

Clinicians need education on the reasons for introducing the observation and response chart (ORC) and on how to use it. Training clinicians to use the chart also provides an opportunity to revisit the clinical skills of taking a set of observations and interpreting them. This fact sheet contains some strategies that may be helpful when planning training sessions about new observation and response charts.

This fact sheet is one of a series that provides specific information about the process of selecting, implementing and using an observation and response chart. The other fact sheets in this series are:

- EE1 ORC1 Introducing an observation and response chart
- EE1 ORC2 Modifying the observation and response chart for local use
- EE1 ORC3 Potential practice changes associated with implementing an observation and response chart
- EE1 ORC5 Why is it crucial to test any non-approved ORC modifications?
- EE1 ORC6 How to run a behavioural study to test chart modifications



Who needs training and how should it be approached?

It is necessary to provide training about using the charts to all clinicians involved in patient care. This includes doctors and nurses at all levels and in all specialties at your facility. It is common to provide a series of short training sessions at handover times, or during team meetings and orientation. It is useful to support face-to-face group training sessions with written information such as leaflets and posters.

Education programs about the ORC should include:

- brief background information about why recognition and response systems are needed
- familiarisation with the layout and different areas of the chart – ‘chart geography’
- skills based training where clinicians practice plotting observations onto the new chart
- brief background information about how human factors design principles have been applied to the charts and why this matters
- expectations for clinician responses when triggers for escalation of care are breached.

Training is resource intensive and time consuming. Many organisations find that implementing the charts in a staged rollout is useful to ensure that adequate training can be provided. This allows trainers to repeat sessions frequently and spend time at the bedside with individual clinicians reinforcing knowledge and skills, and helping to embed new practices. It may also be useful to identify project officers in each clinical area to support trainers and assist in troubleshooting during the implementation period.

Conducting frequent audits of the charts during the initial implementation period will help trainers to identify and target specific issues during feedback sessions.

Behavioural expectations

The ORC is one part of a wider recognition and response system. For the track and trigger system to operate effectively it is crucial that clinicians respond appropriately to triggers for action and calls for help. Training materials should include information about:

- agreed communication processes and protocols
- what to do if the expected response is not forthcoming
- how to report any incidents related to the recognition and response system - for example, when a responder does not attend in a timely fashion, or a colleague has not escalated care on a previous shift.

Clinicians who have a role as responders to the track and trigger system should also receive training that clearly outlines the expectations of that role. It is vital to the success of these systems that responders react positively to calls for help, know what is required of them, and know when and how to call for help themselves.

Answering the fundamental question: why do we need this new chart?

Most clinicians have been monitoring, documenting and interpreting physiological observations for many years. Asking them to use a system of predetermined criteria for action and response can be interpreted as an offense to their clinical judgment and experience. It is common to meet resistance when implementing an ORC. Strategies to address this resistance include:

- Using real cases from your own hospital, and the information in the *Guide to Implementation of the National Consensus Statement* (available from the Commission's web site) to develop training materials that illustrate the problems that can occur when recognition or response to clinical deterioration is inadequate.
- A powerful way to demonstrate the value of a new ORC is to plot the physiological observations of a patient onto both old and new charts. Identify a patient who may have had an adverse outcome associated with a failure to recognise clinical deterioration, or a delayed call to an emergency team. Plot their observations for the period of time before the call or adverse outcome - it is usually much easier to identify deterioration on the new chart. This will help to demonstrate where earlier action could have been taken to intervene and potentially stabilise the patient.
- Emphasise that the ORC chart does not replace clinical judgement but rather provides a validated tool for supporting clinical judgement.
- Meaningful and visible commitment to the system from nurse unit managers, senior consultants and other opinion leaders will help to counter resistance and ensure successful implementation of the charts.

Chart geography

It is important that clinicians understand the chart and how to use it.

- Develop educational posters that map each area of the chart and describe what is expected of the chart user.
- Develop a series of clinical scenarios for use in training sessions – design these so that participants can practice using each component of the chart.
- Work with clinicians at the bedside to make sure they are using the chart correctly and confidently.

Refer to the mapped charts available on the Commission's web site which clearly identify the different areas of the charts.

Human factors design: what is it and why does it matter?

Human factors is the scientific study of human capability, as applied to the design and development of systems. Human factors expertise has been used in developing the ORCs to minimise the risk of human errors incurred through poor design. The charts are designed to:

- Reduce cognitive load and processing. For example, this includes limiting the need to memorise key information and instructions.
- Improve usability and interpretation of data. For example, minimising clutter and using design features to prevent error (e.g., using a bold line every third column of the graphing area to prevent column shift when recording data).

A series of simulation experiments were conducted comparing the ADDS charts (on which the ORCs are based) to observation charts that were in common use in Australian hospitals. When participants were asked to identify abnormal observations on the charts, the ADDS charts were found to reduce error rates and improve response times.

Further information

Further information about implementing recognition and response systems can be found in the Australian Commission on Safety and Quality in Health Care publication *A Guide to Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration* (2011).

Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney NSW 2001
Telephone: (02) 91263600
Email: mail@safetyandquality.gov.au

This can be downloaded from: www.safetyandquality.gov.au