RECORD

Reviewing the Clinical & Organisational Response to Deterioration

Adapted from the Portsmouth Hospitals NHS Trust Time to ACT project data collection tool.

A “measurement for improvement” approach to support the implementation of NEWS2 by evaluating the effectiveness of the recognition of, and response to, patient deterioration.

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Proposed Criteria

Observation Parameters		
Patient ID / Hospital No.	OP1	
Admission Date	OP2	
Ward / Dept	OP3	
Outlier Status	OP4	
Date / Time of Data Collection	OP5	
Recognition - Trigger Factors		**If Triggers present - ? n/a option for routine reviews**
Trigger? (e.g. NEWS or Cause for Concern)	TR1	NEWS or CFC
What was the NEWS or CFC?	TR2	Score / Description
Any prior increase in freq. of Obs?	TR3	Y/N
Recognition (All Triggers)		
Escalation by Nursing Staff?	RC1a	Y/N (? Appropriate / Not appropriate)
Escalation process used?	RC1b	e.g. SBAR(D) or Local options e.g. Outreach, H@N, Ward Round, Other (Comm = GP, 111, 999 etc.)
Seen by Clinician?	RC2	Y/N
Treatment Escalation Plan in place?	RC3	Y/N/Not Seen (Or Advance Care Plan (ACP) etc.)
New Treatment Escalation Plan agreed?	RC4	Y/N
DNACPR in place?	RC5	Y/N
New DNACPR agreed?	RC6	Y/N
Possible Sepsis?	RC7a	Y/N/Not seen
If ? Sepsis – Was Sepsis actioned? (Sticker or Proforma)	RC7b	Y/N

Response – Trigger = Cause for Concern		
Was Pt seen in response to CFC Trigger?	RSC1	Y/N
What time was Pt seen in response to Trigger?	RSC1b	Time of Day or Time taken to respond. Timescales in accordance with organisational policy.
Grade of Dr first seeing Pt?	RSC2	Grades in accordance with organisational policy e.g. FY1, FY2, SHO, Reg, Con etc.
Consultant informed < 12 hrs?	RSC3	Timescales / Grades in accordance with organisational policy
Any documented Communication?	RSC4	Y/N

Care Escalated?	RSC5	Y/N and/or Description (e.g. HDU, ICU, Transfer)
If yes - Process used for Communication or Escalation?	RSC6	e.g. SBAR(D) or Local options e.g. Proforma, Outreach, H@N, Ward Round, 2222, Other (Comm = GP, 111, 999 etc.)

Response – Trigger = NEWS2		
Was Pt seen in response to NEWS2 Trigger?	RSN1a	Y/N
What time was Pt seen in response to Trigger?	RSN1b	Time of Day or Time taken to respond. Timescales in accordance with organisational policy.
Pt seen in an appropriate time in accordance with NEWS?	RSN2	
Grade of Dr first seeing Pt?	RSN3	Grades in accordance with organisational policy e.g. FY1, FY2, SHO, Reg, Con etc.
Pt seen by an appropriate Dr in accordance with NEWS?	RSN4	
Consultant informed < 12 hrs?	RSN5	Timescales / Grades in accordance with organisational policy
Any documented Communication?	RSN6	Y/N
Care Escalated?	RSN7	Y/N and/or Description (e.g. HDU, ICU, Transfer)
If yes - Process used for Communication or Escalation?	RSN8	e.g. SBAR(D) or Local options e.g. Proforma, Outreach, H@N, Ward Round, 2222, Other (Comm = GP, 111, 999 etc.)

Review Outcome		
Seen in accordance with Trust Policy (CFC) or NEWS	RO1	
Good Clinical Review (some elements missing)	RO2	
Partial Clinical Review	RO3	
Near Miss (Seen at time but not in response to Trigger)	RO4	
Not seen (appropriate)	RO5	
Not Seen (inappropriate)	RO6	

Design considerations

What if there are Multiple Triggers - same score, changing score (worse or better)	How to review multiple escalations (once (?first), all , once per 24hrs (but which)
Definitions (with examples) – National & Local	'immediately' and 'urgent' (with examples of appropriate clinicians) 'providing clinical care in an environment with monitoring facilities' 'Emergency assessment by a team with critical care competencies' (with examples)
What constitutes a 'review' of a patient	Only if in response to Trigger? To consider - what if • Patient is seen but for non related reason e.g. other medical visits, scheduled ward rounds • Dr conducts a telephone consultation providing recommendations for care until able to attend • There is a plan but it is of poor quality e.g. plan = bloods / CXR • actions are noted in e.g. nursing notes but not medical notes • There is evidence of actions taken but they are not documented in the notes
What if observations / review not conducted in an appropriate manner	What is tolerance on time of obs e.g. is 10 minutes late ok? If patient is unavailable e.g. due to treatment/tests ?=appropriate ?depends on which treatment/tests If patient is unavailable e.g. due to other reasons such as left ward ?=inappropriate What if patient does not consent to monitoring / treatment
Potential Exclusions	Patient has a TEP and/or is for end of life care Staff not escalating because they know the patient Patient is in an exclusion group e.g. <16 or pregnant woman Patients is in HDU/ITU/ED resus on one to one monitoring
What if Treatment Escalation Plan or Advance Care Plan in place	Exists Y/N or Followed Y/N (latter complicates review) Worth noting if TEP or ACP implemented at time of review
Data Collection	Sample or all Patients? Use of Point Prevalence studies Potential links with PSMU / SOS Insights Dashboard
Transferred to another organisation	How to access records, review care if patient transferred to another organisation (especially if uses other protocols)?

Potential for Organisational Learning

Review of patient care	
Understanding of organisational response to Deterioration	
Assessment of escalation response and can be used to identify themes and develop quality improvement projects to improve	
Recognition, communication and response to deterioration	

Identification of learning objectives for specific areas regarding the escalation of unwell patients	
Potential to drive very significant improvements for high-risk and deteriorating patients.	

Resource Implications

Depends if replacing current CQUIN data collection	
Potential for System Bias - Electronic system will make identification of patients and their care very much easier.	
Potentially less work for trusts on an electronic health record system.	
Random retrospective selection of patient triggering clinical records to be selected and delivered may be time consuming. Selection of patients may be more difficult for those hospitals without electronic records.	
Consider having admin staff responsible for data entry, overseen by clinical staff to ensure validity of the data.	

Appendix 1 - NEWS2 – Escalation Parameters (RCP)

NEWS2 score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	Continue routine NEWS monitoring
1-4	Minimum 4–6 hourly	Inform registered nurse, who must assess the patient Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more urgent response threshold	Minimum 1 hourly	Registered nurse to immediately inform the medical team caring for the patient Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients Provide clinical care in an environment with monitoring facilities
Total 7 or more emergency response threshold	Continuous monitoring of vital signs	Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills Consider transfer of care to a level 2 or 3 clinical care facility, i.e. higher-dependency unit or ICU Clinical care in an environment with monitoring facilities

Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017.

Appendix 2 - NEWS2 – Competency Criteria (RCP)

Clinical competencies of responders to the NEWS [1]

The clinical responders to critical NEWS triggers (score of 5 or more) should have the appropriate skills and competencies in the assessment and clinical management of acute illness.[38] In hospitals, team members should be clearly identified and provide coverage 24/7.

The original NEWS Development Group noted that the Department of Health (DH) had published a framework of the competencies for recognising and responding to acutely ill patients in hospital. [38] This document should be referred to for a detailed description of the competency framework that underpins the recommended graded clinical response to the NEWS.

This framework was produced in response to the NICE guideline CG50 [9] and noted that 'staff caring for patients in any acute hospital setting should have competencies in monitoring, measurement and interpretation of vital signs, equipping them with the knowledge to recognise deteriorating health and respond effectively to acutely ill patients'.

1. Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017.

9. National Institute for Health and Clinical Excellence. *Acutely ill adults in hospital: recognising and responding to deterioration*. Clinical guideline 50. London: NICE, 2007. www.nice.org.uk/guidance/cg50 [Accessed 9 August 2017].

38. Department of Health. *Competencies for recognising and responding to acutely ill patients in hospital*. London: DH, 2009. http://webarchive.nationalarchives.gov.uk/20130123195821/http://www.dh.gov.uk/en/Publicationsandstatistics/

Publications/PublicationsPolicyAndGuidance/DH_096989 [Accessed 10 August 2017].