

High quality care requires not only excellent decision making but quality support systems around the decisions. Decisions made under our current ward round format may not be identified by all participants and, hence, not carried out. Changes to the ward round are being developed to improve recall and performance of tasks.

#### TRANSFER OF SEVERELY ILL PATIENTS

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Interhospital transfers of severely ill patients are a common occurrence. Our aim was to determine whether transferred patients have increased mortality rates and whether this is related to increased severity of illness prior to transfer.

A review was undertaken of medical records at transferring and Liverpool hospitals of all patients identified as being transferred to Liverpool Hospital ICU. Areas of comparison included pre-transfer and post-transfer APACHE II scores; and calculation of relative risk of death in ICU compared to patients admitted from within Liverpool Hospital.

Two hundred and ninety-nine patients were admitted between January 1992 and August 1993 with APACHE II score greater than 20. Of these 299, 36 were transferred from another hospital. The 95% confidence interval for pre-transfer minus post-transfer APACHE II score was -6.72 to 0.72. The mean difference was -3.00.

The relative risk of death in ICU of the 36 transferred patients compared to non-transferred patients was 2.24 (95% CI 1.18-4.27) after adjustment for APACHE II score.

We conclude that interhospital transfer is a risk factor for ICU death. The increased risk of dying is not because severity of illness was higher before the transfer. Transferred patients should be viewed as having extra risk of death in ICU.

#### AN EVALUATION OF AN EDUCATION PROGRAM IN THE USE OF INTERHOSPITAL TRANSFER GUIDELINES

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As health resources are rationalized, an effective interhospital patient transport system is becoming important. Patients are transferred between a network

of hospitals within South Western Sydney to provide access to a full range of clinical services.

An evaluation of an education program in the use of interhospital transfer guidelines was undertaken. The aim of the guidelines is for clinical staff to match patient needs to an appropriate level of escort (retrieval team, advanced skills team, basic skill team). Forty-eight medical officers and nurses working in intensive care units or emergency departments from referral and teaching hospitals and Careflight were given a set of scenarios prior to (time 1), immediately after (time 2) and 3 months after (time 3) an education program. Participants' responses to the level of interhospital transfer required were compared against a panel of experts. Conjoint analysis was performed to characterize participants' decision to organize an escort.

The mean scores for appropriate escort decisions were  $7.35 \pm 1.89$  (time 1) and  $9.50 \pm 1.49$  (time 2) and this improvement was significant ( $t_{47} = -6.66$ ;  $P < 0.01$ ). Patient factors influencing the level of escort were rated to give their relative importance. Overall weightings were treatment (52%), age (21%), physiology (21%) and diagnosis (6%) at time 1. In contrast, at time 2, three factors were more evenly weighted (treatment 34%, diagnosis 27%, physiology 25%) and age accounted for 14% of the overall decision.

Results at this stage suggests that the education program was effective in changing the decision making behaviour of clinical staff, which may lead to improved resource allocation of patients transferred between hospitals.

#### MEDICAL EMERGENCY TEAM: IMPLEMENTATION OF MODIFIED CALLING CRITERIA

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The Medical Emergency Team (MET) was established in 1990 and utilizes a standardized calling criteria to facilitate the early identification and resuscitation of patients who show signs of acute deterioration before cardiac arrest occurs. A study evaluating the MET suggested that a simpler and more discriminating set of criteria was needed. Modified calling criteria utilising abnormal physiological parameters were implemented. The aim of this study was to describe the utilisation of the MET over a 3 month period following their implementation.

MET calls occurring between April and July 1994 were examined for demographic details, admission