Patient Deterioration

Taranaki District Health Board
Emma Jordan
Jonathan Albrett

Population: 118,000
Beds: 239 resourced, 271 maximum occupancy
160 Medical FTE.13 first year doctors.

Background

- We had a local EWS scoring chart
- Scores were not done routinely
- Escalation did not reliably occur
- A lot of critical incidents could have been identified earlier

Past efforts

- Resuscitation committee
- Hospital mortality review
- Developed an education programme for house surgeons regarding deteriorating patients
- Included serious event learnings in teaching and simulation
- Started doing in situ simulation with RMOs and ward nurses

Past efforts

- Grand rounds
- Department meetings
- MMM&I meeting
- Audit

Resuscitation coordinator

- Annual resignations for three years

Other local factors

- Open ICU/HDU
- No formal PAR team
- ICU nurse attends peri-arrest
- Director of nursing
- High staff turnover rates

Planning

- Governance – Resuscitation Committee, EWS steering group
- EWS and Resuscitation Policy adapted
- Oversight from Senior Leadership

Implementation & Education

- Resources – posters, PowerPoints, laminated charts, fact sheets
- Ongoing scenarios focused on management of the deteriorating patient
- Deteriorating patient study day for nurses
- Nursing/Medical orientation and Clinical Compulsory Training

Audits

- 10x Audits/week done by ward champions and sent to resuscitation coordinator
- Overseen by Clinical Nurse Managers of the wards
- Audit results discussed with steering group monthly
- Weekly random chart checks and opportunistic education

Doctors

- Resistance
- Resentment
- Defiance

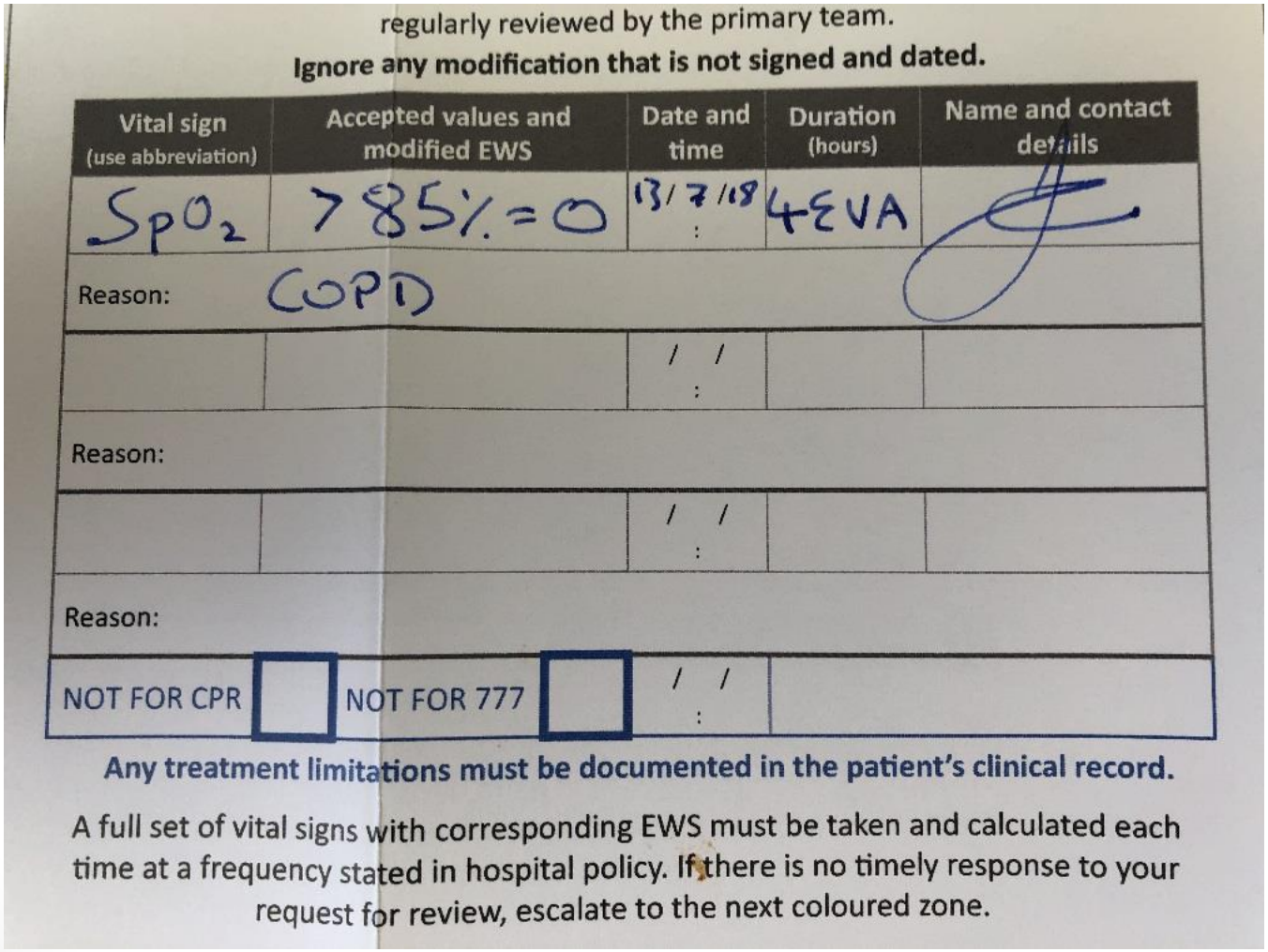
Examples

- I can’t put a screw into a pneumonia so I don’t want know!

I am outraged I wasn't consulted

- I am sorry you missed the posters, e mails, workshops, reminders and grand round. We did not intend to exclude you, your input is most welcome.

Expect the unexpected



regularly reviewed by the primary team.

Ignore any modification that is not signed and dated.

Vital sign (use abbreviation)	Accepted values and modified EWS	Date and time	Duration (hours)	Name and contact details
SpO_2	> 85% = 0	13/7/18 :	4EVA	
Reason: COPD				
		/ / :		
Reason:				
		/ / :		
Reason:				
NOT FOR CPR ☐	NOT FOR 777 ☐	/ / :		

Any treatment limitations must be documented in the patient's clinical record.

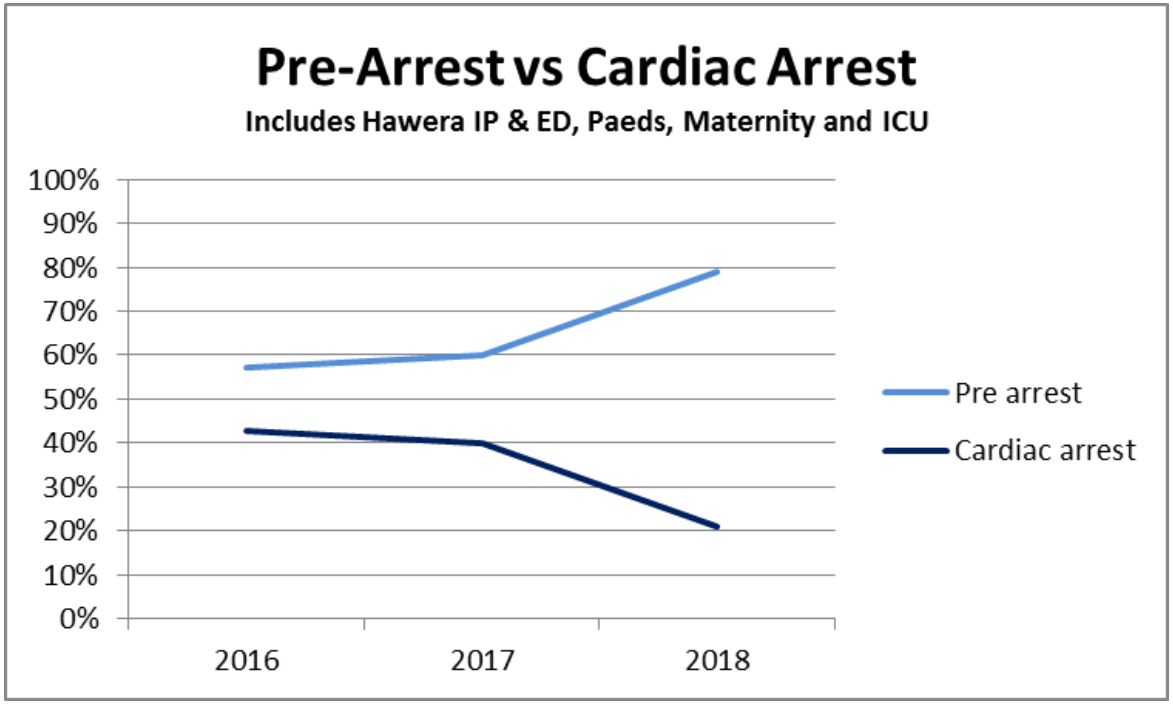
A full set of vital signs with corresponding EWS must be taken and calculated each time at a frequency stated in hospital policy. If there is no timely response to your request for review, escalate to the next coloured zone.

Working with the doctors

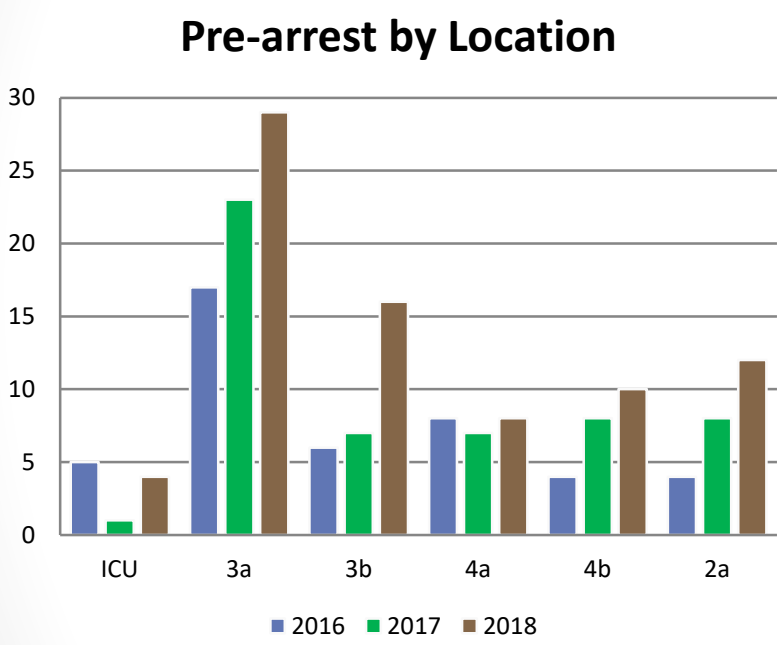
- Genuine concerns
- Patient centred care

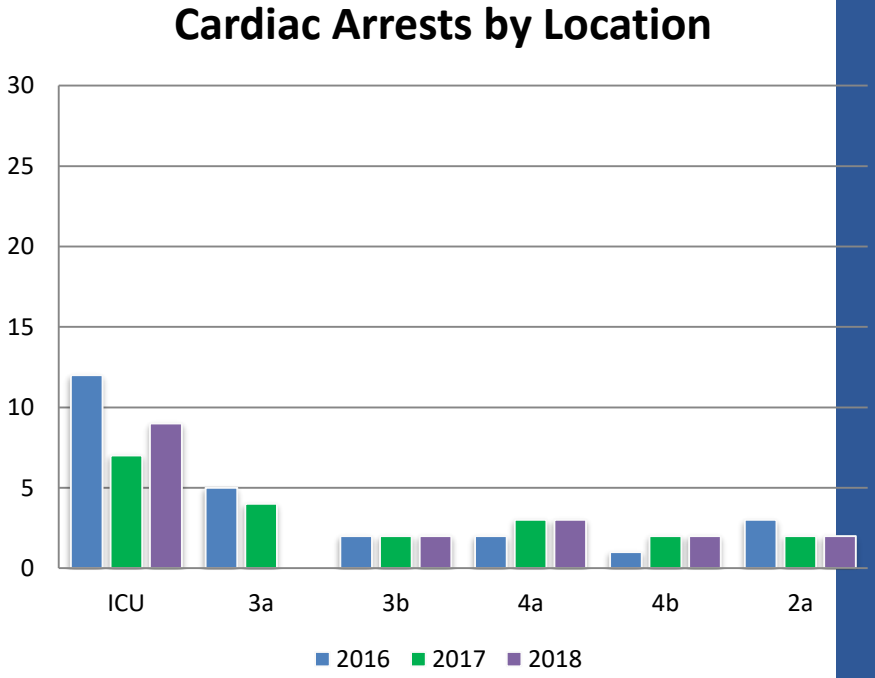
Results

- 2016 – Pre arrest 57%, Cardiac arrest 43%
- 2017 – Pre arrest 60%, Cardiac arrest 40%
- 2018 – Pre arrest 79%, Cardiac arrest 21%



Results


Pre-arrest by Location
30
25
20
15
10
5
0
ICU
3a
3b
4a
4b
2a
2016
2017
2018


Cardiac Arrests by Location
30
25
20
15
10
5
0
ICU
3a
3b
4a
4b
2a
2016
2017
2018

What made the difference?

HQSC

- National directive
- Prescriptive
- Backed by evidence
- Resources
- Monitored

Deteriorating patient steering group

- DON
- CMA
- Clinical lead
- Resus Coordinator / Educator

The future

- PAR nurse – interviews January 9, 2019
- Implementation of SBAR
- Deteriorating study day for nursing leadership
- Korero Mai
- Shared goals of care
- Redeveloping an old ward into a interdisciplinary interactive training centre.