“Adapting the Flags”
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Senior Pharmacist
Drug & Alcohol Clinical Services

Newcastle
Newcastle
Hamilton South

Hamilton South
The beginnings

• Brain child of Senior staff specialist Dr Sally McKenna

• Required to complete a clinical practise improvement project as part of a course through the Clinical excellence commission

• 2 major issues drove the direction of the project

#1 The Big issue

“Mortality and cause of death among 1705 illicit drug users: A 37 year follow up”.
Stenbacka et al. Drug & Alcohol Review Jan 2010

Drug abusers die 25-40 years younger than general population (particularly opioid dependent individuals).

Causes:
• Etoh / drug causes – main or contributory
• Accidents – transport, falls, police arrest
• Cardiovascular
• Suicide – intoxication, suffocation, drowning
• Cancer – ¼ liver
#2 The Local issue
(Instability and non-attendance)

Of all the facilities that Dr McKenna had worked in, Newcastle had the largest rates non-attendance.

Designing a project

How were we doing taking care of our unstable patients?

* What information are we gathering?
* What were we doing with it?
* Where were the holes? - project
Dosing cards were audited to see how incidences of missed doses and intoxicated presentations were being recorded, discussed at clinical handover and recorded in medical records.

**Audit**

**Audit Results**

<table>
<thead>
<tr>
<th></th>
<th>Missed Doses</th>
<th>Target</th>
<th>Intoxicated Presentations</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number</strong></td>
<td>689</td>
<td></td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>% Discussed at clinical handover</td>
<td>4.0% (100%)</td>
<td></td>
<td>80.7% (100%)</td>
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<tr>
<td>% Recorded in medical records (CHIME)</td>
<td>4.6% (100%)</td>
<td></td>
<td>84.6% (100%)</td>
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<tr>
<td>% Recorded in ‘ISBAR’ format</td>
<td>68.5% (100%)</td>
<td></td>
<td>81.6% (100%)</td>
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</tr>
</tbody>
</table>

Table 1. Missed doses and intoxicated presentation data September to November 2014. ISBAR (Information, Situation, Background, Assessment, Recommendation)
Designing a project
Making sure we were getting all the information

* Improve and expand our current clinical practise
* Focusing on information gathering and documentation
* To better identify and flag unstable patients and giving them appropriate attention/care?

Inspiration

“Between the Flags (BTF) system is a 'safety net' for patients who are cared for in NSW public hospitals and health care facilities. It is designed to protect these patients from deteriorating unnoticed and to ensure they receive appropriate care if they do”
The Slippery Slope

Within 6 months, 100% of patients in care with the Hunter New England Local Health District (HNELHD) Newcastle Pharmacotherapy Service (NPS) who are not attending for treatment or presenting for treatment intoxicated will be:

* Flagged
* Discussed at clinical handover
* Appropriately documented
Cause and Effect Diagram

Technology

- Impact of new automated dosing system
- Problems with CHIME eg crashing
- Multiple EMR's delay handing clinical information
- Takes too long to document in CHIME

Workload

- Staff not recording information eg dating
- Doctors too busy
- Corridor conversations
- Staff "too busy" to document information
- Not enough time to discuss unstable patients

Staff Education

- What is clinically important information
- Variation in quality of clinical information
- No formal staff orientation of determining patients

Process Issues

- Issues with information flow from other clinics
- No checking system for following up
- No formal handover process
- No standardised process to communicate information
- Inadequate preparedness for clinical handover

Staff Factors

- Staff mix - some part time, not at work for handover
- "Bigger issues" may distract and smaller issues not handed over
- Stable unstable patients, information not handed over
- Discussed - but "not for noting"
- "We've always done it like that"

Organisational Factors

- "Bigger issues" may distract and smaller issues not handed over
- Maths officer not included in handover
- No policies and procedures to guide practice
- No system for checking the quality of handover or medical record keeping

Pareto Chart

- No standardised communication process
- No audit system
- Uncertainty about what clinical indicators are important
- No standardised process of handover from HCV clinic or Antenatal clinic
- Issues discussed at handover "not for noting"
- Time management of clinical handover
- Issue with information flow between medical and nursing handover
Interventions

March 2015
Development and trial of a standardised clinical handover template for use at point of contact with patients with information then discussed at clinical handover and documented in the medical record.

Dosing room
Non attenders template

Interventions

March 2015
Development and trial of a standardised clinical handover template for use at point of contact with patients with information then discussed at clinical handover and documented in the medical record.

Remaining contact areas
Template:
- Front desk
- Dr handover
- Other clinics
**April 2015**

Development and introduction of a monthly audit process with NPS staff informed of the quality improvement philosophy, particularly focusing on process improvement not blame.

**Interventions**

**Plan**

**Study**

**Do**

Audit tool

MONTHLY AUDIT TOOL

"Adapting the Flags" – Monitoring for Deterioration (OST) patients – Clinical Indicators

MONTH:  

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MRN</th>
<th>Clinical Indicators</th>
<th>Date</th>
<th>Clinical Handover</th>
<th>CHIME</th>
<th>ISBAR format</th>
</tr>
</thead>
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Clinical Indicators:  
- Did not attend (DNA)  
- Did not dose (DND)  
- Breath Alcohol reading (BAL)

April 2015 (McKenna)

**May 2015**

Information and feedback session with NPS staff regarding the clinical importance of patient identification, clinical handover and medical record keeping with relation to patients with clinical indicators of deterioration.

**Interventions**

**Plan**

**Study**

**Do**
Table 2: Percentage of missed doses discussed at clinical handover, recorded in CHIME in ISBAR format pre and post interventions.

Table 3. Percentage of intoxicated presentations discussed at clinical handover, recorded in CHIME in ISBAR format per and post interventions.
The implementation of a standardised clinical handover template has led to sustainable improvements in staff communication, identification and recording of missed doses and intoxicated presentations.

- Given us more confidence in our early recognition and response to indicators of deterioration from patients
- Simple, cheap and non invasive

Conclusions

Moving forward

- Continued Training & Education for new staff
- Continued review and audit
- Implementing these standardised processes within the other Opioid Treatment Programs within HNELHD.
Team Members

Sally McKenna  Senior SS
Jennifer Willis  A/g NUM
Michelle Gallagher  RN
Anthony Winmill  Pharmacist
Amanda Brown  Research Team Leader

Thank you 😊