Teams working together

PIPER retrieval team
and
Referring hospital clinical team

…..a framework to support shared expectations to enhance patient care

December 2020

Provide immediate resuscitation if required

Prepare

Introductions
PIPER and referring team – Names and Roles

Clinical Handover – ISBAR format
Referring unit Medical and Nursing staff and PIPER team

Patient Assessment – PIPER Team

Plan

Discussion with PIPER Consultant
Includes situational assessment, plan and timeline. Consider videoconference.

PIPER and Referring teams discuss provisional plan and timeline

PIPER and Referring teams agree on tasks and role allocations

Discuss Anticipatory Plan for Management of Major Deterioration
Additional personnel e.g MET team, skill sets, roles

Do & Review

1 hour after arrival (earlier if significant deterioration)
Timeout and review of Plan

If team still present 2 hours after arrival (earlier if significant deterioration)
Mandatory update with PIPER and referring Consultants/GPs/Clinicians

Background

There are well recognised challenges in healthcare when "flash teams" are formed to manage acutely unwell patients. The coming together of a retrieval team and referring clinical team is an example of such a "flash team".

At one level the retrieval team configuration and capability can be considered as being relatively stable and predictable. The variation in team configuration across the large number of hospitals who refer to PIPER is much greater. This applies both between hospitals but also within the same hospital. The consistency of staff skill mix and level of comfort in working with the retrieval team can vary from shift to shift, so even while traveling to a familiar hospital the retrieval team cannot be sure that the circumstances that prevailed on previous missions will necessarily be the same.

This mandates that any framework designed to facilitate the smooth working of these teams must have both overarching agreed principles as well as flexibility. This facilitates the rapid ascertainment of available resources and capabilities to minimise misunderstanding and differing expectations of how the combined team collaborate to ensure best care is provided for the patient.

Effective communication and collaboration between two teams coming together is an important determinant of safe patient care. The aim of this document is to provide a framework for shared expectations between these teams, and to highlight both the challenges and opportunities for optimisation where these exist

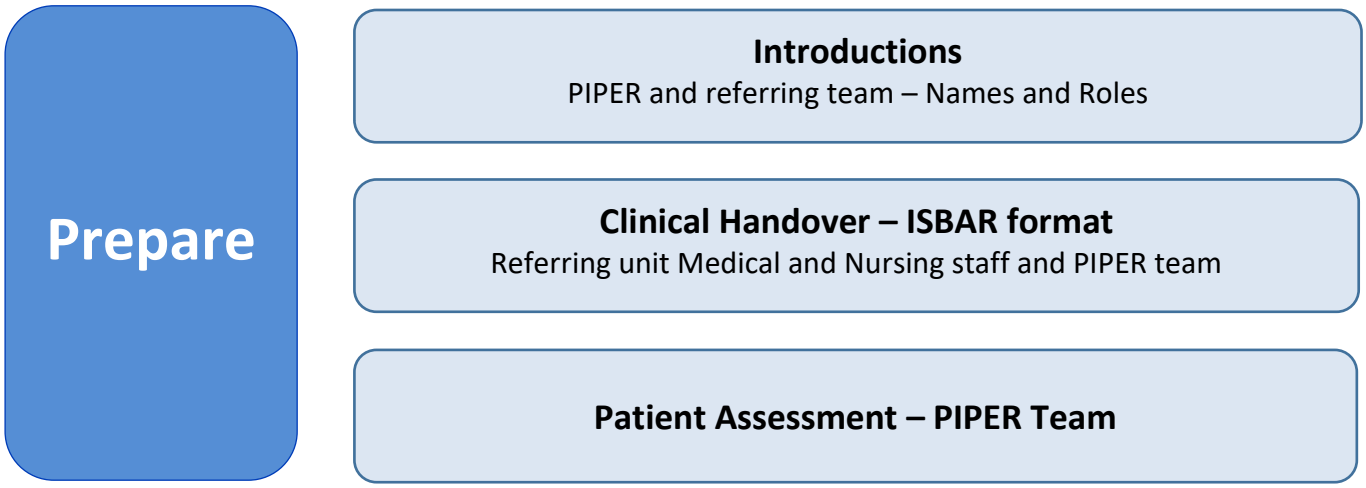
A framework for shared expectations

The flow chart on page 1 outlines the process under 3 phases: **Prepare – Plan – Do and Review**. It provides a basis for setting shared expectations that all referring and retrieval staff can familiarise themselves with.

Some underlying principles, and lessons from previous experiences include:

1. Responsibility for the patient to be retrieved is shared between the referring facility and PIPER. Outcomes are best when both teams complement one another's skill mix
2. Collaboration between both PIPER and referring team, while paramount for babies' care, is an active process – it cannot be assumed to occur without being actively encouraged and fostered
3. Skill mix in referring facilities can vary, with a wide range of nursing and medical comfort and experience in managing young infants. However, there are often more resources available if required and these should be anticipated and clarified. These resources may include senior clinicians in paediatrics, emergency and anaesthesia for example. Identifying and understanding how to mobilise them is essential, particularly in the event of acute deterioration.
4. Similarly, the retrieval team has its own escalation options e.g., a Consultant joins the team. This is a well-established process at the point of referral and triage however when a stabilisation becomes more complex than anticipated there is a less well signposted process that prompts a "retrieval MET" response.
5. Task fixation is a very real risk. Unnecessary delays in stabilisation and transport increase the risk of adverse events, and having simple guides and 'rules' to keep this in check improves the safety of our management
6. Preparation, anticipation, review of initial plans and an awareness of cognitive bias are some ways to proactively cope with potentially stressful clinical situations

Phase 1 – Prepare



Introductions

Introduction by name and role including parents if present.

The aims of the introduction are for:

- Both teams to understand the retrieval process and agree a plan of action
- Both teams to be aware of a shared responsibility for patient management and agree on core personnel to support stabilisation
- The retrieval team to have an awareness of other issues impacting on the referring hospital and team
- Parents/guardians are kept informed
- The referral team should:
    - Have a clear vision of a process for handover, stabilisation and PIPER team departure
    - Feel empowered to continue to take responsibility for the patient's care alongside PIPER team
- The PIPER team should:
    - Get a brief understanding of human and auxiliary resourcing in the facility
    - Communicate process for handover, stabilisation and departure
    - Appreciate and communicate a shared responsibility for patient care. Flag that it is usually helpful to have a discussion around shared care and role delineation following handover and assessment
    - Acknowledge and keep parents/guardians informed
- *If parents/guardians are present, the PIPER team indicates when they ought to expect an update on patient's progress and process for stabilisation and transport. Referring team/PIPER give guidance to parents of where to safely wait (bedside if possible)*

Clinical handover (Referring Facility to PIPER)

Handover in the retrieval situation relies on the same principles as any other clinical context. There are however a few common challenges that can stand in the way of effective communication.

- An unwell patient undergoing or in need of resuscitation as the PIPER team arrive should have the continuation of resuscitation prioritised. An abridged handover should still be undertaken.
- There is a tendency to rush a handover if a patient is perceived to be unwell. However, for a patient not requiring immediate resuscitation, a thorough yet time efficient handover will save time in the long run and reduce the risk of important information being missed. Avoid informal handovers.
- It can seem unclear to the referring units as to who has been listening to the initial referral/s, and therefore how detailed to make the handover when the PIPER team arrives. For the safety of the patient, the default should be to provide a face to face handover of all relevant information.

Handover format

- Format in which referring team most comfortable. ISBAR if this is a familiar concept

Active listening with minimal interruptions is the default approach. Clarifications, questions, and additional input by other team members can follow the initial handover.

- There are a number of online resources for handover, including video resources. The ISBAR format (or modifications of it) has become standard across most facilities:

			Example
I	IDENTIFY	Identify the patient and participants	Age, gestation, corrected gestation, birth weight, current weight
S	SITUATION	Nature of presenting problem	Respiratory distress, apnoeas
B	BACKGROUND	History and primary problems	Antenatal and birth history. Progress since birth
A	ASSESSMENT	Current problems and treatment. Airway, breathing, circulation, drugs, disability, environment, electrolytes, fluids, fasting, glucose, pain, social	Examination findings
R	RECOMMENDATION	Plan, therapies, interventions	

The PIPER team **recapping** the salient information provided in handover is an important safety measure.

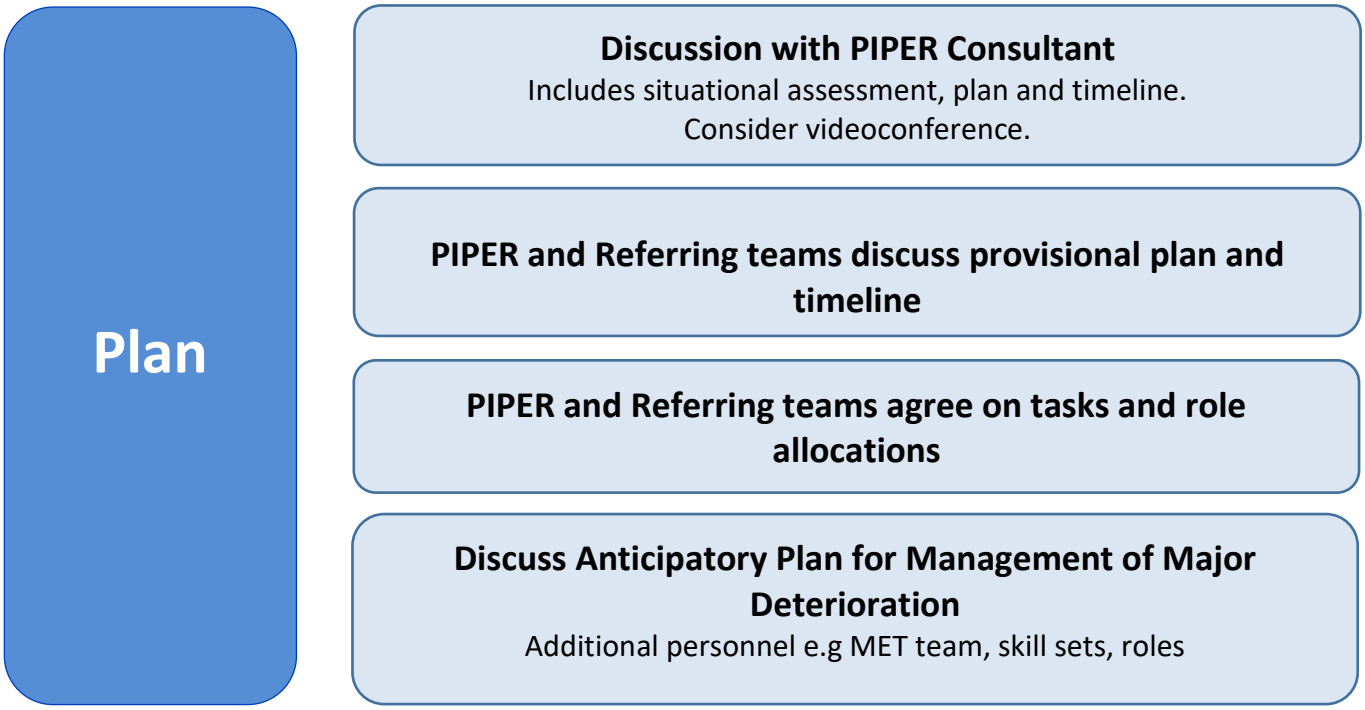
ISBAR, Neonatal e-handbook:

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/resources/clinical-handover/handover

Clinical assessment

Assessment by the PIPER team, consisting of a primary survey, consideration of differential diagnoses, and a plan for whether further therapies are required for safe transport.

Phase 2 - Plan



Discussion with PIPER consultant

The PIPER team will discuss the clinical situation with the PIPER consultant. Referring medical and nursing clinicians are welcome (and encouraged) to join this conversation. The conversation aims to establish:

- Overarching clinical aims prior to departure
- Interventions required and resources needed to carry these out
- Time frame estimate for interventions so that re-conferencing plan can be agreed.
- Plans for major deterioration (depending on the clinical situation)

Provisional plan and timeline; Tasks and role allocation; Anticipate major deterioration

The safest course of action for a sick infant in a retrieval setting is the least amount of intervention required to ensure the transport can be safely completed. The PIPER consultant, in discussion with the retrieval Fellow and Nurse, and the referring staff will determine this. They consider a number of factors including the patient's clinical situation, the referring hospital context and other relevant logistic issues.

Responsibility for the patient's care is shared by the referring team and PIPER. What this means in practice at a particular time and for a particular patient is arrived at by a conversation that needs to occur once a plan for management has been developed. Being realistic and judicious with resources is important, particularly when working with referring units that face concurrent competing clinical priorities.

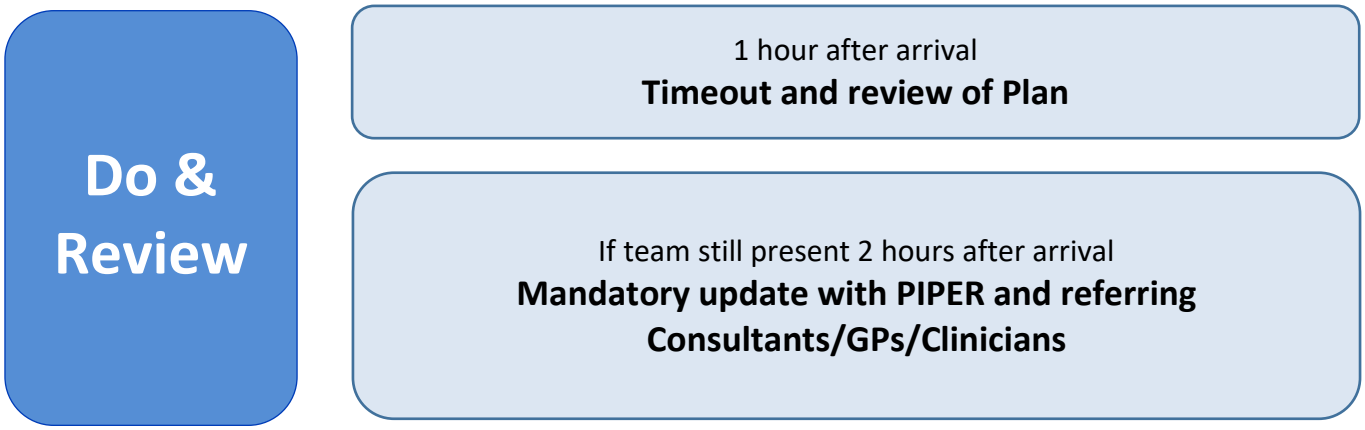
A management plan should be discussed clearly with the referring team, with specific emphasis on:

- Overall clinical objectives prior to departure
- Specific tasks that need to be completed
- Skill set of team members, and role allocation/delineation:
    - Clear indication by PIPER team of what level of medical and nursing support they require to optimise the safety of the patient e.g. local clinician physically present during stabilisation phase, or contactable within short time frame; nature of nursing support
- Need for pathology, imaging services, and how to access these
- Time frames for task completion and departure

Learnings from critical incident reviews highlight the importance of *anticipating a significant deterioration* and having a plan in place to manage this. This will be more applicable to some babies than others, although unpredicted clinical deterioration is a real possibility. This discussion would include:

- Role allocation in the case of a resuscitation, specifically who will lead, manage airway, prepare and administer drugs
- Availability of additional support if required (MET/code blue system, ICU, anaesthetics, GPs, paediatricians) if required

Phase 3 – Do and Review



Time-out and review plan:

Regroup 1 hour following initial management discussion. Review progress, and whether initial time frame is realistic. Consider whether support is required (either more hands, or different skill set). Consider whether agreed upon management plan needs to be refined. Update the retrieval consultant AND senior clinician responsible for the patient at the referring hospital (if not present) if there has been a substantial change to the initial plan.

Mandatory update:

It is important that the entire team has an understanding of direction: what has and is being done, what needs to be done, with projected time frames. Sometimes unanticipated delays occur – stabilising a deteriorating patient, technically difficult procedures, logistical issues etc. This is not necessarily a problem, as long as communication is clear and ongoing. For a proportion of babies, however, delays could mean a missed opportunity for safe transport prior to a clinical change that cannot be managed optimally outside a tertiary centre. Management plans are dynamic and should be open to change. Because of the risk of task fixation, teams should reconvene with **both** the PIPER consultant and referring senior clinician within 2 hours of arrival (or reconvene at a time agreed upon by all in previous discussion). While initiation of this update is primarily a team responsibility the PIPER Consultant also needs to maintain an awareness of time issues and contact the team if they have not received an update.

Getting ready for a retrieval

Please prepare the following for a retrieval:

- Consent forms for PIPER retrieval (neonatal only, 2 copies including the original)
- A discharge summary (2 copies) OR a NETS referral form
- Antenatal history (where relevant, if not detailed in discharge summary, 1 copy)
- Observation, fluid, medication chart photocopies (1 copy)
- Resuscitation documents photocopies (if applicable, 1 copy)
- Placenta (where relevant), doubled bagged and in a plastic container
- Baby book (for neonates)
- Copies of investigations (1 copy) – cord and blood gases, bloods, x-rays (hard copies / CD / or Hub and Spoke)
- Maternal EDTA tube, labelled and with local pathology request slip (if already collected)
- Mobile numbers – mother and/or father / guardian

Parents

Parents will be counselled and given information about the retrieval process on or shortly after PIPER arrival. Depending on mode of transport and other logistics, a parent/guardian may be able to accompany the patient on the trip. Transferring an inpatient, recently birthed, mother to the same hospital receiving the patient can sometimes occur, although it is dependent on a number of factors including bed state, and the mother's projected length of stay and care needs. It is helpful for midwives/nurses looking after an admitted mother to explore this option once a receiving hospital is identified for the patient.

Useful links:

- Neonatal e-handbook - https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/neonatal-ehandbook
- ISBAR: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/resources/clinical-handover/handover
- PIPER website: https://www.rch.org.au/piper/