Leadership and clinical governance for recognition and response systems

Introduction

Clinical governance is essential to provide oversight and expert advice about the safety, effectiveness, and ongoing improvement of the recognition and response system. In some centres this may be a separate patient deterioration committee whilst smaller centres may take an approach to clinical governance that relies on linkages with pre-existing structures such as organisational patient safety or a wider clinical governance committee. What is important is that ongoing effectual clinical governance is essential to anticipate, adapt, learn and respond, enabling a resilient and sustainable approach to the system.

Factors contributing to failures to recognise or respond to patient deterioration are complex and wide-ranging. These include a lack of formalised systems and processes; inadequate clinical governance; a siloed and super-specialised hospital workforce; problems associated with inadequate clinical knowledge and skills; suboptimal handover, communication and teamwork; inconsistent patient and family engagement; organisational resource constraints; and competing priorities.[1–4]

The function and sustainability of recognition and response processes depends on underpinning structures for clinical governance; teamwork, handover and communication; education and training; and measurement and evaluation. Clinical and administrative resources are required to support sustainable and effective functioning of the system. Recognition and response systems therefore require a whole-of-hospital approach for successful implementation and sustained improvement.

Recognition and response systems must be part of the strategic plan to make a hospital safer.[4] Visible and ongoing executive, clinical and operational leadership and clear clinical governance structures are needed to ensure that recognition and response systems are adequately supported and functioning successfully. Those who are accountable for the performance of the recognition and response system must oversee a range of activities such as policy and process development, evaluation and quality improvement, resourcing and equipment, education and training, and patient and family engagement. A collaborative model of executive, clinical and operational leadership is required.

Purpose

This paper is intended for project teams responsible for improving recognition and response systems in Aotearoa New Zealand hospitals. It briefly outlines recommendations for ongoing clinical governance. Example terms of reference for the committee with responsibility for clinical governance of the system are included in Appendix 1.

Clinical governance committee

Regardless of the structure of the governance committee, oversight of the recognition and response system must be provided by a multidisciplinary committee. The committee will have terms of reference focused on early recognition and response to patient deterioration, inclusive of maternity early warning, Kōrero mai and shared goals of care (see Appendix 1).

The committee should provide a recognition and response system policy that addresses:

- the core set of vital signs to be obtained
- the early warning score and triggers for escalation, which reflects patient or whānau concerns (Kōrero mai)
- recommended minimum frequency for measurement of vital signs
- the mandated escalation pathway
- the response protocol, including expected response times and identification of responders both during office hours and out-of-hours/weekends
- expectations for communication and documentation when clinical deterioration may occur achieved through shared goals of care discussion and decision.

A range of related policies and guidelines should be aligned to reflect the requirements of the recognition and response policy. These may cover many different aspects of clinical practice, including documentation, handover and communication; monitoring requirements for particular procedures, medications or interventions; and referral or discharge guidelines. Consider how shared goals of care link to the organisation's models for planned and unplanned care, and specifically advance care planning, Serious Illness Conversation Guide training and end-of-life pathways.

Data for collection and review include:

- hospital-wide cardiac arrest rates (reported per 1,000 hospital admissions)
- hospital-wide rapid response team activation rates (reported per 1,000 hospital admissions)
- rates of unplanned transfers to higher acuity care (for example, to intensive care or to a tertiary hospital)
- intermittent audits of vital sign and early warning score documentation
- where available, data from electronic systems to identify missed or delayed escalation
- data from retrospective case note review to identify missed or delayed escalation
- periodic surveys of staff attitudes and patient, family and whānau experiences of using the recognition and response system.

Refer to the measurement guidance provided by the Health Quality & Safety Commission for further information about measures that need to be nationally reported through the quality and safety markers.

Leadership and operational management

Multidisciplinary leadership is required for maintaining successful recognition and response systems. Leadership includes medicine, nursing, midwifery, allied health and Māori health outcomes. The committee should also include a minimum of two consumers and members from the advance care planning programme and end-of-life pathways.

Responsibilities of leaders may include:

- advocating for use of the recognition and response system with clinical colleagues
- working with consumers to co-design elements of the recognition and response system (for example, patient, family and whānau escalation pathways)
- collaborating with colleagues with expertise in patient safety and quality improvement, and with consumers, to design processes, policies and improvements to the recognition and response system
- providing or seeking expert clinical advice to inform adverse event investigations where there is opportunity for the system to improve in recognition or response to deterioration
- advising on the content of education and training about topics such as vital sign and early warning score measurement and documentation, escalation of care, assessment and care of patients whose condition deteriorates, and teamwork, handover and communication.

Day-to-day management of the recognition and response system should be allocated to people with the relevant skills, experience and delegations to address operational requirements. These may be specifically established roles in large hospitals or incorporated into existing roles in smaller hospitals. Responsibilities of the operational leader of the recognition and response system include coordination and oversight of:

- managing specialist responders (for example, intensive care outreach nurses or other senior medical nursing or midwifery staff) and coordinating the day-to-day work of rapid response team members
- coordinating access to required education and training for participants in the recognition and response system
- data collection reporting and analysis
- policy and process implementation
- managing day-to-day process issues.

References

1. Cioffi J, Salter C, Wilkes L, et al. 2006. Clinicians' responses to abnormal vital signs in an emergency department. *Australian Critical Care* 19: 66–72.

2. Endacott R, Kidd T, Chaboyer W, et al. 2007. Recognition and communication of patient deterioration in a regional hospital: A multi-methods study. *Australian Critical Care* 20: 100–5.

3. Van Leuvan C, Mitchell I. 2008. Missed opportunities? An observational study of vital sign measurements. *Critical Care and Resuscitation* 10: 111–5.

4. DeVita M, Hillman K, Bellomo R. 2010. *Textbook of rapid response systems: Concept and implementation.* New York: Springer.

Appendix 1: Example terms of reference for recognition and response system clinical governance committees

This document provides a generic example of clinical governance for recognition and response systems. It will need to be modified to reflect the local circumstances of each organisation.

1. Purpose

The purpose of the committee is to provide oversight and expert advice about the safety, effectiveness and ongoing improvement of the recognition and response system.

2. Membership

The committee should include nursing, midwifery and medical staff representing the acute specialities most relevant for the hospital, representation from members of the rapid response team, and the person or people with responsibility for day-to-day operational leadership of the system. Additional members may include consumers and representatives from allied health, hospital administration, and quality and safety.

3. Responsibilities

The committee:

- oversees development and review of practice and policy relating to management of acute deterioration
- sets expectations for workforce capability in relation to managing patient deterioration effectively and determines the requirements for staff orientation, education and ongoing training related to the recognition and response system
- reviews and monitors standards of recognition and response system performance against key local and national objectives
- reports summative data to senior governing committees (such as the clinical board or clinical governance committee)
- oversees processes to ensure that real-time data about performance at the ward or unit level is reported to each ward or unit and used for local quality improvement
- provides recommendations around access to, and standardisation of, equipment required to safely recognise and respond to acute deterioration
- identifies risks that could reduce the effectiveness of the recognition and response system and provides advice about managing identified risks to relevant professional or operational leaders
- works in partnership with regional patient deterioration quality networks to maintain a consistent and coordinated approach to recognising and responding to acute deterioration.

4. Governance

The committee reports to the highest level of clinical governance in the organisation – for example, the clinical board, clinical practice committee, patient safety committee or similar.

The committee has the delegated authority to set up and disband specific working groups in order to effectively discharge its functions. Any such groups will be time limited and have clear terms of reference.

5. Meetings and decision-making

At a minimum, the committee will meet quarterly. Advance notice of the regular meeting schedule should be made available to members as early as possible to optimise attendance.

More frequent meetings may be required at times – for example, if significant patient safety concerns indicate urgent improvements are needed. Such arrangements should be agreed through consensus of a majority of committee members.

The committee has delegated authority to make decisions about policy and practice issues in line with the responsibilities described above and within delegated parameters from the organisation.

Clear processes must be in place for the committee to escalate issues impacting on the effectiveness of the recognition and response system that it does not have delegation to resolve. For example:

- significant patient safety issues should be escalated via quality and safety managers and professional leads to the executive
- resource issues should be escalated via operational managers to the chief operating officer
- individual performance management issues should be referred to the relevant line manager.

6. Reporting and communication

Meeting minutes are documented and made available to all hospital staff.

The committee communicates timely summative reports of recognition and response system activity and performance aggregate data to key hospital committees (for example, the clinical governance committee, the clinical board, and the quality and safety committee).

The committee provides a summary of the recognition and response system performance data and any consequent improvement actions to the board, the consumer network, and all hospital staff at least annually.

7. Terms and conditions of appointment

Members will be appointed to ensure appropriate representation from medicine, nursing, midwifery, allied health, quality and safety, operational management, and consumers. Specific time will be allocated to ensure that members are able to fulfil their responsibilities for the committee.

A chair for the committee will be nominated from the membership and appointed with agreement of senior professional leaders.

The terms of reference for the group will be reviewed annually.