



SOUTH EASTERN SYDNEY
ILLAWARRA
NSW  HEALTH

Implementing

PATIENT WITH ACUTE CONDITION
FOR ESCALATION
in a large facility

St George Hospital:

- 626 bed facility.
- ED presentations 55,000/year (180/day)
- 20 ICU beds (15 general, 5 cardiothoracic)
- 12 HDU- Independent of ICU medical governance (PACE implemented)
- 8 CCU beds/ 8 SAC beds (PACE implemented)
- 1400 Nursing Staff
- 455 Medical Staff
- 110 Relevant Allied health staff
(physiotherapists & speech pathologists)
- >30 Relevant medical specialities

The Goal

- 80% of ALL relevant staff orientated prior to PACE implementation

The Timeframe

- 4 -6 weeks from onset of education

Considerations

- What, who & how to educate
- Who will respond to PACE calls- 24hr cover
 - How will they be notified
- Where will PACE be implemented

- Use established resources
 - Don't reinvent the wheel- remodel it.
- Phase 2 facility
- Networked executive/ key staff
- PACE Calling criteria
- Posters
- Calling cards for all staff – lanyard size
- PACE Modification form
- Used the 'lessons learnt'

Adult PACE Calling Criteria

If acute changes in any ONE of the following, activate a PACE Tier 1 call with patient's medical team, Ward, Bed number

Airway	Threatened
Breathing	Respiratory rate < 8 or > 30
O ₂ Saturation	≤ 90% and/or increasing oxygen requirements
Circulation	Heart rate < 45 or > 130
Systolic BP	< 90mmHg or > 200mmHg
Neurological	Seizures OR Sudden decrease in level of consciousness OR Altered mentation (new)
Urine Output	< 200mls/8hrs
BGL	< 3
Any rapid change in observations	
Any other condition you are concerned about	

Turn over for PACE Tier 2 Criteria

Obstetric PACE Calling Criteria

If acute changes in any ONE of the following, activate a PACE Tier 1 call with patient's medical team, Ward, Bed number

Airway	Threatened
Breathing	Respiratory rate < 8 or > 30
O ₂ Saturation	≤ 94% and/or increasing oxygen requirements
Circulation	Heart rate < 45 or > 130
Systolic BP	< 85mmHg or > 170mmHg
Diastolic BP	>110
Neurological	Seizures OR Sudden decrease in level of consciousness OR Altered mentation (new)
Urine Output	< 100mls/4hrs
BGL	< 3
Any rapid change in observations	
Any other condition you are concerned about	

Turn over for PACE Tier 2 Criteria

Where to start?

■ Executive engagement:

- Form a steering committee with persons within the facility with the ability to make key decisions and provide sponsorship.
 - Executive staff had been briefed by Area prior to PACE coordinators appointed.
- Meet regularly- every 2 weeks until implemented

■ Identify champions:

- Meet with CNE's, NE's & CNC's before beginning to educate in earnest- their questions are often the hardest to answer.

Know where PACE is to be implemented & who the responder will be.

- All inpatient areas without 24 hour registrar level medical cover.
- Assess the needs of relevant outpatient departments:
 - Haematology and oncology day centre
 - All haemodialysis patients
 - Ambulatory care unit
 - Mental Health Unit

Nursing & Allied Health

- Ensure that PACE takes priority for education.
 - **Executive engagement- make the directives come from above**
 - Access NUM's & Nursing Co-Directors to ensure that PACE education is championed above all others.
- Ensure resource effective education-
 - Don't use small facilities, book the largest conference room in the hospital every day for at least 1 month.
- Night duty
 - **Executive engagement- Altered nursing shift start times to capture all staff rostered onto ND**
- Casual and agency nursing staff
 - Invite to attend PACE orientation
 - Ensure hard copy material available that staff sign for when read and understood.

The obstacles:

- **Medical Staff-**
 - Elusive
 - Cautious of any trigger based referrals
- **SURGEONS-**
 - Hard to access
 - Reluctant to become involved in 'medical issues'
 - Want to ensure that surgery time is not compromised.
- **Engaging autonomous departments-**
 - Obstetrics – identifying the potential benefits
- **The PACE calling criteria**
 - Changing preconceived ideas that the calling criteria was rigid.
- **Workload**
 - Estimating the impact of PACE in a busy, resource stretched facility (especially after hours)

Working Solutions:

- Attend departmental meetings- answer questions face to face.
 - Meet with HOD's prior to gauge response and to try and limit negativity by explaining the rationales and goals of PACE
 - Champion the modification form!
- Target JMO and Registrar management to access relevant medical staff.
- Develop hard copy PACE packs- there will be staff missed
 - Delegate to JMO and Registrar management to keep maintenance of a tally of who has received the information.

Working Solutions:

- Surgery- Alleviate fears that they will not be unsupported to manage acute deterioration.
 - Tier 2 escalation process to get urgent ICU support.
 - Tier 1 are often early signs of deterioration when there is time to get relevant consults.
- Back up surgical roster- make as fool proof as possible.
 - Back up roster based on the 4 week rotating subspecialty roster.
 - The covering group is paged at the commencement of the AM or PM operating session to remind them that they are the 'PACE back up team for surgery'
- The prediction for St George prior to PACE implementation:
 - **6-8 PACE calls/day.**

No department or unit is an island

- ICU, operating theatres, PACU, and ED are not exempt from PACE orientation.
 - Modify PACE presentation to suit the target audience
 - Ensure that staff are aware that they are included in PACE & how it will impact them.
 - Discharge planning
 - Handover
 - Tier 2 responders

Don't Forget

- Communications
- Who will get called following a PACE call-
 - Medical, nursing and managerial support staff
 - Triple check all of the groups prior to implementation
- Programming takes time
- Ensure that there is education on what PACE is as well as operational issues.
- Develop a prompt/flow sheet to be used to ensure all relevant information is captured at the time of the PACE call.

Before implementation

■ Be visible

- Road Show
- Posters/Flyers
- Be available to answer questions.
- Have a countdown.
- Don't implement PACE after hours-
Start Monday 0800.

Take home messages:

- Ensure as much executive level support as possible.
- Have all (or most) of the answers before you start education in earnest
- Engage communications early- include them in why PACE not just what to page.
- Ensure resource effective education- avoid small venues.
- Attend departmental meetings- their concerns/questions vary per specialty.

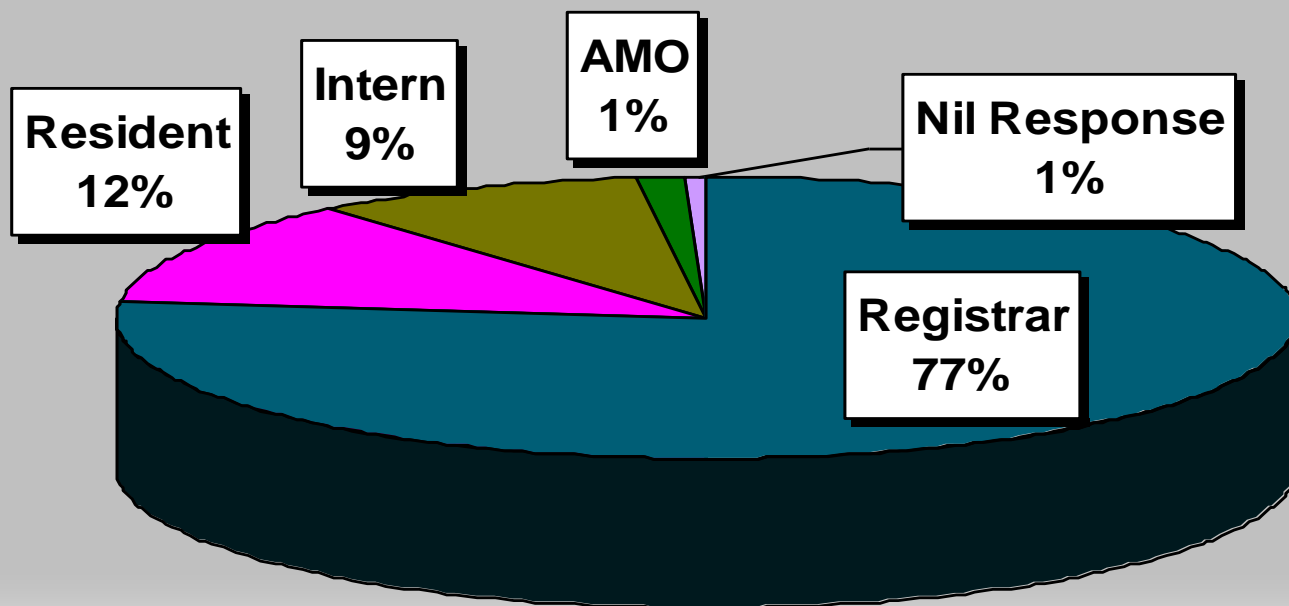
What then?

- Education is ongoing
 - New Staff
 - Reinforcing PACE policy and rationales

2010 Goals for St George

- Improve feedback
- Increase education on recognition and management of deteriorating patients
- Improving documentation of the elusive management plan.

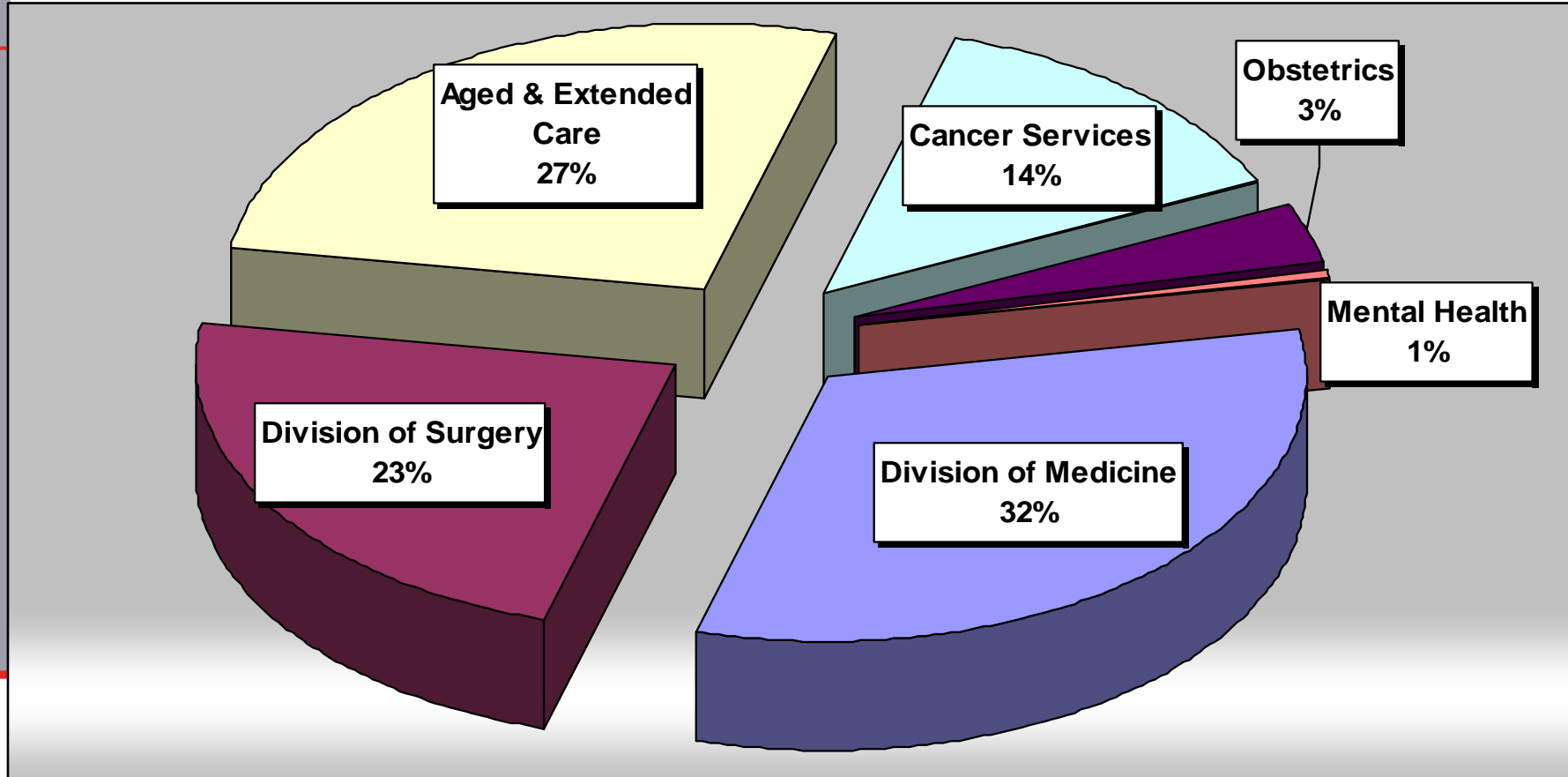
PACE at St George Hospital Medical Responder



Data from October 2009-February 2010 inclusive

Total number PACE calls: 1139

PACE call by divisions

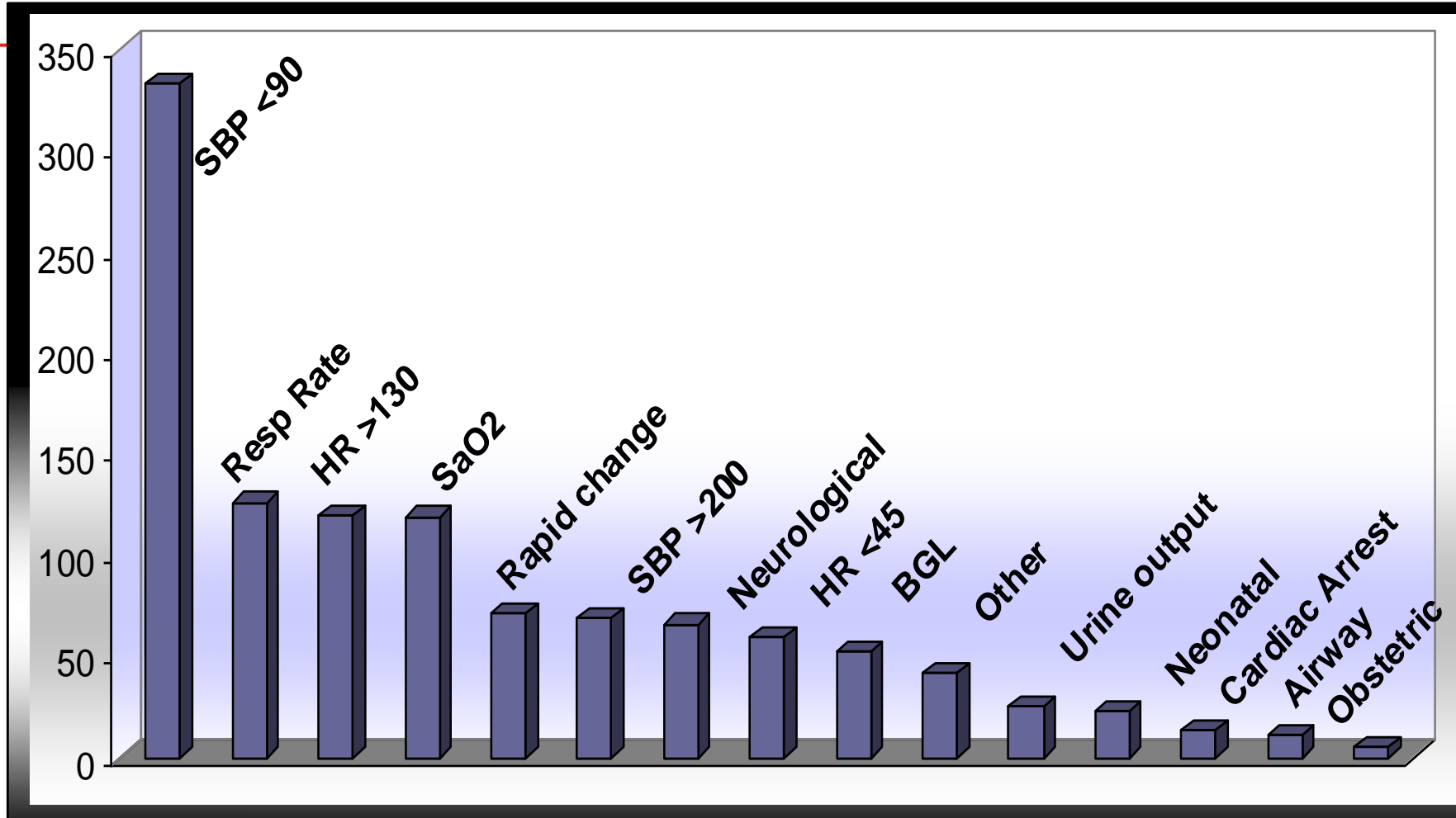


Data from October 2009-February 2010 inclusive

Total number PACE calls: 1139

Average: 7.6 PACE calls/day

Triggers

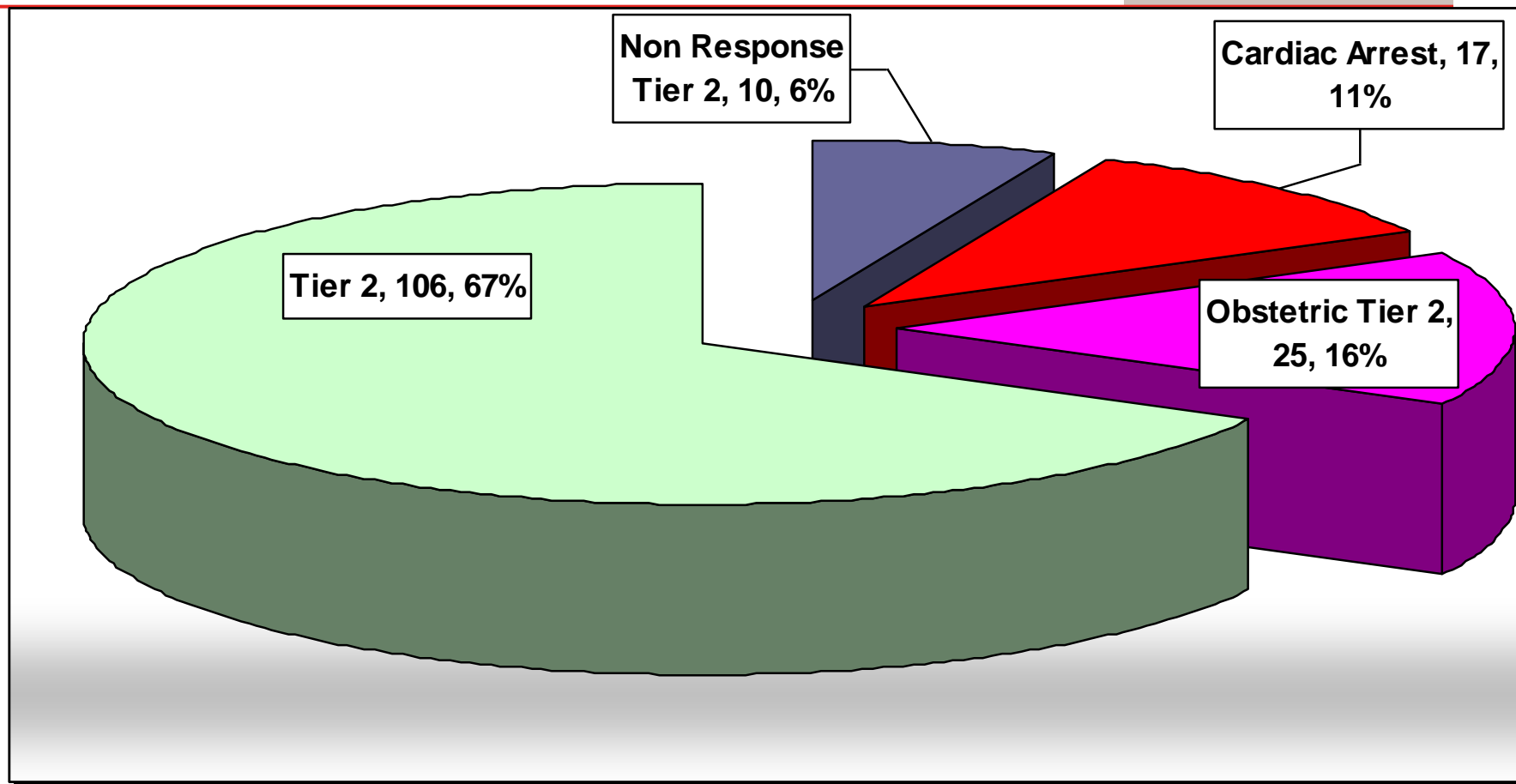


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Tier 2 & Cardiac Arrests

- No comparative data collected prior to PACE implementation-
 - Cardiac arrest call activation rate 0.47/day (18 months pre PACE).
- 17 Cardiac Arrest/implementation- 0.11/day
- Anecdotal feedback is positive.

Tier 2/ Cardiac Arrest



Data from October 2009-February 2010 inclusive
Percentile of total number of PACE calls: 14.2%



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**PACE**
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