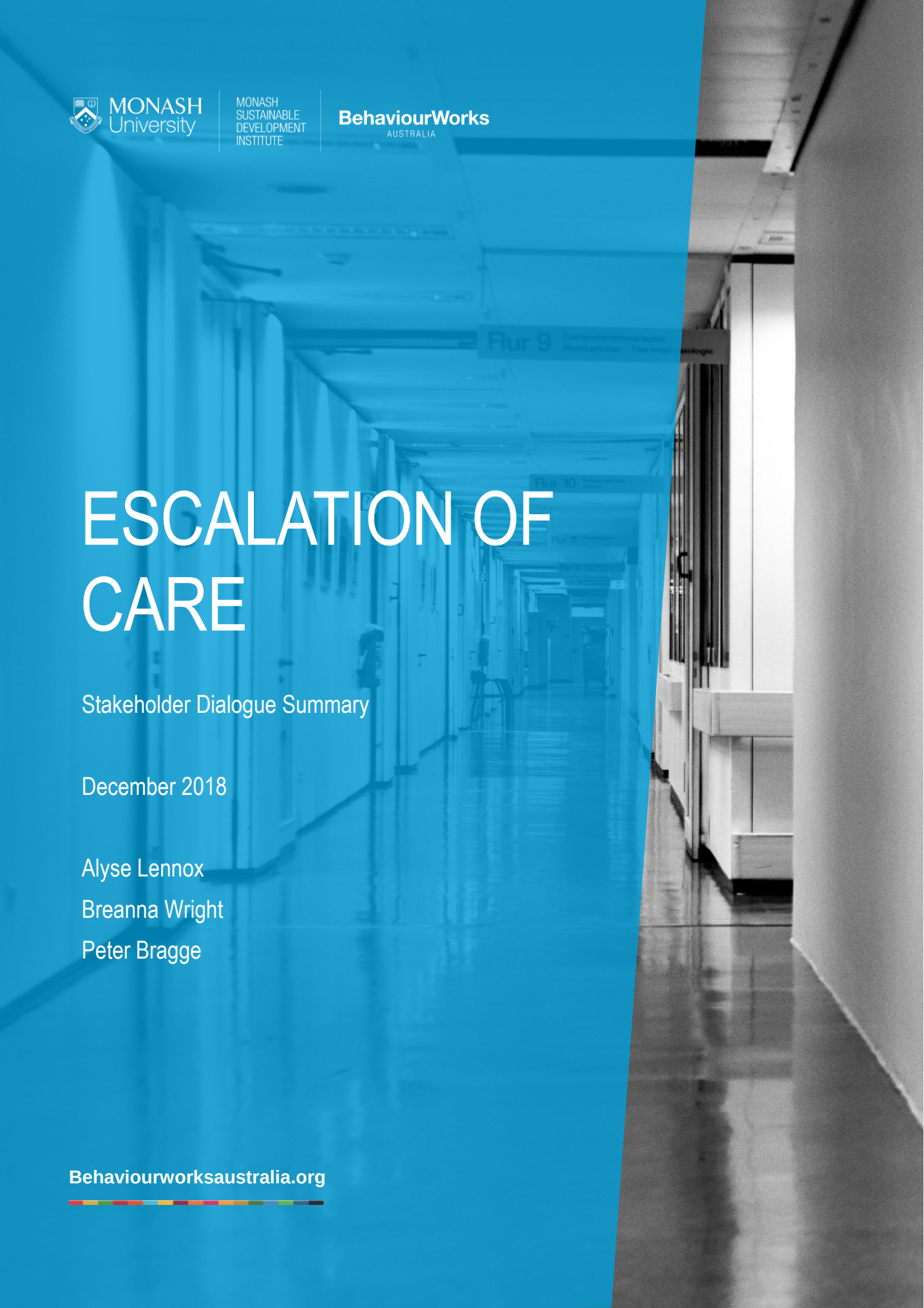

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BehaviourWorks AUSTRALIA

ESCALATION OF CARE

Stakeholder Dialogue Summary

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Alyse Lennox
Breanna Wright
Peter Bragge

Behaviourworksaustralia.org

ESCALATION OF CARE: STAKEHOLDER DIALOGUE SUMMARY

Authors

Alyse Lennox, BPsych(Hons), Research Assistant, BehaviourWorks Australia, Monash Sustainable Development Institute, Monash University; Melbourne, Australia

Dr Breanna Wright, PhD, Research Fellow, BehaviourWorks Australia, Monash Sustainable Development Institute, Monash University; Melbourne, Australia

Associate Professor Peter Bragge, PhD, BPhysio(Hons), BehaviourWorks Australia, Monash Sustainable Development Institute, Monash University; Melbourne Australia

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BehaviourWorks Australia
Monash Sustainability Institute
Monash University, Victoria 3800, Australia
+61 3 9905 9656
behaviourworksaustralia@monash.edu

EXECUTIVE SUMMARY

A day-long, structured stakeholder dialogue was convened on November 26, 2018 to address the issue of *"Improving escalation of patient deterioration in the hospital setting"*. This project was funded by the Victorian Managed Insurance Authority (VMIA). The dialogue was attended by 16 people representing government, insurance, clinicians, media communications and research. A briefing document summarising findings of a rapid review of academic evidence, practice interviews and citizen panel outcomes pertaining to this topic was sent out to all dialogue participants in advance of the day. The dialogue had three aims:

1. **Gain a shared understanding of evidence, practice and key issues relating to escalation of patient deterioration in the hospital setting.**

The biggest challenges to escalating deterioration include:

- Failure to complete basic observations and/or document them
- Fear of hierarchy
- 'Normalising' concerns (e.g. explaining away)
- Lack of risk awareness
- Lack of skills/knowledge/competence
- Failure to encourage patients and families to recognise and escalate deterioration and listen to their concerns

2. **Identify interventions to improve escalation of patient deterioration that could be trialled and scaled across Victoria**

Detection of escalation can be addressed through policy (i.e. 4-hourly observations), while recognition can addressed through education and training. While it was acknowledged that initiating the Medical Emergency Team (MET) system is a relatively smooth process with defined behaviours, there are no defined behaviours surrounding pre-MET conversations. These conversations can be difficult to initiate due to hierarchy and culture and staff may receive inappropriate responses e.g. pushback or anger. Staff who need to escalate deterioration must be empowered to do so and the person responding needs to do so appropriately. This was identified as an appropriate focus for a trial.

The discussion unpacked what good and bad escalation conversations looks like. There was consensus that conversations should be calm, respectful, succinct and non-judgmental. Both the initiator and responder should have clear expectations about their roles.

3. **Prioritise an intervention and determine measures of success**

A range of suggested options centred on improving escalation conversations arose in the discussion. The most popular components included:

- Training that covers the expectations of the initiator and responder during an escalation conversation
- Opportunity to practice these conversations using role play / simulation

INTERVENTION DEVELOPMENT

FOCUS AREA FOR AN INTERVENTION TO IMPROVE ESCALATION OF DETERIORATION

There are five stages of escalation of care, each of which involves challenges and barriers to action. These are:

- **Prevention** (preventing deterioration from occurring in the first place)
- **Detection** (measurement of vital signs and observations)
- **Recognition** (recognising that there is a problem)
- **Escalation** (initiating pre-MET or MET to address the deterioration)
- **Response** (by senior clinicians or MET)

Potential interventions to improve detection of deterioration need to focus on policy surrounding frequency of observations, while recognition of deterioration could be improved through the provision of education and training. The initiation of a MET is a relatively smooth process as it has well-defined criteria, response timeframes and scripts. While the pre-MET stage also has defined criteria and an expected response time, there are no expectations around conversations. This stage was deemed to be an appropriate focus for a trial as these conversations can be difficult to initiate, due to hierarchy and culture, and there is also room for improvement, such as reducing pushback, in responses to concerns. Furthermore, ensuring that patients and their families know how to raise concerns and are responded to appropriately is also important, given that all hospitals will soon be required to have a system in which patients and their families can escalate deterioration.

THE INTERVENTION

Intervention

To address the barriers involved in the escalation / pre-MET stage, an intervention that provides participants with training on the expectations of the initiator and responder during an escalation conversation could be effective. This could also be enhanced by simulation or role-play to practice skills in navigating these conversations. The intervention could also draw upon insights from debriefing, structured planning huddles, challenge checklists, mindfulness and learning from previous experiences.

The following resources/tools could be drawn upon to develop the intervention:

- Non-technical skills research conducted by Stuart Gillon
- Microteams research conducted by Charles Pain
- Second victim debrief research conducted by Susan Scott
- First 3 minutes
- PACE (Pose, alert, challenge, escalate)
- Night team model
- Name tags
- MET running sheet
- MET scripted pad
- Nightlife program

Delivery mode

The intervention could be delivered face-to-face, however it does not need to be time intensive. The use of clinical champions was proposed and the 'train the trainer' approach could also be adopted. Other delivery modes include video simulation.

Target audiences

The intervention should be provided to multiple disciplines including ICU staff, consultants, registrars, junior doctors, nurses, patients, families, clerical staff, allied health staff and volunteers as it is a team responsibility to address deterioration. It should be co-designed with consumer input. It was acknowledged that it would be difficult to focus the intervention on one condition because symptoms aren't always specific.

POTENTIAL INTERVENTION OUTCOMES

- Confidence to initiate a conversation/make a call
- Self-reported attitudes and beliefs
- Duration and number of calls
- Knowledge and awareness of roles
- Qualitative/focus group reflection
- Feasibility/cost
- Victorian Public Sector Commission (VPSC) 'People Matters Survey'

IMPLEMENTATION CONSIDERATIONS

It was acknowledged that as staff workloads have increased, education/training time is no longer protected. Implementing an intervention involving training would require buy-in from the hospital Executive Team in order to provide staff with time to participate. Furthermore, implementing an intervention using a top-down approach is likely to be the most effective approach, as seen with the implementation of the MET system.

KEY THEMES OF THE DISCUSSION

CURRENT CHALLENGES TO ESCALATING DETERIORATION

Detection and Recognition

- There were concerns that staff may not be completing basic observations or documenting them which increases the risk of missing deterioration.
- Participants also suggested that staff are not primed to be looking for deterioration, particularly in patients who are 'typically well' e.g. maternity patients.
- The risk for failed escalation is greater in regional/rural areas because they don't see deterioration as often.
- There are often peaks in MET calls after shift changes because new staff come on and notice previously unrecognised deterioration.
- Staff need to listen to patient and family concerns and view them as an additional safety net, rather than a failure to recognise deterioration themselves.

Escalation and Response

- Culture and communication were consistently raised as issues contributing to poor escalation.
- Despite well-established protocols, staff are still reluctant to escalate deterioration, especially in an unfamiliar environment and culture i.e. agency nursing staff, staff turnover.
- Leaders set the culture in an organisation and staff may not be given explicit (or implicit) permission to escalate deterioration.
- Hierarchy often prevents further escalation – for example, senior staff may normalise concerns by arbitrarily changing or dismissing clinical thresholds for escalation.
- The MET criteria were stated to be sensitive but not specific, resulting in excess MET and pre-MET calls which teams are not always resourced to deal with.
- The MET criteria put patients into 'siloes' when they may not necessarily require a MET, consequently limiting clinician ability to use their judgement to manage a patient.
- The gap between what doctors are expected to do and what they can do is increasing, which means they are often inexperienced at managing deterioration.
- The current passive methods which inform patients and families about how to escalate care (e.g. via posters and leaflets) were viewed as inadequate.

ESCALATION CONVERSATIONS

During an escalation conversation, both the initiator and responder should have clear expectations of their roles. Outlined below are characteristics of good and bad escalation conversations.

Good	Bad
• Primed mindset • Calm • Respectful • Listen and then ask clarifying questions • Communication of pertinent information • Succinct • Mindful, meaningful connection • Non-judgmental i.e. recognition that handover may be imperfect • Tailored to capability • Permission to obtain a second opinion	• Normalising • Confirmation bias • Insufficient information • Irrelevant information • Communicating under stress/panic • Inappropriate referral • Anger

NEXT STEPS

- Assemble steering group
- Identify trial sites
- Liaise with Safer Care Victoria to coordinate site selection
- Fine tune the intervention based on individual site requirements

APPENDIX 1: BACKGROUND AND METHODS OF THE STAKEHOLDER DIALOGUE

The stakeholder dialogue was convened to enable a comprehensive discussion of relevant considerations (including research evidence) about a high priority clinical or system issue in order to inform action. The key features of the dialogue were:

1. It identified an issue that was considered a high priority;
2. It focused on different features of the problem, including (where possible) how this differed across settings and contexts;
3. It was informed by a pre-circulated briefing document that summarised contextual information on the current situation;
4. It brought together parties who would be involved in or affected by future decisions related to the issue;
5. It engaged a facilitator to assist with the deliberations;
6. It allowed for frank, off-the-record deliberations, by following the Chatham House rule:

   'Participants are free to use the information received during the meeting, but neither the identity not the affiliation of the speaker(s), nor that of any other participant, may be revealed'; and

7. It did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue aimed to connect the information from the briefing document with the people who can make change happen, and energise and inspire the participants by bringing them together to address a common challenge. This use of collective problem solving can create outcomes that are not otherwise possible, because it transforms each individual's knowledge into collective 'team knowledge' that can spark insights and generate action to address to issue. The dialogue summary was prepared based on notes of discussion taken independently by a BehaviourWorks Australia staff member (audio of stakeholder dialogues is not recorded). These notes were analysed to identify key themes and other information relevant to identifying priority areas.