to escalate the patient's care to an appropriately trained clinician or team. The lack of an escalation process has been cited as a contributory cause in several Root Cause Analyses (RCAs).

4. Caution should be exercised when transferring patients who may be at risk

The acuteness of the inpatient population is increasing. Older patients are admitted with multiple co-morbidities. Care must be taken to ensure that recognition of patients at risk occurs at presentation and that patients are stabilised prior to transfer from ED or other acute care areas to general ward areas.

5. Effective communication is vital in patient care

Poorly structured or ad hoc handover practices can result in important information not being passed between clinicians, between teams and between facilities. Effective communication can be fostered through the use of clear prescriptive communication methods [3]. Communication pathways and methodologies can facilitate clear and timely communication between and within different clinical disciplines. Bedside handover is recognised as an effective means of handing over patient information. The use of multidisciplinary case reviews is also a valuable activity to promote good communication within teams.

6. Effective teams understand the role of each member of the team

For a team to provide effective and coordinated care it is important that each person is aware of the role and function of each member of the team. Initiatives can be developed to promote better understanding of the clinical roles of team members through collaborative work with undergraduate clinicians.

7. Organised wards provide more time for patient care

As ward work has evolved, a large number of tasks have been incorporated into the work practices of clinical staff. Careful examination of work practices identifies that ward layout and some work practices reduce the efficiency of staff and reduces the opportunity for staff to spend time directly caring for patients. Ward layout and work practices require careful review to maximise the opportunity for patient care. Lack of equipment or the lack of appropriately maintained equipment is associated with adverse patient outcomes.

8. Care Plans and Pathways improve patient care

Incident reviews suggest that there is a lack of use of Care Plans and Pathways in planning patient care. Lack of care planning is evident, not just in cases where patients deteriorate without evidence of a plan of care, but also when a patient's deterioration is expected and anticipated without appropriate consideration of end of life care and palliation being made.

9. Compliance with Policy improves patient safety

Where policies exist for the purpose of safeguarding patients, processes should be in place to audit and reinforce compliance with the policies.

10. Facilities need to put in systems for safeguarding patients at night

Work in the UK has identified a range of strategies to improve the safety of patients in hospital at night. When there are fewer staff and visitors to assist in identifying patient deterioration. Consideration should be given to models of care at a time when skill mix and staff numbers are different to levels found during the day. Careful consideration needs to be given to planning work practices, in particular the performance of technical or high risk activities on night shifts when staff fatigue may contribute to clinical risk.

11. Special consideration needs to be given to rural facilities

Patients in rural facilities face additional challenges. The size and function of remote and rural facilities limits their capacity to provide Clinical Emergency Response Teams [4, 5] so alternative models of clinical escalation should be determined.

12. Measuring and monitoring performance helps determine the efficacy of initiatives

As with changes to any practice, it is critical that Key Performance Indicators should be determined to identify the outcomes from changes in practice. Many relevant measurements are already recorded including: Cardiac arrest and unexpected deaths, unexpected ICU admission and the number of emergency calls per month,

13. Clinical Practice Improvement (CPI) Methodology helps staff to develop and improve clinical practices

Clinical practice improvement methodology is a process for improving care and service delivery through the identification and diagnosis of a problem, measurement of the scope and size of the problem, identification of various interventions that night reduce the problem, implementation of the intervention/s and re-measurement to determine whether the intervention/s have been successful.

CPI is underpinned by evidence-based practice (EBP), incorporating best available evidence, based on scientific research, into the clinical decision making process using tools such as clinical practice guidelines, peer reviewed clinical research and direct clinical measurement.

These themes were distilled down to the 5 pillars of the 'Between the Flags' project, and considered in the development of the Policy Directive.

More information on the initial Between the Flags Project can be found in the 'Between the Flags: Interim Report' at www.cec.health.nsw.gov.au

The Five Elements of Between the Flags'

The 5 elements of the 'Between the Flags' Program are based on the BTF Diagnostic Project and are designed to establish a sustainable state-wide program which will deliver improved systems for the recognition and response to deteriorating patients.

The 5 inter-dependent elements of the 'Between the Flags' Program are:

1. Establishment of guidelines for an administrative structure to oversee the implementation and sustainability of the system in each of the State's acute hospitals (governance).

2. Standard calling criteria used for early recognition of the deteriorating patient incorporated in standardised observation charts (clinical observation and 'track and trigger" system).

3. Clinical Emergency Response System (CERS): process for escalation of concern and response to the deteriorating patient in every facility.

4. Tiered education packages aimed at ensuring skills for the recognition and management of the deteriorating patient, awareness of the track and trigger and Clinical Emergency Response Systems and essential skills and knowledge necessary to operate in the Clinical Emergency Response System.

5. Standard key performance indicators to be collected collated and used to inform the users of the system and those managing the implementation and continuation of the strategies.

Governance and Administration

The success and long term sustainability of the Between the Flags Program will depend crucially on appropriate governance structures and processes at all levels of the organisation.

Where possible, it is advised that governance for the Between the Flags Program occurs within existing structures. The 'recognitions and management of patients who are clinically deteriorating' policy directive defines the roles of key organisational and executive position holders in the Between the Flags Program. Area Health Services will need to identify and appoint key area and facility position holders with operational responsibility for implementation of the Program.

In addition, these guidelines provide guidance on the roles of other key staff. Position holders will need to have access to implementation advice from appropriate advisory committees and experts.

Roles of Key Staff in Implementation

Executive Sponsor

- Ensure that all key personnel have been identified and appointed
- Establish an effective governance structure for the area health service
- Implement the 5 five elements in all AHS facilities
- Identify and allocate resources to support implementation of the 5 elements of the Between the Flags Program.
- Ensure that escalation and referral networks are formed and formalised in policy.
- Ensure compliance with the minimum standards.
- Assist and support Clinical Leads (Champions) by endorsing the Between the Flags program as a vital initiative to respond to the patient who is deteriorating.

Clinical Champions

- Act as a resource for setting up the Clinical Emergency Response System (CERS)
- Participate in the development of local policies for the Clinical Emergency Response System
- Promote the issue of the deteriorating patient and the State-wide response to this - Between the Flags
- Work with the Area and Facility Project Lead/ Manager (see below) to engage department and unit heads.
- Support clinicians as they implement and adjust to the altered clinical environment

Project Lead / Manager

- Ensure that stakeholders at AHS and Facility level have been consulted and engaged in the development of the Clinical Emergency Response System
- Ensure campaign materials are freely available and widely promulgated in all facilities
- Implement the communication plan – work with Clinical Leads to engage department and unit heads
- Co-ordinate awareness and education sessions pertaining to the implementation of the Between the Flags Program.

Area Director Learning and Development

- Roll out awareness package from standard presentation, incorporating the local referral and escalation protocols
- Incorporate Between the Flags into the area orientation program

- In conjunction with area project manager, identify key staff for phase 1 Implementation of DETECT
- Develop a plan for all clinical staff to receive DETECT training within phase 1 and 2.
- Identify and prioritise staff to become key trainers for the DETECT face to face workshops.

Role of Area and Facility BTF Advisory Committees (May be current CERS / ALS / Resuscitation Committees)

- Support the Executive Sponsor by advising on implementation of all 5 elements of the BTF Program.
- Advocate for the BTF Program and liaise with clinical and management colleagues to facilitate implementation of the Program
- Review current referral networks and protocols
- Assess current response systems and help develop Clinical Review and Rapid Response systems that build upon existing structures and processes.
- Assess current skill mix and develop a plan for training of Rapid Response Officers to the minimum standards.
- Review available equipment for resuscitation and measure against the minimum equipment list

Suggestions for advisory committees

- Amend agenda and terms of reference to include the 5 elements of Between the Flags for implementation committees as well as key facility committees e.g ward meetings, NUM Meetings, or facility resuscitation committee.
- Ensure linkage between the AHS Quality committee and the AHS and Facility Between the Flags Steering Committees
- Ensure that there is representation on the committee from sub-programs of Between the Flags i.e paediatrics, maternity, emergency.
- Monitor the progress of implementation, and ensure that problems and risks are identified and reported to the AHS steering committee.

NSW Health Standard Observation Charts

What is a track and trigger tool?

A 'track and trigger' tool refers to an observation chart that is used to record vital signs or observations graphically so that trends can be 'tracked' visually and which incorporates a threshold (a 'trigger' zone) beyond which a standard set of actions is required by health professionals if a patient's observations breach this threshold.

The Standard Adult General Observation Chart

The Standard Adult General Observation Chart was developed by the Between the Flags Management Committee, and has undergone extensive consultation.

Key Features:

1. The most sensitive indicators of deterioration are represented on the chart. Therefore, respiratory rate, pulse, blood pressure, SaO_2, oxygen requirement and neurological assessment are included.
2. There are no overlapping observations, to reduce confusion when recording or interpreting vital signs.
3. Observations are displayed graphically so trends can be monitored (tracking).

4. Trigger zones are colour coded to draw attention to when calling criteria are met.
5. The Chart allows for the recording of variations to the standard calling criteria for individual patients, as appropriate. The supervising medical officer must sign the alterations. (Registrar may alter criteria only in consultation with AMO /VMO and must document the agreed alterations in the clinical record).
6. The number of charts that a patient has is minimised by combining the BTF standard observations with the more commonly recorded general observations in a single chart
7. The calling criteria are clearly displayed and easily accessible.
8. Space is allocated to allow for the recording of Blood Glucose Level (BGL). This is so that a one-off BGL check does not require a separate BGL form, particularly if it is part of the assessment of a deteriorating patient.
9. The ability of the Chart to identify deterioration depends on the reliability and completeness of observation
10. A Clinical Review or Rapid Response call can also be initiated under the 'serious concern by any staff member' criterion. For example, if a deteriorating trend in clinical observations is detected, even if the patient is not yet in a coloured zone, a clinician may initiate either a Clinical Review or Rapid Response.

Key suggested strategies for implementation of the Standard General Observation charts are at **Appendix 1**.

Order numbers for observation Charts

Standard General Observation Chart: SALMAT Stock Code NH 606512 (pack 200)
Standard Paediatric Observation Charts

- Under 30 days: SALMAT Stock Code TBA
- 1-12 months: SALMAT Stock Code TBA
- 1-4 years: SALMAT Stock Code TBA
- 5-11 years: SALMAT Stock Code TBA
- 12 years and over: SALMAT Stock Code TBA

Maternity Observation Chart: SALMAT Stock Code TBA

How to Use the SAGO Chart

The SAGO Chart should be used like any other adult general observation chart. The Chart indicates which symbols should be used to record observations and these should be charted graphically so that the trend in each observation can be monitored. If a patient's observations enter the Yellow Zone, you should refer to the back of the SAGO Chart for the instructions on what you should do next. The instructions describe when to make a call not how to make a call. Your local escalation protocol will explain how to make a call.

All the Clinical Review criteria are listed in the Yellow box on page 4 of the Chart. If a patient has any one or more of these criteria present you should consult with the Nurse in Charge and assess whether a Clinical Review is needed. Use your clinical judgement regarding whether a Clinical Review is needed. There may be some circumstances in which a patient may have Yellow Zone criteria present but they do not represent deterioration in that patient. You should know what is usual for your patient. For example, exercise by a physiotherapist or an emotional reaction to an incident could raise a patient's heart rate to above 120 beats per minute (into the Yellow Zone), yet this may not represent deterioration. Clinical judgement remains paramount at all times. If you are concerned about your patient you can call for a Clinical Review at any time, regardless of whether Clinical Review criteria are met. For example, your patient may have an increasing trend

in their respiratory rate that does not yet reach the Yellow Zone yet but you are concerned because he or she doesn't feel well or has a heart rate which shows a rising trend but has not reached the Yellow Zone.

If a patient has criteria within the Red Zone, there is no discretion. You must call a Rapid Response. This is because patients who have criteria within the Red Zone are likely to be seriously ill. The only exemption to this rule is if a doctor has documented a variation to the calling criteria on the front page of the Chart. This may be appropriate for some patients. For example, patients with chronic obstructive airways disease or emphysema may have a usual respiratory rate that does not represent deterioration in their condition and it would be inappropriate to call a Rapid Response in these cases.

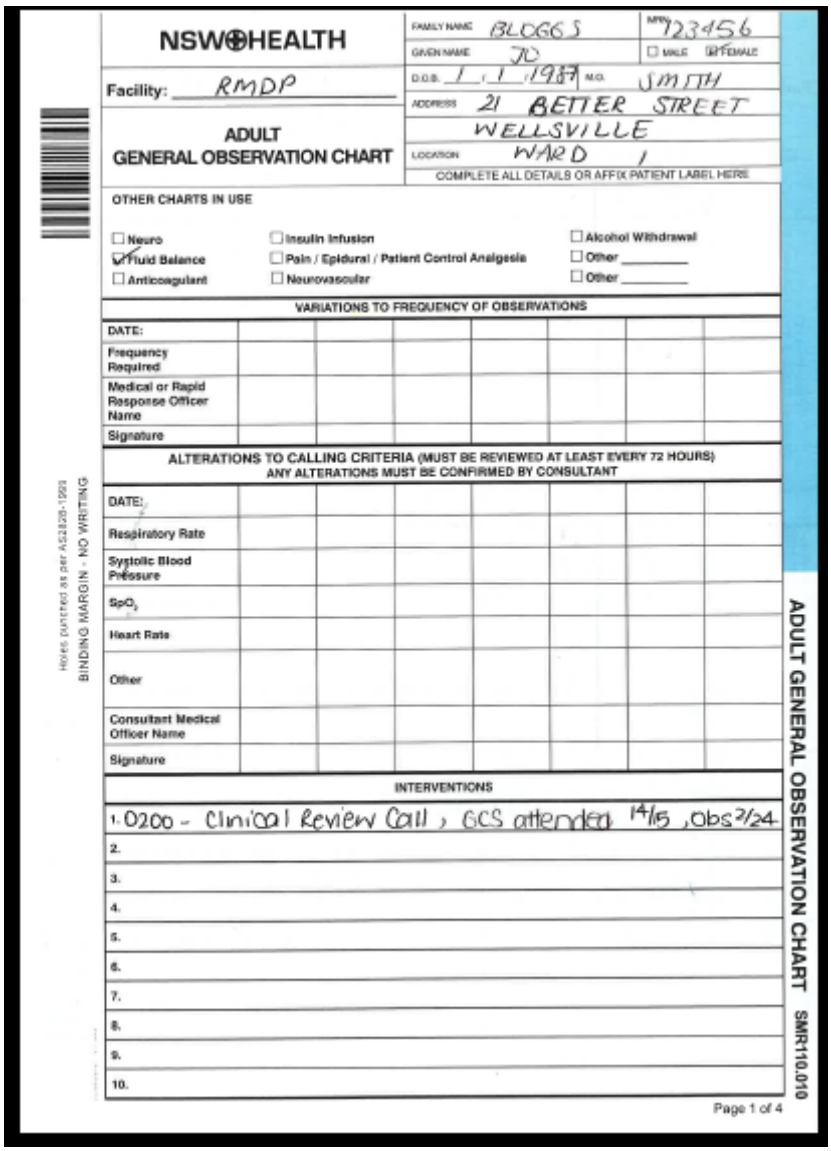
At all times, you remain responsible for your patient and for giving them appropriate treatment for their condition, within your scope of practice.

The Between the Flags Program is designed to give you the confidence to call for help when you and your patient need it.

A standard set of general observations should be documented on the SAGO Chart at least once every shift or three times per day, whichever is the more frequent. Refer to the Policy Directive for exceptions.

Standard observation charts are being developed for a number of other patient groups, including paediatric patients, maternity patients and patients attending emergency departments.

Example of a completed SAGO



NSW HEALTH

Facility: RMDP

ADULT
GENERAL OBSERVATION CHART

FAMILY NAME: BLOGGS
GIVEN NAME: JO
MRN: 123456
☐ MALE ☒ FEMALE
D.O.B. 1 / 1 / 1987 M.O. SMITH
ADDRESS: 21 BETTER STREET
WELLSVILLE
LOCATION: WARD 1
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

OTHER CHARTS IN USE

☐ Neuro
☑ Fluid Balance
☐ Anticoagulant
☐ Insulin Infusion
☐ Pain / Epidural / Patient Control Analgesia
☐ Neurovascular
☐ Alcohol Withdrawal
☐ Other _____
☐ Other _____

VARIATIONS TO FREQUENCY OF OBSERVATIONS

DATE:							
Frequency Required							
Medical or Rapid Response Officer Name							
Signature							

ALTERATIONS TO CALLING CRITERIA (MUST BE REVIEWED AT LEAST EVERY 72 HOURS)
ANY ALTERATIONS MUST BE CONFIRMED BY CONSULTANT

DATE:							
Respiratory Rate							
Systolic Blood Pressure							
SpO_2							
Heart Rate							
Other							
Consultant Medical Officer Name							
Signature							

INTERVENTIONS

1. 0200 - Clinical Review Call, GCS attended 14/15, obs 2/24
2.
3.
4.
5.
6.
7.
8.
9.
10.

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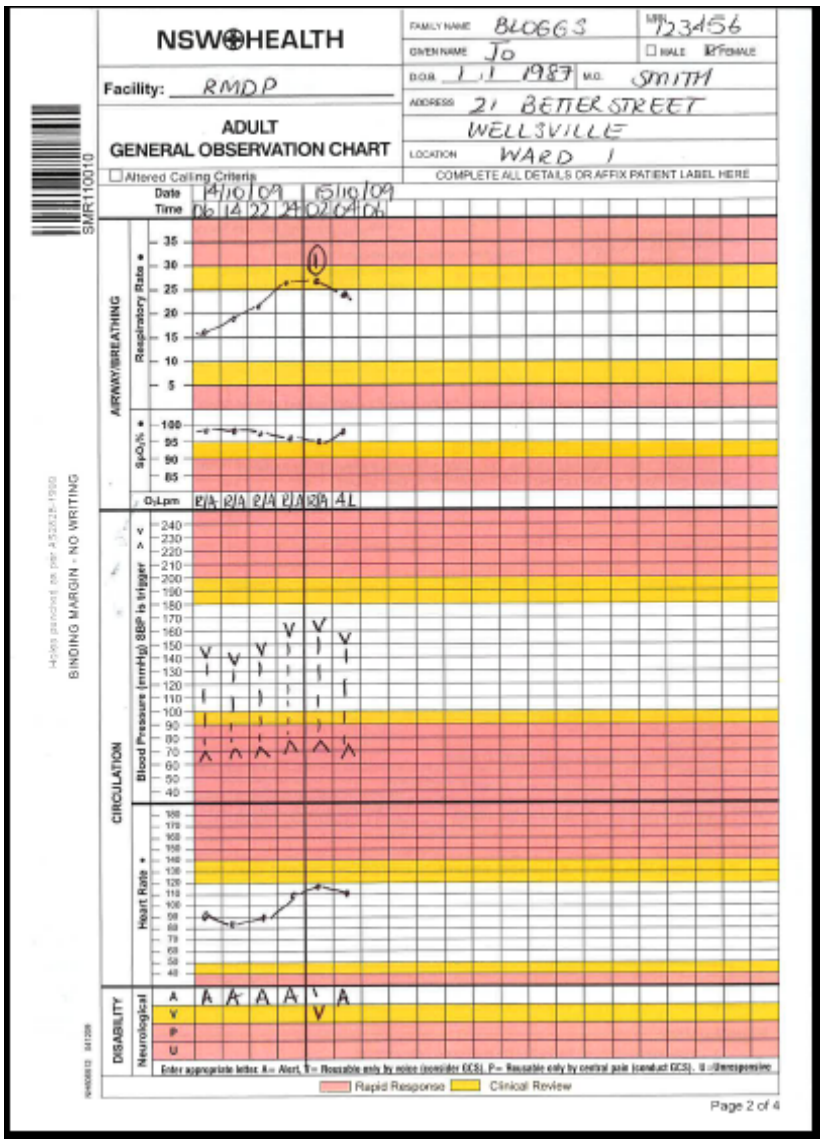
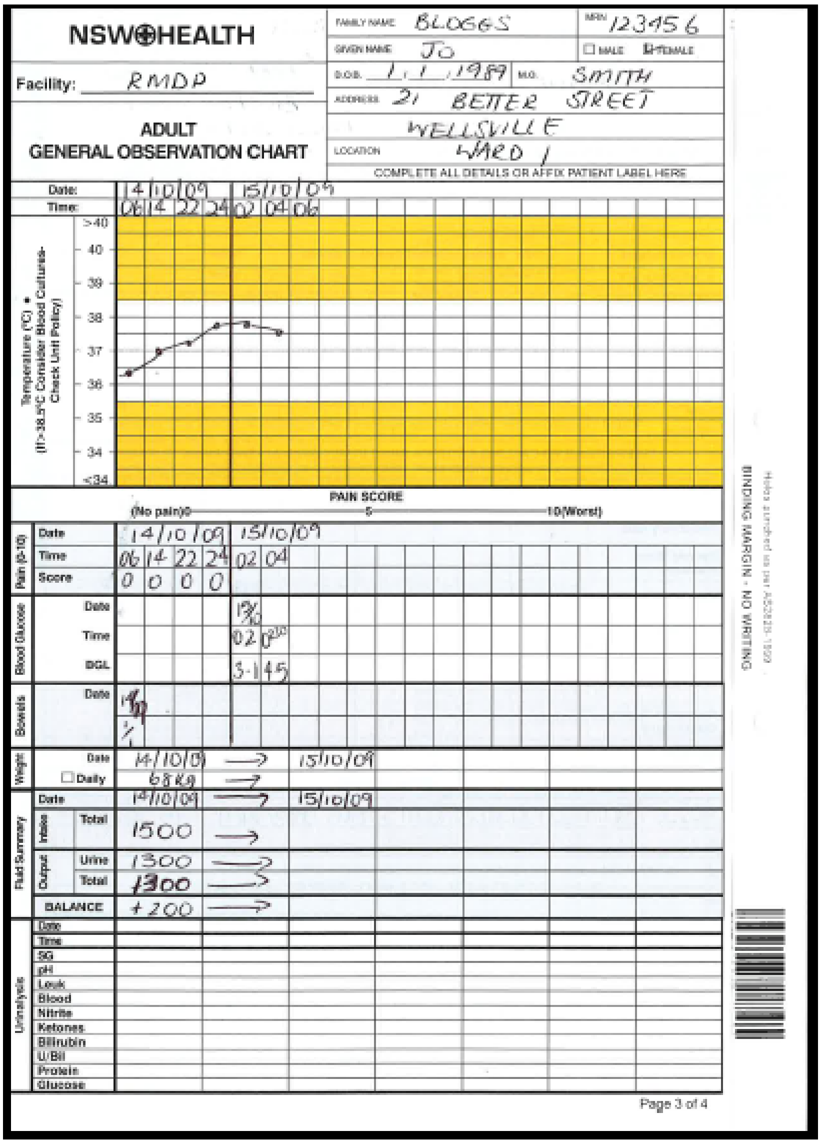
ADULT GENERAL OBSERVATION CHART SMR110.010

Holes punched as per AS2828-1993
BINDING MARGIN - NO WRITING


NSW HEALTH
Facility: RMDP
ADULT
GENERAL OBSERVATION CHART
Altered Calling Criteria
FAMILY NAME BLOGGS
GIVEN NAME Jo
MRN 123456
MALE FEMALE
D.O.B. 1/1/1987
M.D. SMITH
ADDRESS 21 BETTER STREET
WELLSVILLE
LOCATION WARD 1
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
Date 4/10/09 5/10/09
Time
AIRWAY/BREATHING
Respiratory Rate
SpO2 %
O2 Lpm
CIRCULATION
Blood Pressure (mmHg)
SBP is trigger
Heart Rate
DISABILITY
Neurological
A
V
P
U
Rapid Response
Clinical Review
Page 2 of 4



NSW HEALTH

Facility: RMDP

ADULT GENERAL OBSERVATION CHART

FAMILY NAME: BLOGGS MRN: 123456
GIVEN NAME: JO ☐ MALE ☑ FEMALE
D.O.B. 1/1/1989 M.O. SMITH
ADDRESS: 21 BETTER STREET WELLSVILLE
LOCATION: WARD 1
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date:	14/10/09				15/10/09		
Time:	06	14	22	24	02	04	06

Temperature (°C) • (If > 38.5°C Consider Blood Cultures - Check Unit Policy)

>40, 40, 39, 38, 37, 36, 35, 34, <34

PAIN SCORE
(No pain) 0 — 5 — 10 (Worst)

Pain (0-10)						
Date	14/10/09				15/10/09	
Time	06	14	22	24	02	04
Score	0	0	0	0		

Blood Glucose	
Date	15/10
Time	02 0230
BGL	3-1 4.5

Bowels — Date: 14/10 ✓

Weight			
Date	14/10/09	→	15/10/09
☐ Daily	68kg	→	

Fluid Summary			
Date	14/10/09	→	15/10/09
Intake Total	1500	→	
Output Urine	1300	→	
Output Total	1300	→	
BALANCE	+200	→	

Urinalysis: Date, Time, SG, pH, Leuk, Blood, Nitrite, Ketones, Bilirubin, U/Bil, Protein, Glucose

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BINDING MARGIN - NO WRITING

Clinical Emergency Response Systems (CERS)

What is a CERS

A CERS is a system for obtaining urgent assistance to treat a deteriorating patient. All clinical emergency response systems should include three main escalation components:

1. A Clinical Review process in response to the Clinical Review Criteria which must have the capacity to respond within 30 minutes.
2. A Rapid Response process in response to the Rapid Response Criteria, which needs to be available immediately and
3. An escalation process for obtaining higher-order care for patients who need to be transferred out to a facility that can provide critical care for patients that require it.

For Background on the development and evolution of CERS, please refer to Appendix 2.

CERS Minimum Standards

Refer to the policy: *Recognition and Management of Patients who are Clinically Deteriorating: Policy Statement and Standard* for the minimum standards for CERS.
The local CERS needs to be documented in local procedures and supported by the Area Health Service.
All facilities and AHSs must have an agreed facility specific procedure, based on the NSW policy, which defines roles and responsibilities for those who respond to Clinical Review and Rapid Response calls. This procedure should ensure Clinical Review within 30 minutes, immediate Rapid Response and escalation processes.
All facilities must have the necessary equipment to institute advanced resuscitation and a process of timely transfer to a higher level facility when necessary

How to set up a CERS

1. Identify the key area and facility stakeholders. This may include an already functioning ALS / resuscitation committee.
2. Review the current escalation, review and transfer processes for your facilities, in many cases it may be possible to align current systems with the Clinical Review and Rapid Response processes.
3. Engage departmental, service and unit heads and recruit them to your 'guiding coalition'. Seek their input regarding needs and resources available.
4. Examine the resources and skill mix available in each facility. Staff may need additional training in order to meet the standard for the Rapid Response Team (RRT). Ensure that there is adequate resuscitation equipment at each facility
5. Review the levels of care and specialty services offered by facilities in your AHS.
6. Engage with the AHS / Clinical Leads (Champions)
7. Engage in discussion with the Ambulance Service and Ambulance Medical Retrieval Service (AMRS) to identify workable solutions for assistance and retrieval.
8. You may find it helpful to conduct focus groups to identify problem areas and possible solutions. Suggested questions at **Appendix 3**
9. Focus groups may also be helpful to identify and solve problems related to the availability and storage of essential equipment, including ward lay-out.
10. Once the protocol/procedure is agreed and approved, ensure that the policy is widely displayed and promulgated in all facilities.
11. Ensure patient safety and the CERS are an agenda item on unit, departmental and leadership group meetings. This has been a successful strategy for facilities who have previously implemented a CERS.
12. Ensure that AMO's and senior medical staff who may be called upon to respond to CERS calls are appropriately consulted on the development of these systems.

13. Decide on the method for communicating the need for Clinical Review and Rapid Response, it may be appropriate to engage hospital switchboard or communications staff.

When establishing a CERS, it is important that the principle of independence be applied to reviews, as far as is possible. This means that the person conducting the Rapid Response should be different from the person conducting the Clinical Review. This is because an independent assessment of a patient who may be deteriorating is often complementary and may help to reveal underlying causes of patient deterioration that may be missed by another, who may be more familiar with the case. Establishing this independence between the two review processes may be difficult in small facilities. In such circumstances, it may be possible to supplement the Rapid Response with an external telehealth consultation, with an intensive care or emergency physician, for example. In small facilities it may be also appropriate to consider early transfer to another facility.

Documentation following activation of CERS

Comprehensive documentation in patient notes following activation of CERS – Clinical Review or Rapid Response – is important and should include:

- Date
- Time
- Name of staff notified
- Reason for call
- Time patient is seen for Clinical Review or Rapid Response
- Treatment/Action arising from Clinical Review or Rapid Response
- Outcomes following treatment/action

Suggested Clinical Emergency Response System implementation strategies are at **Appendix 4**

EDUCATION

All AHS must have in place an education program for each facility that is based on the Between the Flags Education Program that facilitates the training of staff to recognise and appropriately manage patients who are clinically deteriorating.

The Between the Flags Education Program will include aspects of clinical assessment of the patient, the facility escalation protocol and appropriate care to provide while waiting for assistance.

The three levels of the Between the Flags Education Program are:

1. Awareness Training: All clinical staff and students should be aware of the Between the Flags Program. They should also be able to recognise a patient who is clinically deteriorating, identify the key features of the standard observation charts and explain how to apply the principles of Clinical Emergency Response Systems
2. DETECT: All clinicians providing direct patient care should have the theoretical and practical knowledge to recognise and provide appropriate treatment to patients who are clinically deteriorating and incorporate appropriate communication, escalation and handover processes into their practice. DETECT is aimed at enhancing clinical assessment and management skills for early intervention for adult patients who are clinically deteriorating.

   The DETECT education program comprises:

- The DETECT e-learning resource (www.nswhealth.moodle.com.au)
- The DETECT Manual
- A face-to-face practical session.

3. Advanced clinical and resuscitation skills: The Rapid Response Team are required to have advanced clinical and resuscitation skills for example Advanced Life Support. These clinicians provide an immediate response to a Rapid Response call

Education Implementation phases

Phase 1– All Area Health Services deliver Awareness Training to all staff in priority order and commence training of DETECT trainers.
Phase 2 – All Area Health Services deliver DETECT training to relevant staff in priority order.
Phase 3 – Ongoing Maintenance and Improvement of education program.

A suggested Strategy is provided in Appendix 5

Summary of Between the Flags Education

Level	Target Group	Education Program	Components	Prerequisites	Comments
1	All staff, including nursing, medical, allied health. Undergraduates should be included here.	Introductory Awareness Package	Powerpoint presentation with audio voice- over.	Nil	Available via www.nswhealth.moodle.com.au
2	All ward based clinical staff (those who respond to the yellow zone)	DETECT	E-learning materials Practical Skills Workshop	Level 1 Awareness is preferred	Must complete e-learning modules prior to attending the workshop Available via www.nswhealth.moodle.com.au
3	Rapid Response Team Members / Rapid Response Officer (those who respond to the red zone)	Advanced Life Support / FLEC RN		DETECT training	A number of ALS courses are already operating

SUGGESTED PRIORITISATION FOR EDUCATION

TIER	PHASE 1	PHASE 2	PHASE 3
1- AWARENESS	All staff who have clinical contact with patients (Nursing/Medical/Allied Health	Nursing / Medical and Allied Health Administration staff	Cleaners/ Environmental Services Ward Clerks
2- DETECT	Staff who are responsible for Training of clinical staff (Educators/Clinical School Trainers) Supervision / support of clinical staff (NIC/MIC/Snr Registrar / AMO) Conduct the Clinical Review as part of their clinical role (JMO's/ Registrars)	Remaining Nursing and Medical Allied Health staff team leaders e.g physiotherapy and occupational therapy	Remaining Clinical Nursing , Medical Allied Health staff Nursing , Medical Allied Health staff in administrative roles.
3- ALS	Staff who perform the role of Rapid Response Team Leader (RRTL) who have not completed ALS training	Staff who are members of the RRT, who have not completed ALS training	New members of the RRT

PATHLORE CODES FOR EDUCATION

Between the Flags (Awareness)- - CSK 909
DETECT e-learning- CSK 910
DETECT Face to Face Workshop-CSK 911
DETECT Trainer Workshops-TBA

Suggested education implementation strategies are at Appendix 5

EVALUATION

Principles of Evaluation

It is important to evaluate the Between the Flags Program to ensure that the system is working. There are a number of key performance recommended by the Between the Flags Steering Committee for evaluation of implementation of Between the Flags Program.

Unexpected deaths

Defined as those deaths where there was no not for resuscitation order

Unexpected potentially preventable deaths

Defined as those deaths where there was no not for resuscitation order and there was in the previous 24 hours a "rapid response' call criterion met for which there was not appropriate action taken.

Unexpected Cardiac arrests
Defined as those cardiac arrests where there was no not for resuscitation order
Unexpected Potentially Preventable Cardiac Arrests
Defined as those cardiac arrests where there was no not for resuscitation order and there was in the previous 24 hours a "rapid response' call criterion met for which there was not appropriate action taken.
Audits: An audit tool for observation charts has been provided in Appendix 8, for those who wish to assess the observation charts for completeness. If you have any tools that you have found useful and you would be able to share them, please contact the CEC Between the Flags Project Officer.
It is important to ensure that clinical staff are initiating the appropriate actions when call criteria are being met, e.g that a rapid response call is made when a patient's observations have been recorded in the red zone. A number of facilities have already developed tools for assessing this.
Rapid Response Calls: A database for standardising collection of information from rapid response calls is being developed, it is anticipated that this will be expanded to include Clinical Review calls also.

COMMUNICATION AND KEY MESSAGES

A communication strategy for Between the Flags has been developed and is included in Appendix6.

Suggested implementation activities for enhancing communication is also included in Appendix 7

For the purposes of education, awareness and promotion the following key messages regarding the Between the Flags Program have been prepared.

1. NSW Health is leading the world by introducing a comprehensive system to standardise processes for recognising and responding to patients, whose condition is deteriorating, across an entire state public hospital system. This will prevent deaths and reduce the risk of harm to patients.
2. This introduction of the Clinical Excellence Commission's Between the Flags Program was recommended by the Garling Commission and is strongly supported by clinicians across the NSW public health system.
3. The program uses the analogy of Surf Life Saving Australia's lifeguards and lifesavers who keep people safe by observing them closely and preventing them getting into danger. Importantly, they are also ready to rescue them should anything go wrong.
4. Between the Flags will see the implementation of standardised colour coded observation charts in all NSW hospitals to support staff in early recognition and escalation of a response to patients at risk of clinical deterioration.
5. A Clinical Review will be initiated when a patient's vital sign observations fall within the Yellow Zone on an observation chart. In response, staff will conduct a patient assessment, review the plan of care and initiate interventions to prevent deterioration.
6. A Rapid Response will be initiated if any patient's observations fall within the Red Zone. Immediate assessment will occur with appropriate interventions to resuscitate patients or treat underlying causes of deterioration.

Between the Flags information brochure and poster have been developed and are able to be downloaded from the NSW Health Intranet. Further information regarding these and other collateral material in development is available through:

- **Clinical Excellence Commission**
  Between the Flags Project Officer
  Clinical Excellence Commission
  GPO Box 1614
  Sydney NSW 2001
  (02) 9382 7600
  www.cec.health.nsw.gov.au

- **NSW Department of Health**
  Quality and Safety Branch
  LMB 961
  North Sydney, 2059
  (02) 9391 9000

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Appendix 1 Standard Adult General Observation Chart suggested implementation activities

LEVEL	STRATEGY	ACTIONS	RESPONSIBLE [amend as appropriate]	TIMEFRAME
Area	• Implement the NSW Standard General Observation Charts	• Deliver General Awareness Education for BTF to all clinical staff, then at facility level link to facility-specific Rapid Response (see Education) • Incorporate into orientation program- observation chart is part of mandatory education for all clinical staff • Support staff to attend external / referral network training to attend awareness training and usage of observation chart. • Ensure all facilities have adequate stocks of Charts.	• Area Project Manager • Area BTF Advisory Committee • Area Learning and Development • Director Corporate Services	• Phase 1
Facility	• Implement the NSW Standard General Observation Charts	• Ensure Clinical Emergency Response System is in place prior to implementation of chart. • Implement Standard Chart • Basic Vital Signs Education • Conduct awareness education- principles of BTF +Facility specific plans • Use feedback from Essentials of Care work and initiatives to support the rationale for implementation of BTF • Incorporate into orientation program- observation chart is part of mandatory education for all clinical staff • Ensure adequate	• GM/DMS/DONS • Facility CNC- Program Co-ordinator • Facility Clinical Lead • Facility BTF Advisory Committee	• Phase 1

		availability of Chart stocks on wards and units. • Ensure existing Clinical Emergency Response Systems are linked to implementation of the observation Charts.		
Unit	• Implement the NSW Standard General Observation Charts	• Implement Standard Charts • Conduct Basic Vital Signs Education • BTF on ward meeting agendas • Unit audits- ensure observations are completed and recorded correctly. • Incorporate feedback from Essentials of Care work done in the unit to support BTF. • Ensure observations are taken correctly	• **NUM** • **Medical Dept/Unit Heads** • Allied Health Leaders • **Unit Education Staff** • CSO's	• Phase 1

Appendix 2 Information related to Implementation of CERS

Background to the Development of CERS

Escalation protocols provide a structured means for determining when a Clinical Review or Rapid Response is necessary. Typically these escalations occur in response to predetermined changes in a patient's observations. Escalation protocols are enablers for staff. They provide justification for junior clinical staff in seeking that assistance of more senior clinicians. Escalation documentation frequently contains an algorithm and is supported by policy documents. Education in the use of escalation protocols is considered crucial to ensuring their effectiveness in clinical practice. Cards and posters are visible means of reminding staff of escalation criteria and required responses.

Examples of CERS Models

Some successful implementers of CERS are

- Liverpool Hospital –SSWAHS (MET)
- Westmead Hospital – SWAHS (PACE)
- Royal Prince Alfred Hospital – SSWAHS (CERS)
- GSAHS (Colour coded observation chart)
- SESIAHS (PACE)
- NSCCAHS (MET)

MET (Medical Emergency Teams) were initially developed at Liverpool Hospital, a number of criteria were developed from physiological findings and qualitative assessment to trigger an emergency call and immediate review of a patient.
The MET is primarily composed of Critical Care clinicians, who bring advanced resuscitation skills to wherever the patient is. A number of facilities have adopted this model. This type of system

can impose a high burden of workload on the Intensive Care Unit, when they are responsible for managing all calls for response to clinical deterioration in a facility.

Hybrid Systems

Westmead Hospital, SESIAHS and GSAHS have developed a system which involves a designated rapid response team responding to life-threatening situations but have also formalised and delineated the responsibilities of primary teams in recognising and managing their patients.

In these systems there are additional criteria that trigger an urgent clinical review within 30 minutes of a call being made. In large facilities this is usually attended by the attending medical team at registrar level, at a minimum.

The Between the Flags Program does not define what the response should be in each facility. Each facility or service will have its own needs and resource availability. However, the aim is to ensure that all patients regardless of location receive prompt assessment and treatment when required.

For further information contact:
Liverpool MET Co-ordinator- Liverpool Switchboard 9828 3000
Westmead CERS Co-ordinator- Westmead Switchboard 9845 5555
SESIAHS PACE Co-ordinator- Prince of Wales Switchboard 9382 2222
RPAH CERS Co-ordinator – RPAH Switchboard 9515 6111
GSAHS – (CNC/ICU) – Queanbeyan Switchboard 61289777

Appendix 3 Questions for Focus Groups for establishment of CERS

What model is currently in operation in the AHS/facility?

What is the skill mix and supervision in your areas?

How are junior staff supported?

What is the current escalation process for obtaining assistance, referral and retrieval?

What are the problems with the current process?

What are the advantages of the current system?

Where are patients currently transferred to?

Do staff need to leave the facility to chaperone patients when transferring/ retrieving?

Does the equipment in each clinical area meet the minimum standard?

Appendix 4 Clinical Emergency Response System suggested implementation activities

LEVEL	STRATEGY	ACTIONS	RESPONSIBLE [amend as appropriate]	TIMEFRAME
Area	Implement Clinical Emergency Response System in all area facilities and departments, including an escalation plan and clinical review and rapid response teams or alternative rapid responders, such as by means of referral and escalation networks.	Review resources and develop Clinical Emergency Response Systems for all facilities Document Facility CERS/escalation plan and display in all Clinical Areas Implement standards for Clinical Emergency Response System Develop strategy and timeframe for training and up-skilling of staff to Rapid Response Officer (RRO) level. E.g. Rural implications- FLEC trained nurse (1 per shift – refer to Policy Standard) Support staff to attend external / referral network training to up-skill to RRO level Ensure referral / escalation networks are formalised and written into policy ensure provision of staff with advanced skills 24/7 Ensure that formal network and referral policies are widely promulgated and available in clinical areas Ensure minimum required equipment (see Policy Standard) is available and in working order Establish procedure for stickers to be included in clinical record when a Medical Review or Rapid Response call has been made (see Toolkit). Establish formal agreements between providers and networks (e.g. AMRS/Ambulance/RFDS/Base Hospital) to ensure an effective Clinical Emergency Response System that meets minimum standards, as contained in the Policy Directive (where appropriate to circumstances).	Area Executive Sponsor Executive Clinical Director Area Project Manager Area Clinical Lead Area Learning and Development	Phases 1 and 2
Facility	Implement Clinical Emergency	Implement standards for Clinical Emergency	GM/DMS/DONS	Phases 1 and 2

	Response System in facility	Response System Establish BTF Committee or work within current Resuscitation / ALS Committee structure Ensure minimum required equipment is available and in working order (see Policy Standard)	Facility CNC-Program Co-ordinator Facility Clinical Lead	
Unit	Ensure compliance with Clinical Emergency Response System Standards at Unit Level	Implement standards for Clinical Emergency Response System Support clinical staff to assess patients and escalate patient care Ensure minimum required equipment is available and in working order (see Policy Standard)	**NUM** **Medical Dept/Unit Heads** Allied Health Leaders **Unit Education Staff** CSO's	Phase 1, 2 and 3

Appendix 5 Education Strategy suggested implementation activities

LEVEL	STRATEGY	ACTIONS	RESPONSIBLE [amend as appropriate]	TIMEFRAME
Area	• Provide General Awareness Education regarding recognition and management of deteriorating patients (see Toolkit) • Provide DETECT program to Tier 2 staff *(see definitions of tiers in Toolkit) • Promote awareness of DETECT and its benefits (cf Communication) * Note on Education Tiers: - Tier 1 – all staff – awareness - Tier 2 – key clinical staff – recognition and response - Tier 3 – rapid response staff (See Toolkit for definitions)	• Deliver General Awareness Education for BTF to all clinical staff, then at facility level link to facility-specific Rapid Response (see Standard Adult General Observation Chart, and Toolkit for General Awareness Education Presentation) • Identify key staff (see Overview) for DETECT (Tier 2) education in Phase 1.* • Deliver Standard Education Package (DETECT) to Tier 2 staff. • Develop plan for DETECT training of staff to ensure adequate availability and release of key staff to attend training within Phase 1 and Phase 2. • Integrate BTF/ Deteriorating Patient into • appraisal/performance development system for all clinical staff. • Education outcome recording and reporting (Phase 3) • Continue/cascade training of trainers	• Area Project Manager • Area BTF Advisory Committee • Area Director Learning and Development • Area Director of Clinical Governance	• Commence Oct 2009
Facility	• All facility clinical staff to receive DETECT training	• Support delivery of Standard Education Package (DETECT) to Tier 2 staff. • Support / release staff to attend training • Provide material to link content of DETECT to the facility- incorporate case studies from IIMS, or data from Essentials of Care to illustrate relevance of BTF to the facility. • Maintain records to document completion of training within required timeframe. • Deteriorating patient education incorporated	• Facility Manager • Facility DON • Facility DMS • Facility CNC-Program Co-ordinator • Facility Executive Clinical Director	▪ Phases 2 and 3

		into unit/departmental in-service programs		
Unit	• All unit clinical staff to receive DETECT training	• Manage rostering to release staff for training	• **NUM** • **Medical Dept/Unit Heads** • Allied Health Leaders •	▪ Phases 2 and 3

Appendix 6: Communication Strategy Action Plan

Overall Communication Strategy Aim

To communicate with key stakeholders within the NSW Health System, to improve knowledge and understanding, of the purpose and initiatives of the Between the Flags Project, with the aim of improving the recognition and management of deteriorating patients through clinician and executive buy-in.

Key Stakeholders and Role

Key Stakeholder	Role
AHS Chief Executive Officers Directors of Medical Services Directors of Nursing Directors of Clinical Operations / General Managers Cluster Managers/ Stream Managers	To ensure implementation of the Between The Flags project in compliance with the Minimum Standards. Incorporating: • Allocation of resources (training, equipment) • Clinical Governance • Collection and distribution of reports related to outcome measures • Provision of education resources •
Directors of Clinical Governance	To support the implementation of the Between the Flags project through an appropriate governance structure. Facilitate collection, evaluation and reporting of outcomes measures. Ensuring that clinical staff is updated on the outcomes in their clinical areas.
Nursing Leaders (Clinical Champions)	To effectively communicate the rationales and processes involved in the Between the Flags project to Nursing staff. To advocate and lead the implementation process Model and support appropriate behaviours for recognition and escalation of care for deteriorating patients. Feedback of outcome measures to clinical unit staff.
Nursing staff	To work with nursing leaders, and medical staff to change behaviour to improve the recognition and escalation of care for deteriorating patients

Key Stakeholder	Role
Medical Leaders (Clinical Champions)	To effectively communicate the rationales and processes involved in the Between the Flags project to Medical staff. To advocate and lead the implementation process Model and support appropriate behaviours for recognition and escalation of care for deteriorating patients. Feedback of outcome measures to clinical unit staff.
Medical Staff	To work with Medical Leaders and nursing staff to improve the recognition and escalation of care for deteriorating patients.
Allied Health Leaders	To work with and assist Allied Health professionals to understand their role in the recognition and escalation of care for deteriorating patients. Ensure that feedback is given to allied health staff in relation to the outcome measures for the clinical units in which they work.
Allied Health Professionals- Physio, OT, Pharmacy and Pathology	To work effectively with nursing and medical staff to recognise deterioration and escalate care as per facility protocols
NSW Ambulance Service Leaders	To effectively communicate the rationales and processes involved in the Between the Flags project to ambulance service staff To liaise with AHS in the planning process for formalising referral networks. To advocate and lead the implementation process Model and support appropriate behaviours for recognition and responding to deteriorating patients in partnership with AHS Feedback of outcome measures to clinical staff
Ambulance Medical Retrieval Service (AMRS)	To effectively communicate the rationales and processes involved in the Between the Flags project to ambulance service staff To liaise with AHS in the planning process for formalising referral networks and escalation procedures. To advocate and lead the implementation process Model and support appropriate behaviours for recognition and responding to deteriorating patients in partnership with AHS Feedback of outcome measures to clinical staff
Key Stakeholder	**Role**

NSW Ambulance Service Clinical Staff	To work with AHS staff to improve recognition and response to the deteriorating patient
Royal Flying Doctor Service (RFDS) Leaders	To effectively communicate the rationales and processes involved in the Between the Flags project to ambulance service staff To liaise with AHS in the planning process for formalising referral networks and escalation procedures. To advocate and lead the implementation process Model and support appropriate behaviours for recognition and responding to deteriorating patients in partnership with AHS Feedback of outcome measures to clinical staff
Royal Flying Doctor Service Staff	To work with AHS staff to improve recognition and response to the deteriorating patient
Hospital 'Hotel' Services staff (cleaning, food)	To have an awareness of the Between the Flags Program. Report unusual behaviour, failure to eat meals to nursing staff.
Critical Care Practitioners & ALS / Resuscitation Committees	To provide advice and assistance with the development of Rapid Response / Medical Review escalation protocols within their facilities
Professional Bodies (Associations, Colleges and Boards)	To communicate with their members regarding the importance of recognition and appropriate management of deteriorating patients. Provide support and endorsement of the Between the Flags Initiative.

Target Audience	Aim of communication to target audience	Communication Vehicles / Tools	Who to Action	By When	Costs
AHS Management Chief Executive Officers Clinical Leads Executive Sponsors Directors Of Nursing Directors of Clinical Operations / General Managers Cluster Managers/ Stream Managers	To engage area executive leaders, and enlist support for implementation of Between the Flags in all AHS Facilities through: • Compliance with minimum standards • Delineate responsibility for data collection, monitoring and reporting. • Provision of adequate resources for education, staffing and equipment	• BTF Brief • National Deteriorating Patient Workshop • BTF Newsletter • Updates /presentations on progress • How will data be fed back to facilities and units.	• CEC (CP) • CEC/ACSQHC • CEC / DoH	August 09	
Facility Management Directors Of Nursing Directors of Clinical Operations / General Managers	To engage facility executive leaders, and enlist support for implementation of Between the Flags in all NSW Facilities through: • Compliance with minimum standards • Delineate responsibility for data collection, monitoring and reporting. • Provision of adequate resources for education, staffing and equipment	• BTF Brief • National Deteriorating Patient Workshop • BTF Newsletter • Updates /presentations on progress • How will data be fed back to facilities and units.	• CEC (CP) • CEC/ACSQHC • CEC / DoH	August 09	
Directors of Clinical Governance	To engage Directors of Clinical Governance to enable implementation of the Between the Flags Project, through an appropriate governance structure to allow for collection, analysis, review and reporting of data related to project strategies for improving recognition and management of deteriorating patients.	BTF Brief	CEC- CP and CD	August 09	
		CEC Information Booth- AQHC Conference	CEC		
Nursing Leaders / Management	To engage nursing leaders to effectively communicate, advocate and lead the implementation process for Between the Flags To work with the CEC, Department of Health, AHS, allied health and medical leaders to develop and refine implementation strategies for their health care facility	BTF Briefing to • NaMO • NSW Nurses Association • College of Nursing • Nurses and Midwives Board • Presentations /Updates	CEC		

Target Audience	Aim of communication to target audience	Communication Vehicles / Tools	Who to Action	By When	Costs
Nursing staff	To engage Nursing staff in the use and acceptance of BTF Strategies, including adult observation chart, DETECT education program, recognition and escalation of care for deteriorating patients,	• Area Health Service Newsletters • Agenda item on ward meetings • Orientation sessions to BTF/ forums /meetings • National Deteriorating Patient Workshop • Feedback loop / process for comments (regarding the 5 pillars)	Nursing leaders / Clinical Champions Project Leaders CEC / ACSQHC		
Medical Leaders (Clinical Champions)	To engage medical leaders so that they can effectively communicate with medical staff and advocate and lead the implementation process of Between the Flags in their facilities. To work with the CEC, AHS Executive, Nursing and Allied Health leaders to implement the Between the Flags strategies.	Brief to • Australian Medical Association • NSW Medical Board Committee of Presidents of Medical Colleges (CPMC)- meeting agenda • GMCT • Institute of Medical Education and Training • Directors of Clinical training forum • Rural Doctors association	CEC		
Medical Staff	To engage Medical staff in the use and acceptance of BTF Strategies, including adult observation chart, DETECT education program, recognition and escalation of care for deteriorating patients,	• Area Health Service Newsletters • Orientation sessions to BTF/ forums /meetings • National Deteriorating Patient Workshop • Professional Body letters of support for the project	AHS Executives Medical Leaders Project Leaders		

Target Audience	Aim of communication to target audience	Communication Vehicles / Tools	Who to Action	By When	Costs
Allied Health Leaders	To engage Allied Health leaders so that they can effectively communicate with medical and nursing staff and advocate and lead the implementation process of Between the Flags in their facilities. To work with the CEC, AHS Executive, Nursing and Allied Health leaders to implement the Between the Flags strategies.	Brief to • OT Association • Physiotherapists • Pathology College			
Allied Health Professionals- Physio, OT,	To engage Allied Health Staff in the use and acceptance of BTF Strategies, including adult observation chart, DETECT education program, recognition and escalation of care for deteriorating patients,	• Area Health Service Newsletters • Orientation sessions to BTF/ forums /meetings • National Deteriorating Patient Workshop			
NSW Ambulance Service Leaders	To engage Ambulance Service leaders so that they can effectively communicate with medical and nursing staff and advocate and lead the implementation process of Between the Flags in their facilities. To work with the CEC, AHS Executive, Nursing and Allied Health leaders to implement the Between the Flags strategies	• Brief			
Ambulance Medical Retrieval Service (AMRS)/ Neonatal Emergency Transport Service (NETS)	To engage AMRS/ NETS leaders so that they can effectively communicate with medical and nursing staff and advocate and lead the implementation process of Between the Flags in their facilities. To work with the CEC, AHS Executive, Nursing and Allied Health leaders to implement the Between the Flags strategies	• Brief			

Target Audience	Aim of communication to target audience	Communication Vehicles / Tools	Who to Action	By When	Costs
NSW Ambulance Service Clinical Staff	To engage Ambulance Service personnel in the use and acceptance of Between the Flags strategies To work with AHS clinicians to improve recognition and response to deterioration, by participating in rapid response and transfer of patients.	•			

Target Audience	Aim of communication to target audience	Communication Vehicles / Tools	Who to Action	By When	Costs
Royal Flying Doctor Service (RFDS) Leaders	To engage RFDS leaders so that they can effectively communicate with medical and nursing RFDS staff and advocate and lead the implementation process of Between the Flags in their services. To work with the CEC, AHS Executive, Nursing and Allied Health leaders to implement the Between the Flags strategies	• Brief			
Royal Flying Doctor Service Staff	To engage RFDS personnel in the use and acceptance of Between the Flags strategies	•			
Hospital 'Hotel' Services staff (cleaning, food)	To raise awareness of the Between the Flags Program To encourage reporting of ill or injured patients to ward staff Report uneaten meals to nursing staff	•			
Critical Care Practitioners & ALS / Resuscitation Committees	To engage advanced care practitioners as leaders and advocates for the implementation of Between the Flags in health care facilities.	• Briefing to ALS committees • Briefing to ICU's and ED's • Australian College of Critical Care Nurses • Emergency Nurses Association • ACEM (Australian College of Emergency Medicine0 • ANZICS	CEC		
Professional Bodies (Associations, Colleges and Boards)	To engage professional associations and registration boards to communicate to their members the importance of the Between the Flags project. Tier 1- education into tertiary pre-registration courses	BTF Brief to • Health Services Union • ACHS • Tertiary Institutions including TAFE NSW (EN's) • Nurses and Midwives, Medical and Allied Health registration Boards.	CEC		
Community	To inform the community about the actions being taken to identify at risk patients and reduce consequences on mortality and morbidity. Official Launch of BTF	Media Releases Information Pamphlets for patients and families Posters in clinical areas	CEC Media Liaison (MP) DoH Media Liaison CEC Official Launch- OCT 09		

Appendix 7 Communication Strategy suggested implementation activities

LEVEL	STRATEGY	ACTIONS	RESPONSIBLE [amend as appropriate]	TIMEFRAME
Area	▪ Market BTF so it is recognised as the state program for improving recognition and management of deteriorating patients	▪ All communications, tools, products are branded with the BTF logo ▪ Common 'badging' and naming of program and the 5 elements ▪ BTF Preamble is included in all products (see Toolkit) ▪ Promote the benefits and progress of the BTF Program ▪ Promote awareness of DETECT and its benefits, as a key component of BTF ▪ Promote key messages (see Toolkit) ▪ BTF-promoted as core business in all clinical areas ▪ Roll-out Awareness Education from standard presentation (see Toolkit) ▪ Engage Medical/ Nursing / Allied Health / Management /Networks and Clinical Streams ▪ Meet with key committees / forums • Incorporate BTF into Area Orientation Program	▪ Area Executive Sponsor ▪ Area Project Manager ▪ Area Clinical Lead ▪ Area Director for Workforce Development	▪ Phase 1, 2 and 3
	▪ Minimise resistance to BTF from existing similar programs	▪ Celebrate success-of existing programs, new initiatives and recruit them as lead implementers	▪ Area Executive Sponsor ▪ DCG ▪ Area Project Manager ▪ Area Clinical Lead	▪ Phase 1
Facility	▪ Local Ownership of BTF Implementation at facility level	▪ Identify and support Clinical Champions. ▪ Ensure adequate supply of promotional materials ▪ Incorporate BTF into Facility Orientation ▪ BTF on agenda on Senior Clinician Meetings eg NUM Meetings	▪ GM ▪ DMS/DONS ▪ Facility Program Co-ordinator ▪ Facility Clinical Lead	▪ Phase 1, 2 and 3

Appendix 8 – Standard Adult Observation Chart Audit Tool.

Observation Chart Audit Tool – this is not compulsory, but is a tool that has been made available for use if you wish.

Instructions:

- Audit 10 observation charts for patients currently on the ward each week.
- Colour the box GREEN if criterion is met or is NA. (There are only 3 criteria with NA on the audit)
- Colour the box RED if criterion is not met.
- Only charts meeting ALL audit criteria, ie ALL BOXES GREEN, are considered complete.
- Score = number of complete charts for this audit

Date: / / 20___

Facility:

Ward:

	1	2	3	4	5	6	7	8	9	10	Comments
Patient Label											
Date and Time											
Altered Criteria if present are signed											
Observations graphed, not written											
Observation frequency TDS or as charted											
Pulse Rate											
Blood pressure											
Respiratory Rate											
Temperature											
O_2 Saturation (Y/N/NA)											
Oxygen (How? How much?) (Y/N/NA)											
Daily Weight (N/A)											
Observations Outside normal range											
Calls made in response to criteria being met.											
Total number of charts meeting all criteria for this audit period											/10
Percentage											%