Clinical Management SIR Sub-Committee

Key Messages – October to December 2022

Purpose

This document is a summary of key messages identified by the Clinical Management Serious Incident Review Sub-Committee during its meetings held in the last quarter of 2022. These messages are gleaned from serious adverse event reviews (SAERs) and reviews of other serious incidents to provide useful learnings for clinical care. Clinicians and managers are encouraged to consider the following key messages and apply to clinical practice and clinical service delivery.

Alterations to Calling Criteria

A medical officer may alter the Between the Flags standard calling criteria (blue, yellow or red zone parameters) following assessment of the patient and in consultation with the AMO/ delegated clinician responsible and the patient, carer and family.	**Resource:** NSW Health Policy Directive *Recognition and management of patients who are deteriorating* - PD2020_018.

Cardiopulmonary resuscitation

When a cardiac arrest occurs during a procedure separate the roles of proceduralist and team leader for the resuscitation.

Consent for a procedure

The Junior Medical Officer (JMO) may not be the appropriate clinician to obtain a valid consent if the procedure is complex and the JMO is not familiar with the procedure, may not have seen the procedure performed or has not previously performed the procedure.	**Resource:** Consent to Medical and Healthcare Treatment Manual - Section 5.3

End of Life Care

It is important to have early discussions with patients around their end of life wishes and expectations. Ensure their wishes are documented and accessible in their medical record and made known during transfers of care. Use the resources to ensure the patient's wishes are followed when they are no longer able to speak for themselves.	**Resources:** NSW Health - End of Life care at NSW Health Guideline End of Life Care and Decision-Making – GL2021_004 CEC AMBER care bundle. Last days of life toolkit.

Pulmonary Embolism

Consider pulmonary embolism in patients with recent and long COVID-19.

Extracorporeal membrane oxygenation (ECMO)

ECMO is a highly specialised service provided in specialist tertiary intensive care units, where clinicians with expertise in ECMO are available to support the initiation, ongoing management and post-ECMO patient care. Timely referral to an appropriate ECMO facility is paramount. ECMO is provided by either Royal Prince Alfred Hospital (RPAH) or St Vincent's Hospital (SVH) via a roster system.	**Resources:** Contact details in NSW Health Policy Directive NSW Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS) – PD2018_011 Agency For Clinical Innovation – ECMO Resources

Medication Reconciliation

Ensure medication reconciliation during transitions of care especially in patients with chronic medical problems and complex care needs.	**Resource:** CEC – Medication Reconciliation

Re-presentations to the ED

When a patient re-presents to the Emergency Department within 24 hours consider differential diagnosis to minimise the risk of diagnostic error (anchoring bias).	**Resource:** CEC – Be a voice for safety

Reviewing clinical incidents

When reviewing clinical incidents focus more on the care pathway for the patient and less on the patient outcome. The care pathway is more likely to reveal systems issues that, if addressed, will improve patient safety and the quality of care of patients generally.

Sepsis

Sepsis is a medical emergency, and a national Sepsis Clinical Care Standard was released in June 2022. Use the Clinical Care Standard in conjunction with the following resources to improve the recognition and management of sepsis.	**Resources:** Australian Commission on Safety and Quality in Health Care – Sepsis Clinical Care Standards CEC – Sepsis Kills Program

Speaking up for safety

All members of the procedural team, regardless of role, are encouraged to speak up for safety and to listen up for safety specially to prevent procedures involving wrong patient, wrong procedure, or wrong site.	**Resources:** Australian Commission on Safety and Quality in Health Care – Sepsis Clinical Care Standards CEC – Listen up for safety with George Douros - Episode three

We value your feedback. If you have any questions or comments about this report, please email CEC-PatientSafety@health.nsw.gov.au