Setting the Standard:
A patient journey at Royal North Shore Hospital
The challenge...

• To educate an entire hospital workforce in a new hospital about a new service to improve management of deteriorating inpatients
  –Rapid Response Team
The vision...

• Create short films *for the people by the people*
• Utilise a fictitious patient journey to tell an engaging story
• Mass screenings for staff orientation and then distribute as a resource
The team...

Carole Foot
Intensivist & Film Maker

Liz Hickson
Intensivist & Producer

Dave Wastell
BTF Coordinator & Script design

Jess Butler
ICU nurse & Set manager

Sarah Webb
Resuscitation Coordinator & Set design

Brenda Gillard & Jonny Taitz
Executive sponsors & stars
The shoot...
The premiere...
The films...

A Patient Journey at RNSH
Chapters in the series

• Chapter 1 – Introduction to the Standards
• Chapter 2 – Clinical Handover
• Chapter 3 – Use of Standard Observation Charts
• Chapter 4 – Frequency of patient Observations
• Chapter 5 - Recognising clinical deterioration
• Chapter 6 – Ordering yellow zone review
• Chapter 7 - Ordering red zone review
• Chapter 8 – Rapid Response Team Review
• Chapter 9 – Code blue response
• Chapter 10 – Changing the call
• Chapter 11 – End-of-Life planning
• Chapter 12 – REACH initiative
• Chapter 13 – Red zone EMR form for the Rapid Response Team
• Chapter 14 – Conclusion and credits
From “Introduction”
From “Frequency of Observations”

STANDARD 9

Establishing recognition & response systems
Recognising deterioration & escalating care
Responding to deterioration
Communicating with patients & carers
From “RRT review”
From “Code Blue response”
Results

• Cast and crew valued the opportunity to be the face of the institution and leaders in organisational improvement
• The films are a key component of nursing and medical staff mandatory training and are available on the hospital intranet
• Capacity to re-edit and develop further chapters
Results

• Improved compliance with all aspects of ‘Between the Flags’
• Trends to reduced cardiopulmonary arrests and hospital mortality
• No SAC 1 serious clinical incidents in 2013 to date
Lessons – CORE values matter

• **Collaboration** – the film making cemented relationships between executives, managers, nurses and doctors of all levels

• **Openness** – cast and crew worked as equals, inviting essential input and feedback

• **Respect** – there was recognition and valuing of the diverse talent of individuals

• **Empowerment** – all involved were energised to be role models and have been leaders of change
Advice

• Projects that bring teams together across craft groups can be powerful levers of change
• Utilise hidden talents of individuals
• Sustaining change requires ongoing activities
Questions?