Rapid Response Systems and collective (in)competence

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Introduce the fundamental principles of Collective Competence

Develop greater understanding of the situated nature of collaborative decision-making in RRS
Theory of Collective Competence

Understanding collaborative decision-making in Healthcare
Collective Competence

- **Social learning theory**: learning is cognitive process that takes place within a social context

- **Collective competence** refers to the cultural processes of:
  1. Making collective sense of events in the workplace
  2. Developing and using a collective knowledge base
  3. Developing a sense of interdependency

  (Boreham, 2004)
What happens when you don’t have collective competence?

The example of rapid response systems

# The Rapid Response System

## Physiological Criteria / Triggers

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **Airway** | - Respiratory distress  
- Threatened airway |
| **Breathing** | - Respiratory rate >30 breaths per minute  
- Respiratory rate <6 breaths per minute  
- Oxygen saturation <90% on oxygen  
- Difficulty speaking |
| **Circulation** | - BP <90mm Hg despite treatment  
- Pulse rate >130 beats per minute |
| **Neurology** | - Decreased LOC  
- Fitting |
| **Other** | - Concerned  
- Need for treatment and prompt help |

(Shearer, Marshall, Buist, et al., 2012)
Case Study

- Case study is RRS in a university affiliated health network
- Teaching mandate

Data Collection

- Ten focus groups
- Four Australian hospitals

Data Analysis

- Open coding to identify key themes (conventional content analysis) and;
- Codes guided by literature review and theory (complementary directed content analysis)
Lack of collective understanding of RRS events

Professions had different knowledge of criteria

- Staff unable to articulate exact criteria
- Unit-specific informal criteria and protocols
- MD has authority to change criteria
Two separate knowledge systems and decision pathways

<table>
<thead>
<tr>
<th>Profession</th>
<th>Pathway Type</th>
<th>Junior Staff</th>
<th>Senior Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Hierarchical</td>
<td>Rarely activated the RRS without nursing consensus</td>
<td>Comfortable activating the RRS as a patient management tool</td>
</tr>
<tr>
<td>Medicine</td>
<td>Autonomous</td>
<td>Underuse the RRS out of concern for being perceived as competent</td>
<td>Felt calling a RRS took away training opportunities for junior medical staff and students.</td>
</tr>
</tbody>
</table>
The Power Effect: “Interprofessional Workarounds”

“If [the patient] meets the criteria and or you’re not happy with the medical decision that’s being made, and you’d like, in effect a second opinion … we’ll call a call just to get some quick decisions made by ICU”

(Senior Nurse)
## The Outcome: Collective Incompetence

<table>
<thead>
<tr>
<th>Collective Competence</th>
<th>Collective Incompetence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making <strong>collective sense of events</strong> in the workplace</td>
<td>1. There are multiple profession-based understandings of events in the workplace that drive clinical behaviour(s)</td>
</tr>
<tr>
<td>2. Developing and using a <strong>collective knowledge base</strong></td>
<td>2. There are multiple profession-based development and usage of knowledge</td>
</tr>
<tr>
<td>3. Developing a sense of <strong>interdependency</strong></td>
<td>3. There is a sense of profession-based intra-dependency</td>
</tr>
</tbody>
</table>
Why....???

- Understanding RRS performance is more than a Quality improvement problem

- Focus on structure and process solutions is not enough

- Theory of socio-cultural reproduction in medicine
  - Sociology of Professions
  - Construction of professional identity
Why.....?

- Multiple Epistemic cultures of Wards
  - Multiple and silo based

- Clinical/Education space and place
  - Tensions in academic health sciences centres

- ‘Apprenticeship’ system in both professions
  - Based on intra and inter-professional power relationships
What does one do with this? Raise a few questions

- What is the range of understandings of the problem(s) that the RRS is built to solve in your setting?
  - Do you know?

- How is the RRS disseminated and practiced?
  - Are there expectations of standard application or ward specific modification?
Some more questions

- How does RRS education and training occur on the ward?
  - (in)formally?
  - Intra – interprofessionally?
  - Standardised or localised?

- What is the ‘health’ of the ward based RRS decision-making team?
  - Intra and inter professionally
THANKYOU

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