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COMPETENCY, CAPACITY AND CONSENT

- Patient must have **competence** (or capacity) to give **consent**
- **Competence**

A Patient must have CAPACITY to be COMPETENT to give CONSENT

  - Must be able to **comprehend**
  - **Retain** treatment information
  - Consider or **process it** to reach a decision
  - **Clearly communicate** a choice, with reasoning
  - ASK PATIENT IF THEY UNDERSTAND, and PARAPHRASE IT BACK INDICATING THAT THEY UNDERSTAND THE *CONDITION, TREATMENT OPTIONS, RISKS, BENEFITS, ALTERNATIVES AND CONSEQUENCES*
  - The patient should have a Mini-mental or Abbreviated Mental state exam done and a neuro exam.

- Where a patient is unable to give or refuse consent, it is ***NOT NEEDED IN AN EMERGENCY*** where treatment is required to:
  - Save their life
  - Prevent serious injury to a person's health
  - To prevent suffering serious pain or distress

In this case, the patient can be treated under DUTY OF CARE

- Patients **DO NOT HAVE COMPETENCE / CAPACITY WHEN..**
  - Heavily intoxicated (failing the 'capacity' testing above)
  - Unconscious (temporary medical conditions)
  - Mental illness
  - Intellectual Impairment
  - Dementia
  - Brain Damage
  - Child < 14 years old

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LEAVING AGAINST MEDICAL ADVICE

- Ensure **patient safety**, and consider lethality vs relative benign nature of their presentation.
- **Listen** and allow patient to express ideas and concerns
- **Acknowledge and apologise for distress** as appropriate (if long wait)
- **Encourage them to stay** for assessment
- Consider initiating **investigations** if appropriate whilst waiting for assessment (ECG, X-Ray)
- Assess patient's **capacity/competence**
- Consider treating them under **duty of care** if serious or potentially lethal problem and patient not competent (restrain as appropriate)
- **Recruit help of their friends** / relatives if appropriate
- If determined to leave and competent / has capacity, **advise to follow up with Primary Care** Provider ASAP, advise of alternatives (GP after hours) and **safety net** ('Seek urgent medical attention if increasingly unwell or concerned')

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VIOLENCE IN THE WORKPLACE

- Duty of care - **Safety of patient and staff is paramount**
- Remove Staff member from Area
- **Attempt verbal De-escalation** (calm, non-judgemental, offerings of piece, patient ideas, concerns, position yourself adjacent to the exit)
- **Show of force –-> Physical and Chemical Restraint** (IM droperidol 10mg, rpt once, then ketamine 4-5mg/kg IM)
- **PPE for all staff**
- **Monitoring post sedation** (HR, pulse Ox, sedation score - document)
- Remove physical restraints when possible

- **Deal with Staff**
  - Remove
  - Treat injuries
  - Replace them if necessary
  - Work cover Certificate

- **Deal with Patient**
  - Ongoing monitoring and care
  - Rx medical issues
  - Refer appropriately (D & A, Psychiatry, General Medicine for delirium, Social worker)

- **Deal with Department afterwards**
  - Risk Management (incident reporting, Staff health follow up, ensure duress buttons are available for staff, ALERT on PiMS/iPiM)
  - Quality Improvement (Investigate, form or review protocols, education and training for staff)

- **Red Flags for violence** - Male patient, drug / alcohol intoxication, previous Hx of violence to health care workers or others, Staff 'Gut Feeling'

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COMPLAINT (ABOUT MISSED FRACTURE OR TREATMENT)

- **Acknowledge** the complaint / problem (ideally ASAP, within 72 hours certainly, give a time limit for response)
- **Deal with the problem personally**, as the senior medical officer
- **Medical care for patient** (arrange them to come in, attend medical care if needed)
- **Open disclosure** with patient
    - **Apology** of expression of regret
    - **Explain what happened**
    - **Allow patient to speak** and express their feelings, concerns, ideas
    - **Discuss** any potential consequences
    - **Assurance of steps being taken** to manage the event and prevent recurrence
- Ensure careful and adequate **documentation** of all meetings and events
- **Notify stakeholders** (Staff involved, ED director, GP, Medical Indemnity Insurer, media as appropriate)
- **Ongoing Support**
    - **Staff** / doctor involved (exclude blame, promote education - **2nd victim**)
    - **Patient** involved and their family

- **Investigate** the Case
    - Maybe both **internal and formal** (RCA and incident management)
    - **Gather information** (clinical notes, talk to staff involved)
    - Assess **System, Process and Individual Factors**
    - Define **Corrective steps** (protocol, education)
    - **Make Changes** (M and M education, formal radiology interpretation/orthopaedic teaching)
    - **Audit** after a set time period (6 months)

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DEALING WITH A CRITICAL INCIDENT ON THE FLOOR

- **Take over / take leadership** of the clinical situation
- **Ensure the rest of the department** is well covered
- **Support of doctor** involved - continue the case vs handover and debrief
- **Document** the case and all procedures
- Consult stakeholders
  - **Open disclosure** to the patient and family
  - **Inform ED director**, IP team, Medical Indemnity Providers

For causal factors when an incident occurs related to a medical procedure (such as CVC line insertion..consider :

Systems - Poor protocols/guidelines, inadequate training or supervision

The Process itself - patient, equipment, operator and environmental factors (asepsis, use of US, correct kit used, etc..)

Individual factors - patient selection, tired or impaired clinician etc

- **Investigate factors**
  - **Systems** (as per RCA)
  - **Processes** (Indications for a treatment or Ix, alternatives, appropriate equipment, training and support for a procedure)
  - **Individual** (follow up with the doctor involved - **the 2nd victim** - Time off, EAP/Employee Assistance Program, **exclude blame and educate**. If dangerous or impaired, notify AHPRA and advise to notify indemnity insurer, send home).
- **Follow up**
  - M and M
  - Education opportunity
  - Develop or review a guideline
  - Audit

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PATIENTS WHO DID NOT WAIT (DNW)

- Principles as for **Leaving against medical advice**
  - **Acknowledge and apologise**
  - **Patient safety** and potential lethality
  - **Competence / capacity**
  - Encourage to stay
  - **Enlist friends /family** members
  - **Provide alternatives**
  - **Safety Net advice**

- **This is an ED KPI. Acceptable rates are < 4%**. Demonstrable **association with higher mortality and adverse events** than patients who are seen by a doctor.

- General Causes / risks
  - **Long wait to be seen**
  - Young male
  - **Paediatric Patients**
  - Indigenous
  - **Lower acuity / lower triage categories**
  - Social / behavioural issues

- **Strategies to manage** increasing numbers of DNW
  - **Systems** (whole hospital approach to access block and surge which is usually the cause, waiting room design)
  - **Processes** (WR Nurse / CIN nurse, models of care such as SAS and Fast Track Area, alternate referral services like GPAAH)
  - **Individual** (Staffing skill mix and rostering)

- **Follow up** (follow up phone calls, audit as per QI cycle)

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THE QUALITY IMPROVEMENT CYCLE (QI CYCLE)

- In essence the question will be along the theme of ***'Something in ED is not working very well or below expected performance / KPI. What are you going to do about it?'***

- This means ..
  - **Plan** (….some sort of change. Acknowledge the issue, understand it, and gather information / consult stakeholders)
  - **Do** (Implement the change) - Formulate a response, disseminate for comment, then implement it
  - **Check** (Monitor, review, change and audit)
  - **Act** (revise/review plan and repeat cycle)

- **Some ED KPIs** (these can be the 'something' that is failing, and the theme of the question)
  - ATS Compliance
  - Access block %
  - DNW %
  - Time to analgesia / antibiotics / thrombosis
  - NEAT Compliance
  - Admission rates
  - Staff retention and sick leave
  - No of deaths in ED
  - Number of complaints
  - Notes Audit
  - Missed Fractures / pathology audit

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DESIGN A GUIDELINE / WRITE A PROTOCOL

- **Acknowledge and identify need**
  - Benefit to patient care
  - Benefit to the department through standardisation

- **Gather information**
  - Current evidence
  - Involve stakeholders (ED Physician colleagues, specialists - Cardiology, Gastroenterology, ENT, etc)
  - Consult your local Clinical Governance department
  - Benchmarking (see what other hospitals, Heath Services or Countries do)

- **Formulate a draft and circulate for comment**
- **Implement a Pilot** and gather feedback
- **Implement the guideline** and provide staff education
- **QI cycle** (audit)

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DEALING WITH AN IMPAIRED COLLEAGUE

- **Privacy, discretion, transparency and confidentiality** are key
- **Acknowledge** complaint about staff member
- **Gather Information**
    - From those making the complaint
    - From the staff member involved **(dignified and non-judgemental approach)**
    - **Ask about physical or mental well being** (6B's - bonkers, booze, boys/girls, bereavement, blues, bank)

- **Explain that the behaviours must stop**
    - Treat any specific issues
- **Offer support**
    - At work - alternative duties, meetings with mentor
    - Outside work - involve GP, EAP, psychology/psychiatry

- **Give a timeframe** for change, and then a follow up meeting
- **Report any significant issues to AHPRA** and Hospital Administration

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DESIGN AN ED – JUST WALK THROUGH YOUR OWN ED IN YOUR HEAD AND IMAGINE WHAT YOU SEE..

- General
  - Rapid Access to all areas, wide corridors, non-slip floors
  - Group Clinical areas around staff station
  - Some natural light
  - Gas outlets, power points, IT points, phone points, scavenger outlets
  - Surge and cardiac protected areas
  - Monitored areas, call bells, access to bathrooms, and privacy (curtains or individual treatment cubicles)
- Clinical Areas
  - Resus room
  - Acute treatment area
  - Single rooms
  - Isolation room
  - Acute mental health area
  - Plaster and procedure rooms
  - Staff Station
  - SSU (Short Stay Unit)
- Clinical Support Areas
  - Dirty and clean utilities
  - Store room
  - Pharmacy and medication rooms
  - Bathrooms and shower
  - Distressed relatives room
  - Blanket warmer and Linen Trolleys
  - Drinking and eating facilities for patients
  - Interview room
- Non-Clinical Areas
  - Waiting Room
  - Reception / triage / Clerical area
  - Tutorial Room
  - Offices
  - Staff Rest Area

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MORBIDITY AND MORTALITY MEETINGS (M & M)

- **An essential part of the QI cycle**
- Essential Features
    - Should be **onsite,** preferably within the ED
    - **Medical and non-medical staff** invited
    - Appointed **chair**
    - **Minute-taking** - circulated to all attendees
    - **Regular meetings**
    - **Mandatory** and record of attendance
    - **Confidential**
    - Non-judgemental open forum for case discussion

- Case Selections (…related to ED performance indicators)
    - **Deaths** in ED (since last meeting)
    - **Critical incidents**
    - Deaths within 1 weeks of ED discharge
    - Procedural complications
    - **Complaints**
    - **Prescribing Errors**
    - Hospital Acquired Infections
    - **ED KPIs** (DNW, time to analgesia, time to antibiotics, notes audit)

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EQUIPMENT PURCHASE, DRUG PROTOCOL OR BUSINESS CASE. . . LIKE 'INTRODUCING BEDSIDE ULTRASOUND, OR OPENING A CHEST PAIN UNIT"

- **Identify the need** (…why should this be acquired?)
  - Benefit to patient
  - Benefit to department
  - Meets a service need

- **Gather Information**
  - **Current literature** on equipment types or models, disadvantages and advantages
  - **Availability** of a drug in the hospital, area health service or nationally
  - **Benchmarking** (see how other places do it, and what's held as the standard of care)
  - **Cost analysis** (lifetime + consumables for equipment)
  - **Risk Management** (what could go wrong and how could we minimise this or deal with it?)

- **Consult stakeholders** (Clinical Governance, Pharmacy, ED director and physicians, legal authority / PBS via medicare)
- **Formulate a plan** / policy and circulate for comment
  - **Indications** and contraindications or **inclusion / exclusion criteria** (unit)
  - **Credentialing** (procedure)
  - Storage and maintenance (equipment)
  - Administration guide (drug)
  - **Staffing and rostering** (unit)
  - **Education for staff / users**
- **Implement the change** / policy / guideline
- **Review / Audit** (QI cycle)

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BREAKING BAD NEWS…..UNEXPECTED DEATH OF A RELATIVE FOR EXAMPLE

- **Do not tell them over the phone**… Say relative is unwell and they need to attend urgently
- **Ensure privacy**
    - Appropriate room
    - Delegate other roles so that you will be uninterrupted
    - Take another staff member with you
- **Introduce** yourself, confirm identity and relationship of all present to the deceased
- **Sit yourself at the same level** of the one you are addressing (immediate spouse / sibling / child)
- **Warning shot '**I have the worst news possible to give you…'

    * A preamble or 'recap' has little value - family member s hang onto every word until the one piece of info they want to hear. Alive or Dead?. Deliver this within 30s of starting the meeting
- Tell them their family member has died
    - **Use 'dead' or 'died'**. No euphemisms.
    - Consider a **shoulder touch**
- **Allow for a grief reaction / acute grief spike**
    - Kubler-Ross stages of grieving, people progress at variable rates. Seconds to hours to years. 1 - Denial. 2 - Anger. 3 - Bargaining. 4 - Depression / guilt. 5 - Acceptance.
    - **Be silent**, be empathic. Average time of silence is around 3 minutes.
    - **Allow the relatives to break the silence**, usually 'Can we see him/her?' or 'What happens now?'
- **Comfort and exonerate**
    - Tell them the deceased did not suffer
    - Tell them nothing they could have done would have changed the outcome
- **Next Steps**
    - **They can view the deceased if they wish**. Warn of medical paraphernalia / clean up first as much as you can. After some minutes tell them it's ok for them to go and that their loved one will be looked after with care and respect.
    - Tell them the **coroner may be notified** for autopsy if appropriate
    - **Offer telephone, food and drink**
    - **Offer pastoral care** or social work
- Ask **'Is there anything I can do?'**
- 'Do you have any questions?'
- **Leave families a card** or a piece of paper with your name on it and contact so they can ask anything later on
- Leave the room **'I'm going to have to excuse myself, but if you have any questions, I am available at any time. I'm truly sorry for your loss'**

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EMERGENCY SHORT STAY UNIT / OBSERVATIONAL MEDICINE

- A question will either
  - Examine knowledge of how and why a SSU functions and key features
  - Tell you that the SSU is not performing well (deteriorations, longer than anticipated stays, high admission rates) and ask you why

- The ideal ESSU..... lack of adherence to these usually causes problems such as poor performance or patient deteriorations (as above)
  - Clear rules - **inclusion / exclusion criteria for patient selection** (this is key) - ED patients who would benefit from extended treatment and observation, anticipated stay < 24 hours
    - **Exclusion -** undifferentiated, elderly, paediatric, complex medical, surgical or social issues, no clear management plan, resource intensive patients, risk to staff patients - psychotic, intoxicated, violent, forensic hx
  - Close to ED
  - Managed by ED team, **for ED patients only - Not for admitted patients or IP team decision making**
  - Consistent and accessible **senior decision making**
  - **24 hour access to investigations** (radiology, pathology)
  - Strict limited time stays (24 hours) with **discharge plans or admission plans for treatment or management failure**
  - **Access to allied health**, social work, discharge planners
  - Avoid admitting patients who are **resource intensive - poor patient selection**

- Pros
  - Resources all in one place
  - Doesn't disrupt ED or hospital flow
  - **Reduces ED workload**
  - **Reduced length of stay** compared to hospital admission
  - **Early and constant senior involvement** - safety net for junior staff
  - **Improved patient satisfaction**

- Cons
  - **May reduce decision making in ED** (educational impact)
  - Can become a social care centre rather than medical care centre - **'dumping ground'** for patients refused admission but not safe for discharge.
  - If criteria not adhered to (see above point) - ED workload actually higher (ongoing investigation, readmission etc)

- **Planning to improve a failing unit - PDCA (QI Cycle) -** Acknowledge the issue, gather information, formulate a solution, disseminate for comment and consult stake holders, implement/enact, review and audit/re-audit
  - Investigate **system factors**
    - Patient selection, senior supervision, ED control of patients sent to ESSU, adequate nursing staff, adequate equipment
  - Investigate **Process factors**
    - Obs, / vitals, CERS - Consolidated Emergency Response / MET criteria, regular senior review of patients
  - Investigate **Individual factors**
    - mis-diagnosis, patient selection, no blame approach
  - Formulate solutions
  - **Implement / enact solutions**
    - ED senior leadership, engage stakeholders, educational sessions, admission forms with exclusion/inclusion criteria, Obs forms with vital sign triggers and escalation plan 'between the flags'
  - **Review and audit / continuous re-audit**
    - Adverse events
    - Patient / staff satisfaction

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TRIAGE AND THE ATS (AUSTRALASIAN TRIAGE SCALE)

- **Triage -** A **process for sorting** patients **based on urgency of need** for medical care. Another ED Performance Indicator
- Principles include
  - **Equity** (fairness/justice) - treating those in greater need ahead of those who arrived first
  - **Efficiency** (assigning a category should take no more than 5 minutes)
  - **Doing the greatest good for the greatest number**
- 'This patient should wait for medical treatment no longer than ….'

AUSTRALASIAN TRIAGE SCALE CATEGORY	TREATMENT ACUITY (Maximum waiting time for medical assessment and treatment)	PERFORMANCE INDICATOR THRESHOLD
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

- ***A question might give a table of values for a given hospital, and ask you to comment on performance with regards to ACEM targets***

- Measures that can be taken to improve if a hospital is falling behind KPIs
  - **ED Measures**
    - **System** - **staffing** : skill mix and disciplines, **rostering** to cover periods of higher demand and ensure prior EMS notification about category 1 or 2 patients.
    - **Process** - **Early senior review** to facilitate decisions and disposition
      - Waiting room Dr
      - **Nurse initiated labs / pathology**
      - Effective communication systems (radiology, wardsmen, other ED staff - DECT phones)
    - **Individual** - Education (times and need for improvement, ED role and when to handover care)
  - **Hospital Measures**
    - **System** - **ancillary dept resources** (timely radiology / labs, timely specialty review in ED, timely moving to IP beds)
      - **Bed numbers if access block a problem**
      - Out of hospital **Step Down Units**
    - **Process** - Timely pharmacy and allied health
      - **Discharge planning**
    - **Individual** - **Education** that seeing patients in ED is a priority

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ACCESS BLOCK, NEAT AND ED OVERCROWDING

- NEAT Target
  - By 2015 90% of patients presenting to public EDs will be admitted, transferred, or discharged within 4 hours. This time based target merely a tool for driving reforms and is a hospital and system performance indicator and NOT an ED performance indicator - clinically appropriate patient care remains paramount.

- Access block
  - % of patients admitted / planned for admission but remaining in ED for > 8 hours(without disposition/reaching an inpatient bed, but also hospital transfer, discharge from ED or death)
  - ACEM recognises access block is due to hospital bed occupancy, and rather than an 'ED problem' its addressed as a 'whole of hospital problem' (whole system problem).

- ED overcrowding
  - ED function impeded by no. of patients in ED waiting to be seen, undergoing treatment, or awaiting departure exceeds the number of staff or physical beds.
  - Access block is the principle cause (usually admitted patients 'boarding' in ED as there are no IP bed to go to)
  - Associated with diminished quality of care and poor patient outcomes (increased morbidity and mortality, adverse events, violence, errors, delayed time to critical treatments)
  - Markers in ED include
    - Inability to offload ambulances
    - Inability to place critically ill patients in appropriate areas
    - Clinical treatment in non-treatment areas (lack of privacy, resources, equipment)
    - Admitted patients receiving lesser quality of care than if they were in their destination unit
    - Obstruction to access and egress routes (OH and S issue, corridor blocking)

- 6 Phases of ED care - interventions to maximise efficiency can be at various stages
  - Pre-Hospital (EMS notification)
  - Triage (rapid, nurse initiated Ix, SAS model)
  - Rapid Assessment (senior review early, appropriate and timely investigations)
  - Senior Review (disposition decision)
  - Exit (appropriate ESSU patients, early allied health, direct IP admissions, timely tool-based communication like ISBAR)
  - Follow up (F/u of case, notification of misses)

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ACCESS BLOCK, NEAT AND ED OVERCROWDING (2)

- Solutions to Access Block and ED Overcrowding
  - Reduce Demand
    - In the community - improved GP funding, improved end-of-life care planning in residential and community care, coordination of community services including care of frequent attenders, hospital outreach like HITH or HIT-Nursing-Home
    - In the ED - Senior decision making 24/7, ESSU, ADPs
  - Increase Capacity
    - In the ED - fast track area, pathology/radiology turnaround times, 24/7 senior staffing, Full capacity protocol - patients seen by IP teams on wards
    - On the wards - 24/7 whole of health service bed coordinator, hospital bed manager, daily consultant rounds, improved consult and investigation speeds, increase acute hospital beds to >3 per 1000 population - takes time but AUS has amongst the lowest in the world.
  - Improving Exit
    - Morning and weekend discharges
    - Use of transit / departure lounge
    - Improved allied health and pharmacy access after hours
    - Post acute care community services (CAPAC)
  - Monitoring / audit
    - ED processes (KPIs, CQI, education about teamwork and culture)
    - Hospital Processes
    - Community Processes
- Things that don't work
  - Nurse on call
  - Telephone Triage
  - Ambulatory Care Clinics
  - Hospital bypass

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DISCUSSING END OF LIFE CARE . . . THE 7 STEP PROCESS

Always consider **patient autonomy**, **realistic outcomes** of treatments, **what's important to the patient**. Family needs considered and dealt with empathically but **do not override patient autonomy.** If there is a **disagreement or discrepancy** between clinician and patient or family, **encourage them to seek a second opinion** and recruit the medical consultant or ICU consultant.

- **Preparation**
  - Would it be ok if we discussed your/your wife's condition so we can make the best medical plan for you/her?
- **Establish knowledge**
  - What have you been told about your / your wife's illness?
- **Assess willingness to hear information**
  - I have some serious news to share about your / your wife's condition. Is that something you are ready to hear?
- **Deliver medical information**
  - Im afraid I have some difficult news. Your/her illness has progressed despite our best efforts to control it. At this point, I think that you / she is dying.
  - I wish things were different.
  - I wish there were better treatments for your / her condition
- **Respond to emotions**
  - This must be hard to hear
  - Tell me what's on your mind
- **Establish goals of care**
  - Knowing time is short, what would you / your wife say is most important to you / her?
  - Are there any particular worries you have?
- **Establish ceilings of treatment**
  - When an illness is this aggressive and advanced and the body dies, invasive attempts at resuscitation like CPR, breathing tube placement, and heart-lung machines will not be curative . They will only cause suffering and artificially prolong the dying process.
- **Make medical recommendations and summarise**
  - We will aggressively manage her symptoms and continue your/her treatments (antibiotics, IV fluids, oxygen, NIV)
  - We will make sure we use all our resources to support all of you through the dying process
  - We will allow a natural and peaceful death, free of suffering.
- **Do you have any questions or is there anything else you want to discuss?**