36 Non-Clinical

CONSENT

Principles

- Beneficence: *do best for the pt*
- Autonomy: *pt right to decide*
- Non-maleficence: *do no harm*
- Justice: *responsibility for community*

Types

- Implied eg taking blood
- Verbal (legally as valid as written if documented)
- Written

Valid Consent

ASCIF
- **A**ctually done, covers
- **S**pecific (context)
- **C**apacity/Competence
- **I**nformed (pros/cons/alt)
- **F**reely given

Competence/Capacity

NB Capacity is a functional term, competence is a legal term of having sufficient capacity, ability or authority

CURVES
- **C**hoose/**c**ommunicate: recognise that there is a decision
- **U**nderstand risk/benefits/alternatives/consequences
- **R**easoning: rationally manipulate information
- **V**alues consistent
- **E**mergency - risk to pt/pt safety
- **S**urrogate - are there surrogates or allies available?

Minors

- <18yo
- ≥ 16yo can consent TO tx (no consent to refuse)
- <16yo can consent TO tx under ***Gillick competence***
  - Maturity
  - Marital status
  - Emancipated
  - Understanding of risk/benefit
  - Economic independence

Decision Makers

0. Duty of Care
1. Adult patient with capacity/competence or Parent
2. Medical Enduring Power of Attorney
3. Written Advanced Directives
4. NOK
5. Guardianship Board

REPORTING

Reportable Deaths

- In custody
- Unexpected
- Unknown cause
- Unknown patient
- Violent, unnatural, accidental
- Suspicious circumstances
- Related to health care
- Child

Mandatory Reporting

Mandatory	***Good Practice***
- Child abuse/at risk	- DV
- Violent injuries	- OH&S
- Firearms	- Medical conditions & driving

Mandatory Reporting to AHPRHA

- Witnessed intoxicated whilst practicing
- Can also make a voluntary notification
- Sexual misconduct
- Undisclosed harmful health condition
- Severe deviation from standard practice

COMPLAINTS

Doc ANSR

At all times ensure

- Senior staff to provide consistency
- ***documentation***
- ***open disclosure***

1. Ensure patient ***safety/care***
2. ***Apologise***: open disclosure, commit to Ix, thank
3. ***Notify***: staff + indemnity, reporting sys, higher level
4. ***Search/Ix***: notes, interviews, critical incidence panels
5. ***Response***
   - External ie to patient/family, outcome/initiatives
   - Internal: QI, Performance Mx, Audit cycles

Open Disclosure

- Apology with expression of regret
- Factual explanation
- Opportunity for pt/family to relate experience
- Discussion of potential consequences
- Explanation of what's being done

Acute Mx of Complaint

Same as general complaint but also:
- De-escalate: introduce, identify, establish rapport
- Gain their understanding, ***realign expectations***

Root Cause Analysis (RCA)

- Identify root cause
- ***No Blame Approach***
- Prevent same errors recurring
- Looks at:
  - timeline
  - relationships between factors
  - independent contributors

RISK & ERROR

Human factors	**Patient factors**
- HALT - shift work - Junior staff - Interruptions	- undifferentiated - high risk pts[1] - high risk sx[2]
Staffing factors	**Environmental factors**
- high staff turnover - high rate of handover	- noisy - over crowded

[1]*Extremes age, NESB, ALOC*
[2]*CP, headache, abdo pain old*

Risk Mitigation

- Credentialing (college, hospital, AHPRHA)
- Complain/incident monitoring/tracking
- Clinical performance monitoring eg M&M
- Document templates eg proc sedation, sepsis, trauma
- Policy development & review

Performance Management (of Junior Doctors)

- Recognise
- Graded intervention
  - 1 Contemporaneous
  - 2 ED supervisor
  - 3 Hospital JMO manager
  - 4 Hospital admin
  - 5 AHPRHA
- Remediation plan
  - Steps, actions, goals
  - Review date
  - Document
  - Outline consequences of failure to comply
- Quality Assurance: ensure no ED factors eg rostering

Process & System Errors

- System is the infrastructure that supports a process
- Process is the sequence of activities leading to a result

Eg chest pain protocol is a process, triage is process whereas how/when Tn is done is system or who triages is a system issue

EQUIPMENT PURCHASE

- Assess: lit search, other sites
- Features:
  - new
  - safety
  - cost
  - ease of integration
  - ease of use
  - size, portability
  - maintenance
  - warranty
- Trial & feedback
- Purchasing argument:
  - Patient care, safety
  - OH&S issues
  - Compliance with standards
- Source of funding
- Implementation: training, education
- Quality Assurance

QUALITY & SAFETY

Quality Cycle

PDSA: 1. Plan → 2. Do → 3. Study → 4. Act

Quality Standards

- ***Safety*** eg patient falls, medication errors
- ***Access*** eg wait times
- ***Acceptability*** eg pt feedback
- ***Effectiveness*** eg time to…
- ***Efficiency*** eg ATS compliance

ED KPIs

- Time to ecg, analgesia, door-to-balloon (90min)
- Access block (80% < 8hrs)
- Triage time

Other ED Indicators

- Missed XR follow up
- Staff retention
- Readmission
- Falls

Did Not Wait

Cause	***Consequence***
- Waiting time	- Admission (5-10%)
- Alternative care	- Worsening Sx (25%)
- Not urgent enough	- Seek Rx elsewhere (50%)

High Risk DNWs

- Impaired: drugs, etoh, psych
- Kids
- Presentation: chest pain, head injury
- Referral to ED

DNW Mitigation

- ↓ wait times
- early analgesia
- educate re ATS
- geographic based care
- Specialty nurses
- Nurse initiated mechanisms
- DNW process & follow up

Discharged Against Medical Advice

- Same causes, consequences
- Ensure competence & document
- Sign DAMA form
- Safety net: social support, location, advice on returning

PATIENT FLOW

- ↓# movements
- ↓# people involved
- ↓Timeline of services
- ↑ Access to next phase of care

ED OVERCROWDING

ED function impeded due to no pt waiting care > physical/staffing capacity

Causes

- ***Access block***
- Pt surge
- Pt complexity
- Staff skill mix
- Staff number
- Delays to Ix
- Delays to Referral
- Delays to Inpt review
- Delays to Allied health
- ED design & size

Complications

- ↑ LOS
- ↑ M&M
- ↑ wait times
- ↑ Complaints
- ↑ DNW
- ↑ Ramping
- ↑ Burnout
- ↓ Community access
- ↓ Confidentiality
- ↓ Staff retention

Solutions

Also see Access block solutions

- Geographic based care
- Balance skill-mix
- Early/fq rounds
- ***Early sr review (dr/nurse)***
- Early disposition decision
- Nurses: NP, PEN, NIX
- Announce Cat 1&2
- Effective tracking system
- Planning (eg ext disaster)
- ED pathways/protocols
- SSU utilisation
- Prioritise Ix to ED
- Interim mx plan
- Hospital-in-the-home
- Diversion: GP, phone
- Comms sys eg orderlies, rad

Access Block

% patients last 6 months planned/admitted but in ED > 8 hrs

Causes

- ↓ inpt beds
- Bed competition (eg surg)
- ineffective DC

Complications

Same as ED overcrowding

Solutions

Also see EED overcrowding solutions
- Early/Fq comms with bed manager
- ↑ Inpt beds: cancel elective OT, political
- ↑ Inpt staffing: nurses/review doctors
- Hospital-wide surge protocol
- Pt review: early sr, early discharges, wknd rounds
- Managment plan for long stayers (> 120 days)
- Utilise transit lounge

Time Based Targets

Pros

- ↑ ED LOS < 4hrs
- ↑ Pt satisfaction
- ↓ ED occupancy
- Focus on 24/7 care
- ↓ All the complications of block
- Unproductive people leave
- Focus on ED OC as a Sx

Cons

- 23% ↑ same day admit
- 1% ↑ ED readmit < 28 days
- ↑ 20% ED admissions
- ↑ ED attendance
- ***Patient safety***
- ↓ System productivity
- Honest people leave
- Virtual wards
- Data fabrication

Short Stay Units

Differentiation from inpatient ward

- High turnover
- Specialist handover
- Fq review/assessment
- ED ownership/decision-making
- 24hr discharges
- Expected LOS < 24hrs
- Limited ability to follow up

Pros

- Avoid night discharge
- Prevent unsafe discharge
- Operational eg wait t'port
- Allows further/safe Ix/Mx
- ↓ LOS
- More fq reviews
- Empowers ED

Cons

- General ***ward creep*** eg ↓ flexibility
- Defer decision making (dumping ground)
- Failure to exclude serious dx
- Staff optimism/pessimism
- Access block

Predictors of Failure

Optimal failure rate 10-15%

- Declined admission by inpt team
- NWB
- Ongoing active treatment
- ≥ active problem
- Progressive deterioration

PROTOCOLS

Design/Development

- Objectives
- Timing/timeline
- Current prac & Benchmark
- Research: lit, ACEM, other EDs
- Write
- Educate/implement
- Audit & Review
- Refine

Protocol Format

1. Authors, Stakeholders, Version Control, References
2. Reason for protocol
3. Scope of practice
4. Indications/Contraindications/Precautions
6. Procedure
7. Complications & Mx
8. Post procedure Mx
9. Review schedule
10. Feedback mechanism
11. Resources

BREAKING BAD NEWS

- Senior staff
- Quiet, private area
- Introduction of ALL present & relationship
- Delivery - clear, slow, no medical jargon
- Content - summarise, express regret for loss
- Outcome - ask for question
  - allow for grief reaction
  - provide support (SW, pastoral care)
  - allow viewing
  - consider organ donation
- Legal - life extinct, death cert, coroner
- Debrief team

HISTORY OF EM

Definitions

- EM: field knowledge/skill, prevent/dx/mx, acute/urgent, all ages
- ED: place in hosp, organise & admin to community who perceive need

History

- ACEM founded in 1983 (ASEM 1981)
- 1975 Medicare introduced
- 1993 Specialist recognition
- 2014 NEAT

International

- RCEM (UK); ACEP (US); CAEP (Canada)
- 1967 ACEP founded
- 1979 CAEP founded
- 2008 CEM founded – 2015 RCEM
- 2001 4hr rule UK
- 1989 IFEM

TRIAGE

- ongoing sorting
- basis of urgency (not severity)
- principles of equity, efficiency

ATS

- 1994
- based on pain, life/limb/organ threats, physiology, acute interventions

Cat	Max Wait Time	Target
1	0	100%
2	10	80%
3	30	75%
4	60	70%
5	120	70%

Limitations

- Re-triage
- Failure to recognise:
  - severe pain
  - high risk complications
- Time for patients
- Documentation
- Privacy & security
- Consistency
  - Hospitals: rural, metro, tertiary
  - Shift load
  - Nurse skill mix
  - Patient groups: Paed, O&G, trauma

Benefits

- Urgency
- Sorting/flow
- Equity/efficiency
- Standardised
- Benchmarking
- Front load with seniority

CULTURE COMPETENCY

Culture: underlying values/understandings of the world that inform thought, act/interact, motivations, decision making

Influences of cultures

- ethnicity
- race
- religion
- education
- gender
- age
- dis/ability
- sexual orientation

CC Patient Centred Care

- Aware of cultural aspects of health/care
- Understand illness is culturally shaped
- Aware how own culture influences practice
- Self reflection, empathy, curiosity, respect
- Improve skills in CC
- Positively integrate cultural factors in mx
- Have knowledge of race/ethnic specific data

Benefits of CC

- Communication
- Better use of health service
- More likely to listen

Minorities are

- over-represented in ED
- have higher burden of disease
- underserved by local health car & social services
- receive lower level care

Indigenous

- International term; originally local to a region
- 3% population
- 90% aboriginal
- 6% Torres straight islanders
- Dont like to be called indigenous
- Like to be called people of…[insert aboriginal nation]

Multiculturalism

- 28% Australians born OS
- 49% either born or 1 parent born OS
- UK > NZ > China > India > Italy > Vietnam
- 60% religious (52% total christian)

Cause of Death in ATSI, 2016

- IHD12.6%
- DM 7.8%
- Chronic lower resp disease 6.9% (biggest diff from white)
- Cancer trachea, bronchus, lungs 6.3%
- Suicide 5.5%
- CVD 3.3%
- Liver 3.2%
- MVA 2.7%
- Accidental poisoning 2.6%

Communication Styles

Complications of poor communication

- pt outcomes
- misdiagnosis
- unaware of options
- lack of informed consent
- poor adherence & follow up
- anxiety
- ↓ satisfaction

Good Communication

- Understood
- Build rapport
- Slow down & pay attention
- Allow silence
- Time may not be linear
- Eye-contact
- Check taboo body parts
- Gender preference
- ALO/interpreter
- Use plain English

Health Beliefs

- Explanatory Model
- Biometrical Model
- Health literacy (60% Australians illiterate)
  - understand, manipulate, make a decision
  - strong predictor of poor health

Patient-Centred Approach

- what they understand about their illness
- what it means to them
- why they have come to ED for help

Use ETHNICS approach

- **E**xplanation eg how do you explain your illness
- **T**reatment eg what have you tried
- **H**ealers eg who else have you sought help from
- **N**egotiate eg how do you think i can help?
- **I**ntervention
- **C**ollaborate
- **S**pirituality

Interpreter

Interpreter Service

- Same benefits as above
- Also cultural translation
- Pt comfort in expressing
- Use for ANY lang barrier

Limitations of family as interpret

- More errors in translation
- Less accuracy
- Other motives
- Uncomfortable telling family

Working with interpreter

- Briefing
- Introduce
- Short sentences
- Use 1st person and talk to pt
- Tell pt re examination
- Debrief

Aboriginal Liaison Officer Roles (ALO)

- Advise on cultural styles/preferences
- Pt more willing to disclose
- Interpret health care
- Assist with community integration

Strategies to Effective Care

Reducing Take Own Leave

- talk
- use interpreter
- revisit hx
- family presence
- assist with ED system understanding (system literacy)
- emphasise need
- AWS

Improving compliance

- Explaining benefits in respectful way
- Understand barriers to compliance eg health literacy
- understand socio-economic context eg access to power

Access to Medicine

- Section 100 script
- Close the gap script

Common Health Issues in Refugees

- Latent TB
- Anaemia)Fe def, malaria)
- Parasites
- Blood borne viruses esp Hep B & Syphilis
- Dental disease
- Chronic pain
- Violence
- Malaria