FACT SHEET Tips from the real world

The intensive care medical director

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In this fact sheet, Imogen Mitchell shares her experiences of leading the implementation of a recognition and response system, and educating clinicians about clinical deterioration. She is currently completing doctoral studies looking at the influences of systems and humans in patient deterioration including the effect of patient deterioration education.

Identifying the problem and getting started

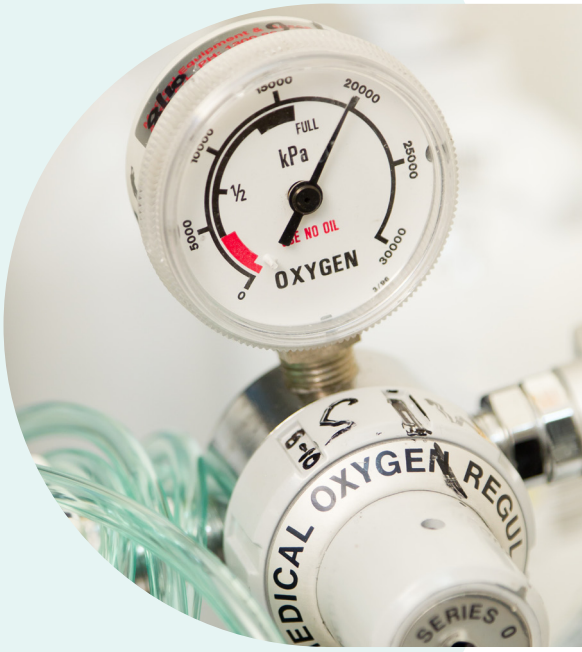
- The hospital participated in the MERIT trial so has had a medical emergency team (MET) system in place since 2003. A Clinical Review Committee was also established then and cases were reviewed by a multidisciplinary group which included junior nurses and doctors, allied health and administrators.
- We ended up having 34 people on the committee, which at times was fascinating in terms of steering it, but it worked. Because the committee wasn't run by one particular unit you got quite an objective view, and, most importantly, it was trusted by the clinicians.
- Because of issues identified by the Clinical Review Committee, a risk register was generated in 2005, and recognition of the deteriorating patient was identified as being the number one clinical risk in our hospital. In 2006 we gained funding for a project officer to pilot MEWS and the graded response system in addition to MET.
- Engaging the administrators by including them in the Clinical Review Committee was crucial – it gave us an opportunity to show them the data and get them on board.

Education

- When I was involved in setting up a medical school at ANU, I asked 15 senior academics why we do blood pressures every 6 hours or so and was met with deathly silence. This made me think, if even senior medical academics can't answer this question then how can we expect junior bedside nurses to understand the importance of what they do?
- It made sense to me that in order for junior nurses and doctors to perform and interpret vital sign observations they needed to understand why it was important – we had go right back to the physiological basics of what vital signs mean.
- We've developed the COMPASS program with the goal of helping clinicians in the hospital to think about and understand the meaning of what they do in terms of basic physiology. We now teach specific content according to specialty (obstetrics, paediatrics, psychiatry) and this has improved uptake of the course in these groups.
- In many universities, topics such as basic life support, vital signs, the Krebs cycle and oxidative phosphorylation are all taught in separate educational silos - actually they are closely related and need to be taught in a way that adds clinical meaning to theoretical knowledge. We need to get in early to teach students to link it all together with real cases so they can understand why they've learnt what they learnt.
- For me it was relatively easy to infiltrate undergraduate medical education – I work in a small jurisdiction so wear multiple hats, one of which is sitting on curriculum committees. I pushed very heavily for basic physiology, and how that relates to assessment at the bedside, to be included as a core element of the undergraduate curriculum.
- Although traditionally undergraduate medical courses have been set in stone and it has been difficult to influence what is taught, there are more opportunities for leverage now. Health Workforce Australia, the Australian Medical Association and university accreditation processes are driving a change so that graduates come out with much more defined learning outcomes and competencies – this is a great opportunity to get the management of clinical deterioration onto the curriculum.

So, what next?

- We simply can't keep running hospitals the way we are doing it at the moment – this is a bigger issue than just the deteriorating patient, but these patients are at the pointy end of the problem.
- Engagement of senior clinicians outside intensive care remains one of our biggest deficiencies. You hear arguments that ICU outreach and MET are deskilling ward clinicians but really I think these systems have been developed in response to a gap in people's skills – we need to develop long term solutions to address this gap.
- Decision making amongst junior staff is an enormous issue – we have woefully inexperienced staff who simply won't make decisions at two o'clock in the morning when they are too frightened to call the consultant. As consultants we need to try to understand how we influence juniors in terms of what they do or don't do and take responsibility for developing better systems.
- In the short term we need more senior doctors and nurses looking after patients, particularly in the 70% of the week that is out of hours.



My top tips

- Never accept the status quo.
- Data is power – collect it, share it, use it.
- You can never do enough talking – engage and communicate anyhow, anytime and everywhere.
- Avoid being a lone voice – find the opinion leaders and decision makers amongst the core groups and ask them to approach their peers. Large groups of specialists can be very defensive and difficult to win over - start one on one and present cases to illustrate the problems.
- Never give up – it can be tough as you are often greeted with negativity, but you have to be persistent and have hard facts that no one else can argue with.
- Remember it's all about the patient, and that what you are doing makes a real difference to what happens to the patients in your hospital.

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* (2012). This can be downloaded from:

www.safetyandquality.gov.au

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