ACT Government | Canberra Health Services

COMPASS Implementation Guide

2011

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Introduction

So you are thinking about introducing COMPASS at your hospital? Well hopefully this manual may help.

The COMPASS© program has been developed by Canberra Health Services and has been made available for use by other facilities. This manual will assist you in the introduction of the program within your facility.

If you have any questions or require assistance please contact us on (02) 6207 6827 or compass@act.gov.au

Background

Canberra Health Services formerly endorsed the Early Recognition of the Deteriorating Patient Project through the appointment of a project officer in January 2006. Resulting from this a joint project team from Calvary Health Care and Canberra Hospital was established. The team has looked at what contributes locally to the failure of early recognition of the deteriorating patient.

The gold standard process that has to take place to recognise early deterioration is outlined below with examples of some of the issues related to the gold standard that you may be experiencing:

- Observations need to be performed
  - Routine observations not consistently being performed
  - Observations not being performed when clinically appropriate
  - Observations not getting done post procedure
  - Respiratory rate frequently not done
- Nurses need to interpret observations
  - Observations out of normal range *are* documented but not actioned appropriately
  - Medical Emergency Team (MET) not being called despite patient observations meeting the MET criteria
  - Once an alteration is documented there is lack of escalation of frequency of observations
- Nurses need to communicate to the medical staff the abnormality in observations
  - Significant changes in observations or significant deviation from patient's normal range are documented but not actioned
  - A MET call is not always activated when the patient meets the criteria
  - Communication from nurses to doctors regarding the patient's change in condition is not always clear and concise

- Doctors need to review patients
  - Competing priorities cause delay in review
  - Lack of documentation once reviewed
- Doctors need to interpret the observations made
  - Doctors review patients, however may not seek appropriate assistance from more senior medical staff
  - Nurses concerns are often dismissed by doctors
- Doctors need to employ appropriate action
  - Diagnosis and management plans not developed and clearly documented
  - MET not called
  - Communication with registrars and consultants not documented

The introduction of a track and trigger system (Modified Early Warning Scores [MEWS]) and new observations charts, independent of the introduction of the simultaneous education package, is setting up the project to fail. MEWS alone will not suddenly change the issues that have been identified. An education package will allow a greater understanding of the difficulties identified and ensure greater "buy-in" from the areas examined. It will

allow the opportunity for the health care professionals to have an understanding of why "boring and seemingly meaningless" observations are performed on the ward. This, in turn, would increase the frequency with which they are carried out and an understanding of what to do next.

Evidence from the literature suggests that education is an important aspect of early recognition and compliments as well as supports the introduction of a MEWS.

- MEWS was not consistently applied and there was a documented deficit in frequency & consistency of observation reported (Chellel et al, 2002) Education in conjunction with MEWS is needed to enhance the understanding of the meanings of the scores.
- Informal and an interactive approach in training optimized the effectiveness of early warning score (Shapley & Halden,2004)
- Strategies to prevent cardiac arrest should include training for nurses and physicians that concentrates on cardiopulmonary stabilisation and how to respond to neurological and respiratory deterioration (Franklin & Mathew, 1994)
- In the recommendations from the United Kingdom Resuscitation Council (2005), was the need to ensure that all clinical staff are trained in the recognition, monitoring, and management of the critically ill patient
- Smith, Osgood, & Crane (2002) pointed out that sub optimal care is frequently related to poor management of simple aspects of acute care
- The ALERT course currently being used extensively in the UK for interdisciplinary education has beneficial effects on the confidence levels and attitudes of health care

staff in relation to the recognition and management of acutely ill patients" (Featherstone, Smith, Easton, & Osgood, (2005)

Aim

The aim of the COMPASS© program is to enable health care professionals to recognise the deteriorating patient and initiate appropriate and timely interventions.

The objectives are:

- For participants to understand the importance and relevance of observations and the underlying physiology
- For participants to be able to recognise and interpret abnormal observations
- For participants to be able to communicate effectively to the right people and at the right time
- For participants to feel confident in recognising and managing deteriorating patients
- To facilitate teamwork within the multidisciplinary team
- To enable nurses, doctors, and physiotherapists to develop management plans together

The COMPASS© Program

The Early Recognition of the Deteriorating Patient Program in Canberra Health Services includes three interventions:

- Colour coded observation charts
- A track and trigger system (Modified Early Warning Scores)
- The COMPASS© education package

The COMPASS education consists on the following components:

- Prelearning:
  - Interactive COMPASS Online Learning application - the physiology of vital signs
  - The COMPASS© manual which provides more detail on physiology as well as initial management (The manual along with the Online Learning make up the prelearning component)
- A quiz to be completed before attending the face to face session
- A 3 hour face to face session that includes the local coloured observation charts and the local escalation strategy:
  - A PowerPoint presentation covering the track and trigger score
  - ISBAR communication strategy (Identify, Situation, Background, Assessment and Recommendation)
  - Three interactive case studies

Getting ready

From our experience the program will be more successful if some ground work is done before any training occurs. Hopefully this section will assist you in establishing this.

Governance

The first task is the establishment of the governance for the deteriorating patient work at your hospital. This may be a specific Steering Committee established for the project or it may sit within an existing committee such as a Resuscitation Committee. This governance structure needs to be established to ensure the responsibility has been allocated to enable the project to progress. It will provide consistent guidance, decision making and policy development/approval for the program.

Having an Executive Sponsor will raise the profile and provide the leadership required for change.

Below is one way of identifying the governance of a project:

Responsible – who will do the work

Accountable – who will sign off the work

Consulted – whose opinions are important

Informed – who needs to know what is happening

http://www.productdevelopmentmanagement.co.uk/RACI_roles_responsibilities_matrix.shtml Sourced 11 October 2010

Key Tasks

Some of the key tasks that need to be completed include:

- Establish a small team (be sure to include clinicians who do direct patient care) to actually do the work such as:
  - design/adapt the chart
  - write the policy
  - conduct the training.
- Who will be the Executive Sponsor?
- Have a Medical Clinical Lead
- What is the nature and extent of the current problem at your facility?
  - Identify adverse events and local issues
  - Where can you tap into existing data?
  - Conduct pre audit of vital signs and actions

  - Consider staff surveys or focus groups to gain information on knowledge levels and/or issues
- Decide on how you will do it (i.e one ward, whole hospital) - This may be depend on the size of the facility
- Decide and agree on timelines
- Decide what track and trigger you will use (MEWS, single trigger)
- Decide what observation chart you will use
- Do you need resourcing (cost of printing manuals and producing CDs, Train the Trainer, staff time, etc)
- Decide on what you will audit to see if things improve

Barriers

You will inevitably come across some barriers as the work progresses.

Some common barriers you may face include:

- Lack of motivation
- Lack of knowledge about the need for the project
- Attitudes or beliefs
- Change fatigue
- Engaging senior medical staff
- Resourcing
- Engaging Executive Sponsorship
- Reality and perception mismatch

Identifying the barriers upfront will assist in planning an approach to overcome them. If you do come up against a barrier and you are unsure how to overcome it please feel free to contact the COMPASS team as we may be able to assist with some strategies.

Communication

Communication will be an essential part of the program's success. Anyone who either has impact on the program or will be impacted by the program should be either included (or a representative for larger groups) or kept in the loop as the work progresses.

Some ways to raise the profile of the project can include:

- Newsletters, Posters, Giveaways
- Progress reports
- Morning teas for clinicians
- Individual letters or conversations

- Committee meetings (Morbidity and Mortality meetings, Executive, Senior Nurses, Medical Staff Council.....)
- Don’t forget the Night Duty staff

Factors for Success

Some of the factors for success for us have been:

- Executive level support (Chief Executive, Health Minister)
- Stakeholder involvement from the start
- Aim- it’s about the patient
- Start small
- Staged rollout
- Consumer involvement
- Education to local educational institutions “get them while their young”
- Evidence, evidence, evidence…
- Evidence of the need for change
- Evidence of improvements made
- Use “opinion leaders”
- Tailor to the audience “what's in it for me?”
- Resistance- can’t argue against evidence!
- Communication- progress reports, newsletters. Posters, presentations, one on one
- Keep the profile high
- Adaptability- escalation in other areas (rural)

Lessons we have learned while working with other facilities in implementing COMPASS© include:

- Ensuring you have strong leadership and sponsorship of the program
- Ensuring that background work has been done in raising the awareness of the program at your facility with clinicians
- Ensuring participants in the COMPASS© training have had access to COMPASS Online Learning and the COMPASS manual to complete the prelearning component
- Ensuring the escalation suits your facility and available resources

Conducting COMPASS training

There is a series of steps to take to get the COMPASS© education up and running:

1. Download the COMPASS© materials from our website (www.compass.act.gov.au), including the COMPASS Online Learning application (or ensuring participants have access to the internet, Online Learning can be completed once the participant has registered on the COMPASS website (this is free))\
2. Adapt the COMPASS manual to reflect your policy. Adaptations can be made to suit the local track and trigger system and local escalation guidelines and resources in the chapter on Modified Early Warning Scores (MEWS) and any reference to the local systems throughout the remaining of the manual. **Adaptation for other components of the manual requires written permission from Canberra Health Services**. If you need a word version please contact the COMPASS team. If you make these changes, insert a statement on page ii that changes have been made. If required you may place you badge/logo on the back cover of the manual.
3. Adapt the PowerPoint to reflect your policy and chart
4. Adapt the Case Studies to reflect your policy and chart
5. Establish a system to conduct the quiz, this may be with an online quiz or paper based depending on your available resources. The aim of the quiz is to ensure that participants have done the prelearning around physiology before they attend a face to face session.
6. If you would like ACT Health staff to conduct the initial training, book the training date in conjunction with the COMPASS© team. The longer lead up time we have the better the chance we will be able to attend on the dates you wish.
7. Raise awareness of the program in each clinical area that will be affected. This may be a brief introduction in-service to outline the work you are doing, or spending 10 minutes at a ward meeting.
8. Select who your trainers will be. They should be well respected clinicians who have the knowledge, competence and ability to facilitate a deteriorating patient case study.
9. Distribute COMPASS Online Learning application and manual to trainers for the prelearning component (allow 2 weeks for completion)
10. Conduct the train the trainer (with or without Canberra Health Services assistance)
11. Schedule the face to face sessions
12. Organise trainers to assist in the case studies
13. Advertise the sessions for participants
14. Distribute COMPASS Online Learning application and manual to participants for the prelearning component (allow 2 weeks for completion)
15. Do an evaluation of the education at end of each session
16. Ensure at least 50% of staff have completed training in each clinical area before the new charts are implemented
17. “Go live”
18. Evaluate the pilot

COMPASS Course Preparation Checklist

Raising the awareness of the program at your facility is essential for its success. Staff who will be attending training should already be aware of your local plans and be provided with the prelearning materials.

- The face to face component usually takes 2 ½ to 3 hours, the first 1 ¼ hours is the PowerPoint component then about 1 hour to complete the 3 case studies (20 minutes each).
- Usually one person does all the PowerPoint sections (educator, project person etc), then trainers are brought in to facilitate the case studies.
- Ideally the case studies have 3-6 participants in each group, and the group rotates to each of the 3 case studies stations.
- The number of participants in each session will depend on the number of trainers you have available. So if you have 3 trainers, then 18 participants can attend, if you have 6 trainers you can take up to 36 participants (and run two lots of cases at once), and so on.

Before the day

- Dates selected and venue booked
- Participant List finalised
- Trainers booked and confirmed including 3 for scenarios
- Materials sent to participants 2 weeks before including manual, Online Learning application & quiz
- Afternoon tea organised if required
- Laptop & projector for presentation organised
- PowerPoint altered if needed to suit local changes
- Scenarios and observation charts available
- Course evaluation sheets printed
- Certificates printed

On the Day

- Tea/coffee and biscuits available for break if needed
- All materials and equipment for the day assembled (see above)
- Certificates to be given out at the end of the session
- Evaluation sheets to be given out and completed prior to the leaving

Maintaining the changes

Like any change, sustainability is a key to ongoing improvements.

As part of our sustainability plans we do:

1. Annual refreshers of 1 hour which includes a new quiz, two way feedback on any issues and one new case study
2. Monthly auditing of each clinical area that has introduced the program
3. Ongoing leadership of the program and executive support
4. Quarterly reports on progress and audit results
5. Audit results sent back to each clinical area

Our Publication

I.A. Mitchell, H. McKay, C. Van Leuvan, R. Berry, C. McCutcheon, B. Avard, N. Slater, T. Neeman, P. Lamberth. A prospective controlled trial of the effect of a multi-faceted intervention on early recognition and intervention in deteriorating hospital patients. Resuscitation 81 (2010) 658–666

National Consensus Statement

Australian Commission on Safety and Quality in Health Care, National Consensus Statement: essential elements for recognising & responding to clinical deterioration.

Access document at:
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/home

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