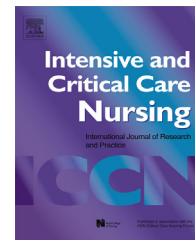




Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/icc



Our approach to changing the culture of caring for the acutely unwell patient at a large UK teaching hospital: A service improvement focus on Early Warning Scoring tools



S.D. Wood*, J.L. Candeland, A. Dinning, S. Dow, H. Hunkin, S. McHale, G. McNeill, N. Taylor

Nottingham University Hospital NHS Trust, Nursing Development, Derwent House, City Hospital, Hucknall Road, Nottingham NG5 1PB, United Kingdom

Received 14 March 2014; received in revised form 27 August 2014; accepted 25 November 2014

KEYWORDS

Deterioration;
Early warning scoring;
Escalation;
Quality improvement;
Rapid response

Summary

Introduction: Early Warning Scoring tools (EWS) play a major role in the detection of the deteriorating ward patient. EWS tools have been in place in Nottingham University Hospitals NHS Trust for over five years but compliance has been low. A service improvement project commenced across all admission wards in 2013, initiated through a financially driven CQUIN. Prior to the project, only one out of five clinical care targets set were achieved.

Strategy: An established framework for service improvement was used to guide delivery. The approach has consisted of multi-faceted, inter-professional high impact interventions including ward delivered education, human factors training and clinician feedback, combined with regular performance audits.

Results: Since introduction of the service improvement team, consistent signs of improvement have been visible across the admission areas in four out of five of the clinical care targets.

Conclusion: The first 12 months of the project has seen tangible benefits in patient care and staff experience. Personal feedback both to medical and nursing staff has been effective where a top-down approach may not have been.

© 2014 Elsevier Ltd. All rights reserved.

* Corresponding author. Tel.: +44 7968493503.
E-mail address: Sally.wood@nuh.nhs.uk (S.D. Wood).

Implications for Clinical Practice

- The benefit of investigating local culture prior to improving compliance with policies.
- The need to gain staff engagement when improving compliance with an established policy.
- Training surrounding early warning scores must include a human factors approach.
- Personal feedback displaying areas of excellence and areas of improvement is a powerful method to influence compliance.

Introduction

This paper describes the results of the first 12 months of a two-year service improvement project, which aims to improve the care of the deteriorating ward patient. The focus of the project was to increase compliance with completion of an adult early warning scoring tool (EWS) and paediatric EWS tool (PEWS) and improve timely escalation at Nottingham University Hospitals NHS Trust (NUH). The project achieved financial backing as it was agreed as a Commissioning for Quality and Innovation project (CQUIN). A CQUIN enables commissioners to reward improvement in an area highlighted as substandard, where a proportion of English healthcare providers' income is allocated conditionally on achievement of pre-negotiated targets (DOH, 2008). The project focussed on improving patient safety, but also had major financial implications for the Trust if achieved.

NUH is a tertiary 1700 bed, acute teaching hospital based on three sites. A well established Critical Care Outreach team (CCOT) provides clinical support to all adult wards from 8 am to 10 pm, seven days per week. There has also been a team of senior paediatric nurses in the Children's Hospital supporting and educating staff about caring for sick children since 2009. Despite EWS/PEWS being in place in NUH for over 13 years, a local antecedents audit investigating the care, intervention and escalation processes of adult patients suffering in-hospital cardiac arrests showed similarities to the findings of the National NCEPOD report (2012). In 2013 at NUH, 37% of adult patients with physiological warning signs prior to suffering a cardiac arrest showed no evidence of escalation of care. The audit concurred with many recent papers that there are often significant delays in both the detection and escalation of the critically ill ward patient (CEMACH, 2008; NCEPOD, 2013; O'Dell, 2014).

Background

The Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013 identified serious failings in patient care that included poor monitoring of observations and fluid balance of emergency admissions (Francis, 2013). Nurses often failed to recognise the clinical urgency of patient deterioration and the medical staff were criticised for not reviewing patients in a timely manner and not documenting evidence of escalation to senior colleagues (Healthcare Commission, 2009). Prompted by this report, and the success of the USA Virginia Masons Production System approach (VMPS) in highlighting serious unsafe events as the impetus for drastic change in healthcare, the Medical Director for NHS England was asked to review the quality of care provided to emergency admissions by 14 NHS Trusts. These Trusts were chosen as Hospital

Standardised mortality rates (HSMR) were identified as being 'higher than expected' (Keogh, 2013). The Keogh report found that almost all 14 Trusts showed one consistent theme regarding mortality rates for emergency admissions; basic failure of performing timely and adequate observations of patients at ward level and staff acting upon them. Keogh concluded that "...all Trusts should rapidly embed the use of an early warning system and have clinically appropriate escalation procedures for deteriorating high-risk patients – in particular at weekends and out of hours". A recent Care Quality Commission Report for NUH confirmed the HSMR (mortality risk) to have 'no evidence of risk' (CQC, 2014).

It is well acknowledged in recent studies that physiological deterioration precedes critical illness (Jacques et al., 2006). A National Confidential Enquiry into Patient Outcome and Death report (NCEPOD) summarised that for the 75% of cases who displayed physiological warning signs prior to suffering a cardiac arrest, identification, action upon, and escalation to senior staff occurred infrequently (NCEPOD, 2012). This inability of healthcare staff to recognise and act upon deterioration in a timely manner was first recognised over 20 years ago (NCEPOD, 1993, Payne et al., 1993) and has been the impetus for the development of Rapid Response Systems (RRS) for acutely ill ward patients.

A Rapid Response System relies on two processes: the afferent limb (detection pathway) and the efferent limb (response). Either or both can be at fault when failure to rescue occurs. Failure to recognise deterioration may lead to harm for the patient ranging from a minor adverse event to mortality. Early Warning Scoring tools play a major role in the timely detection of the deteriorating patient (RCP, 2014). The EWS policy at NUH provides a clear strategy for frontline staff to increase clinical observation of the patient and to escalate care to more senior nurses and doctors (see Fig. 1).

Failure to follow protocols

The evidence regarding EWS tools and their ability to improve patient outcome is difficult to substantiate due to confounding factors and the difficulty in establishing compliance with parts of the protocol. Hands et al. (2013) identified that patterns of compliance with protocols for the deteriorating patient exist with peaks and troughs of compliance at different parts of the day, confirming that increasing frequency of observations as the patient's condition deteriorates does not occur routinely.

The Junior Doctor Support Forum at NUH investigated the views of junior doctors around escalation and decisions regarding escalation in line with EWS policy (Khan and McNeill, 2013). The findings of this report concluded that

Download English Version:

<https://daneshyari.com/en/article/2652113>

Download Persian Version:

<https://daneshyari.com/article/2652113>

[Daneshyari.com](https://daneshyari.com)