Successful implementation of recognition and response systems in mental health settings requires some basic organisational pre-requisites. Ensuring that there are adequate resources in terms of workforce, training and equipment is important for developing and maintaining effective response systems. It is also a key responsibility for health services in meeting Standard 9 of the National Safety and Quality Health Service Standards.

This is the second in a series of four mental health fact sheets. The others in the series are:
- Mental health fact sheet 1: An overview of recognition and response systems
- Mental health fact sheet 3: Communicating about physiological deterioration
- Mental health fact sheet 4: Strategies for engaging mental health clinicians in the implementation of recognition and response systems.

Workforce skills

Observation, communication, intuition and reflection are the clinical skills mental health clinicians must rely on, and they practise these in highly developed ways. However, skills like observation and intuition must be augmented by standardised objective measures when monitoring patients’ physiological status. Incorporating the objective physiological assessments required to detect physiological deterioration into the therapeutic approaches routinely used in mental health settings is possible, but may carry some specific challenges.

Skill mix refers to the level of training, experience and ability that a complement of staff collectively possess on any particular shift. This complement includes medical, nursing and allied health staff. Problems with skill mix, particularly where there might be a majority of inexperienced staff, can contribute to adverse incidents that occur in health settings. A typical workforce in a mental health inpatient setting includes medical and nursing staff with different levels of experience, both in general health care, and mental health care.

In the past, it was possible to receive specific psychiatric nursing qualifications, with more emphasis on the skills of mental health nursing, and less broad training in physiological health and monitoring. Modern curricula potentially contain very little training in the field of mental health. An inpatient unit may have senior nursing staff with a wealth of experience in responding to changes in patients’ mental state leading junior staff with more recent practice in managing physiological changes. This mix is not always characterised by mutual respect, but handled well it can be of significant benefit to patients.

An additional challenge for many inpatient units is the high turnover of clinical staff, with junior medical and nursing staff doing rotations on units from anywhere between six months to two weeks. Maintaining team effectiveness involves recognition of, and adaptation to this atmosphere of constant change.

Strategies to combat these challenges may include:

- Develop clear policies and processes about physiological monitoring and the management of physical deterioration and incorporate these into orientation and annual competency materials and training.
- Embed processes for recognising and responding to clinical deterioration into practice, for example, include physiological monitoring plans in admission documentation packs or develop routines for regular vital sign monitoring.
- Rostering an appropriately skilled team of staff for every shift is almost always a challenge. Develop a system for staff to obtain rapid access to help when necessary. This might involve reaching agreement with the local ambulance service or acute hospital.
- Encourage staff to access training in recognition and management of physiological deterioration as part of their professional development. This might involve attending a formal course, or spending some time with the local hospital medical emergency team.
- Develop a team approach to medical emergencies and ensure that roles are clearly identified – running regular simulations of medical emergency events in the unit will allow team members to test out and maintain their skills, try out different roles and discover where problems might arise before a critical event occurs.
- Identifying clinical champions can be useful, but this strategy needs to be accompanied by developing succession plans so the intervention can be sustained even following the departure of key staff.
Observation and monitoring processes

The National Consensus Statement recommends a minimum set of core observations for the recognition of clinical deterioration. These are respiratory rate, oxygen saturation, heart rate, blood pressure, level of consciousness and temperature. Mental health facilities should ensure that staff have access to appropriate equipment to measure these core observations. Some of this equipment will be standard on acute psychiatric inpatient units, but other items such as oxygen saturation monitors may not have been previously available. The Commission has developed a checklist of basic equipment required to effectively provide for monitoring the core set of observations. This is available at:


Regular checks on the availability and functioning of equipment should form part of routine ward audit. Suitability of equipment should also be recognised, for instance a significant proportion of mental health patients are overweight yet many inpatient units are not equipped with appropriately sized cuffs to effectively monitor blood pressure in this population.

Observation charts should incorporate a track and trigger system and reflect human factors in their design. Some services may already be using such a chart. If not, the Commission has developed a number of observation and response charts and resources to support their implementation. These are available at:


It is important that a determination on the required frequency of observations be based on a clinical assessment of the risk of physical deterioration for each patient. Patients with multiple co-morbidities, particular medical conditions, or treatment-related risks are likely to need more frequent monitoring. Plans for frequency of observations may be protocol based (for example monitoring during clozapine initiation) or individualised for the needs of particular patients (for example those with medical problems such as congestive heart failure).

Monitoring plans should be clearly documented and state the ongoing frequency (times per day or per week) and duration (number of days or weeks) of physiological monitoring. Specific monitoring may be required for particular patients (for example blood sugar levels in patients with diabetes) and these can also be documented in the monitoring plan. In some populations modifications to the triggers for escalation of care may be clinically indicated, for example, in people with severe eating disorders.

Training

Different educational programs and packages have been developed in Australia specifically to improve practice regarding the recognition and response to clinical deterioration. Some of these have been developed as part of statewide programs and are required for health professionals in those states. Key programs are:

- DETECT: a program developed by New South Wales Health as part of the Between the Flags program. See: http://nswhealth.moodle.com.au/DOH/DETECT/content/index.htm

References