Identifying the Deteriorating Patient

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Overview

• A broader view of the deteriorating patient
• Some work in Lothian and Forth Valley
  – Ward rounds
  – Ward structure
  – Feedback and learning
  – Review of care
It’s not all about NEWS

• Early Warning Scores are important
• But they can’t be the only answer
  – Errors
• Some patients can be very unwell without ‘triggering’
• Some healthcare professionals can become NEWS obsessed
Identifying deteriorating patients

- Clinical concern – experienced nurse (or other)
- Pattern of concerning features: chest pain with ECG changes, SIRS criteria, altered conscious level, new focal neurology
- ‘they’re just not right’
Identifying patients AT RISK

• Safety briefs – every 8 hours asking ‘who is at risk of deterioration?’
• (And what’s being done about it?)
• Regular reviews – ward rounds, care rounds
• Knowing the background to your patients and what deterioration may look like for them
It’s not just identifying…

- EWS compliance looks lovely in Lothian
- Response poorly measured and often outwith recommendations
  - Medical
  - Other healthcare workers
  - Approx 60% seen within 20 mins (worse overnight)
  - Less than 20% had obs repeated at correct time
Some strategies

• Structured ward rounds
• Daily review: problems identified, daily goals set, discharge planning, active safety checking.
• Identification of patients at risk and decisions re: escalation
• Aim: No surprises = Anticipation
Review

Daily goals: 1) .................................................................
2) ..............................................................................
3) ..............................................................................
4) ..............................................................................
5) ..............................................................................

Nursing: PVC Y/N Needed Y/N Review site
Incontinent? Diarrhoea?
For LCP?

Pharmacy: Antibiotics.................................
Thromboprophylaxis Y/N
Dosette box Y/N

Patient at risk of deterioration Y/N
FOR ESCALATION/ NOT FOR ESCALATION/ UNDECIDED
FOR CPR/ DNACPR/ UNDECIDED

Signed...................................................... Bleep........................................
Structured Ward Round

• LoS: reduced by 0.7
• <11am discharge increased to 18%
• Transfers to critical care: 3.2% to 0.7%
• PVC bundle compliance 52% to 93%
• Cardiac arrest calls 2 to 0
• Number of outliers 15 to 9.4
• Number of 4h breaches 20.8 to 10.8
• Antibiotic prescribing 100% from 85%
Structured ward round

• The less measurable…
  – DNACPR
  – Palliative care referrals
  – Complaints/ communication

• The not so good:
  – readmissions ↑ 7.8% from 6.3%
Further development

- MDT huddle/ward round – group ownership of daily goals
- Patient ownership of Daily Goals – orientation board
- Daily Goals redesign
- Testing in other areas
- Improving discharge communication
- Teach back, goals for discharge
Electronic Patient Record

• Different proformas for different days:
  – Admission
  – Significant Event
  – Communication
  – Pre-discharge

Other tools: Frailty checklist, SPICT
Parallel Interventions

• Ward at a glance
  – Patients at risk identified
• EWS on electronic patient management system
• EWS part of handover to hospital at night
• ‘consultant aware of deterioration’ part of handover
Recognition/ Response stickers

- Developed in Forth Valley
- 2 parts: A and B
- Part A >90% completion
- Part B >60%
- Allows easier data collection
- Improves documentation
- Scope for development electronically
PART A SEWS 4 or above
Recognition/ Escalation

Date: Time:

SEWS:
Perform ABCDE (on SEWS chart)
Nurse in charge informed
Doctor contacted: Time:
Trak alert (if available)
Increase frequency of observations
Commence fluid balance chart
Consider hourly urine volumes
Completed by (name):
Signature:

PLEASE ENSURE PART B IS COMPLETED BY THE REVIEWING CLINICIAN
PART B SEWS of 4 or above
Response/ Intervention

Time doctor attended:
Discussion with nursing staff regarding patient
Documentation of assessment and management plan including frequency of observations and review time
Consider sepsis (see SEWS chart)
Consider resetting SEWS parameters/ trigger for patient if appropriate
For escalation? Y/ N/ Undecided
Resus status: CPR/DNACPR/Undecided
Discussed with middle grader/higher

Signed________________________________
Name___________________ Bleep______
Structured Response Stickers

• When used:
  – shorter time to r/v
  – ‘better’ management plan
  – Better documentation particularly regarding escalation, r/v, repeat EWS and communication with others
  – Improvement in EWS
Using the Supportive & Palliative Care Indicators Tool (SPICT™) in Hospital

- SPICT™ lists common signs that suggest a patient’s health is deteriorating.
- These patients and families benefit from assessment of their current and future care.
- SPICT™ does not give a ‘prognostic score’ but supports clinical judgement.
- Some people use the SPICT™ to help them decide that it would ‘not be a surprise if this patient died in the next year’.
- Some patients & families will want to talk about ‘palliative care’ but others prefer to think about ‘what we might do if your health gets worse’ and ‘having more support at home’.

Some ways to use SPICT™:

- To help you assess and plan care for patients with long term conditions or multi-morbidity/ general frailty who have had several unplanned hospital admissions
- To help identify people who might benefit from a review of their care, including CPR status
- As a prompt to starting a conversation with a patient and family about goals of care
- To guide a care planning review of a patient on the ward who is not responding to treatment.
- To identify patients needing a clear anticipatory care plan and documented goals of care
- To prompt referral for structured discharge planning and social care packages/ equipment
- To identify patients at risk of re-admission needing an anticipatory care plan on discharge
- To help you decide if a specialist palliative care assessment/ advice is needed
Who can benefit?

■ The patient
  • Opportunities to ask for information about their illnesses, treatments and outcomes
  • A gradual shift in focus to maximising quality of life and important patient/family goals
  • Optimal treatment of underlying conditions combined with good symptom control
  • Clearer goals of care and an anticipatory care plan during admission
  • A structured discharge summary including information for a primary care - Key Information Summary (KIS)
  • Reduced risk of health care decisions in a ‘crisis’
  • Opportunities to discuss other family or legal concerns eg Power of Attorney and/or making a ‘living will’ or an ‘advance decision about treatment’.

■ The family
  • Better information and support for carers; help in managing and coordinating care

■ The team
  • Improved communication between professionals and services in hospital and community
  • More effective handovers; better continuity of care and care planning
  • Reduction in unplanned admissions, and inappropriate investigations or treatments
EWS Patient with Physiological Decline

Identification

Decision making

Actions

End of life care

Structured response

DNACPR decisions

Clarity about ceilings of care

Invasive Organ Support (Critical Care)

Diagnostic Process

Active Treatments
Education

- Foundation doctors
- ‘Lessons learned’ every month as part of Foundation Programme Teaching
- Introduction to patient safety and incident reporting
- Simulation training
- Induction
- E-learning
Education

• Weekly nurse education sessions
  – Cardiac arrest
  – Asthma
  – Diabetes
  – Sepsis
  – Cardiology
  – ABGs
Education

• MDT teaching
  – M&M
  – Sepsis
    • table top exercise
    • septris

• Medical Students
  • Patient Safety
  • Simulation
Education

• Quality Improvement
• SPSP
  – Deteriorating patient workstream
  – Sepsis
  – Critical Care and General Ward
National picture

Further improve the safety of people in Acute Adult Healthcare

Reduce Harm:
95% of people in acute adult healthcare free from harms in SPSI:
- Cardiac Arrest
- CAUTI
- Pressure Ulcers
- Falls

Reduce HSMR by 20%
By December 2015

Strategic Priority

- Ensure safety and quality are organisational priorities
- Provide leadership & oversight to ensure delivery of programme
- Actively develop your safety culture
- Essentials of Safety are comprehensively implemented

Point of Care

- Reliable person-centred response to deteriorating patients
- Reliable recognition & care delivery for patients with Sepsis
- Reliable care delivery for patients with Heart Failure
- Prevent avoidable Pressure Ulcers
- Reduce SSI
- Reliable risk assessment to prevent VTE
- Prevent CAUTI
- Reduce Falls
- Safer Use of Medicines

Infrastructure

- Develop & utilise local capacity & capability in QI
- Effective measurement systems
- Programme Management
- Effective Communications
- Manage transitions of care
<table>
<thead>
<tr>
<th>AIM</th>
<th>PRIMARY DRIVER</th>
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<tbody>
<tr>
<td>95% of people with physiological deterioration in acute care will have a structured response and plan</td>
<td>Early Anticipation, collaborative planning and decision making</td>
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<tr>
<td>A reduction of inappropriate interventions</td>
<td>Scottish Structured Response Processes Reliably Implemented</td>
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<tr>
<td>50% reduction in CPR attempts (with chest compressions and/or artificial respirations) in general ward setting by December 2015</td>
<td>Infrastructure</td>
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<tr>
<td>Physiological deterioration: early warning score trigger or of concern to staff</td>
<td></td>
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<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td>Inform Nurse in Charge</td>
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<td>Increase frequency of observations</td>
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<tr>
<td>Screen for Sepsis &amp; treat as appropriate</td>
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<tr>
<td>Deliver Sepsis 6 within 1 hour</td>
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<tr>
<td>Nurse and Doctor meet at or near the patients’ bedside &amp; agree and document a plan together using the following script or checklist</td>
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<table>
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<tr>
<th>Person Centred Team Based Decision Making (structured response)</th>
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<tr>
<td>Access information from Primary Care – ePCS/eKIS</td>
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<td>(admission wards only)</td>
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<tr>
<td>Nurse and Doctor discuss the plan together</td>
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<td>Active problems, working diagnosis and management plan recorded in case notes</td>
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<td>Review &amp; increase frequency of observations if appropriate</td>
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<td>Escalation ceiling recorded: Level 1, 2, 3</td>
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<tr>
<td>Early referral to critical care or rapid response team if ceiling of care would include level 2 or 3 care</td>
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<tr>
<td>DNACPR considered and completed if appropriate</td>
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<td>A structured response has occurred only if all boxes have been ticked (or key processes occurred) within.......</td>
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Know your weaknesses

• Adverse Event Case Note Reviews
• Mortality Reviews
• Development open culture
• Ask for feedback and views
Harm in Lothian – Rate of adverse events

Rate of Adverse Events per 1000 patient days (as at August 2011)

8 data points below current median = a shift in the data. New process median provisionally 30 per 1000. This is a 42% reduction from current baseline.
Commonest triggers

- Lack of SEWS
- Antiemetic
- Readmission to hospital within 30d
- Falls
- Complication of procedure/ treatment
- Wound Infection
- Nosocomial pneumonia
- Failure to manage pain
Mortality Reviews

- 3x2 mortality tool
- Terminal care/ non-terminal care
- Critical care/ ward level care
- Issues in communication, concerns not addressed, escalation
- GTT to screen for harm
Feeding Back

- Weekly M&M meetings
- Review of systems, weak points
- MDT discussion
- Invite other specialities
The Challenges

• Recognition and Management of unwell patients in a system under pressure
• Overcrowded EDs, AMUs
• Overstretched General Wards
• Patients in the wrong bed, under wrong team
• Matching Capacity to Demand
Next Steps

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