



NEWSLETTER

ISSUE 3

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INSIDE THIS ISSUE:

Summary of the
ACSQHC & CEC
Nov 2009
Workshop

QLD Health
Patient Safety
Centre
RMDP Program

Recent Articles
on Recognition &
Response to
clinical
deterioration

Paediatric
COMPASS

Nov 2010
Deteriorating
Patient
Workshop

Launch of Between the Flags

NSW Health is implementing Between the Flags, with support from the NSW Clinical Excellence Commission, who developed the program. The program is designed to improve recognition and response to patients when their clinical condition starts to deteriorate.

The NSW Minister for Health, the Hon Carmel Tebbutt, launched the program at Westmead Hospital in January 2010, announcing its roll out across the state.

With implementation across all NSW public hospitals, implementation is the largest of its kind and includes standard observation charts to ensure patients remain safe. Colour-coded charts have been developed in consultation with expert clinicians to include observations that are the most sensitive indicators of deterioration, including: breathing rate, blood pressure, heart rate, and level of consciousness.

The charts act as a track and trigger system where observations are graphed to track trends in a patient's condition, triggering an appropriate response if observations move into the yellow or red colour-coded zones.

The **DETECT** e-learning program is another key component of the Between the Flags Program which is required to be undertaken by all clinical staff. This stands for Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams.

The program has been designed to equip staff with the tools and key information to be able to:

1. detect signs of deterioration in patients on the wards
2. know when a Clinical Review or Rapid Response should be activated
3. provide simple and timely interventions to reverse deterioration
4. communicate effectively as a team member.

You can access **DETECT** online at:

<http://nswhealth.moodle.com.au/>

If hospitals, healthcare facilities and jurisdictions wish to use the education program, please ensure that NSW Health and the authors are recognised and that no changes are made to the content without prior written approval.

General advice on the program is available from the Clinical Excellence Commission by contacting Dr Charles Pain on (02) 9382 7832 or email charles.pain@cec.health.nsw.gov.au.

Should any jurisdiction wish to use the materials for local roll out please contact the NSW Health Clinical Safety, Quality & Governance office via email quality@doh.health.nsw.gov.au or phone Dr Paul Curtis on (02) 9391 9944.



Implementation Guide for the Consensus Statement

The Commission would like to thank everyone who responded to the call for comments on its draft Consensus Statement. All feedback has been considered in finalising the Statement which will be presented to Health Ministers in April for endorsement as the national approach to recognising and responding to clinical deterioration in Australia.

To support the use of the Consensus Statement an implementation guide will be developed to provide information on how acute care facilities can tailor systems that utilise the elements of the Consensus Statement and that best fit their setting and capacity.

The Recognising and Responding to Clinical Deterioration program team would like to welcome Ms Kerrie O'Leary who will be working with them to write the Implementation Guide.



The Implementation Guide will provide information by way of tools, worked best practice examples and case studies and will also be developed as a web-based interactive resource to allow users to easily interact with material.

In writing the Guide, **we want to hear from you**. What information will assist

you with implementing the Consensus Statement?

Do you have examples of policies, procedures, clinical pathways, audit tools or presentations and training tools, that would help other clinicians improve systems for recognising and responding to clinical deterioration?

Kerrie will be starting to contact the Commission's mailing list over the next month to request information. In the mean time, any ideas and examples can be emailed to Kerrie at kerrie.oleary@safetyandquality.gov.au or alternatively you can contact Kerrie on (02) 9263 3630.

Recognising and Responding to Clinical Deterioration: Solutions for Safe Care Workshop

The Commission and the NSW Clinical Excellence Commission held a national workshop in Sydney on 10 November 2009 to showcase current approaches and practical solutions to the problem of properly recognising and responding to patients who deteriorate in hospital. The workshop was attended by over 270 delegates from across Australia and New Zealand and was very positively evaluated.

The presentations are available from the Commission's website for download. All sessions were filmed and are available on a data DVD. To obtain a copy please email your postal details to alexandra.sonsie@safetyandquality.gov.au



Session 1: Recognition of the deteriorating patient

Chair: **Dr Robert Herkes**, Royal Prince Alfred Hospital

Mr Aaron Jones presented the results of a hospital wide vital sign survey and reported on initiatives being undertaken at RPA to improve vital sign monitoring, which has seen the gradual implementation of a Clinical Emergency Response System (CERS) since 2008.

Dr Mark Horswill presented the findings of the first phase of a project funded by ACSQHC and QLD Health involving a heuristic analysis of 25 existing observation charts. He provided an overview of the 'ADDS' chart that has been created by the research team.

Dr Daryl Jones provided an overview of the evidence on establishing MET calling criteria and the importance of setting accurate thresholds to achieve the right balance of sensitivity and specificity. Dr Jones also discussed preliminary results of the RESCUE study on the prevalence of MET activation.

Session 2: Communicating about and learning from patients who are deteriorating

Chair: **Dr Nicola Dunbar**, ACSQHC



This session focused on communication in the health care environment and began with Mr Aaron Armstrong discussing the reasons why delays in activation for emergency assistance occur and how nurses can be better supported when escalating care.

Dr Kim Hill provided an overview of ISBAR, a solution on how to improve handover processes to ensure the required information is known and acted on.

Dr Charles Pain presented on the importance of communication as a key part of the care process. He discussed the need to support teams and provide them with necessary tools to prevent adverse events.

Professor Ken Hillman explained the importance of measuring key performance indicators and providing feedback to assist system performance and organisational acceptance of systems such as MET.

Session 3: Educating staff about deterioration

Chair: **Ms Anna Green**, Western Health

This session commenced with a presentation from Professor Graham Reece on the DETECT education program, a key component of the Between the Flags Program.

Dr Brendan Flanagan provided an overview on the use of simulation training for teaching about recognition and response to the deteriorating patient, including the CONFIRM-OPTIMISE-ASSESS-TREAT (COAT) and REVIEW approach to patient assessment.

Ms Sally Squire provided an overview of the PACT project, designed to facilitate nurse to nurse handover and nurse to doctor communication of patient deterioration. Education tools developed for this project focus on patient assessment skills and assertive communication.

Dr Mary Langcake provided an overview of the Care of the Critically Ill Surgical Patient (CCrISP) course which is administered by the Australasian College of Surgeons.



Session 4: Rapid response systems in metropolitan areas

PAGE 3

Chair: **Professor Rinaldo Bellomo**, The Austin Hospital

This session provided an overview of different perspectives and approaches to rapid response systems in metropolitan hospitals.

Dr Darryl Jones presented on the Medical Emergency Team (MET) and the use of MET calling criteria, drawing on specific experience of the MET system in place at the Austin Hospital.

Ms Anna Green presented data on the implementation of a two-tier, nurse-lead ICU liaison service in place across three hospitals within Western Health. This service has been in operation since 1998 with implementation of hospital-wide calling criteria in 2002.

Dr Robert Herkes made a detailed comparison between traditional MET systems and the Clinical Emergency Response System (CERS), a multiple level system in place at RPA. The CERS has been designed to free-up ICU resources and empower ward staff.



Session 5: Care of deteriorating paediatric patients

Chair: **Dr Kevin McCaffery**, Royal Children's Hospital, Brisbane



This session focused on work that is being undertaken on the deteriorating child in various jurisdictions across Australia. Dr James Tibballs provided an overview of a one-tier MET system that has been in place at the Royal Children's Hospital in Melbourne since 2002.

Dr Jonny Taitz provided an overview of two NSW systems, Paediatric PACE, a program that has been implemented across SESIAHS; and Paediatric Between the Flags, the state-wide approach for NSW planned for rollout in March 2010.

Ms Heather Mugridge presented results of a staff survey and vital signs and MET audit undertaken as part of developing a paediatric version of the ACT Health Early Recognition of the Deteriorating Patient Program.

Ms Ruth McCaffery presented on the development of the Children's Early Warning Tool (CEWT), an observation chart with early warning scores and designed according to human factors principles.

Session 6: Rapid response systems in rural areas

Chair: **Dr Gabriel Shannon**, Orange Base Hospital,

This session provided an overview of different approaches to recognising and responding to patients that deteriorate in rural areas. Dr John Lambert provided an overview of the Greater Western Area Health Service Critical Care Advisory Service and demonstrated the functionality of a one-way video, two-way audio camera planned for implementation across 44 sites.

Mr Graeme Malone provided an overview of NSW ambulance service initiatives, including working collaboratively with area health services and participating in the Between the Flags project.

Mr Doug Gilchrist explained the challenges faced by a remote facility in the Northern Territory and the development of the system REACT'NT, based on the ACT COMPASS program.



Panel Session

Chair: Ms **Alison McMillan**, Department of Health, Victoria

Panelists: **Rinaldo Bellomo**, Austin Hospital, **Margaret Bennett**, Coffs Clarence Network, **Imogen Mitchell**, The Canberra Hospital, **Jeffrey Williams**, St John of God Hospital, Subiaco



The panel session focused on the challenges faced in the implementation and sustainability of systems for recognising and responding to clinical deterioration. Issues raised included: calculation of early warning scores, education and training, clinical judgment, funding implementation of recognition and response systems, advance care plans and approaches to end-of life-care.

Queensland Health Patient Safety Centre: Recognition and Management of the Deteriorating Patient

The Queensland Health Patient Safety Centre will be implementing a number of state-wide strategies to improve both detection and response to clinical deterioration in patients, reduce mortality and morbidity, and minimise the flow-on effects of avoiding prolonged stay and preventing unplanned ICU admissions. Proposed strategies are aimed at addressing the physiological deterioration of adults, children and women (maternity) in acute care settings.

The Children's Early Warning Tool (CEWT) is currently being validated following a clinical pilot in 12 metropolitan, regional and rural facilities involving over 1,800 hospitalised children.

CEWT is an observation chart with early warning scores designed according to human factors principles to improve usability and to assist bedside clinicians to identify and manage the deteriorating patient. Following validation, it is anticipated that CEWT will be rolled out across the state.

The Patient Safety Centre is currently obtaining feedback on the RMDP Options Strategy Paper that outlines the recommended state-wide strategies for RMDP. This paper will be tabled with the QH Executive Management Team for approval by 30 June 2010.

For further information please contact the Patient Safety Centre via email: RMDP@health.qld.gov.au or phone (07) 3636 6646.

Recent Articles

Chan P, Jain R, Nallmothu B, Berg R, Sasson C. Rapid Response Teams: a systematic review and Meta-analysis. Archives of Internal Medicine. 2010;170(1):18-26

This article is a review of 18 studies of the implementation of a rapid response team (RRT) involving nearly 1.3 million hospital admissions. Implementation of an RRT in adults was associated with a 34% reduction in rates of cardio pulmonary arrest outside the ICU, but not lower hospital mortality rates. In children, there was a 38% reduction in rates of cardiopulmonary arrest outside ICU and a 21% reduction in mortality rates (which was not robust to sensitivity analyses).

Avent Y, Johnson S, Henderson N, Wilder K, Cresswell J, Elbahlan L. Rapid response systems: The stories. The Joint Commission Journal on Quality and Patient Safety. 2010;36(1):43-45

A report of one successful use of an RRT in the paediatric oncology outpatient setting which concluded that the RRT, in conjunction with the ICU intensivist successfully detected a very ill patient and facilitated transfer to a higher level of care.

Santamaria J, Tobin A, Holmes J. Changing cardiac arrest and hospital mortality rates through a medical emergency team takes time and constant review. Critical Care Medicine. 2010;38(2):445-450

This prospective study of cardiac arrests and survival in conjunction with a retrospective study of administrative data found that within two years, the introduction of a medical emergency team was associated with a decline of unexpected cardiac arrests and unexpected mortality within four years. The authors suggest that the change in organisational practices can have a beneficial outcome.

Gazarian P, Henneman E, Chandler G. Nurse decision making in the prearrest Period. Clinical Nursing Research. 2010; 19(1):21-37

The article focuses on nurse decision making using a qualitative study of cues nurses rely on to identify and interrupt potentially preventable cardio pulmonary arrest. The nurses interviewed were able to describe organisational factors that help prevent adverse events. The importance of nursing practice and education is also highlighted. Experienced nurses are an asset in preventing adverse outcomes.

Paediatric COMPASS



ACT Health has now made the Paediatric Deteriorating Patient Program available online at their website: www.compass.act.gov.au.

compass

The Paediatric program has been developed around their existing adult program and the COMPASS education package. All of the program resources are available for download and use free of charge once you register on the website.

The paediatric education uses the same CD as the adult with the new manual incorporating both the adult and paediatric sections. The PowerPoint and 4 cases studies for the face to face session is also available.

For further information please contact the ACT Health Early Recognition of the Deteriorating Patient Program team via email compass@act.gov.au or phone (02) 6244 3885.

Next Practical Solutions Workshop - Nov 2010

To build on the success of the November 2009 workshop held by the Commission and the NSW Clinical Excellence Commission, the Commission is planning to hold a second workshop in Adelaide on **8-9 November 2010**. This workshop will be held over two days and will provide opportunities for practitioners to learn from the experts and share information in in depth workshops.

More details of this workshop will be made available in the coming months on the Commission's website and in future editions of the program newsletter.

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE

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