Deteriorating patient's QIP

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Introduction

The WHY?

In 2021, 7B had 2 SI's declared. The Serious incidents both occurred when the patient's deteriorating conditions were not escalated quick enough. The SI's were escalated to the Deteriorating patient collaborative and with the help of the QI lead we set up a Multidisciplinary team and started work on improving our recognition and escalation of our deteriorating patients.

Rationale

Early recognition of deterioration will mean patients are detected, treated and where necessary, escalated to the appropriate teams in a timely manner. This should prevent further deterioration and further unnecessary patient deaths.

Aim

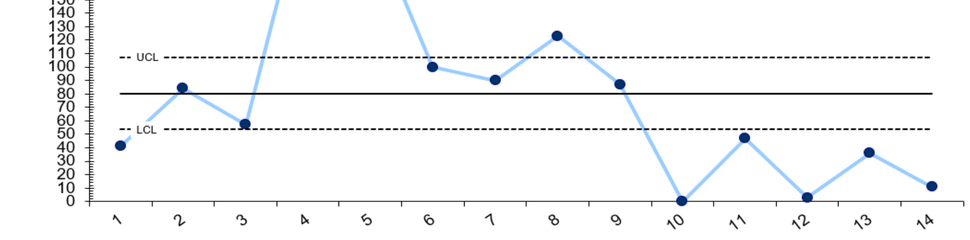
Here to Improve recognition and escalation of the Deteriorating patients on ward 7B:
70% of observations will be recorded on time on nerve centre by October 2021 and 90% by December 2021.

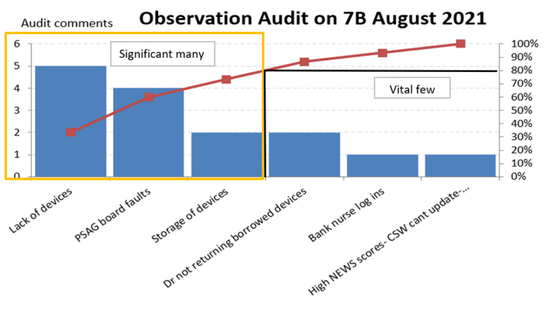
Now, in May 2022, the aim is to have no delays in taking observations and escalating the deteriorating patient – we have enough equipment to prevent any delays!

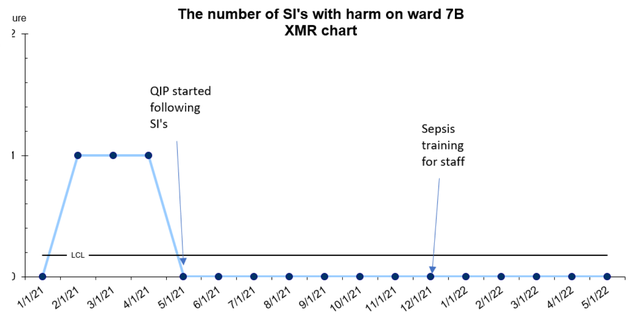
Measures

OUTCOME:

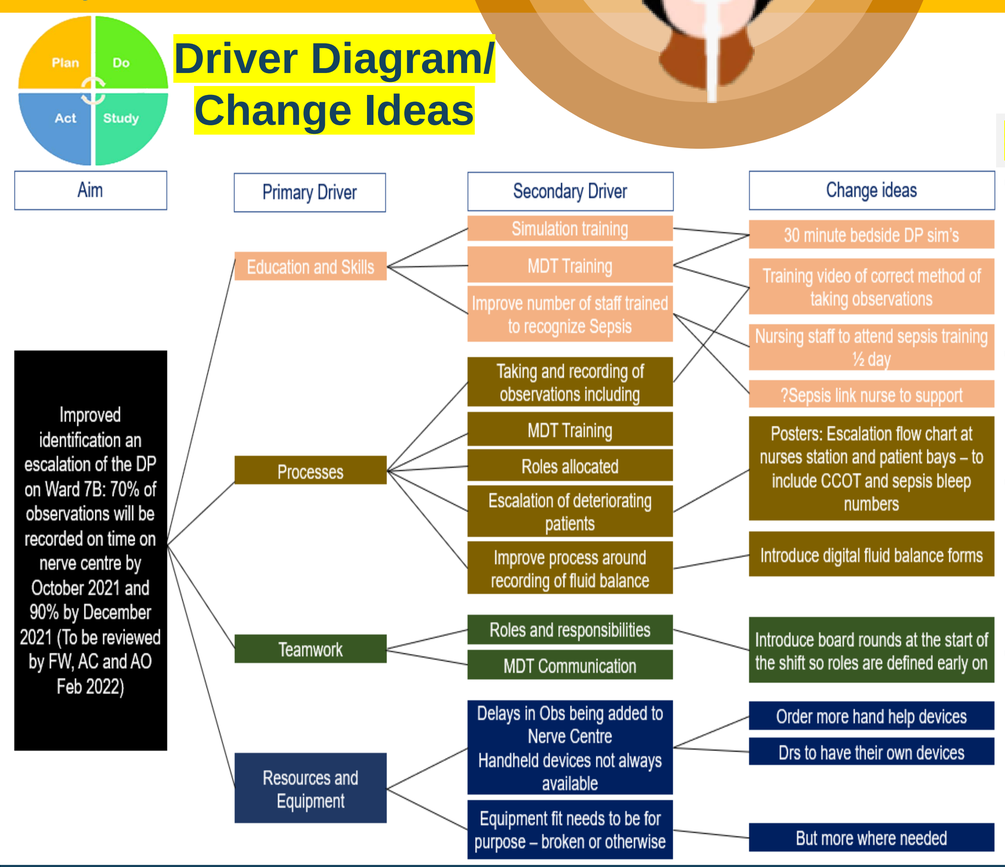
- The minutes between observations due and the time taken and put on nerve centre
- The number of SI's declared on 7B due to delayed escalation of a deteriorating patient







Driver Diagram/ Change Ideas



Change Ideas:

- All staff to have training update on News2 and New confusion
- All staff to have Sepsis 6 update training
- More devices for recording observations on Nervecentre
- Training video for the correct method of taking and recording observations

Next Steps

- Take equipment ordering problems to deteriorating patient collaborative at the end of May.
- To present my project at Quality Huddle, international day of the Nurse, Planned Care divisional Board to all staff in attendance, to share the learning we have gained from the project.
- The next steps will be to share the learning with the 7B team and across the division so we can all learn from the findings. This can be shared at the monthly planned care ward managers meetings.
- A continuous learning process and further development of the staff and the team as a whole.

Leadership Learning

- Expanding a network of leaders within the trust and people to reach out to for advice from their experience has been invaluable.
- Learning and being able to practice coaching skills has been very useful, assisting not only within the sessions on the RCN leadership study days, but in day to day work too.
- Celebrating small wins with the team, gives a sense of satisfaction as a manager and a sense of being valued for the team members. This makes it feel like a big win!!!
- I have learned the importance of delegation with tasks, which I have practised as part of leading the QI project. I have been able to prioritise the workload for the project and putting our patients first.
- Coaching skills learned from the course have been invaluable with both the QI project and day to day work, being able to assist the team with queries and helping them find their own solutions to the issue. This has helped boost morale and has identified areas the team still need support, so this help can be sought for them. I have learned the importance of knowing when to get help, and where to turn to for this.

Additional Info

Digital Fluid Balance compliance

Compliance is low and the need for support and training is high

- This has been taken over by Emma Bailey as part of her QIP- she will be focusing on training staff to improve compliance and understanding.
- To aid this work we have attached orange visual reminders to the observation machines to remind staff to think 'is my patient on a fluid balance?' and hopefully complete this at the same time as other observations.

News2 Refresher training

All staff have had to retrain on NEWS2

- Training is now live on our e-learning platform- ENH academy
- 48% of ward staff have had competencies refreshed so far face to face
- Our CCOT team are training staff on A to E assessments including the NEWS2 criteria, MS Teams and face to face,
- CCOT are working alongside ward staff clinically for escalation support.

Project impact

The Observation audit

To look at delays in observations being input into Nerve centre.

- This showed there were not enough handheld devices available, leading to a delays in recording the data.
- This was reported and escalated to the deteriorating patient collaborative.

Result: 6 new handsets delivered!!!

Sepsis 6 Compliance Compliance was low, The Sepsis team and 7B team, set up sepsis training for RN's and CSW's.

Barriers

- Clinical pressures, Staffing levels
- All Study leave being cancelled
- Delivery method for training

Result: 42% of staff on 7B have has sepsis training from April 1st onwards…More to come! (we can update this with the new number).

Equipment Audit

An audit was carried out by our team which showed:

- A large equipment shortage particularly Observation machines and tympanic thermometers.

Barriers

- The ordering process is extremely complicated
- Delays are huge e.g. 5 months after ordering, equipment has still not been delivered

This is high priority and has been escalated at our deteriorating patient meeting and further work is being undertaken to improve this.

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References: Sepsis.org ,NICE guidelines, NEWS 2, NHS England, Trust policies and guidelines