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LETTERS TO THE EDITOR

Power of sharing the patient journey in implementation of evidence-based care in emergency departments

Dear Editor,

There are limited data about the factors determining successful implementation of evidence in EDs. Based on its 2011 and 2012 evidence-based practice implementation projects, the Emergency Care Improvement and Innovation Clinical Network, a unit within the Victorian Department of Health, had the opportunity to explore this question via a survey of EDs that undertook the project 'Nerve block as adjuvant analgesia for fractured hip'. Eight EDs participated, achieving an overall proportion of 64% of patients with fractured hip receiving a nerve block in the EDs from a pre-project base of approximately 25%. Four EDs achieved a successful implementation (>60% of patients receiving a block) and four were less successful.

We surveyed the project leads at each site about ED, project lead and project team characteristics, implementation strategies used, rating of support from key clinician groups, and success factors and barriers. Eighty-eight per cent (7/8) of project leads responded; the results are shown in Table 1. Despite the small sample, sharing the patient journey with staff was shown to be a predictor of successful implementation (100% *vs* 0%; $P = 0.03$).

Key success factors identified by successful implementers were:

- Driven by good patient care
- Teamwork across disciplines
- Staff belief in project
- Pre-prepared nerve block kits
- Regular reminders
- Feedback on progress during project
- All EDs 'on board'
- Marketing as quick, simple, effective
- Change and best practice ready environment

Barriers identified by participants overall were high staff turnover, lack of time for education/project activities, clinician engagement and competing priorities within ED.

Sharing the patient journey is a form of storytelling. Storytelling has long been recognised in education and change management as an effective vehicle to promote

Table 1. Change strategy comparison

Strategy	High success ED ($n = 4$)	Low success ($n = 3$)	Difference
Sharing the patient journey with staff	4	0	0.03
New clinical pathway	2	0	NS
Change in physical environment or resources	3	1	NS
Discussing the evidence base with staff	1	2	NS
Showing result as you went along/feedback	3	0	0.11
Showing cost savings (real/potential)	0	0	NS
Training using simulation/role play	0	2	NS
Other training, for example, lectures	2	3	NS
Specific skills training in nerve block procedure	3	3	NS
Involving patients/carers	0	1	NS
Email reminders	3	1	NS
Verbal reminders, for example, at handover or meetings	2	3	NS
Written reminders	1	0	NS
Visual reminders at point of care, for example, posters	3	2	NS
Direct clinician coaching (by project lead or clinical champion)	3	1	NS
Clinical champions group (in addition to project team)	1	1	NS
Peer-to-peer coaching	2	2	NS
Change in IT system (e.g. IT-based reminders)	0	0	NS
Management of problems/barriers by DEM or NUM	0	0	NS
New hospital-wide policy/procedure	0	0	NS
Other	0	0	NS
Average number of strategies	8.25	7.33	NS

DEM, Director of Emergency Medicine; IT, information technology; NS, not significant; NUM, Nurse Unit Manager.

change. It transforms facts into an emotional context and engages the listener in a call to action. Research has shown that information is more actionable when embedded in a story.[1] In medical education, stories help transfer 'teachable moments' across time.[2]

In clinical practice, sharing the patient journey is a way of connecting clinicians with patients by helping them to see the condition from the patient's point of view. In the case of patients with hip fractures, this includes poor pain management (both in time to initiation and effectiveness) and transfers on and off X-ray tables and beds exacerbating that pain. By promoting empathy, it motivates clinicians to change practice, in this case provision of nerve blocks as adjuvant analgesia.

Our data reinforce the power of this strategy in achieving clinical practice change in EDs.

Competing interests

A-MK is a member of the editorial board of *Emergency Medicine Australasia*.

References

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Re: Vaginal examination does not improve diagnostic accuracy in early pregnancy bleeding

Dear Editor,

We read Johnstone's article "Vaginal examination does not improve diagnostic accuracy in early pregnancy bleeding" in the June issue of *Emergency Medicine Australasia*[1] with interest. We believe that caution is required interpreting the results. The study was confined to patients with mild–moderate bleeding assessed by junior doctors in a single ED. The finding cannot necessarily be extrapolated to other settings or more experienced clinicians.

The focus on overall diagnostic accuracy misses the point that the purpose of vaginal examination (VE) is as much for prognosis. Early pregnancy bleeding causes significant distress,[2] and most patients are concerned about ongoing viability. VE can provide useful information that, while not changing outcome, may be valuable for the patient. With regard to ectopic pregnancy, a recent systematic review demonstrated that presence of an adnexal mass or cervical motion tenderness increases the likelihood,[3] whereas after 10 weeks gestation, palpation of uterine size effectively excludes this diagnosis.

Although trans-vaginal ultrasound gives superior information, this is not currently available at all times of the day in most hospitals. In many rural and remote areas, there is limited or no local ultrasound service. Initial management must be based on clinical assessment. Additionally patients presenting with severe bleeding or shock may require removal of partially expelled products from the cervix.[4] The ability to perform VE competently is a core skill for emergency physicians. Proficiency is only achieved with practice. Early pregnancy bleeding is a common ED presentation, and this is an ideal opportunity for junior doctors to develop their clinical skills under the guidance of experienced colleagues.

Despite pressure to optimise efficiency, we should resist relegating clinical assessment in favour of simply ordering investigations. Patient evaluation should be individualised. VE should be offered to all women with early pregnancy bleeding and is essential for those with heavy bleeding or instability.