Description/Guideline statement:
Many patients who suffer adverse events or arrests/medical emergencies will have a period of detectable deterioration prior to the event. The provision of a Patient at Risk (PAR) team, able to respond immediately to a set of designated “calling criteria” may reduce the incidence and severity of adverse outcomes; and therefore reduce mortality/morbidity and length of hospital stay.¹

Personnel:
All acute nursing sector staff
All hospital medical staff

Objectives:
1- To provide basic/first line early emergency care to patients where the relevant medical officer/s are unable to attend promptly or within a frame deemed suitable by the ward nurse responsible for the patient.
2- To define a set of “calling criteria” to facilitate early first line care to those patients whom require it.
3- To monitor/audit treatments and outcomes of all patients requiring intervention by the PAR team
4- To provide practical clinical assistance to nursing and medical staff with matters related to the critical care speciality and within the scope of practice of the Critical Care Nurse attending (eg. Re-site difficult intravenous (IV) access, assist with application of Continuous Positive Airway Pressure (CPAP) mask ).

Outcome Standards:
i) Early recognition and management of all patients with acute deterioration as defined in the “calling criteria”.
ii) Early and prompt assessment and management by the PAR team whilst waiting for the arrival of the relevant medical officer/s
iii) Improved outcomes for the patients (as indicated by such as a decrease in mortality/morbidity and length of hospital stay).

¹ Bellomo et al 2004-10-14
iv) Identification of knowledge deficit within medical and nursing personnel throughout the hospital.
v) An understanding of times of peak need for clinical interventions as supplied by a PAR team
vi) Identification of specific areas requiring PAR team intervention/assistance.
vii) Identification of common “calling criteria” in order to assist with identifying common clinical deficiencies in care.
viii) Identification of issues related to inadequate or untimely medical assistance

Equipment:
PAR team trolley
Portable monitor
CPAP delivery device

Guideline Process:

A Senior Critical Care Nurse is defined as being a Critical Care Nurse with
- an appropriate academic qualification in Critical Care, AND
- a minimum skill set of basic and advanced resuscitation competency - as assessed by NHW assessors, AND
- a broad scope of practice
- +/- Formal MET accreditation as per Southwest Area Health Service Liverpool NSW

The PAR team shall consist of Senior Critical Care Nurses.

Role of Part Team –
- Perform baseline physical assessment including 12 lead electrocardiograph (ECG) interpretation
- Initiate limited pathology and mobile chest X-ray.
- Administer supportive respiratory care including high flow oxygen, mask CPAP and non-invasive ventilation.
- Provide initial management of cardio-respiratory arrest
- Co-ordinate medical assistance/consultation

The care of Obstetric and or Paediatric patients would fall outside the scope of practice for most Critical Care PAR Team Nurses. There for it is strongly recommended that every attempt be made to contact the relevant medical officer including VMO responsible for the patients care before calling for assistance by the PAR Team.
A “not for resuscitation” decision can only be made following consultation with the admitting visiting medical officer.

**PAR Calling Criteria**

A call to the PAR Team should be made
- When a staff member caring for a patient is unable to obtain prompt attendance in a reasonable time by the responsible medical officer/s. A reasonable time is dependent on the specific clinical indicator.
- When a patient exhibits ACUTE CHANGES IN:

  **Airway**
  - Respiratory distress
  - Threatened airway
  - Difficulty speaking

  **Breathing**
  - Respiratory rate < 6
  - Respiratory rate >30
  - Acute O₂ Saturation falls to < 90% on O₂

  **Circulation**
  - Systolic BP <90 or >200
  - Pulse rate <40 or > 130
  - Unable to measure O₂ due to poor perfusion

  **Neurological**
  - Sudden or unexplained fall in the level of consciousness
  - Repeated or prolonged seizure activity
  - Sedation score of 3

OR

A staff member is seriously concerned about any particular patient
- A patient has uncontrolled pain
- Failure to respond to treatment
- Technical difficulties- IV access/ O₂ therapy/ other

Medical or Nursing Staff need advice/ consultation regarding any matter that falls within the knowledge base/ scope of practice of the PAR Team.

A PAR call will be activated by phoning the CCU on 250 or 272.

When making a PAR Team call staff should convey
- a brief clinical history and
- the level of urgency.
If CCU nurses are unable to attend a PAR call then the ward nurse must contact the Nursing Co-ordinator immediately.

When the PAR team arrives to the patient ensure
- the patient’s medical history and bed side notes are available on arrival
- The nurse responsible for the individuals care should remain with the patient and be available to assist.

A record of the PAR call will be kept and used for auditing of the service.

References:
Bellomo et al, “Prospective Controlled Trial of Effect of Medical Emergency Team on Postoperative Morbidity and Mortality Rates” Critical Care Medicine 2004 Vol 32 No 4 p916-920.

Additional Information:

Key Words:
Medical Emergency Team
Patient at Risk Team
Emergency
Criteria
Support
Cardiac arrest
CPAP
Non invasive ventilation
Difficult IV access

Formulated by: B. Johnson Nov. 2005