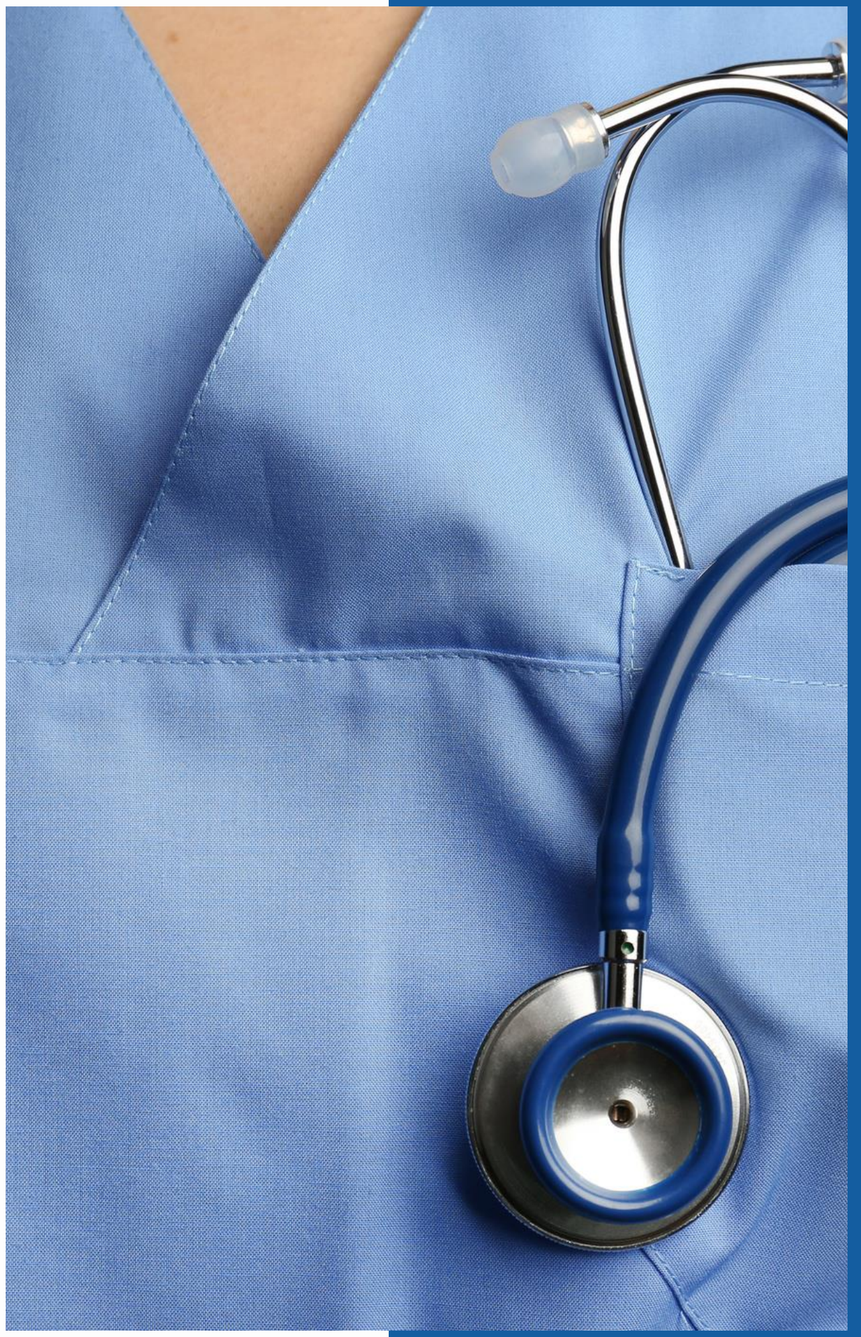
Critical Care Outreach Team - Advanced Clinical Practice

Its Impact on Improving Recognition and Escalation of Deteriorating Patients

Overview

- Background & Ambition
- Methods & Interventions
- Outcome & Value
- Spread & Involvement
- Next Steps



Background

Globally: Failure to recognise and respond to deteriorating patients remains challenging despite various measures to address the problem (Odell, 2015)

In the UK, we have Rapid Response Systems and track-and-trigger tools such as the National Early Warning Score (NEWS2) to optimise prompt recognition and response to deterioration

I**n our trust:** Inconsistencies in clinical practice in patients' physiological observation monitoring posed a risk to patient safety, leading to delays in recognition and escalation of deteriorating patients

Challenges in the wards

High numbers of new nurses who require training

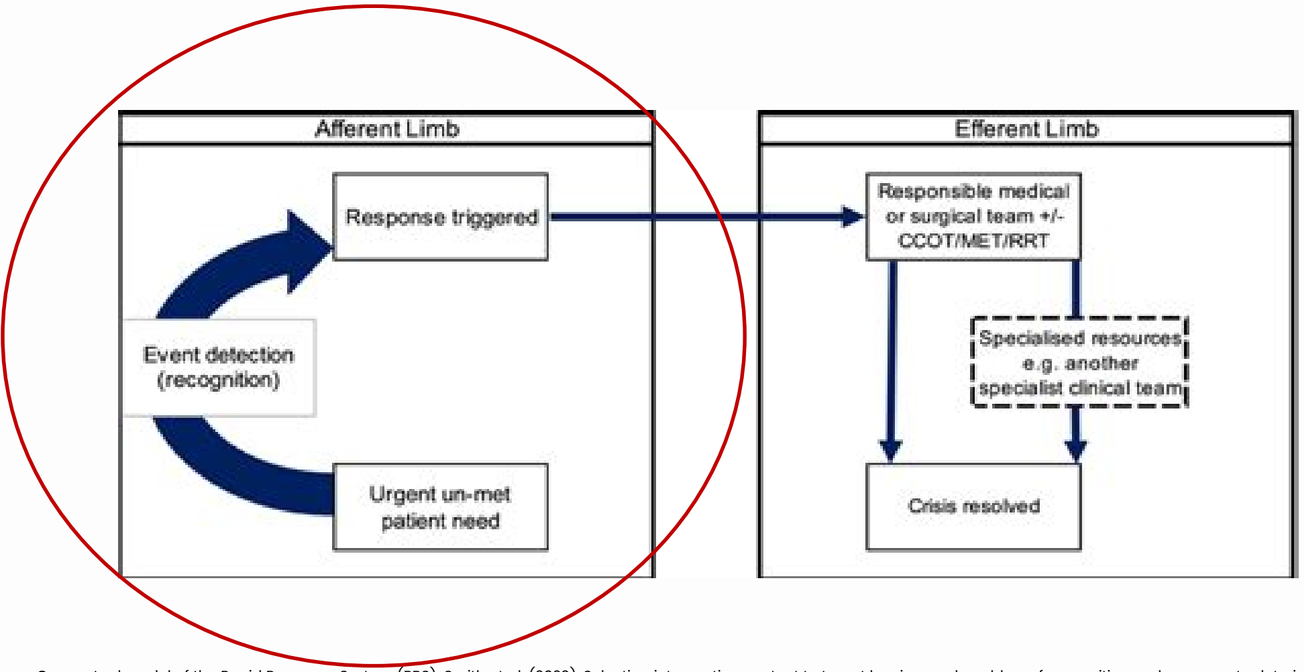
Staff shortage leading to increase use of agency/bank nurses who ae not aware of the Trust’s protocol

Over reliance of nurses on HCAs

Inconsistent use of the available technology in patient monitoring

Ambition

To **enhance** the performance of ward nursing staff in **monitoring** and **escalating** patients' physiological **observations** through new innovative clinical practice that will **facilitate** the **prompt recognition and escalation of acute deterioration**.



Conceptual model of the Rapid Response System (RRS): Smith et al, (2022). Selecting intervention content to target barriers and enablers of recognition and response to deteriorating patients: an online nominal group study. BMC Health Services Research. 22. 10.1186/s12913-022-08128-6.

Methods

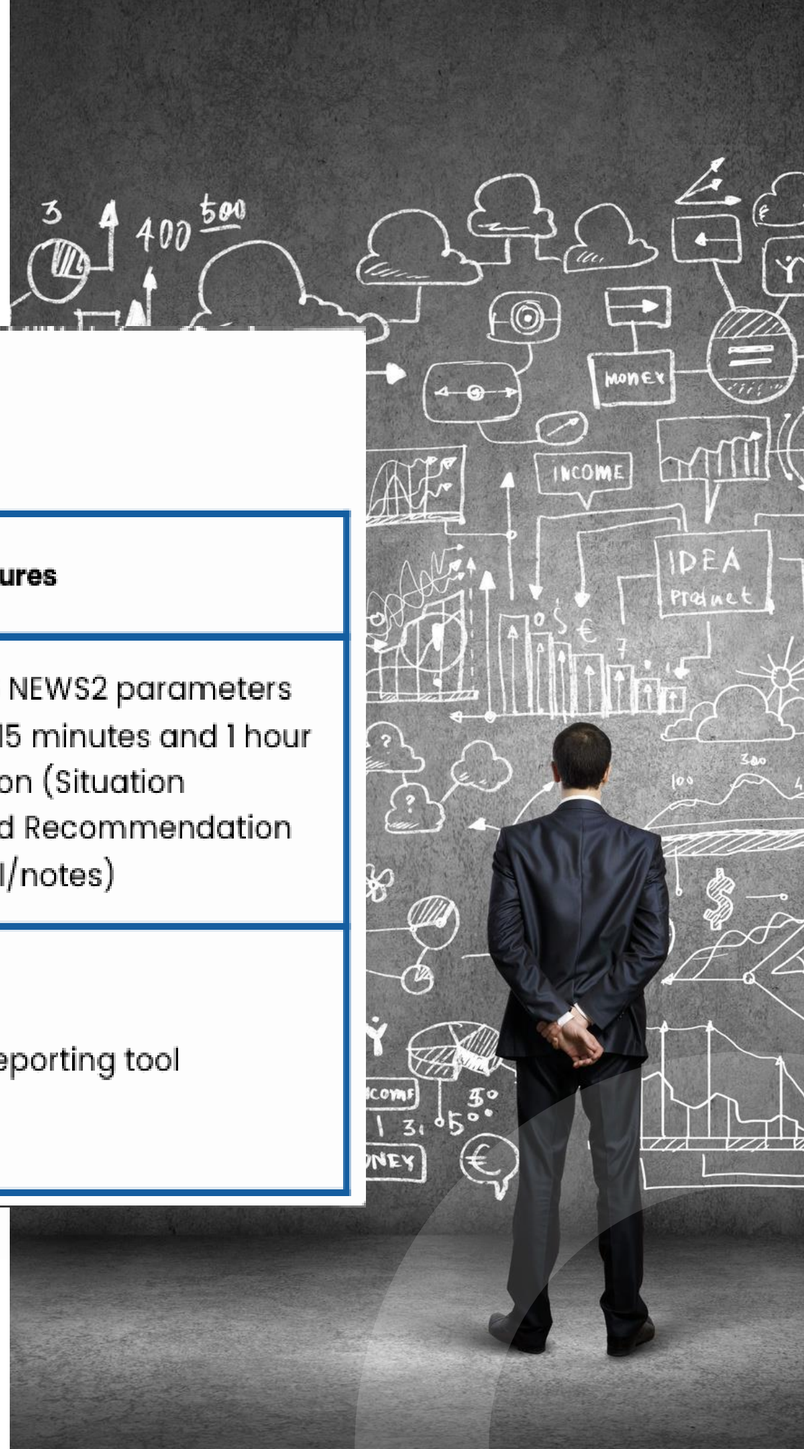
Driver Diagram + Plan-Do-Study-Act (PDSA) Cycle =

Objectives and Outcome Measures

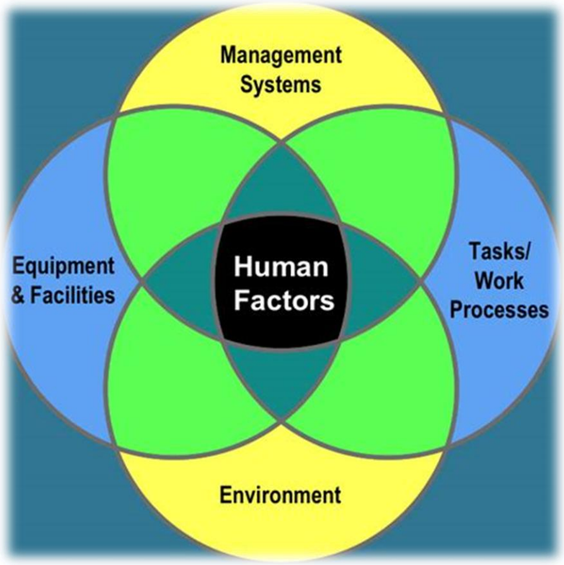
Methods

Objectives and Outcome Measures

Objectives	Outcome Measures
90% Compliance against the NEWS2 Audit	• Accurate completion of all 6 NEWS2 parameters • Repeat Observations within 15 minutes and 1 hour • Evidence of nursing escalation (Situation Background Assessment and Recommendation (SBAR)/2222 Emergency Call/notes)
Reduced Serious Incident reports on "Suboptimal care and or Failure to Rescue" due to failure to recognise and escalate	Monthly report from the DATIX reporting tool



THE INNOVATIVE STRATEGIES



Interventions

Prevention **I**dentification **E**scalation **R**esponse
(PIER Model Approach)

(NHS England ,2021)

- Clinical Practice
- Leadership and Management
- Education
- Research

Clinical Practice

DETERIORATING PATIENTS

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Observation Rounds

10:00 – 14:00 – 18: 00

22:00 – 02:00 – 06:00

(check patients/observation as required)

↓

Check Deteriorating Patient Dashboard
(immediately post observation rounds)

If NEWS2 score ≥ 5 or 3 in one parameter

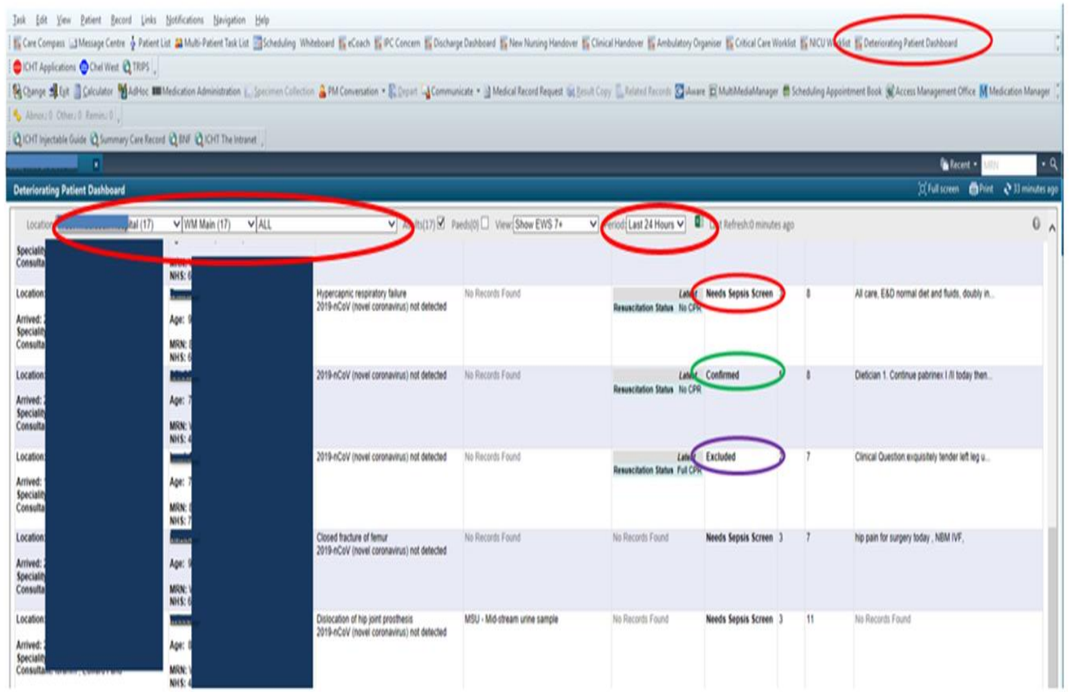
Nurse to re-check observation within 15 mins (FIRST TRIGGER ONLY)

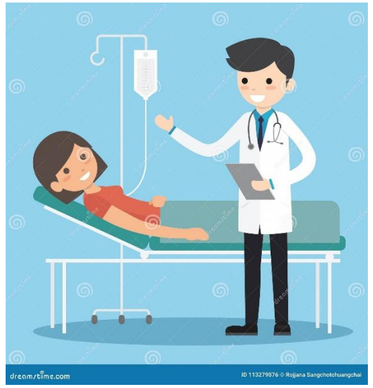
Observation Frequency as per plan (IF ONGOING)

Complete Sepsis Screening as required

Escalate using SBAR as per NEWS2 Trust Protocol

CERNER: how to monitor deteriorating patients in your area





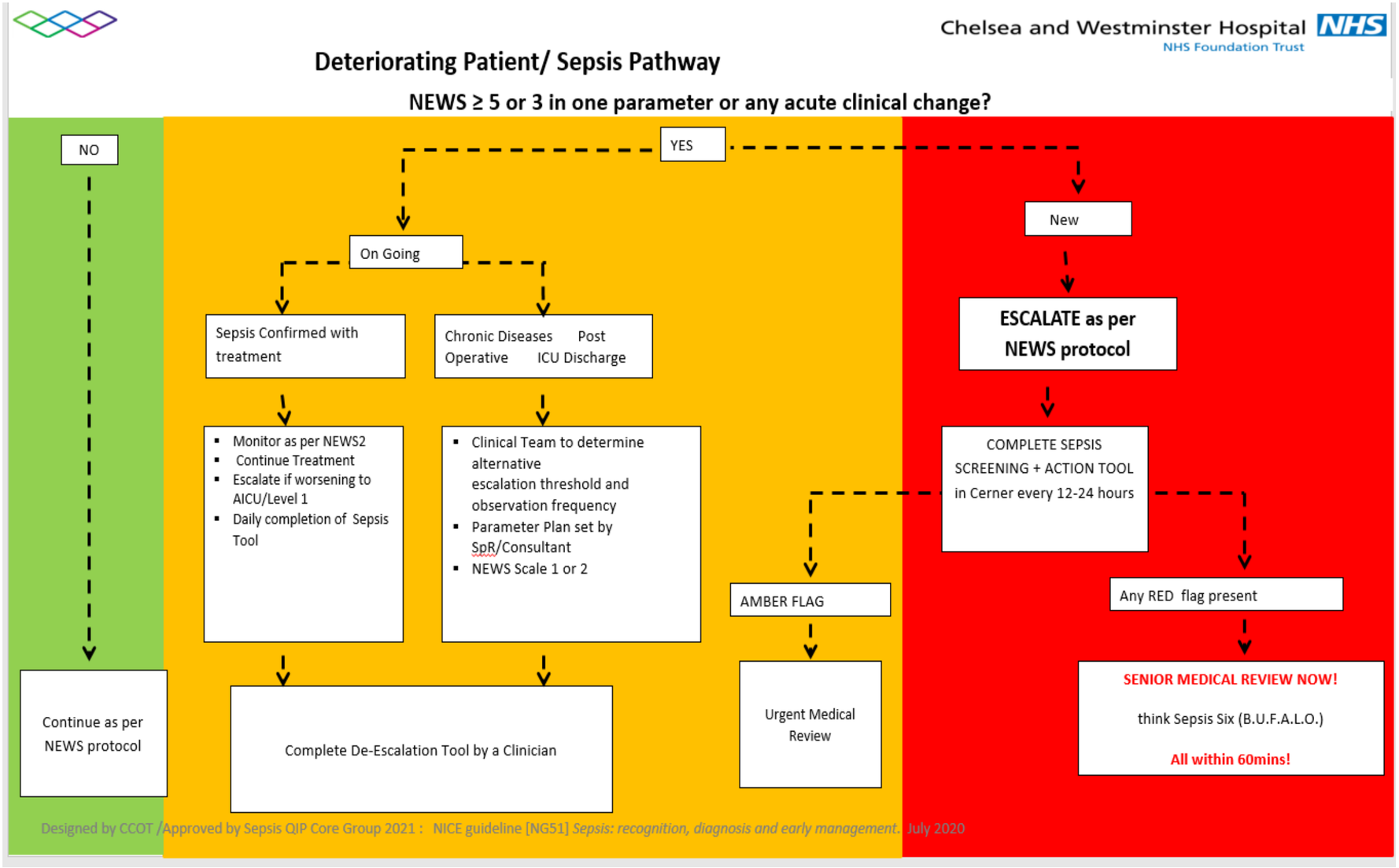
S Situation
a concise statement of the problem

B Background
pertinent and brief information related to the situation

A Assessment
analysis and considerations of options — what you found/think

R Recommendation
action requested/recommended — what you want

Clinical Practice



Leadership

Management

Collaboration between the Critical Care Outreach Practitioner and the Ward Nursing Team

Senior Leaders Engagement and Support

Education

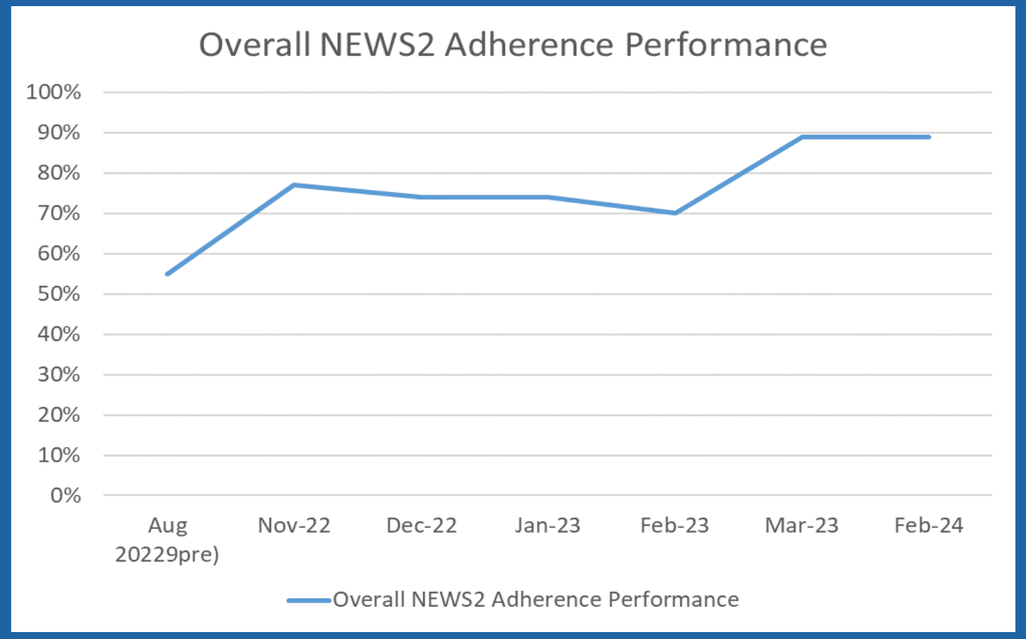
Outcomes


Increased NEWS2 Adherence
Reduced related reported incidents
CQUIN Targets Achieved
Reduced ICU Unplanned Admission
Development of automated dashboard for performance management

Outcomes

Manual audits were conducted on 9 pilot wards

Pre and Post Intervention Implementation



89%

(Post-interventions)

55%

(Pre-interventions)

Increased NEWS2 Adherence

Outcomes

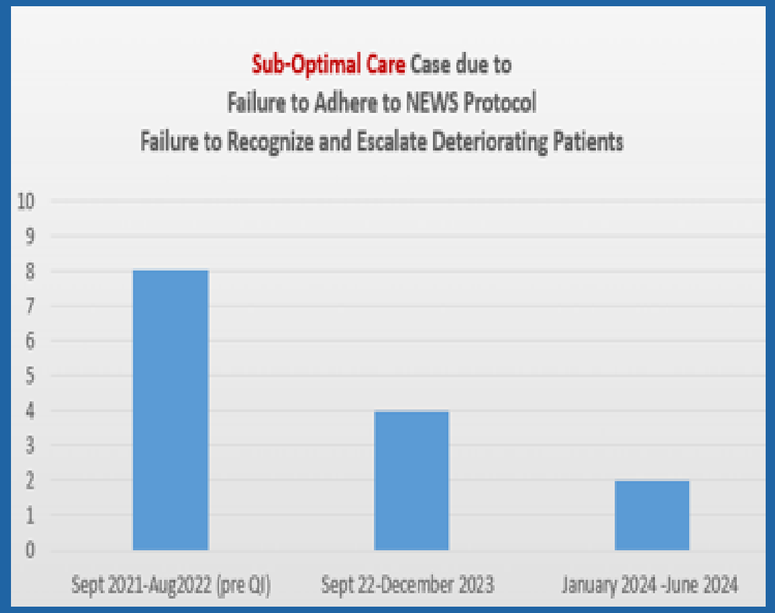
From **manual** snap-shot audit to **automated** comprehensive data collection

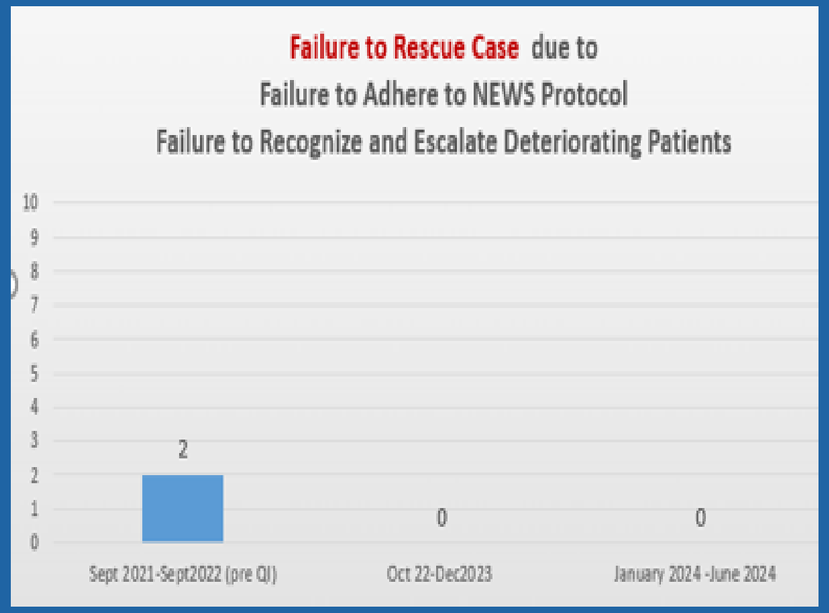
Development of automated dashboard for performance management

1. # of trigger events
2. % of observations repeated within 1 hour
3. % of SBAR logged following trigger
4. % of timely clinician review (< 60 mins)
5. % seen by CCOT
6. % admitted to ICU

Outcomes

DATIX INCIDENTS RECORD





Reduced related reported incidents

Outcomes

CQUIN Targets Achieved

CQUIN CCG3 2022/2023

- Target: 20-60%

Q1	Q2	Q3	Q4
69%	94%	93%	89%

CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions

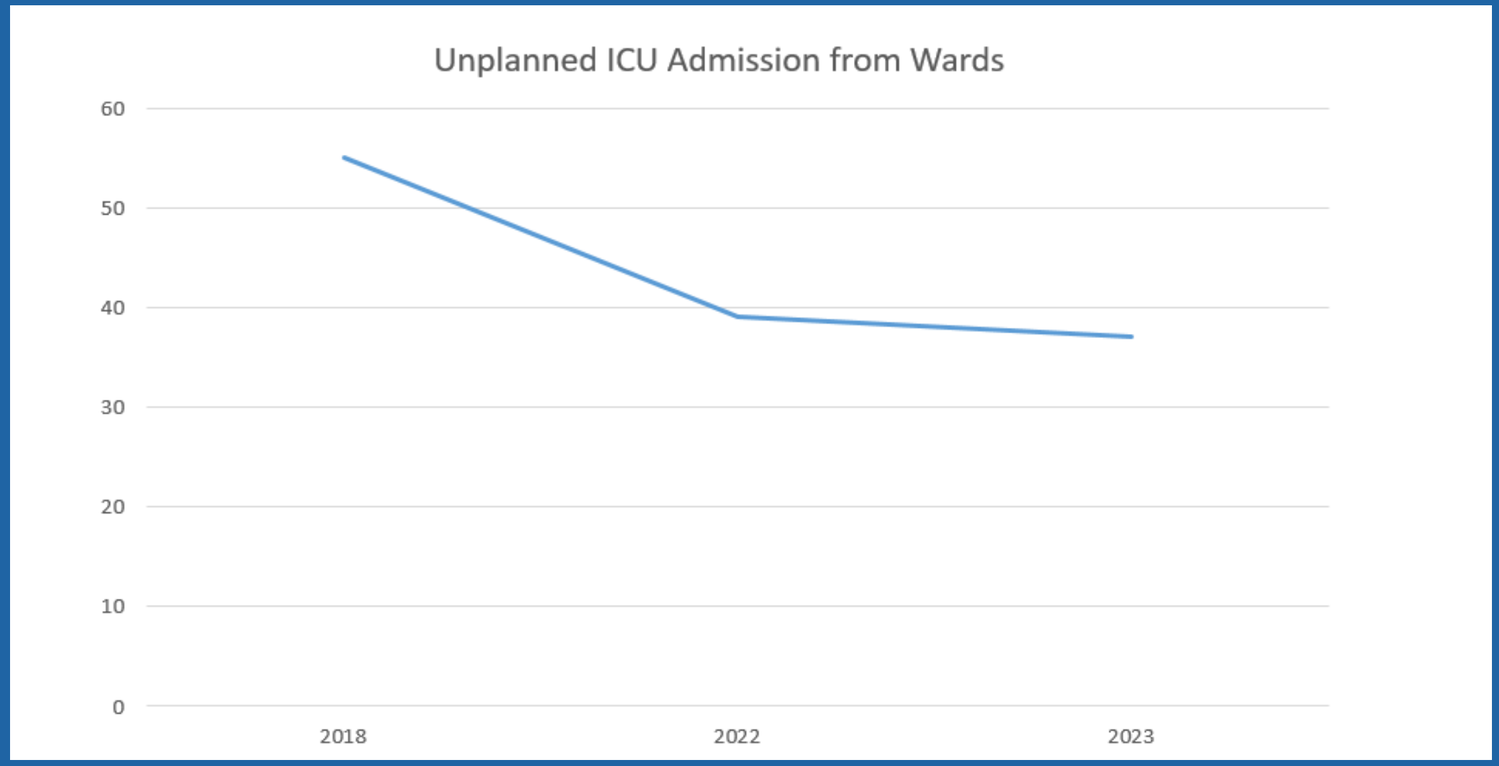
CQUIN 07 2023/2024

- Target: 10-30%

Q1	Q2	Q3	Q4
93%	91%	94%	97%

CQUIN07: Recording of and appropriate response to NEWS2 score for unplanned critical care admissions

Outcomes



Reduced ICU Unplanned Admission

VALUE


PATIENT
PATIENT
CLINIC
DIAGNOSIS
SICK
ERROR
CURE
CARE
HEALTH
MEDICINE
PROVIDER
INPATIENT
SAFETY


workers
workforce
profession
life preserver
faculty
employees
employ
stick
staff
work
occup
hire
rod
crew
prop
mace
crook
baseball bat
crozier
barrister
bludgeon
facilitator
employee
labourers
human resources
tipstaff
paralegal
solicitor
walking stick

PATIENTS AND RELATIVES FEEDBACK ON ‘OBSERVATION ROUNDS’

“The more information you have more adequate treatment my mom will have”

My dad has a better care in this hospital compared to his admission in the other hospital as he is being checked regularly

“I think all the staff have been very concerned and very professional in their observation rounds. I have been checked regularly and appreciate all the attention. This is my first time in this hospital and it has been memorable one. My thanks to all “

“It is good that I have an opportunity to speak to nurses”

“ I do not think it is intrusive at all as I know nurses are only doing their job to look after us well”

I am ok but not at 2 am as nurses wakes me up

“Fantastic that patients are checked and ensure that they are comfortable which is helpful in their recovery”

“I am ok with the observation rounds. It is the nurses 'duty to ensure patients are safe. I can easily go back to sleep anyway..at least I am being checked if I am ok”

I have peace of mind when I go home as I know my dad will be checked adequately

I don’t feel abandoned which make me feel less anxious as I know nurses will check me at set times

“It is a very thoughtful gesture to patients. I feel more assured.”

I can’t believe if it is not being this way, how the patients are kept safe? For me I want my dad to get checked regularly. I trust the nurses’ judgement

NURSES and HCAs FEEDBACK ON 'OBSERVATION ROUNDS'

"It ensure safer monitoring and helps nurse in charge monitor the whole ward safely as we know when to check DPD"

"It is helpful as there is a pattern that will guide staff as to when to do the observation"

"I cannot see how any hospital can run effectively without a systematic and timely method of patients' observations in place. It is paramount that we have a process which we can detect deteriorating patients early "

"It is helpful to detect patients who migh become unwell even if their previous observations are stable"

"It does make a difference as without the time frame it would have been chaotic"

Foster better communication among healthcare professionals as it has structured opportunity for MDT

"We can recognise early signs of deterioration which enable to start treatment without delay"

"it is an essential practice in determining the patients'well-being and detect early decline or progress overall"

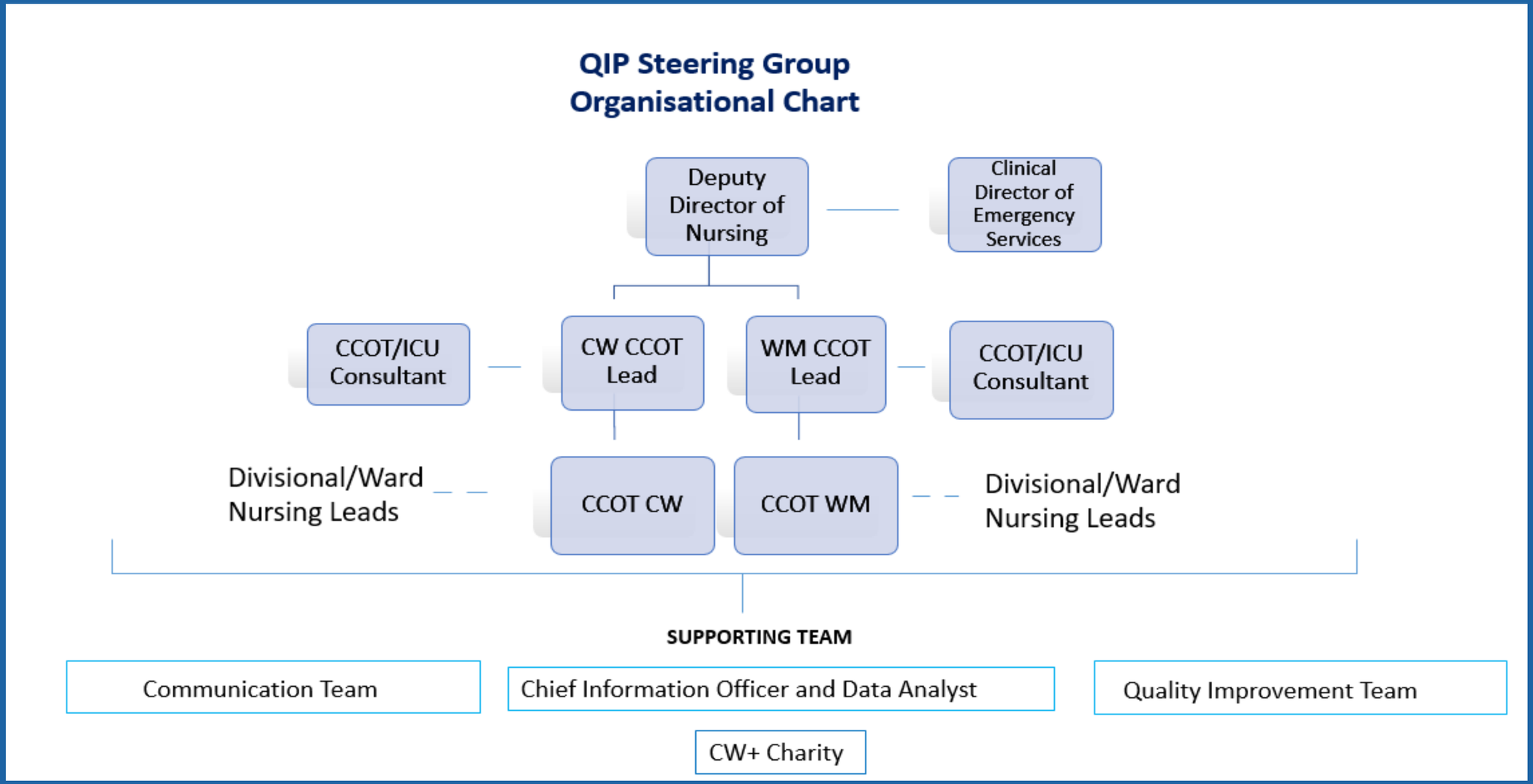
"It allows us to act promptly if there should be any change"

"A considerable and more interacting approach to assess the vital parameters of each patient"

" Apart from we are able to check more regularly the patients, we are also able to build rapport by being able to communicate with them from time to time .and address their concerns as soon as possible "

"Although it is a nursing workload, it impacts significant component in detecting changes and from patient's baseline and other medical problem"

Involvement



SPREAD AND SHARE THE LEARNINGS

Ward managers nurses HCAs CCOT and Director of Nursing

Local Network

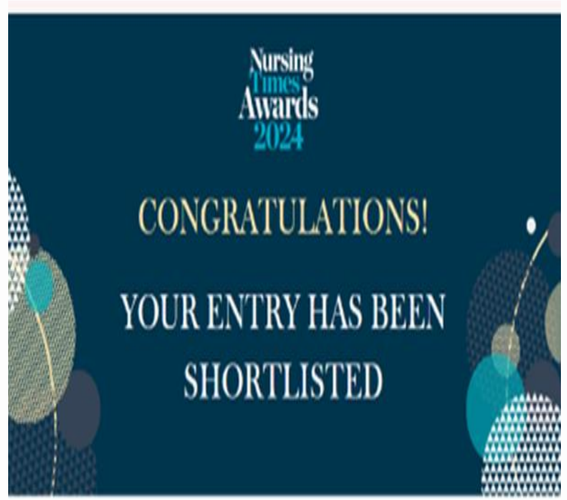
Trust-wide REDP Awareness Day to celebrate the work of the wards and CCOT nurses

Regional Network

Presentations to regional collaborative led to the trusts adapting the strategies within Patient Safety, including creation of an automated dashboard

SPREAD AND SHARE THE LEARNINGS

National Recognition



Presentation at the National Outreach Forum

The CCOT was awarded 1st place in the presentation of their innovation in patient safety

Next Steps

Sustainability

Out-of-hours care

New Alerting System direct to CCOTs and medical team

Patients and Public Involvement

Summary

Clinical Practice

Leadership

Facilitating Learning

Research

THANK YOU