R.E.A.C.H.

TOOLKIT

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CLINICAL EXCELLENCE COMMISSION

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INTRODUCTION

Evidence indicates that delayed activation of a rapid response (RR) for deteriorating patients is one of the strongest predictors of mortality in patients receiving an emergency review. While clinical programs are effective, partnering with patients and families as 'care team members' (i.e. the people who know the patient best) to alert staff to patient deterioration provides additional benefit by spreading the safety net to avoid critical delays. It gives staff back time by catching deterioration earlier on.

Clinical staff may fear that patient & family activation could result in increased workload through non-urgent calls. In reality, when implemented successfully, patients and families use this facility rarely and reasons for calls mirror those identified by staff (e.g. shortness of breath). Research from the USA indicates that over 50 per cent of family activated cases require transfer to ICU which demonstrates the appropriateness and necessity of calls.

> *'I felt frustrated that no one was listening to me and no one was telling me what was going on... how long do you wait and worry before doing something?'*
>
> *Patient Relative*
>
> *REACH Call*

Promoting increased patient and family engagement supports the NSW Government's CORE Values in health through 'Empowerment' of patients in collaboration with health care providers and 'Putting the patient first'. Empowering patients and family through such strategies as patient and family activated escalation also conveys an important message that they are valued as partners in improving safety and quality.

REACH is a patient and family activated rapid response program developed in 2013 by the Clinical Excellence Commission's (CEC) Directorate of Patient Based Care, in conjunction with the *Patient and Family Activated Escalation Working Group*.

The REACH process aligns with the Australian Commission for Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service Standards, *Standard 9.9: Enabling patients, families and carers to initiate an escalation of care response*.

WHAT IS R.E.A.C.H?

REACH **is** a system that enables patients, carers, families to raise their concerns about a worrying change in condition while in hospital.

REACH **is not** a system to enable patients, carers, families to raise concerns or complaints about care received while in hospital.

The CEC has developed a patient and family-focused model with the aim of empowering patients and families to engage with staff if they notice 'something just isn't right' and to call for help if still concerned.

The REACH model builds on the surf life-saving analogy for recognition and appropriate care of deteriorating patients by encouraging patients and family to 'put their hands in the air' to signal they are 'drowning' and reaching out for help. Unlike other models, the REACH model actively promotes engagement with the treating team prior to further escalation steps taken by the patient and family.

The REACH model is a graded approach to patient and family activated escalation:

Recognise: acknowledge that patients and families can often recognise signs of deterioration before they are clinically evident.

Engage: encourage patients and families to engage with their treating team if they are concerned that 'something is not right'.

Act: enable patients and families to act by requesting a 'clinical review'.

Call: provide patients and families with an independent avenue to call for a rapid response if still concerned and other avenues are exhausted.

Help: Patients and families should be assured that help will be on its way in the form of a rapid response team.

IMPLEMENTING REACH

The success of patient, family and carer engagement rests on integrating such approaches into local processes and policies. This change to care delivery considers the above principles and is a flexible approach that ensures REACH can work 'on the ground' within your facility. Local ownership of this change is vital to ensuring changes are sustained. Success in this area is more likely if change is considered as part of an organisational response to improving patient care (rather than '*a six month pilot project*').

Identifying the need

Local health districts (LHDs) and hospitals engaged in implementing patient and family activated escalation should review local incidents to identify case examples of where an earlier response to patient or family concern could have avoided subsequent deterioration and possible death. These de-identified cases should be used to highlight real life examples of where a REACH approach could have provided benefit.

The role of leadership

The commitment and support expressed by the LHD Chief Executive for patient and family activated escalation conveys the importance of patient and family empowerment to the health service. Clear messages of support from senior clinical leaders are vital to promote implementation of this approach within the service. Such approaches embodying the principles of patient partnership should be integrated into the service and viewed as a component of an organisation-wide approach to patient-based care.

Governance should be established to link in with existing approaches to improving quality care:

- Executive sponsor – ideally the Chief Executive or designee
- Clinical sponsor – a senior clinician who can champion the REACH model as 'casting the safety net wider' and help to engage local clinical staff
- Lead site coordinator – ideally already engaged in the *Between the Flags* program to act as a local contact for the CEC and a focal contact point for the lead site
- Patient/family advisors – input from local patient and/or family representatives with recent experience of care within the service

Multidisciplinary team

The success of REACH depends on how the multidisciplinary team works. Some of the benefits of a multidisciplinary team approach include:

- Enhances teamwork and communication

- Improves care by increasing coordination of services, especially for complex problems i.e. time efficient
- Encourages team development in the following areas:
- *Shared Mental Model* (all team members know the plan for the patient)
- *Situational Awareness* (all team members know "what is going on around them")
- *Mutual Support and respect* (all team members are supportive of each other and learn to respect each other's comments)
- The opportunity is explicitly provided to focus on and clarify progress, medication, escalation and other issues with all team members[1]

Lead sites

The CEC has worked with lead sites across NSW to implement patient and family activated escalation by engaging with patients and families to improve the safety and quality of care delivery. The REACH model has been implemented by building on clinical rapid response strategies already in place.

Patient and family activated escalation will work best in hospitals that have already embedded clinical escalation processes such as *Between the Flags*.

Local implementation

CEC is available to assist sites by providing information materials for use within the hospital and education tools to help introduce staff to the process.

With the input of the CEC Patient and Family Activated Rapid Response Working Group, the CEC has developed Guiding Principles and a generic process for patient and family activated escalation. It is acknowledged that local implementation of this process will vary from hospital to hospital based the need to adapt to local resources and on local avenues available to patients to escalate care.

Debriefing and review

It is important that every REACH call by a patient or family member is considered an opportunity to learn how to improve care delivery. A local review process should be conducted after each patient and family activated escalation of care to help staff debrief and to identify areas for quality improvement. A summary report should be provided regularly to a relevant local Quality Committee and then, at intervals, information should be conveyed to the LHD Board.

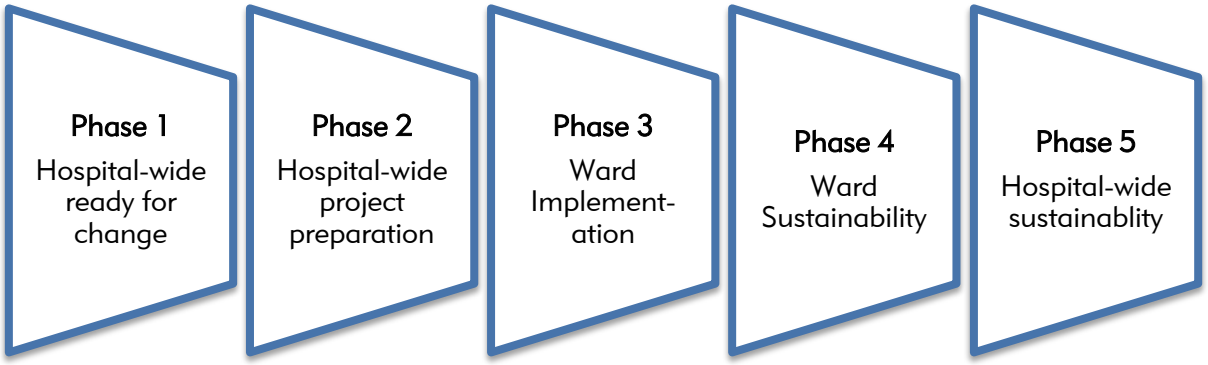
A summary report of the first 12 months after REACH has been implemented should be

[1] Adapted from CEC *In Safe Hands* program

provided to the LHD Board and relevant Local Quality Committee (see Resources for a report template).

Developing the implementation plan

An implementation plan is required to facilitate a robust process for rollout and sustainability of REACH. A five-phase approach for the implementation of REACH is recommended. While each step's strategy needs to be completed for implementation success, the approach is not linear and there is an interchange between all the phases. This includes ensuring that the initial engagement to support REACH is sustained and assessment and planning continues throughout implementation.



GUIDING PRINCIPLES

The following are the Guiding Principles of the REACH program that will assist with implementation.

Partnership

Patient and family activated escalation embodies the principle of 'partnership' and recognises patients and families as key members of the 'care team'. This can be evidenced by:

1. Informing patients and family of a *Between the Flags* 'yellow' zone categorisation when it occurs and its meaning.
2. Informing patients and family if a Clinical Review has been called and 'within a 30 minute' timeframe.
3. Facilitating patients and family directly requesting a Clinical Review.
4. Facilitating patients and families making an independent call for the Rapid Response team.

Responsiveness

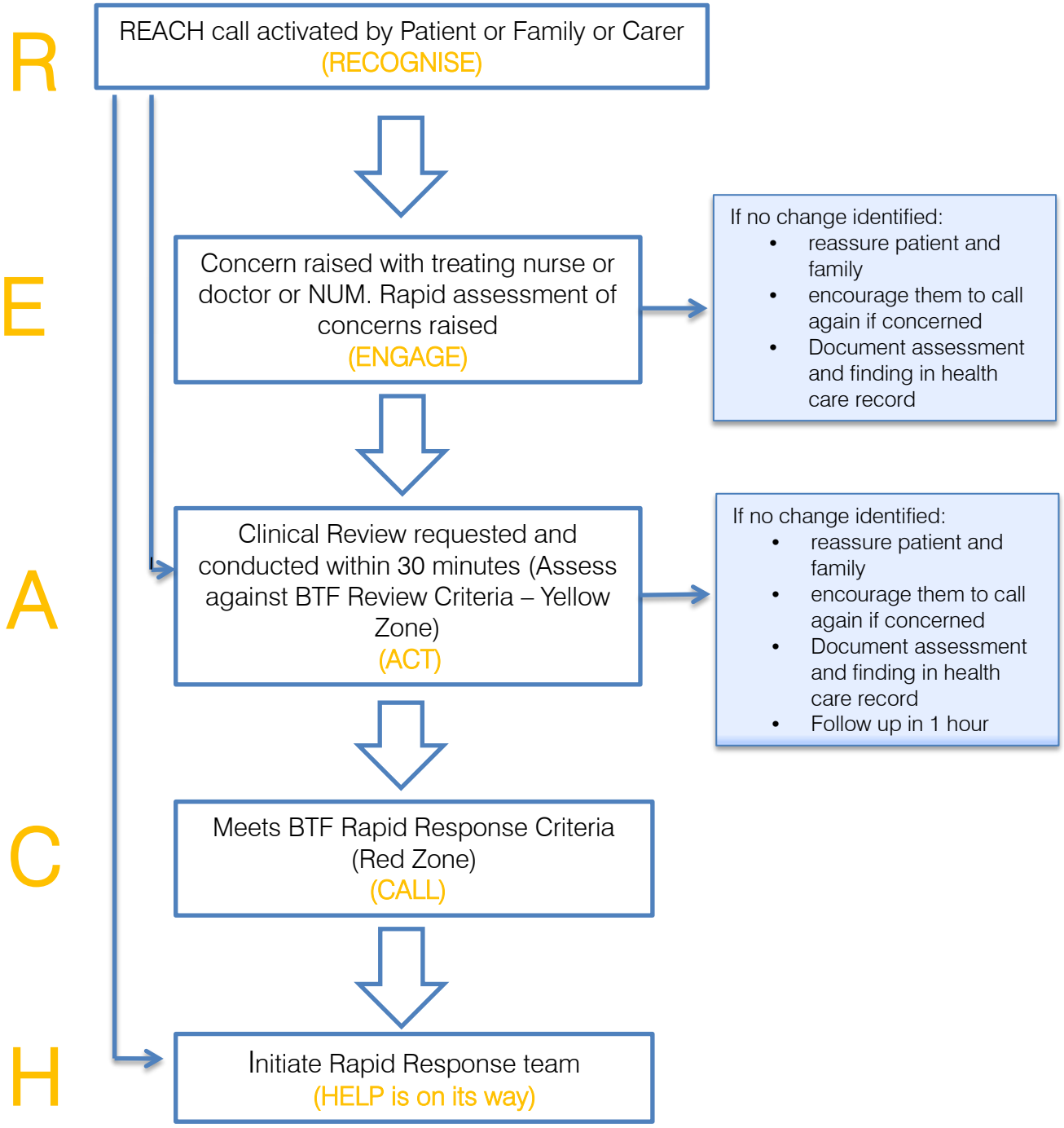
1. Staff are educated about the clinical benefits of patient and family escalated concerns.
2. Rapid response calls by patients and families will be assessed using standard criteria to ensure appropriate use of rapid response teams.
3. A senior clinician from the patient's ward will be alerted to a patient/family direct escalation call for the Rapid Response team and meet the Rapid Response team at the patient's bedside.
4. Patients for whom an escalation of care has been requested by the patient or family will be followed up within 24 hours.

Caring for all

1. Patient and family escalation is a way to '*cast the safety net wider*'. It is intended to make the work of staff easier by engaging with patients and families to help catch deteriorating patients earlier.
2. Every REACH call is an opportunity to learn how to improve care delivery. Implementation of a local review process to be conducted after each patient and family activated escalation of care will help to identify areas for quality improvement.

R.E.A.C.H. PROCESS FLOWCHART

The REACH process should be used by your REACH local working group to assist in identifying the escalation pathway for patients, families and carers activating a REACH call.



NB: if patients/family feel that their concerns about worrying changes are not addressed, they can independently escalate to a clinical review or rapid response

EVALUATION & REPORTING

The evaluation developed by CEC focuses on process impact, clinical impact, patient care experience and acceptability to staff and to patients and family. The REACH evaluation also aligns with the ACSQHC National Safety and Quality Standard*, Standard 9.9.3: the performance and effectiveness of the system for family escalation of care is periodically reviewed* and assists services to achieve *Standard 9.9.4: action is taken to improve the system performance for family escalation of care*.

The CEC evaluation measures for REACH include:

- Number of REACH calls
- Assessment of reason for each REACH call
- Numbers of patients with a change in treatment or transfer to higher care units (ICU) after patient/family activation
- Comparison of the number of clinical review requests and rapid response calls over time period with pre-implementation period
- Awareness of REACH program amongst staff and patients
- Learnings identified for improvement
- How the learnings and outcomes are shared with consumers and clinical staff.

Following a patient or family activated rapid response, discussion should take place with the patient/family or friend who activated the REACH call. A review of the response to identify factors contributing to the activation should occur and note these for compilation after a 6 and 12 month period.

Reporting

Reporting lines to governance about progress and outcomes need to be established. The CEC suggests that Lead Site Coordinators evaluate the progress of REACH using the REACH evaluation process outlined in this toolkit and utilise existing data collections for the *Between the Flags* program to demonstrate outcomes. Feedback from patients and families about the REACH model should also be included. Progress reports should be provided via the Coordinator to managers and clinical leaders and appropriate committees.

REFERENCE LIST

2016

Gill Fenella J., Leslie Gavin D., Marshall Andrea P, World Views on Evidence Based Nursing: Vol13, (4) 257-334 *The Impact of Implementation of Family-Initiated Care on for the Deteriorating Patient in Hospital: A Systematic Review*

2016

Albutt Abigail K., O'Hara Jane K., et al. Health Expectations (On Line Sept 2016) Is there a role for patients and their relatives in escalating clinical deterioration in hospital? A systematic review

2015

Vorwerk Jane & King Lindy. Journal of Clinical Nursing: Vol 25, (1-2) 38-52 *Consumer participation in early detection of the deteriorating patient and call activation to rapid response systems: a literature review*

NOTES

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RESOURCES

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Readiness Self-Assessment

- If there is a 'No' or 'Don't know' response to any of the questions, direct action is required
- If a 'Somewhat' response is chosen, further action is required
- If a 'Yes' response is chosen, no further action is required

Roles and Responsibilities/Leadership				
	Yes	Somewhat	No	Don't know
Senior management is supportive and involved in the implementation of REACH				
A clinical champion has been identified and involved in the implementation of REACH				
▪ medical				
▪ nursing				
▪ allied health				
▪ consumer				
There is an executive sponsor for the implementation of REACH				
Roles and responsibilities are clearly defined for clinicians involved in the program				
The process of escalation has been identified and the flow developed and agreed with responding clinical staff and technical staff				

Reflective Questions

I. Who is responsible for outlining the roles and responsibilities?
II. How can awareness and understanding of patient and family escalation be improved?
III. What barriers exist to adopting the necessary roles and responsibilities in the organization/facility?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Role of Multidisciplinary Team				
	Yes	Somewhat	No	Don't know
Patient care planning is currently addressed in multidisciplinary rounds				
Who participates?				
▪ medical staff				
▪ nursing staff				
▪ allied health staff				
▪ patient/nominated representative				
Members of the health care team know their roles and responsibilities related to developing patient goals of care				
There is an agreed process in place for identification and communication of patients at risk of deterioration				

Reflective Questions

I. How can a multidisciplinary approach be promoted within the facility/clinical unit?

II. What training opportunities need to be explored to adequately train clinicians around recognizing and responding to patient/family concern in a change of condition?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Measurement/outcomes				
	Yes	Somewhat	No	Don't know
The metrics/measures that the team want to use to assess the impact of REACH have been agreed upon				
▪ outcome measures				
▪ process measures				
The process for data collection has been developed				
The responsibility of overseeing the measurement activities has been assigned				

_____
_____
_____
_____
_____
_____

REACH

A program of the CLINICAL EXCELLENCE COMMISSION

INSERT FACILITY NAME LOCAL HEALTH DISTRICT IMPLEMENTATION PLAN

PROGRAM BACKGROUND

Program Title:	REACH
Program Aim:	To improve the recognition and timely assessment of patients who deteriorate through the use of a patient and family activated rapid response program
Program Background:	Patient feedback in NSW has highlighted areas where we can improve care by engaging patients and families as active partners in the care team. Incident reporting data highlighted '*deficiencies in patient monitoring*' as the second most common root cause analysis (RCA) classification in NSW. Opportunities exist for NSW health services to encourage patient and family partnership to avoid potentially life threatening delays for deteriorating patients. Promoting increased patient and family engagement supports the NSW Government's CORE Values in health through '*Empowerment*' of patients in collaboration with health care providers and '*Putting the patient first*'. Empowering patients and family through such strategies as patient and family activated escalation also conveys an important message that they are valued as partners in improving safety and quality. The REACH process aligns with the Australian Commission for Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service Standards, *Standard 9.9: Enabling patients, families and carers to initiate an escalation of care response*.
Program Benefits:	REACH : • Provides a tool to assist patients and family / carers to escalate concerns about a change in condition that needs immediate response • Simplifies key interventions to support best practice around deteriorating patients • Actively promotes engagement with the treating team prior to further escalation steps taken by the patient and family • Gives patients and carers and others close to them the opportunity to be involved in decision making about their care.
Program Objectives: Use SMART objectives: • *Specific* • *Measurable* • *Achievable* • *Relevant* • *Timely*	

SCOPE OF THE PROGRAM

Name of facility and local health district

This program will include:	This program will not include:
Which clinical wards or units will be included, or will it be a whole of facility approach?	*What is out of scope?*

Program Deliverables:	*What will you deliver at the end of the implementation process?* *NOTE: these are the products you will have at the end of the process, e.g. an education program, end of life care tools adapted for local environments, improved awareness levels etc.*
Program Milestones:	*Key activities and dates (month/year) they will be completed*
Evaluation:	*How will you measure the success of the policy implementation?* *NOTE: evaluation criteria must be specific and measurable e.g.* • *% of clinical staff who attend an education session on REACH* • *# of patients identified (RCA, Consumer feedback))who would have benefited from REACH* • *# of REACH calls*
Resources:	*What are the resources required to undertake the program?* *Consider: people, space to meet and access to a computer and internet, etc.*
Linkages:	*Are there opportunities for this program to gain leverage or support from other groups? For example: national accreditation standards, clinical handover, risk management programs.*

RISK ASSESSMENT

Program Risks	Risk Rating	Mitigation Strategy	Residual Risk Rating
What are the risks to successful completion of the program?	*(high, medium, low)*	*List strategies to remove or minimise the risks*	*(high, medium, low)*

SUSTIANABILITY PLAN

Identified barriers to sustainability	Risk Rating	Mitigation Strategy	Residual Risk Rating
What are the risks to successful completion of the program?	*(high, medium, low)*	*List strategies to remove or minimise the risks*	*(high, medium, low)*

EDUCATION PLAN

Clinicians	Unit	Type of education needs	Who will provide?
		Initial/Ongoing	

COMMUNICATION PLAN

Who do you need to engage to make this program successful?

Stakeholder	Position	What are their information needs?	How and when are you going to let them know?

PROGRAM TEAM ROLES

Executive Sponsor:	*Name and designation of Executive Sponsor* *Role of the Executive Sponsor i.e. what do they do?*		
Program Leader:	*Name and designation* *Email* *Phone number* *Role of the Program Leader*		
Clinical Leader(s):	*Name and designations* *Role of the Clinical Leader*		
Program Team Members:	*Name and designations* *Role of the Program Team Members*		
Start Date:		**Completion Date:**	

ENDORSEMENT

Facility Executive Sponsor	*Name:*	*Signature and Date:*
Facility Lead	*Name:*	*Signature and Date:*
LHD Lead	*Name:*	*Signature and Date:*
LHD Director Clinical Governance	*Name:*	*Signature and Date:*

Implementing REACH: Before you commence

Before you commence implementing the REACH program it is essential to your success that you have considered and have all of the following elements in place:

Agree there is a problem worth solving

Is the deteriorating patient an area that needs improvement in your facility/clinical unit? If so, what do you want to achieve by introducing REACH?

ACTION:

- Review data sources such as M&M findings, complaints, RCAs, MET call data and provide clinical staff with results that may demonstrate there is an opportunity for improvement.
- Gain agreement from executive and clinicians that REACH can address the identified issue/s.

Facility sponsor nominated and support processes established

Establish an Executive Sponsor who is part of the hospital executive and in a position to provide organisational support for development and implementation of the program.

A nominated ward to commence program

Choose the initial ward/s based on having engaged medical and nursing staff and an identified need to implement REACH in their ward.

A prepared ward

Prior to commencing establish a medical lead and nursing lead; develop education requirements; clinician engagement plan; and define the roles and responsibilities of all multi-disciplinary team members.

ACTION:

- Define team roles and responsibilities for medical, nursing and allied health staff
- Ensure all senior medical staff are aware of and engaged in the program
- Develop a communication plan

Governance and data collection plan

It is important to monitor report and evaluate the REACH implementation to ensure clinical practice and processes for the acknowledgement and response to patients, families, friends concerns about a worrying change in condition are effective.

ACTION:

- At Unit/Ward: Integrate with existing Deteriorating Patients/M&M/clinical review meetings.
- At Facility: Reporting can be integrated with existing Deteriorating Patient data reporting/Health Care Quality Committee reporting oversight.
- At Local Health District: Oversight for monitoring and reporting requirements from facilities should be established through LHD committee such as peak Healthcare Quality Committee.

.

Implementing REACH: Checklist

Action	Strategies/Outcomes	√
Contact CEC	Invite the CEC team to come and speak to interested parties	
Establish Executive Support/Sponsor	• Establish reporting lines/responsibilities • Overview of results from local data collection regularly	
Establish project coordinator		
Establish REACH Local Working Group	Facility Teams should consist of: • Facility Executive Lead • Between the Flags coordinator (or equivalent) • Senior Medical & Nursing Representative • Senior Allied Health Representative • Consumer advisor	
Engage with clinicians/nominate pilot facilities/wards	• Conduct focus group/discussion with teams to pull teams together and discuss what local issues or barriers around patient deterioration and the implementation of patient escalation	
Escalation process identified and agreed	• Decision made for in-hours and after-hours escalation • Decision made for one ward or all in-patient wards • Decision made for method of escalation; extension, landline, mobile, switch, 24/7 process	
Education program / Communication strategy (developed with LHD Comms)	• Contact CEC team to conduct site visit and introductory education session • Regular education to clinicians in the chosen implementation area/s. • Put posters around facility • Put article in newsletter • Attend grand rounds and specialty meetings	
Review and feedback	• Establish governance of results at LHD level • Establish regular review dates and feedback to MDT e.g. place as agenda item on M&M/clinical review meeting	
Plan your measurement	For example • Outcome measures • #REACH calls • # No of RCAs identifying non-recognition of deteriorating patient • Awareness of process measure • Audit/survey of patient/family/friends/carers' awareness. • Audit/survey of staff awareness	
Develop Evaluation plan	• Use data already collected whenever possible (BTF data) • Local evaluation of every REACH call to look at cause, outcomes and patient and staff feedback	
Implementation	• Communication of 'go live' date within implementation area/s and throughout hospital. • Get resources and localise for your facility/ward/LHD CEC-PatientBasedCare@health.nsw.gov.au	

Insert LHD logo Facility Name Clinical Unit	REACH Toolkit **Pilot Plan**	

Pilot coordinator	
Location	
Tools being piloted	

What are we trying to accomplish?

Aim statement (How good? For whom? By when? 1-2 sentences):

Problem to be addressed (Defines WHAT broadly? 2-3 sentences):

Reason for the effort (Defines WHY? 4-5 sentences):

Expected outcomes/benefits (Defines WHAT specifically, and HOW? 3-4 sentences):

Insert LHD logo Facility Name Clinical Unit	REACH Toolkit **Pilot Plan**	

How do we know that a change is an improvement?
(Identify outcome, process, and balancing measures: 4-5 sentences):

Outcome measure: Balancing measure:

What changes can we make that will lead to improvement?
(Initial activities and ideas for PDSA cycles, including key stakeholders: 4-5 sentences):

What are the constraints and barriers to success?
(Explain what the project will not address: 2-3 sentences):

Education

REACH Training Tools have been provided to support REACH local working groups to implement REACH throughout the hospital or health service. The tools are designed to be flexible and easily adapted to local situations. The scripts for educators, admissions and ward staff have been developed to provide a guide as to how best describe the REACH process.

Scripts for Educators

A PowerPoint presentation is also available to facilitate the education of staff locally. All materials are intended to be augmented with local process for activation and local case histories of incidents where having had such a process in place may have helped identify deteriorating patients earlier and saved lives.

As you are aware, our hospital has implemented the *Between the Flags* (BTF) process for clinical identification and management of deteriorating patients. To support patient and family engagement within our facility, a process called REACH is being introduced to provide patients and families with an avenue to alert staff to deterioration. The aim is to cast the safety net wider and to identify deterioration earlier and respond. This process recognises that patients and families can often detect deterioration before signs are clinically evident. REACH is a staged process of escalation firstly relying on engagement with ward staff. If patients and families escalate to the point of a rapid response, the same rapid response team process will be used as for BTF.

The avenue for patients and family activated escalation within this hospital is: <<.....>> designated phone number for patient/family activated rapid response or buzzer....

For the purposes of this program: “Family” is defined by the patient or, in the case of minors, those without decision-making capacity by their surrogates. In this context the family may be related or unrelated to the patient. They are individuals who provide support and with whom the patient has a significant relationship (*US National Consensus Project for Quality Palliative Care, 2004*).

Program leaders at hospitals already using patients and family activated escalation report that families take the privilege very seriously. If implemented properly, they don’t call for frivolous reasons. Rather, patients and families see this as equivalent to calling 000 for emergency care in the hospital.

It is important that patients and families know that you take their concerns seriously. Many will fear retribution or a decline in the quality of their subsequent care if they activate this process. Staff need to reassure patients and families that they are considered valued members of the care team and activating this process is not considered a criticism of staff.

Information brochures provided to patients and family will emphasize the importance of discussing concerns with their bedside care team first. Patients will be informed about the REACH process firstly by admissions staff or through admissions information sent out prior to arrival and then again by nursing staff when admitted to the ward/unit. <<Brochures will be provided to patients at admission>>. Posters will also be available to include in the patient’s room about how to escalate care and when to call for a clinical review or rapid response.

NOTE TO EDUCATORS:
The following two scripts for admissions and ward staff are intended to assist with providing information to patients and families.

SAMPLE SCRIPT FOR ADMISSIONS STAFF

Here at <<XXXX Hospital>>, we believe that you and your family are an important part of the health care team.

If you notice a worrying change or need urgent help, you can directly call for an emergency response by<<.... calling XXXX... or ..>>

We encourage you to first speak with your treating nurse or doctor who may be able to help you to resolve your concerns. You can request a clinical review or if you are still worried, you can call the emergency team directly.

The emergency response team (also called the Rapid Response Team) is a group of highly trained hospital staff that can be called if it appears that you or your loved one is getting sicker very quickly.

The team works with your doctors and nurses in urgent situations to address worrying concerns.

To call the team, you can just <<call.....using the hospital phone system>>. It is like calling 000 from home for an emergency.

Information is in this brochure. Please feel free to ask us any questions.
<<XXXX Hospital>> prides ourselves on providing quality care. And we consider you a partner in care.

SAMPLE SCRIPT FOR WARD STAFF

Welcome to our ward. Hopefully, on admission you received some information about what to do if you or your loved ones notice a worrying change or need urgent help. (NB: Check brochure received).

First - speak with your treating nurse or doctor who may be able to help you to resolve your concerns. If you feel your concerns are not being addressed, ask to speak to the Nurse in Charge (the Nurse Unit Manager). You can request a clinical review. If you are still worried, you can call the emergency team directly.

To call directly for an emergency response by<<.... calling XXXX... or ..>> You can do this by <<using your bedside phone or.....>>. The number is written here.....This is like ringing 000.

We believe that you and your family are an important part of the health care team. Please let us know if you are concerned.

Please feel free to ask us any questions.

We look forward to caring for you and aim to provide the best quality care. We consider you a partner in care.

Evaluation tools

The REACH evaluation material has been provided within this toolkit to assist hospitals and health services with local evaluation to demonstrate impact, effectiveness and acceptability of REACH during implementation. The CEC recommends that reports of the evaluation for REACH are provided to relevant Local Health District Safety and Quality Committees and the Local Health District Board.

The following evaluation material is provided:

1. REACH Escalation Form
   When: Immediately following a REACH call (as soon as the patient is safe).
   Why: The form should be provided to the Clinical Governance Unit or delegated Patient Safety Manager within 24 hours of the call to review incident.

2. Patient and Family Questionnaire
   When: Within 24 hours of a REACH call. The questions should be asked of the patient or family.
   Why: This provides an opportunity within 24 hours of the activated REACH call to follow up with the patient, family or carer about their experience and reasons for making the call.

3. Clinical Staff Questionnaire
   When: At 6 months, and again at 12 months after starting REACH.
   Why: This questionnaire provides an opportunity to canvas doctors, nurses and allied health professionals about their experience of REACH. It provides information on attendance at education, workload impact, engagement, and acceptability.

4. Management Questionnaire
   When: At 6 months, and again at 12 months after starting REACH.
   Why: This questionnaire provides an opportunity to canvass executives, managers and directors of clinical governance about their experience of REACH.

5. Staff Awareness Surveys
   When: At 8 weeks following implementation after starting REACH.
   Why: The survey provides an indication of how far education and training has spread within the facility. It also identifies areas where more education and training may be required.

6. Patient Awareness Surveys
   When: At 8 weeks following implementation after starting REACH.
   Why: The survey provides an indication of whether patients, families and carers are aware of REACH. It also identifies areas where more education and training may be required for staff.

1. R.E.A.C.H ESCALATION FORM

To be completed by treating nurse after situation is stabilised and returned to Manager.

1. Date: …… Time: ……

2. Location of patient/family activated escalation:

   ……

MRN:
Surname:
M/F:
DOB:

Complete or affix patient label

3. Process used by patient/carer to escalate concerns:
   - ☐ Engaged with nurse/doctor
   - ☐ Requested clinical review
   - ☐Called rapid response (REACH Call)
   - ☐Other

4. Relationship of caller to patient
   - ☐ Patient
   - ☐ Carer (name): ……
   - ☐ Family member (Specify relationship and name): ……

5. Reason given by patient/family for escalation (NB. record specific words and phrases used by patient/carer)

   ……
   ……
   ……

6. Was the reason any of the following?
   - ☐ Pain management
   - ☐ Seeking information on plan of care
   - ☐ Communication breakdown issue
   - ☐ Lack of response to buzzer

7. Please indicate if the escalation of care resulted in any of the following:
   - ☐ Remain on ward
   - ☐ Remain on ward with treating team follow up
   - ☐ Remain on ward with ICU outreach follow up
   - ☐ Transferred to another ward
   - ☐ Transferred to ICU
   - ☐ Other:……

8. Please report what changes were made to meet the patient's needs.

   ……
   ……
   ……

9. Please indicate which zone the patient's clinical observations were in at the time the patient/family/carer activated the escalation, as indicated on the *Between the Flags* bedside observation chart.

☐ The patient was in the WHITE zone, and all observations were within normal limits.

☐ The patient was in the YELLOW zone. Please let us know what observations were in the YELLOW zone:

_____

_____

☐ The patient was in the RED zone. Please let us know what observations were in the RED zone:

_____

_____

10. Were the staff happy with the outcome of the REACH activation?

☐ Yes

☐ No (if no, please tell us why) _____

Thank you for providing feedback

Date form submitted to Manager: ……

☐ Clinical Handover to Manager attended

☐ Entered into IIMS as Clinical Management: REACH call

IIMS notification number: ……

2. PATIENT AND FAMILY QUESTIONNAIRE

To be followed up by Manager (or designated officer) asking questions of the patient or family within 24 hours of escalation

Note: *In the event the patient has deceased, please ensure that any approach made for feedback is done with high levels of sensitivity and distinguished from any RCA process underway.*

Date: .....

Form followed up by (title): .....

MRN:
Surname:
M/F:
DOB:
Complete or affix patient label

Please ask the patient or family member
(depending on who initiated the escalation of care) their views on the following statements:

Ask patient/carer:	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1. I felt that I was given adequate information on how to escalate care					
3. I felt my needs and those of my loved ones were adequately addressed after I requested a clinical review or called for a rapid response					
4. I would feel comfortable calling for another clinical review or rapid response if I had to					

5. Comments from patient/family about anything else that was important to them?
.....
.....

6. Was this the first time the patient/family used this process to escalate care? ☐ Yes ☐ No

7. Did the patient/family have any previous experiences in hospital when they did not feel they could speak up/reach out to staff? ☐ Yes ☐ No

3. CLINICAL STAFF QUESTIONNAIRE

To be completed - at 6months and 12 months post-process commencement
by clinical staff involved in patient and family activated escalations

1. Date:.....

2. Position title:.....
   ☐ Doctor ☐ Nurse ☐ Allied health professional

3. Are you aware of the process used by patients/families/carers to escalate concerns if worried?
   ☐ Yes ☐ No

4. Have you directly been involved in a clinical review or rapid response as a result of a patient or family activated escalation?
   ☐ Yes – Specify your role:.....
   ☐ No

5. Did you attend an education session on patient and family activated escalation?
   ☐ Yes ☐ No

6. Did you receive any written information about patient and family activated escalation?
   ☐ Yes ☐ No

7. What do you think the impact has been on your workload of patient/family activated escalation?
   ☐ Extensive ☐ Moderate ☐ Minor ☐ Don't know

8. Did you feel engaged in the process of implementing patient and family activated escalation?
   ☐ Very engaged ☐ Moderately ☐ Somewhat ☐ Not at all

9. How acceptable has the process of implementing patient and family activated escalation been to you?
   ☐ Very acceptable ☐ Moderately ☐ Somewhat ☐ Unacceptable

10. Did you experience any barriers to implementing patient and family activated escalation?
    ☐ Yes - Specify: .....
    ☐ No

11. In your view, has patient and family activated escalation been of benefit to?
    ☐ the patients/families/carers
    ☐ the way we deliver care in our hospital
    ☐ clinicians and staff
    ☐ other: .....

    Comments:.....

12. What do you think have been key facilitators of implementing patient and family activated escalation in your hospital?
    - ☐ Executive/managerial support
    - ☐ Clinical champions
    - ☐ Support of the Director of Clinical Governance
    - ☐ Support of the Patient Safety Manager
    - ☐ Patient information (e.g. brochures and posters)
    - ☐ Information for staff about patient and family activated escalation
    - ☐ Other:

      .....

13. What advice would you have for other hospitals implementing patient and family activated escalation?.....
    .....
    .....
    .....

14. General comments:
    .....
    .....
    .....
    .....

Thank you for your time in giving us your feedback!

4. MANAGEMENT QUESTIONNAIRE

To be completed - at 6months and 12 months post-process commencement
by clinical staff involved in patient and family activated escalations

1. Date: .....

2. Position title: .....

3. ☐ Executive ☐ Manager ☐ Director of Clinical Governance

4. Are you aware of the process used by patients/families/carers to escalate concerns if worried?
   ☐ Yes ☐ No

5. Have you been engaged as a sponsor/champion for the implementation of patient or family activated escalation within your hospital?
   ☐ Yes ☐ No

6. Have you been involved in a local Working Group/Committee to implement patient and family activated escalation?
   ☐ Yes ☐ No

7. Has your Local Health District Board been updated about progress?
   ☐ Yes ☐ No – future agenda topic? .....

8. How would you rate local staff support for patient and family activated escalation?
   ☐ Very high ☐ High ☐ Moderate ☐ Somewhat ☐ Not at all

9. What impact do you think patient/family activated escalation has had on your staff's workload?
   ☐ Extensive ☐ Moderate ☐ Minor ☐ Don't know

12. Do you think staff feel engaged in the process of implementing patient and family activated escalation?
    ☐ Very engaged ☐ Moderately ☐ Somewhat ☐ Not at all

13. How acceptable has the process of implementing patient and family activated escalation been to you?
    ☐ Very acceptable ☐ Moderately ☐ Somewhat ☐ Unacceptable

14. Has the patient and family activated escalation process created any unexpected benefits?
    ☐ Yes – Specify: .....
    ☐ No

15. Has the patient and family activated escalation process created any unanticipated issues?
    ☐ Yes – Specify: .....
    ☐ No

16. Do you think that there have been any barriers to implementing patient and family activated escalation?
    ☐ Yes – Specify: .....
    ☐ No

17. In your view, who has patient and family activated escalation been of benefit to?
    ☐ The patients/families/carers
    ☐ The way we deliver care in our hospital
    ☐ Clinicians and staff
    ☐ Management
    ☐ Other: .....
    Comments:.....

18. What do you think have been key facilitators of implementing patient and family activated escalation in your hospital?
    ☐ Executive/managerial support
    ☐ Clinical champions
    ☐ of the Director of Clinical Governance Support of the
    ☐ Patient Support Safety Manager
    ☐ Patient information (e.g. brochures and posters)
    ☐ Information for staff about patient and family activated escalation
    ☐ Other:.....
    .

19. Are you aware of any feedback from patients/family/carers about this process to escalate care?
    ☐ Yes – Specify: .....
    ☐ No

20. General comments:
    .....
    .....
    .....
    .....

5. STAFF AWARENESS SURVEY

Thank you for taking the time to give us your feedback so that we can continue to improve

1. Are you aware that your hospital has introduced patient and family activated escalation of care?
   - ☐ Yes
   - ☐ No

2. Please indicate your level of agreement with the following statements:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I feel patient and family activated escalation is a demonstration of how our hospital are engaging patients and families					
I understand the process that we have put in place to allow patients and family to escalate care (referred to by the acronym R.E.A.C.H)					
I felt informed about the discussions on how patient and family activated escalation could work at our hospital					

3. Have you attended an education session in the last 12 months to inform you about patient and family activated escalation?
   - ☐ Yes
   - ☐ No

4. What type of information did you receive about patient and family activated escalation? (Please select all that apply)
   - ☐ Electronic Information
   - ☐ Verbal Information
   - ☐ Written Information
   - ☐ I did not receive any information
   - ☐ Other (please specify) _____

5. How satisfied are you about the introduction of patient and family activated escalation in your facility so far?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied

6. PATIENT AWARENESS SURVEY

Thank you for taking the time to give us your feedback so that we can continue to improve

1. Are you aware that if you are worried about your state of health that you can request a 'clinical review' or call for an 'emergency team response'?
   - ☐ Yes
   - ☐ No

2. Would you feel comfortable requesting a 'clinical review' or ‘emergency team response’?
   - ☐ Very Comfortable
   - ☐ Comfortable
   - ☐ Uncomfortable
   - ☐ Very uncomfortable
   - ☐ Unsure

3. When you were admitted to the hospital did you receive a brochure entitled "R.E.A.C.H out to us" informing you about how to raise a worrying concern about your state of health with staff?
   - ☐ Yes
   - ☐ No

4. Did ward staff (e.g. a nurse) talk to you about what to do if you are worried about yourself and feel your state of health is getting much worse?
   - ☐ Yes
   - ☐ No

5. Did you feel that the hospital staff caring for you valued you and your family/carers whilst in hospital?
   - ☐ Yes
   - ☐ No

6. Do you have any general comments?

_____
_____
_____
_____
_____
_____

Quantitative Summary Table

When: Baseline collection, 6 months, and again at 12 months.
Why: The quantitative information suggested for collection will provide evidence to further support the implementation of REACH. The CEC suggests using data collection methods that already exist through the 'Between the Flags' data collection.

X Hospital
REACH Start Date: <Day, Month, Year>

Evaluation Component	Due Dates		
	Baseline (<Month> 201x to <Month> 201x) – 12 Months Prior	**6-Months (<Month> 201x to <Month> 201x)**	**12-Months (<Month> 201x to <Month> 201x)**
1. Number of REACH Calls	N/A		
2. Number of clinical review requests over time period			
3. Number of rapid Response calls over time period			
4. Number of Root Cause Analysis that relate to deteriorating patients			
5. Number of deaths (*to compare BTF alone pre-implementation vs. BTF + REACH)*			