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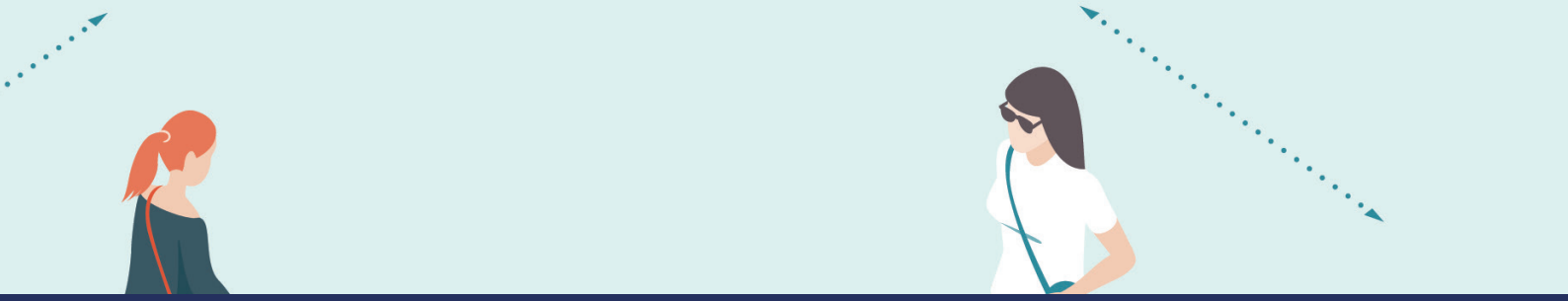

Clinical Communiqué

Next Edition: June 2020

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VICTORIAN INSTITUTE OF FORENSIC MEDICINE

MONASH University

Editorial

Dr Nicola Cunningham

The COVID-19 pandemic has fundamentally changed the world as we know it. The ways in which we now interact with others, do our jobs, and spend our days, are being dictated by the alarming features of this highly infectious virus. At a time when we have to navigate through constant changes, in the face of competing demands and an extraordinary influx of information, it is easy to become concerned and frustrated about how we will be able to continue to deliver quality care to our patients. There is a lot of COVID-19 'noise' around us at the moment. One of the challenges is learning how to find the signal in that noise; and remember the things that will help us perform our roles in times of crisis.

The Communiqués team recognises the need for clinicians to focus on the present and pay close attention to local practice changes. In every health care jurisdiction, there are people working hard to train and prepare their staff for the predicted surge in patient numbers. As such, we do not wish to add to the current arsenal of policies and protocols about COVID-19. Instead, we want to reflect on the wealth of knowledge our experts have shared with us over the years. Lessons on good communication and decision-making, working in rapid response teams, avoiding cognitive bias-related errors, optimising the management of transfers for critically unwell patients, and planning for respiratory pandemics. When our workflows and teams and practices are forced to change for COVID-19, it is imperative that we go back to first principles. By applying systems thinking over everything we do, we mitigate the potential for risks and errors arising in unfamiliar situations.

In this special feature, we have selected six past editions of the Clinical Communiqué that address key themes for improving patient safety. We recall the expert commentaries for each of those themes and reflect on a few practical considerations that are specific to managing COVID-19 patients. We also present our *Polygon of Patient Safety* as a critical reminder of the need to constantly learn on-the-go and maintain staff well-being throughout this period.

As our team is predominantly engaged in critical care, aged care, and public health, our focus will be on efforts to support the health care community through the pandemic. Depending on how that unfolds will determine whether we are able to maintain our planned schedule of publications. We will endeavour to return to our usual format for the next edition and continue reporting lessons learned from deaths in acute health care settings investigated by coroners' courts. Although COVID-19 dominates our thinking at present, it is important not to lose sight of how to safely care for other patients and other clinical conditions during this health care crisis.

There will come a time when the coronial system may look at health care-related deaths in the COVID-19 pandemic to determine whether preventable harm occurred. Until then, we need to utilise lessons already learned to be proactive in our environment, nimble in our response, and adapt quickly in our clinical encounters to keep our patients and ourselves safe.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
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Clinical Decision-Making

A proportion of patients infected with COVID-19 deteriorate rapidly and unexpectedly with little warning. Experiences in other countries have shown that standard protocols must change to enable treating teams to aggressively manage a deteriorating COVID-19 patient while minimising droplet spread. Decisions about escalation of care, such as suitability for intubation and ventilation, must be made with multidisciplinary team input, preferably using a pre-determined protocol.

CC DEC 2014 Vol 1 (2) - Edition Synopsis

This edition included three deaths related to clinical deterioration, and the failure to recognise or respond appropriately to early warning signs. The cases included deaths due to brain herniation, aspiration pneumonitis, and haemorrhagic shock.

When confronted with an unwell patient, there must be strong systems in place to provide support for the individual clinician to effectively identify, escalate and safely manage the situation. Strategies to strengthen systems include protocols to aid communication, processes that support good clinical decision-making, and sufficient resources to allow escalation of care.

When we are fatigued, sleep deprived, or inattentive due to juggling multiple tasks, we are more at risk of errors in our clinical decision-making. External stressors of being time-poor, resource limited, working in a different environment, or with a scenario we have not encountered before, can compound these factors even more. It becomes a fine balance to find an approach to decision-making that allows us to work efficiently, but think effectively and practice safely every time.

Expert Commentary: Heuristic thinking in clinical decision-making - A psychological perspective

Dr Stuart Marshall
Specialist Anaesthetist, Patient Safety Researcher and Educator
Former Director, Patient Safety Unit, Monash Injury Research Institute

Link to the full edition here

Working in Teams

Large scale re-deployments of staff into critical care areas means that many clinicians will find themselves working in new roles, with new colleagues. High levels of sick leave and rapid redeployment of reliever or agency staff means that orientation is important, and should be designed to be reproducible, concise and deliverable by multiple regular team members.

We should use this current precious window of time before the predicted surge of COVID-19 cases to run repeated simulations and drills for regular staff, whether for personal protective equipment (PPE), difficult conversations, or how to rapidly and safely orientate a new team member. Encourage team members to introduce themselves each time, and to wear clear identification tags showing their names and roles. Continue to promote respect and understanding between colleagues who will be facing difficult clinical scenarios together.

Ensure that teams are familiar with the equipment and the protocols they will be using. Most importantly, when faced with information overload, always ask your team what they want to know.

CC JUN 2015 Vol 2 (2) - Edition Synopsis

This issue of the Clinical Communiqué describes two cases of patient deterioration that resulted in the activation of a hospital Medical Emergency Team (MET). The first was a case of oesophageal intubation, and the second, a patient who developed septicaemia with hypoxic brain damage.

In many ways, the principles behind the MET system are applicable to all healthcare environments, not just acute hospital settings. Leadership, decision-making, communication and task allocation are all critical to the effective performance of a team responding to an emergency, whether that be in an operating theatre, a hospital ward, an outpatient clinic, or community health centres.

Expert Commentary: How to make a better medical emergency team?

Dr Antony Tobin
Chief Medical Officer and Deputy Director of Intensive Care
St Vincent's Hospital, Melbourne

Link to the full edition here

Transferring Critically Unwell Patients

COVID-19 clinical management protocols require us to unlearn many goals of care that have previously been second nature. This includes accepting lower cut-offs for pre-oxygenation prior to intubation or transfer of critically unwell patients, and avoiding aerosolised procedures. Clear channels of communication and disposition criteria are essential for timely movement of patients between wards and hospitals. Rapidly changing ambulance protocols in response to COVID-19 add more complexity and potentially prolong the time required for transfer.

CC DEC 2015 Vol 2 (4) - Edition Synopsis

This issue of the Clinical Communiqué deals with the addition of an extra layer to the system of health provision – the transfer of patients between hospitals. The critical elements that need to be present, or performed well, in order to provide safe and effective patient care include communication, documentation, awareness of one's skills and limitations, recognising the deteriorating patient, and following guidelines, to name but a few. Failure or sub-optimal provision of even one element, inevitably leads to a failure in a system and the potential for patients to suffer preventable harm.

When another layer is added to the system, and well-functioning processes are required not only for the care of a patient in a single hospital, but also for the integration of their care between hospitals, the system becomes bigger, more complex, with more room for error. At the primary team level, communication, documentation, and decision-making should be performed as effectively as resources and personnel allow. These professional skills are just as vital however, at the interface of the referral and receiving hospitals, and at the juncture between the hospitals and ambulance or retrieval services.

Expert Commentary 1: Optimising access and care for the critically ill – A regional perspective

Mr Ian Campbell
General Surgeon, Lister House Medical Clinic, Horsham
Former Director of Surgery
Wimmera Health Care Group, Horsham

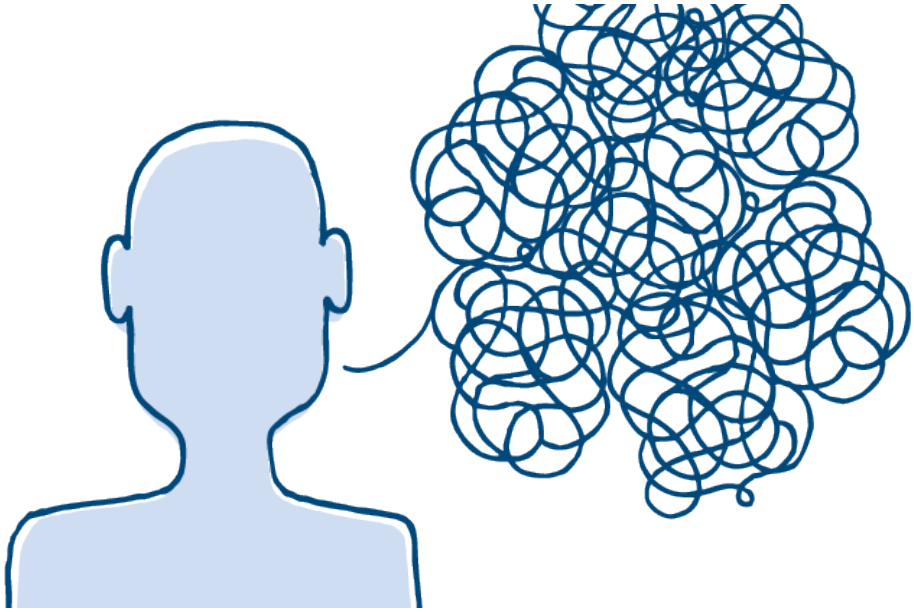
And

Professor Alan Wolff
Director of Medical Services
Wimmera Health Care Group, Horsham

Expert Commentary 2: The anatomy of a modern retrieval service

Associate Professor Matt Hooper
Intensive Care and Pre-Hospital & Retrieval Physician

Link to the full edition here



Communication in the Workplace

Effective communication is vital to reducing anxiety in patients, their families and staff. Your capacity to communicate in a clear, unambiguous, empathic manner will be under challenge from social distancing requirements, visitor exclusions (telephone rather than face-to-face), high case numbers and acuity, and the simple barrier of wearing a mask. Remember to inform patients about any testing that is performed, and the implications of those tests. Be open and frank in conversations with patients and their families about prognosis. Explore their fears about their health and social isolation.

It is important to be cognisant of the challenges of communicating while wearing personal protective equipment. Voices are muffled and staff are often indistinguishable from one another, PPE even covering name badges. Pay extra attention to how you communicate with patients and colleagues in a humanising manner while working in these conditions.

Remember that your patients cannot see you smile or cry while you are wearing a mask and goggles, you may have to tell them you care in other ways.

CC DEC 2018 Vol 4 (4) - Edition Synopsis

This issue contains three cases that have communication issues as a common thread. There are many reasons why patients and their families may not fully appreciate the information given to them by their doctor. Denial, distractions, cognitive or language difficulties, are just a few of the legitimate obstacles to overcome. When we are sick, and in pain, causing us to be scared and worried, it is hard to comprehend even the most simple and direct instructions. So, when our well-intended clinical instructions are nuanced, vague, rushed, or conveyed in overly technical language, we are setting our patients up to miss the cues, and we have failed them.

Medicine is imprecise but that is all the more reason why we need to be precise in how we communicate.

Expert Commentary: Doctor-patient communication: What every doctor should know

Dr Ranjana Srivastava
Oncologist and Fulbright Scholar
Author and Columnist for The Guardian

Link to the full edition here

Fixation Errors

The concept of risk equilibrium means that finding and correcting an identifiable risk in one area may result in an unintended risk appearing elsewhere in a system. If we anticipate that we will fixate on Covid-19 then this problem is predictable. If we take the example of acute myocardial infarction, normally a patient with chest pain and significant ECG findings would present to a hospital with a 'hot cath lab' and have a door to needle time of less than 15 minutes. Fast forward to the same patient in the time of COVID-19 – all staff wear full PPE, an echocardiogram is performed in the emergency department under full sterile conditions to exclude a COVID-19 myocarditis, transfer time is tripled, and the door-to-needle time breaches the first hour. This non-COVID patient has had objectively compromised care and a potentially poorer outcome simply by having their heart attack at this time.

The risk of fixating on COVID-19 is then overlooking or discarding the cues to other clinical conditions or complications, or changing processes and protocols so much that our standard of care is detrimentally impacted.

CC MAR 2019 Vol 6 (1)

This edition includes two cases of Influenza A and Legionella pneumonia and discusses fixation error, the phenomenon whereby a person or group falls into a pattern of thinking that there is only one possible explanation. This can take on several forms, including task fixation on a procedure, or diagnostic fixation to the exclusion of other possibilities.

Just as it is necessary to resist a temptation to fixate on a task or thought, it is also imperative to avoid the tendency to look to humans as the source of all error. Rather, humans are adaptable creatures trying, and generally succeeding, within complex systems.

It is said that human factors engineering seeks to identify and promote the best fit between people and the world within which they live and work. A human factors approach views humanity in the context of community, which is key to ensuring that the lessons are being learned.

Expert Commentary: Using a human factors and systems lens to view why things sometimes go wrong (but often go right)

Dr Miranda Cornelissen
Senior Consultant Human Factors and System Safety Acmena Group Pty Ltd
Former Senior Project Officer, Incident Response Team, Safer Care Victoria

And

Dr Julia Pitsopoulos
Director - HFRM, Human Factors, Risk Management & Organisational Psychology

Link to the full edition here

Learning from Influenza Epidemics

COVID-19 has been widely compared to the 1918 'Spanish Flu' pandemic, mainly for dramatic effect, but differences abound, not least the mortality demographics of those most affected. It is a different beast, but the priorities are the same. We have learnt important lessons not just from the 'Spanish Flu', but from our responses to the more recent pandemics including SARS (2003), "Swine Flu" (2008), and pandemic influenza.

CC JUN 2019 Vol 6 (2)

This edition focuses on the issue of communicable diseases and presents one coroner's finding into the deaths of two patients from Influenza A. The two expert commentaries serve as a timely reminder of what to think about as we experience yet another 'flu season'. What is the same, what is different now, and what do we need to do to keep patients safe?

Expert Commentary 1: Influenza, 10 years on from the "Swine Flu" pandemic

Professor Allen Cheng
Director, Infection Prevention and Healthcare Epidemiology Unit, Alfred Health, Professor of Infectious Diseases Epidemiology, School of Public Health and Preventive Medicine, Monash University

Expert Commentary 2: Planning for both seasonal and pandemic influenza

Dr Michelle van den Driesen
Emergency Physician, Melbourne Health

Link to the full edition here

The Polygon of Patient Safety

The term 'unprecedented' will be remembered as a catchcry of 2020. Social distancing, transmission numbers, death rates, and staff redeployments, among others, are occurring at levels that have not been experienced before in our lifetime. As health care staff prepare for what lies ahead, many are grappling with a sense of trepidation – for their patients, but also for themselves. Never before has the risk to staff and their families been so palpable. It is therefore crucial that concerns of staff around availability and access to personal protective equipment (PPE) are addressed by organisational leaders. Health care worker transmission rates should not be viewed as an acceptable consequence of our calling. Questions of when adequate supply and appropriate level of PPE, as well as the provision of decontamination facilities become available must be answered.

Remove any barriers to safe decontamination so that staff do not make poor decisions in pressured situations. If staff are reassured with demonstrated efforts to address concerns, then they are more able to focus on opportunities to look after themselves and their colleagues during this crisis.

The diagram on page 9 represents the four key goals that clinicians must develop to create real and sustained improvements to patient safety.

Building awareness - incorporates knowledge of cognitive bias, 'red flags' and commonly missed diagnoses, and lessons to be learned from cases.

Strengthening systems - includes learning from what goes wrong ('Safety 1') as well as from what makes high-performing systems work well ('Safety 2'), and then feeding that input back into systems for continuous improvement.

Encouraging reflection - optimises the ability of individuals and systems to improve practice following adverse events, and truly identify the underlying causes, whether through knowledge distribution, or an improved ability to prevent, trap, and mitigate errors.

Maintaining well-being - through fatigue management, breaking the stigma of mental health and providing support for those in distress, building resilience in individuals, and promoting wellness, is the pathway towards a well-slept, well-trained, and well-supported workforce. This will lead to a healthier environment for both staff and patients.

Whether we are at the beginning of our careers, or carry a wealth of lived experience and skill, we should aim to apply these concepts to our clinical practice. The imperative is promoting the well-being and safety of our patients and, notably, ourselves.

The recent special edition of the Residential Aged Care Communiqué is an invaluable insight into the challenges ahead for residential aged care services during this COVID-19 pandemic.

Link to the full edition here

Disclaimer

All cases discussed in the Clinical Communiqué are public documents. We have made every attempt to ensure that individuals and organisations are de-identified. The views expressed are those of the authors and do not necessarily represent those of the Coroners' Courts, The Communiques Australia Inc, Monash University or the Victorian Managed Insurance Authority.

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