FACT SHEET Tips from the real world

Recognising and responding to deterioration in a remote hospital

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In this fact sheet Doug Gilchrist shares his experiences of implementing a recognition and response system in a remote hospital.

Gove District Hospital serves East Arnhem district, which has a population of 16,000 people who are spread across 33,000 square kilometers. The hospital provides eight obstetrics beds and manages in excess of 200 births a year. There is also an emergency department, a 20 bed ward that admits adults and paediatrics, a medical imaging department and a pharmacist. The nearest tertiary hospital is at least six hours away (door to door). Doug implemented the COMPASS system (which was originally developed at the Canberra Hospital). This uses a modified early warning score (MEWS) to trigger escalation of care.

Planning and implementing our recognition and response system

- The first year I was here I observed that we frequently had to emergently transfer sick patients and I was concerned about the number of patients who required intubation prior to transfer. I reviewed cases and found that either people were being admitted already very unwell, or they were deteriorating in the hospital and we were not picking this up early enough.
- In March 2009 some colleagues and I went to the Safe Patient Care Health Roundtable where we learned about early warning scoring systems being used in the United Kingdom to enable earlier recognition of deteriorating patients. I was very interested in how such a system might be applied at our hospital.
- I'm very lucky that in a small hospital like this I am already two parts of the executive – it made things much easier as the buy in and commitment to this project was already there!
- We were told about the COMPASS system that was available for free from the Canberra Hospital and I sent three nurses down to undertake the train the trainer program and bring back the package to Gove.
- After two months of pre-planning we introduced the program over a three month period. We ensured that at least 80% of nursing staff and 100% of doctors had done the four hour COMPASS training session before we rolled out.
- Our Nurse Practitioner ran a concurrent program about physical assessment to enable nurses to undertake a comprehensive systems assessment on any patient scoring over the trigger threshold.
- I appointed a safe patient care nurse one day a week because I realised this required a lot of ongoing work – her main focus was on getting the system up and running and doing evaluation to make sure it was working.
- Because we're at least six hours away from help we really don't want sick people here. We don't have a high dependency unit or access to on-site specialist help - we had to make adjustments to the MEWS triggers to make sure that we had a very low threshold for review and referral on.
- We've probably got the tightest MEWS escalation you'd want to have. I thought I'd get some repercussions from the staff but they've all embraced it. I think this is because when patients are really sick in our tiny hospital it can be very scary - we just don't have the resources to properly manage them.

Learning from our experiences

- Getting it right is an ongoing process - we found the initial MEWS escalation protocol was too open to interpretation. There were issues where people didn't do observations frequently enough, or didn't call for help because they didn't want to wake the second person on call. We had to modify the protocol to be really specific and clear about what the actions and expectations were.
- Regional inconsistencies were problematic initially. We were talking MEWS when referring sick patients but staff at Careflight and Royal Darwin Hospital didn't know what we were talking about. We had to co-operate and introduce the same tool across the board so that we were speaking the same language.
- We still sometimes get patients in from the remote clinics with a MEWS of 10 or 11 because their deterioration hasn't been recognised early enough - that needs to change. I'm currently working on rolling MEWS out to the remote clinics in our region.
- Good governance means monitoring the system consistently and passionately, and following up - otherwise things slip by the wayside. I got a bit of a wake up call late last year when I found that there were a number of staff who hadn't done the online COMPASS training. My solution was to say that nurses were not allowed to enter vital signs onto the chart until they had done the training - your peers very quickly pressure you into completing the training if they have to write the vital signs in for you!

My top tips for implementing a recognition and response system in a remote hospital

- The executive need to be fully supportive of what you are doing because essentially you are telling people you are not comfortable with they way they are managing clinical care. You're taking them back to the basics and for clinicians this can be a bitter pill to swallow.
- You can't sit back on your laurels and think when the system is in it's in. You need to have sufficient trainers available to hold courses regularly and you need extra sessions to touch base and make sure everyone still understands why we do all this.
- In smaller hospitals you have fewer resources so you need to be very mindful that lower trigger thresholds are necessary – you can't just call a paediatrician or take the patient up to ICU.
- You need to develop relationships with the hospitals, transport agencies and clinics in your region – it is very important that clinicians are all speaking the same language when discussing the referral of deteriorating patients.
- Find ways to keep the deteriorating patient at the forefront of people's minds. I have recently introduced a handover protocol where the first thing that is discussed at every shift handover is the patients who are triggering MEWS. This means I can sleep better knowing that MEWS patients are visible and discussed as a group at least three times a day.
- As a Director of Nursing in a small hospital, do regular rounds to ask questions - find out about what is going on and take nothing for granted. Otherwise there'll be an event and it's only then that will you hear about issues that need to be addressed. There are a lot of people with fantastic ideas for patient safety but they don't come forward – you need to get out there and talk to staff, ask them what keeps them up at night!
- Make audit reports and results relevant to individual staff – involve them in data collection and case review. As well as conducting observation chart audits, we log, review and analyse every case of a MEWS of 4 or more.
- Sometimes simple solutions are the best ones. I observed that respiratory rates were really badly done and that many nurses didn't have watches - I bought them all a fob watch for Christmas and have made them part of the standard uniform. Buying a hundred fob watches is much cheaper than transferring a sick patient to Darwin.
- Think about how you can do things smartly and consider how technology can help you. We have internet pathway cameras which are so powerful they essentially allow the consultant in Darwin ED to be there in the room with you. A picture paints a thousand words – reporting a set of observations over the phone sometimes isn't enough and this technology allows specialists to give advice and assess the need for transfer in a much more immediate way.

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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