Welcome Back

Eddie Docherty

Executive Director of Nursing,
Midwifery and AHPs, NHS Lanarkshire

Afternoon agenda…

13:25	**Welcome back and introduction of afternoon plenary**	**Eddie Docherty**
13.30	**Deteriorating Patient introduction**	**Dr Lynsey Fielden**, National Clinical Lead Deteriorating Patient, HIS
13.40	**Deteriorating Patient plenary:** Patient and family worry and concern **Q&A**	**Jane Murkin,** Deputy Director Safety & Improvement, Nursing, Office of the Chief Nurse, NHS England **Liz Tomlin,** Head of Quality Improvement and Clinical Outcomes, Bradford Teaching Hospitals, NHS Foundation Trust
14:10	**Introduction of second breakout session**	**Eddie Docherty**
14:15	**Break and move to breakouts (online hybrid event finishes)**	

…afternoon agenda

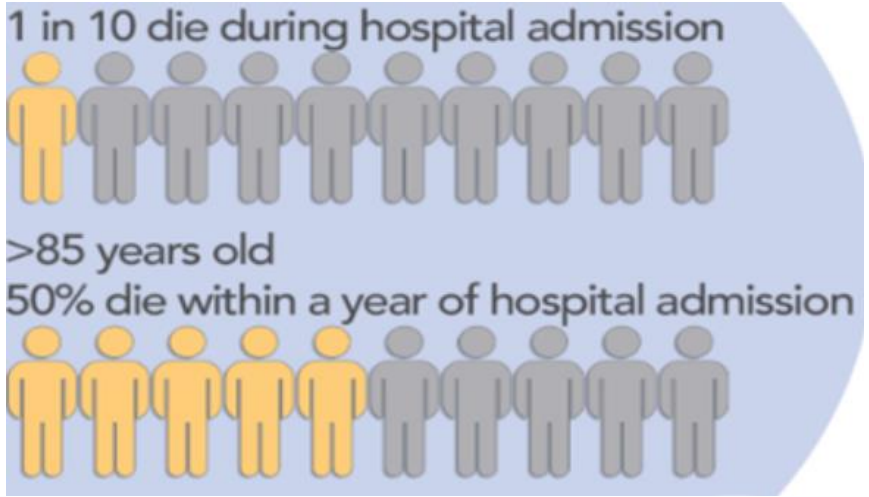
14:15	**Break and move to breakouts (online hybrid event finishes)**	
14:25	• **Breakout session on Falls:** Building on the momentum: the next step forward	**Jackie Bartlett and Stephanie Frearson,** NHS Ayrshire & Arran **Prof Brian Dolan, Dr Lara Mitchell**
	• **Breakout session on Deteriorating Patient:** Find your game changers	**Dr Gregor McNeill, Lesley Morrow, Emma Hearn, Gillian McAuley,** NHS Lothian **Dr Lynsey Fielden**
	• **Breakout session on Wellbeing:** Prioritising wellbeing: self-care and supporting teams	**Dr Christopher Healey,** Airedale NHS Foundation Trust **Scott Hamilton,** HIS
	• **Breakout session on Quality Improvement:** Scale up and spread	**Hazel Devlin and Emily Waite**, NHS Education for Scotland
15:25	**Return to plenary**	
15.30	**Closing remarks**	**Professor Brian Dolan OBE**
15:50	**Chair's close**	**Eddie Docherty**

SPSP Acute Adult Collaborative Deteriorating Patient

Dr Lynsey Fielden
National Clinical Lead, Deteriorating Patient,
Healthcare Improvement Scotland

The context

Inpatient Cardiac Arrest Rates are 1-1.5 per 1000 admissions



REALISTIC MEDICINE


Explainer

Martha's rule: what it will mean for patients and their families

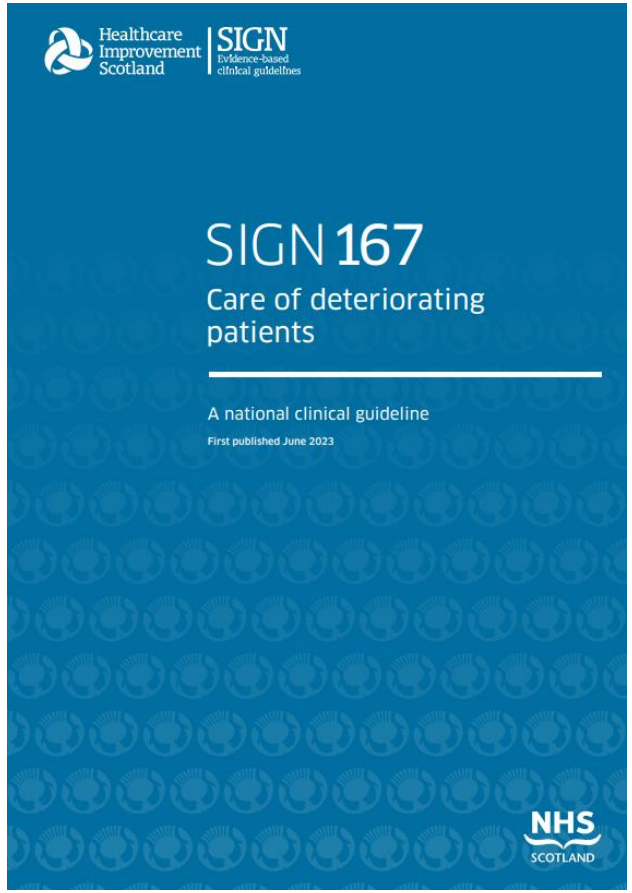
Patients in hospitals in England and their families would have the legal right to a second opinion

Martha Mills died in 2021 after developing sepsis at King's College hospital NHS foundation trust in south London.

The context


Royal College of Physicians
500 years of medicine
National Early Warning Score (NEWS) 2
Standardising the assessment of acute-illness severity in the NHS
Updated report of a working party
December 2017
1518
2018


October 2022 v2.0
(Replaces May 2022 version)
Academy of Medical Royal Colleges
Statement on the initial antimicrobial treatment of sepsis


Healthcare Improvement Scotland
SIGN
Evidence-based clinical guidelines
SIGN 167
Care of deteriorating patients
A national clinical guideline
First published June 2023
NHS SCOTLAND

The start of the collaborative journey

Collaborative launch September 2021

SPSP Acute Adult Collaborative

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

To improve recognition and timely intervention for deteriorating patients

The Team

Claire Mavin
Portfolio Lead

Dr Gregor McNeill
National Clinical Lead

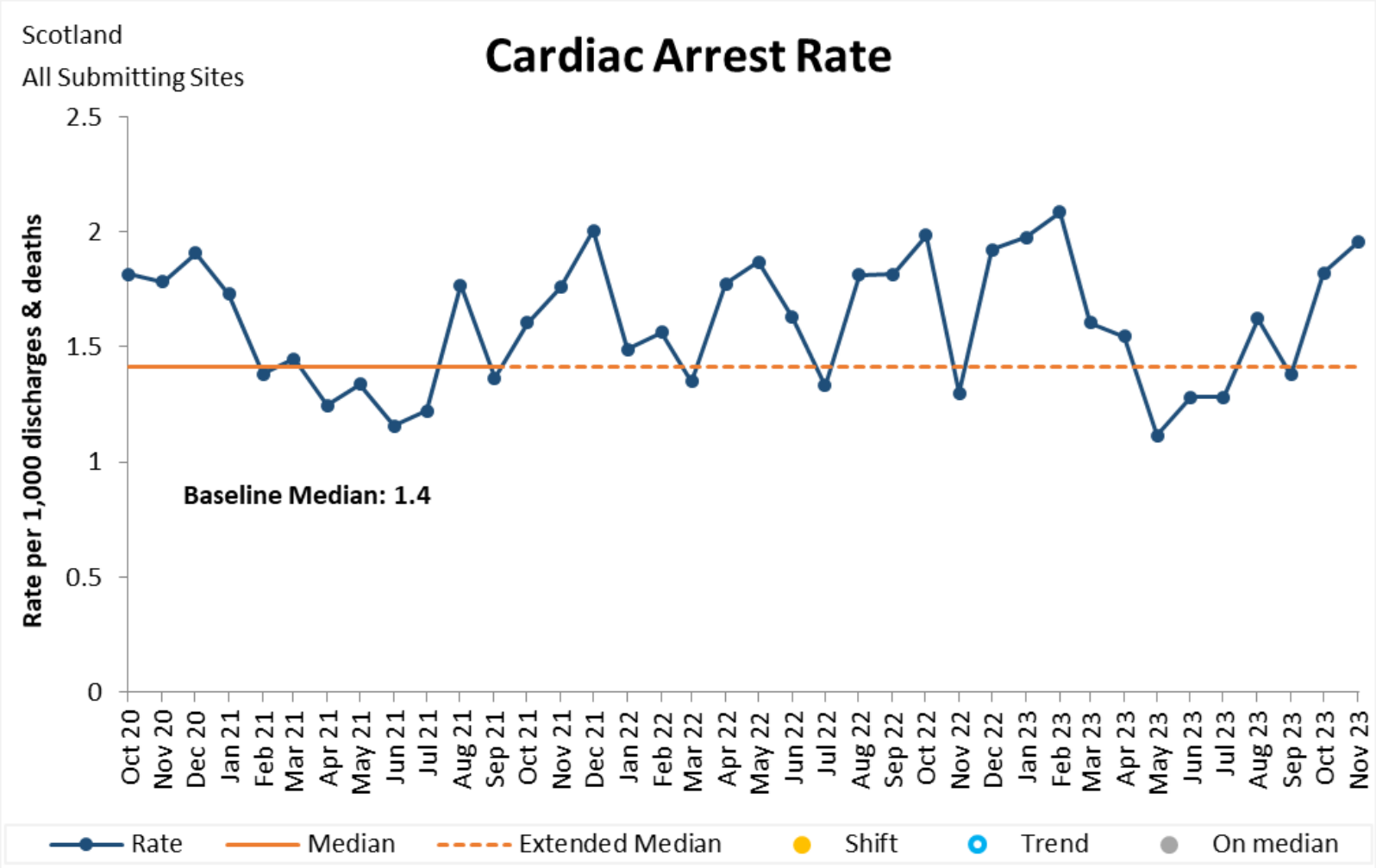
Dr Lynsey Fielden
National Clinical Lead

Meghan Bateson
Senior Improvement Advisor

Scott Hamilton
Improvement Advisor

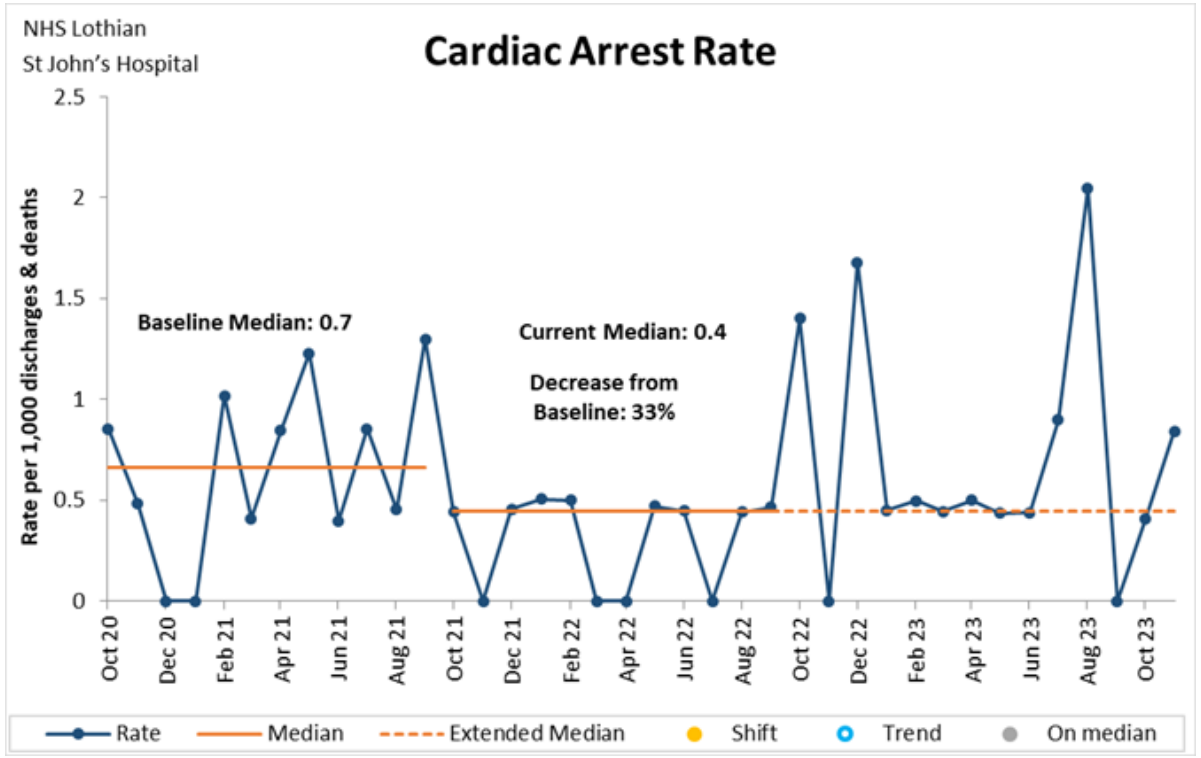
Donna Frew
Senior Improvement Advisor

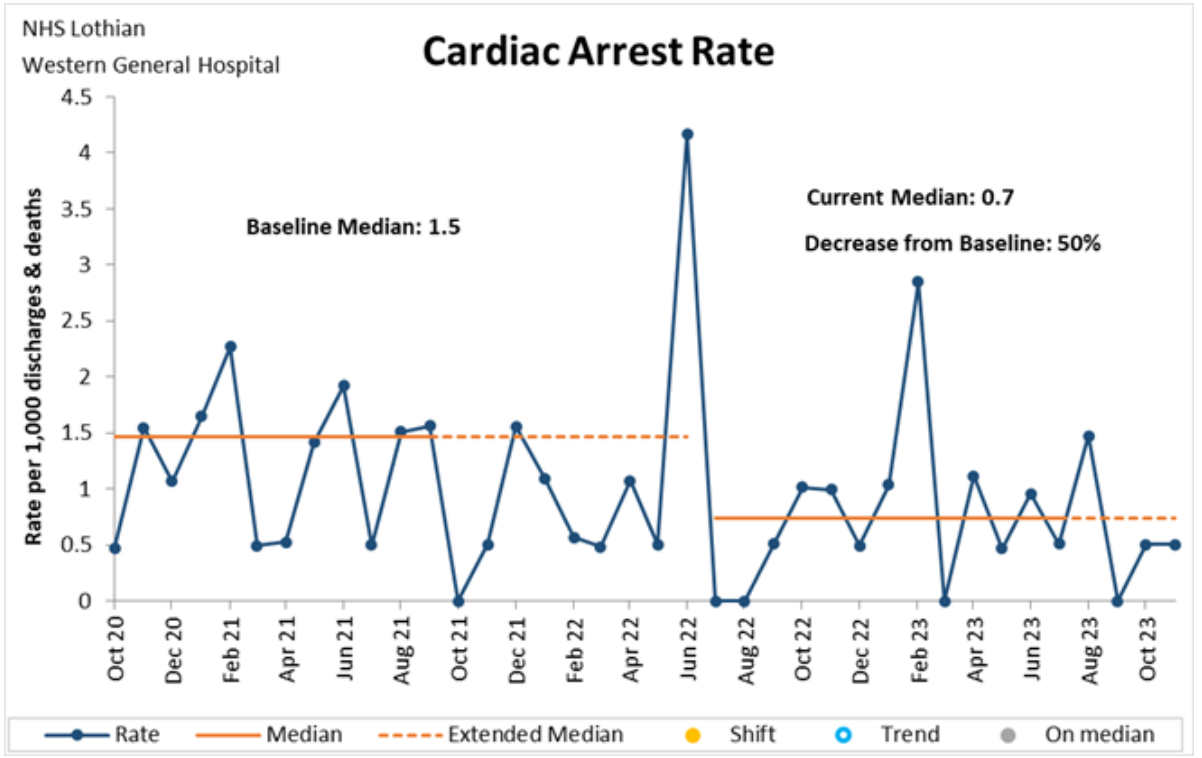
The National picture



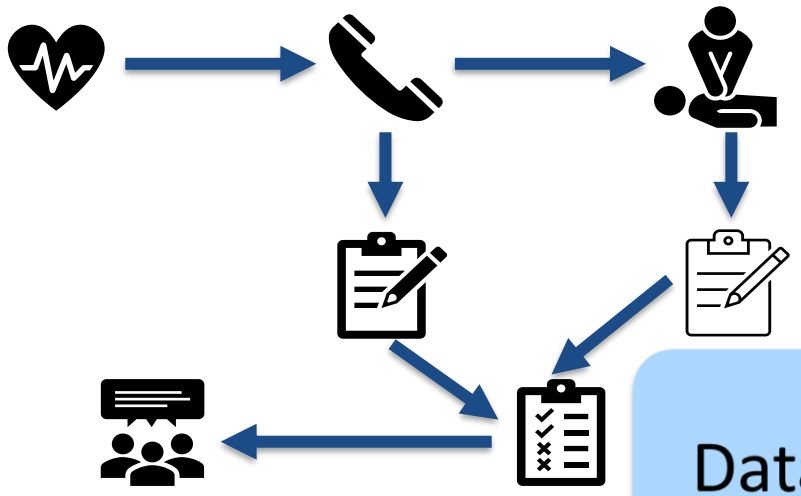
From October 2020 to present, at least **90%** of the Scotland population is covered by NHS Board submissions for all months

Site level reduction





What teams have been focusing on



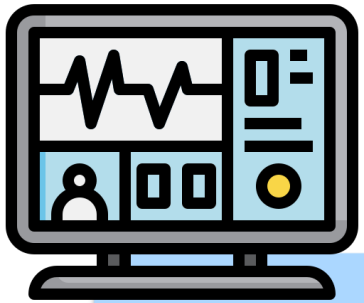
Data reliability

	Principle and Prompts	What we currently do and who usually does it Walk through what usually happens in the ward or clinical area for each principle	Works Well	Potential for Improvement
Recognition	How do you recognise deterioration in your area? • NEWS2 • Clinical concern • Patient, family or carer concern • Locally agreed trigger(s)			
	What is the process for escalation through the team? • Are there particular times of day/days of the week where it is easier or more difficult? • When would you call the [*insert any local teams e.g. outreach*]?			
Response & Review (A to E)	Identifying a working diagnosis What processes are in place to establish a patient's wishes (use of future care planning/TEP) and how reliably accessed/completed are these? Can you reliably access the investigations you most often require? (consider differences in time of day / weekend) What is the process to seek consultant review? How easy is it for you to access critical care support?			

	Principle	What we currently do and who usually does it	Works Well	Potential for Improvement
Response & Review (A to E)	Developing a management plan			
	Are observation frequency plans appropriate, and feasible for clinical area?			
	What is the process for prompting reassessment – criteria, timeframe, other?			
	Triage Decision – considerations about best location for the patient			
Reassess	How do you identify whether patient is still of concern?			
	When reviewing progress since initial response, how easy is it for the team to reconsider: - Working diagnosis - Management plan in light of progress - TEP / future care plan or ACP - Triage decision			
	What is the process for prompting further reassessment			

Principles of a structured response

Shared decision making



eObs

Cardiac arrest review

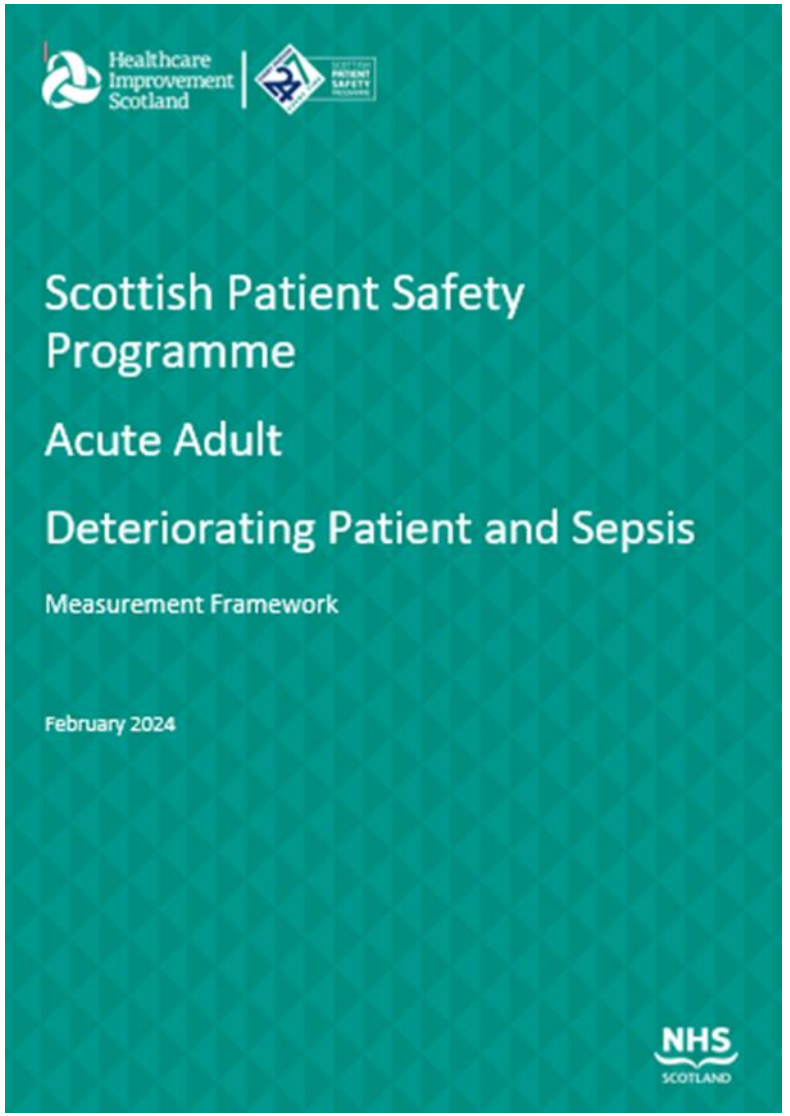
slido

What has been the biggest game-changer in your journey so far?

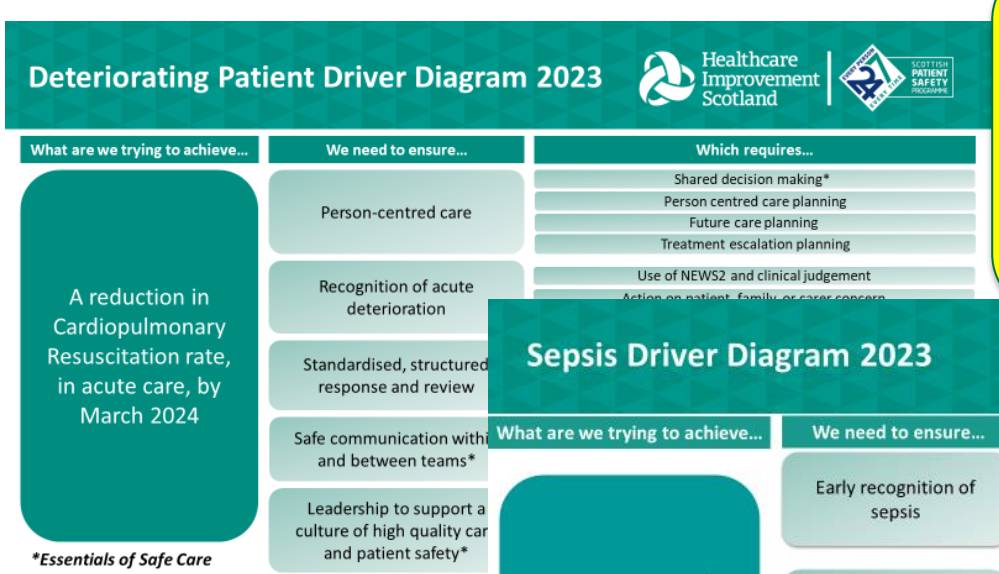
ⓘ Start presenting to display the poll results on this slide.

Reflections

Updated Change packages



The voices of lived experience



"This resource is fantastic, very clear and easy to understand and reflective of patient and carer concerns"

Eleanor,
Zoe's mum

SEPSIS RESEARCH FEAT

"The documents you have shared look better than I had hoped. In particular, the focus on patient centred care. I feel heard. Thank you."

Michelle

Hear the patient voice, at every level, even when that voice is a whisper

(National Advisory Group on the Safety of Patients in England 2013)

Jane Murkin

Deputy Director Safety & Improvement, Nursing, Office of the Chief Nurse, NHS England

Liz Tomlin

Head of Quality Improvement and Clinical Outcomes, Bradford Teaching Hospitals, NHS Foundation Trust

Patient and Family Worry and Concern National Improvement Collaborative

Jane Murkin

Co-chair, NHS England's National Worry and Concern Group & Collaborative Lead

Session aims

- Share our strategic approach and the work of the NHS England Worry and Concern national improvement collaborative.
- Emphasise the significance of the patient and family voice in the recognition and management of deterioration, including using stories to drive change and improvement.
- Share progress insight and learning from our seven regional pilot sites.
- Opportunity for questions & discussion

Drivers for Change

- Patients and families' voices must be heard, listened to, and appropriately acted on.

- Absence of reliable mechanisms for patients at-risk, or those close to them, to escalate concerns in relation to acute illness/ deterioration.

- Learning from Parliamentary & Health Service Ombudsman report– "Broken trust: making patient safety more than just a promise".

- NHS England framework for involving patients in patient safety

- Investigation reports identifying that patients' concerns weren't listened to e.g., Ockenden Report, Francis Report.

Our National Improvement Approach

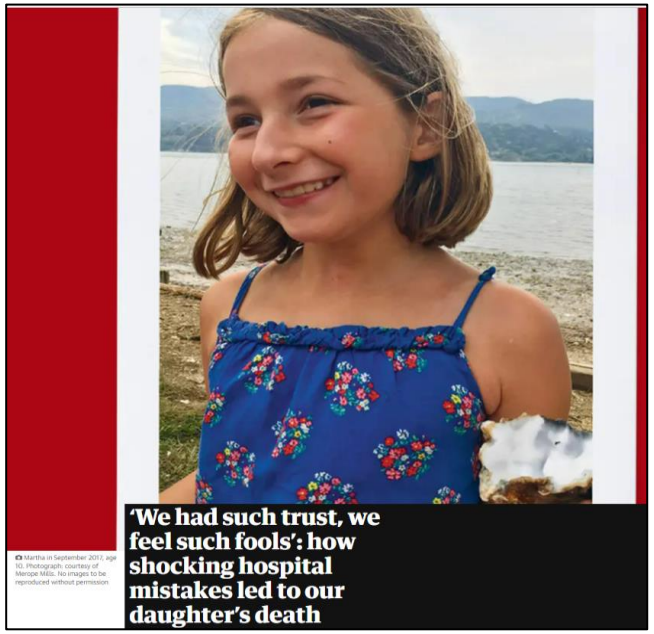
- Quality improvement collaborative: 7 regional pilot sites, two strategic aims

  Aim 1 - Test and implement a reliable method for patients - or their families/carers - to escalate worries and concerns about acute illness and deterioration (when standard care is failing them).

  Aim 2 - Test and implement reliable methods for patients - or their families/carers- to routinely input their views about their illness and any worries and concerns into the health record (with evidence these are included in care and treatment plans).

- Collaborative commenced in **April 2023** with first national learning session
- Learning session 5 – Celebration Event - **April 25th**

Why is this important ……..



Marthas parents raised concerns about her deteriorating health to doctors several times

Maddy's families concerns not listened to or acted upon.

Kane Gorny inquest: Hospital neglect contributed to death

13 July 2012

A post-mortem examination found dehydration caused high sodium levels to lead to his death

Neglect by medical staff contributed to the death of a hospital patient who died from dehydration after calling 999 because he was so thirsty.

Evan Smith inquest: Hospital 'failure' led to sepsis patient's death

7 April 2021

Evan Smith called 999 while in hospital because nurses refused him oxygen, an inquest has heard

A man who suffered a sickle cell crisis and rang 999 from his hospital bed would not have died if medics had offered him a blood transfusion sooner, a coroner has said.


What is most important to you about the work ?

Consideration for our staff

MORAL INJURY

- Emotional impact of work
- Staff survey results 2022 – **14.7 %** of staff experienced physical violence from patients, relatives or members of the public
- Staff health and well being
- Retention
- Compassionate leadership

HSIB report explored impact of staff wellbeing on patient safety

Enablers and barriers

FLORENCE NIGHTINGALE FOUNDATION

Lancaster University

The Kings Fund

Florence Nightingale Foundation

EXPLORING THE INFLUENCE OF LEADERSHIP, CULTURE AND HIERARCHY ON RAISING CONCERNS RELATING TO PATIENT DETERIORATION

Report to NHS England Worry & Concern Steering Group

Essi Vehvilainen, Research and Policy Officer
Ashleigh Charles, Research and Policy Associate
Jessica Sainsbury Head of Nursing and Midwifery Engagement
Professor Gemma Stacey, Deputy Chief Executive Officer
Professor Greta Westwood, Chief Executive Officer

April 2023

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Registered in Scotland Charity Reg. No. SC04824
A company Limited by Guarantee Registration No. 00518623

PSYCHOLOGICAL SAFETY

Collaborative leadership	• Multi-dispalinary decision making • Patient/ carer perceived and treated as experts in care • Power sharing
Education and support	• Training for all to identify deterioration • Clinical supervision to promote reflection and share learning
Feedback and learning	• Positive and active response to concerns raised • Evidence of follow up action • Learning from feedback from all sources

Stacey. G & West. M

Patients don't suddenly deteriorate…

Patient-Safety-Related Hospital Deaths in England: Thematic Analysis of Incidents Reported to a National Database, 2010–2012

Liam J. Donaldson ✉, Sukhmeet S. Panesar, Ara Darzi

>2000 patient safety incidents leading to death

Thematic analysis of Safety Incidents Donaldson et al 2010

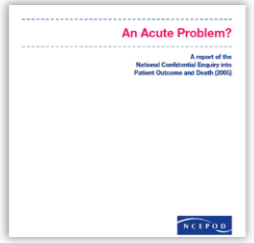
Mismanaged **Deterioration**	35%
Failure to **Prevent deterioration**	26%
Deficient **Checking**/oversight	11%

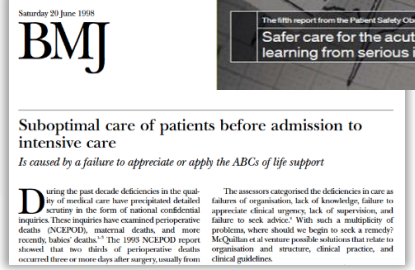
The mismanagement of deterioration is the commonest theme in avoidable patient death
Nearly all avoidable hospital deaths are preceded by a measurable worsening in physiology

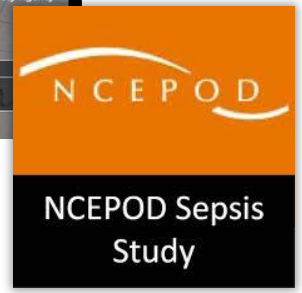
Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis

Helen Hogan,[1] Rebecca Zipfel,[1] Jenny Neuburger,[1] Andrew Hutchings,[1] Ara Darzi,[2] Nick Black[1]

Numbers of deaths	4400
Avoidable deaths	**3.6%**







All were **deterioration** associated factors

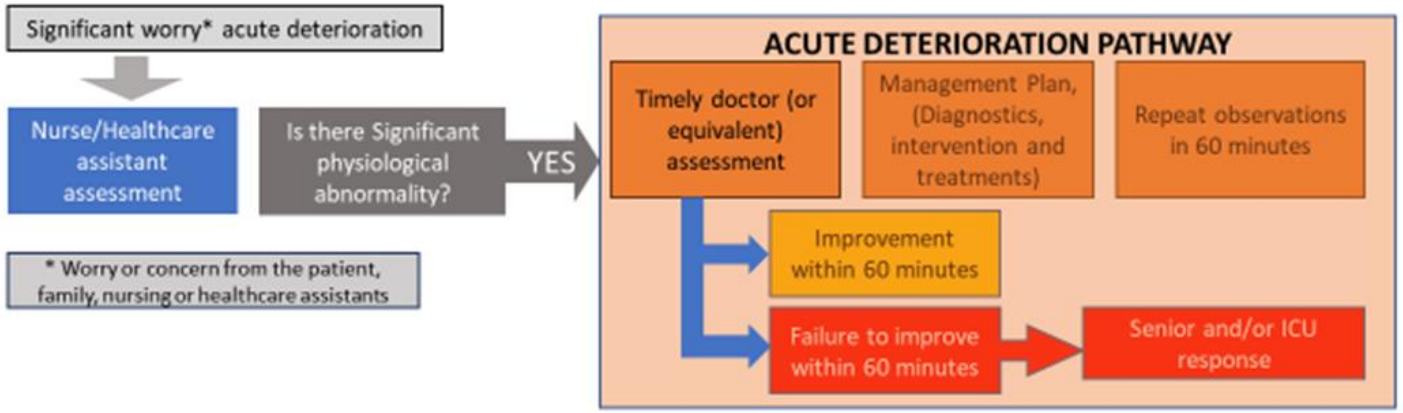
- **Inadequate monitoring/assessment**
- **Failure to spot severity and risks**
- **Failure to optimise/adequate response**
- **Inappropriate environment/delays**
- **Poor communication, documentation**
- **2 in 3 associated with prolonged physiological instability**
- **1 in 5 of ICU admissions avoidable**

….. we suddenly notice

WE MUST IMPROVE THE RELIABILITY OF DETERIORATION CARE

We must give patients/families/clinicians the ability to raise worry/concern, remembering that …

Nearly all avoidable hospital deaths are preceded by a measurable worsening of physiological observations



We should be increasing the emphasis on improving the reliability within the acute deterioration pathway (including but not limited to monitoring, identification, patient voice, escalation and response).

Achieving this should reduce the need for parents/patients to spot critical illness

No observations for 16 hours despite low Blood pressure

'she had a high heart rate, a fever and fast breathing..She had very low blood pressure'

If we do not focus on the deterioration pathway (and in particular physiological observations), Martha's rule will have no impact on improving patient outcomes

In each hospital, there are an average of 4 significant physiological deteriorations per hour
5 avoidable deaths at each NHS hospital trust each month

Insights & Learning

- **Collaborative sites** - testing and implementing mechanisms for patients and families to escalate their worries and concerns - not all via CCOT – using filter mechanisms to support
- **Response mechanisms** - identifying relevant cases, some more related to other clinical or communication issues (which may be important); useful for organisational learning
- **Patients and staff** - importance of involving both patients and staff in codesign and implementation; staff and patient interviews have highlighted important issues
- **Patient recognition - 75% patients** felt they would notice if they became unwell, however **only 35%** of staff felt patients can recognise deteriorations
- **Cultural change -**importance of a collaborative improvement approach, recognition of professional hierarchies, team-working challenges, need for present leadership
- **Measurement for improvement -** length and type of calls, numbers of criteria vs non criteria calls, impact assessment; Datix reports and complaints, failures to rescue, unplanned admissions to higher care, user feedback
- **Evaluation –** phase 1 interviews completed and phase due to commence later this month : Realist Evaluation approach
- **Aim 2** – Proactive approach- patients assessment of their illness / wellness working well; staff saying beneficial, identifying cases 12 – 24 hours pre-NEWS changes - being tested in other areas to support identification and prioritisation of clinical review

Preparation& planning : 135 patients surveyed

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

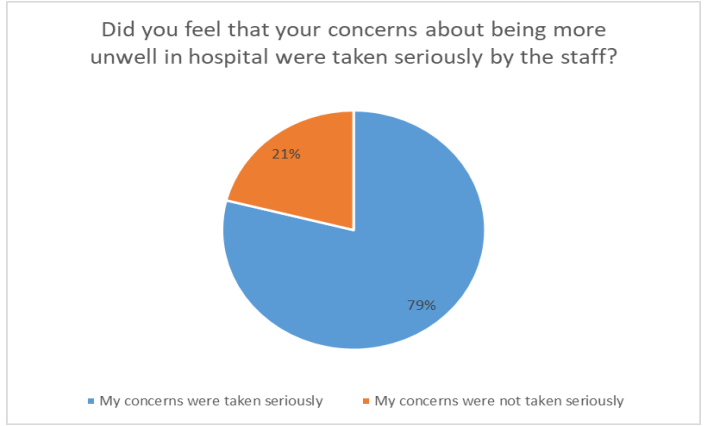
Pioneering better health for all

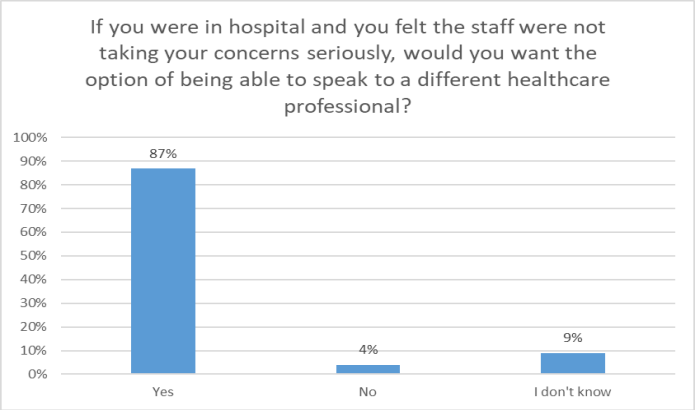
- 50:50 gender split, good representation of age/ethnicity
- 62% considered themselves to have disability
- 42% had ICU admission

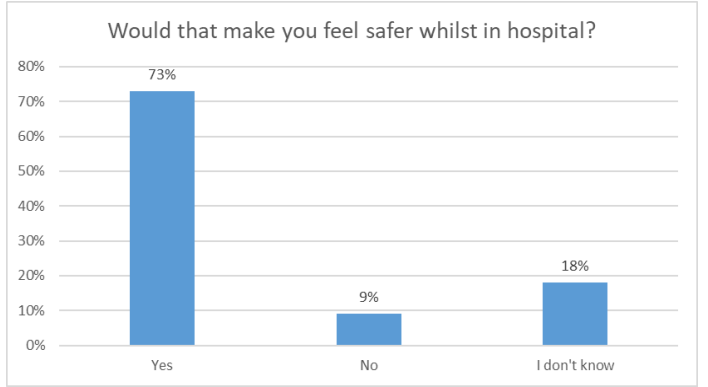
- LD responses less confident in understanding their condition
- 75 years = less confidence in requesting 2nd opinion
- Males more confident in all categories
- No clear difference in ethnicities

- **67% had raised concerns about deterioration**
  - 21% of that group felt their concerns not taken seriously

- **87% want option of 2nd opinion if standard care not working for them**
  - 73% felt that would make them feel safer

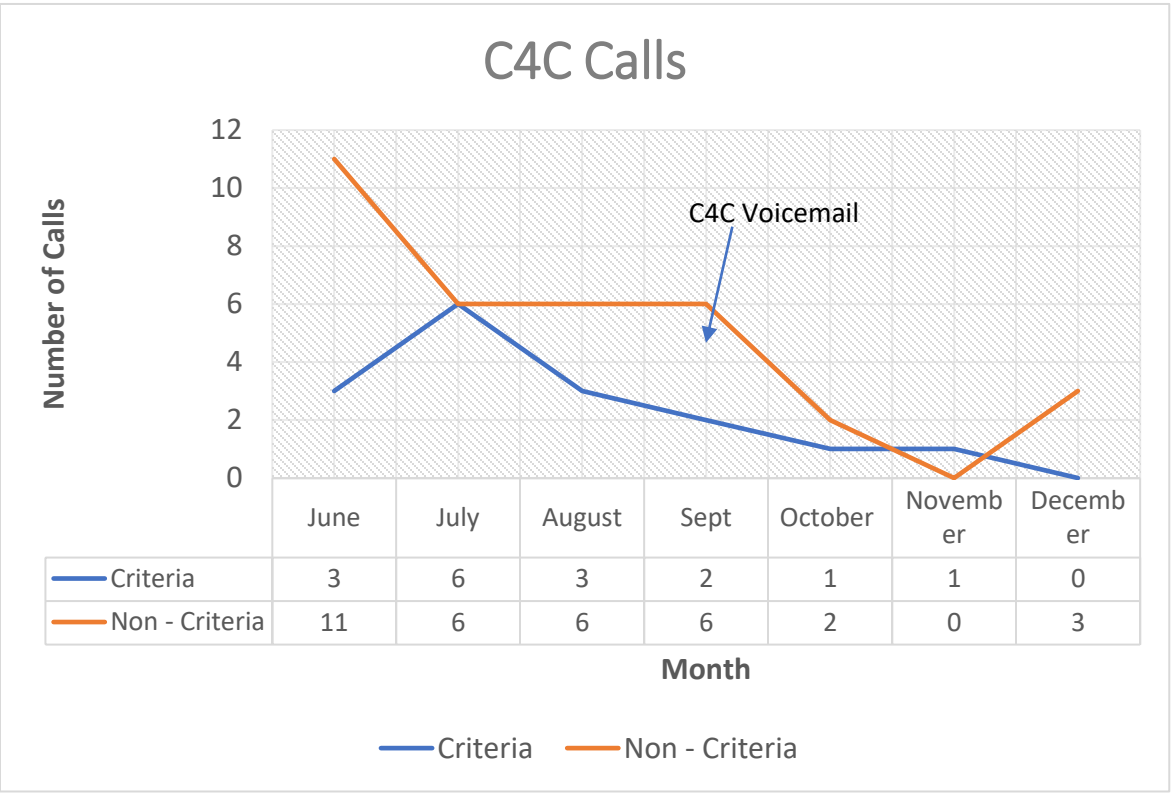






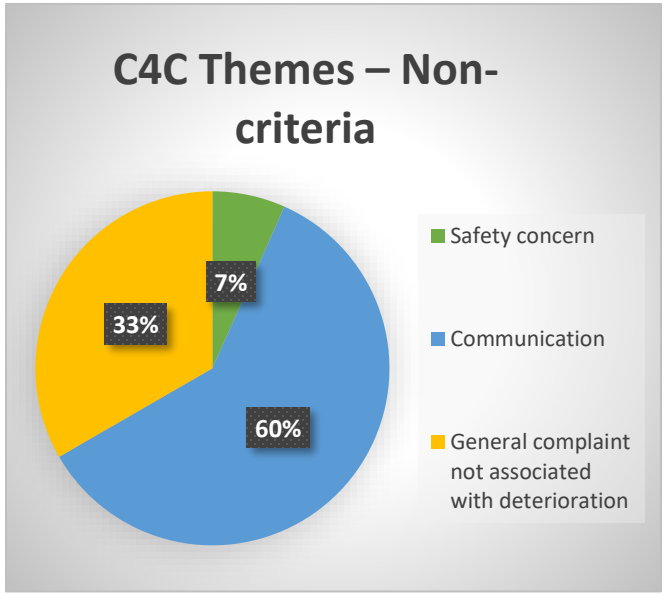
What are we learning from implementing a Patient & Family Response System

Launched trust wide 30th May 2023 – all adult inpatient areas - Total of 35 calls (Jan 24)



Non – Criteria Themes

- Safety Concern
- Communication
- General complaint not associated with a deterioration



Interventions following calls

- Outreach spoken directly to the ward
- Sign posted relatives to other services – PALs,
- Asked the referrer to contact the Ward Manager / Nurse in Charge

Patient Story & Feedback

Northampton General Hospital NHS Trust

My dad attended A&E in July; this was following a previous admission with sepsis secondary to cellulitis in the same hand that he was presenting with this time.

When he left the house, he had a temperature of 38.3 and by the time he arrived in A&E they said his observations were stable, despite my mum being with him and seeing that his temperature was raised, heart rate was high, low blood pressure and oxygen saturations. When she challenged this, she was ignored and there was a delay in antibiotics being administered and bloods taken.

He was clerked and told he would be admitted under the Orthopaedic team, when he arrived onto the ward, he was very pale in colour, sweating and felt flushed. We asked the nurse that his observations were re-checked, he had a temperature of 40.5, low blood pressure and high heart rate.

The nurses tried to escalate this to the Doctor who continually said he would be another ten minutes, another ten minutes, another ten minutes and that my Dad had been admitted with an infection so what did they expect.

My dad explained that he felt he was going to die and was increasingly more tired. The nurses were escalating to site team and sister on to access a doctor. I then knew we were at a point that my dad could die, and I couldn't sit back and let this happen.

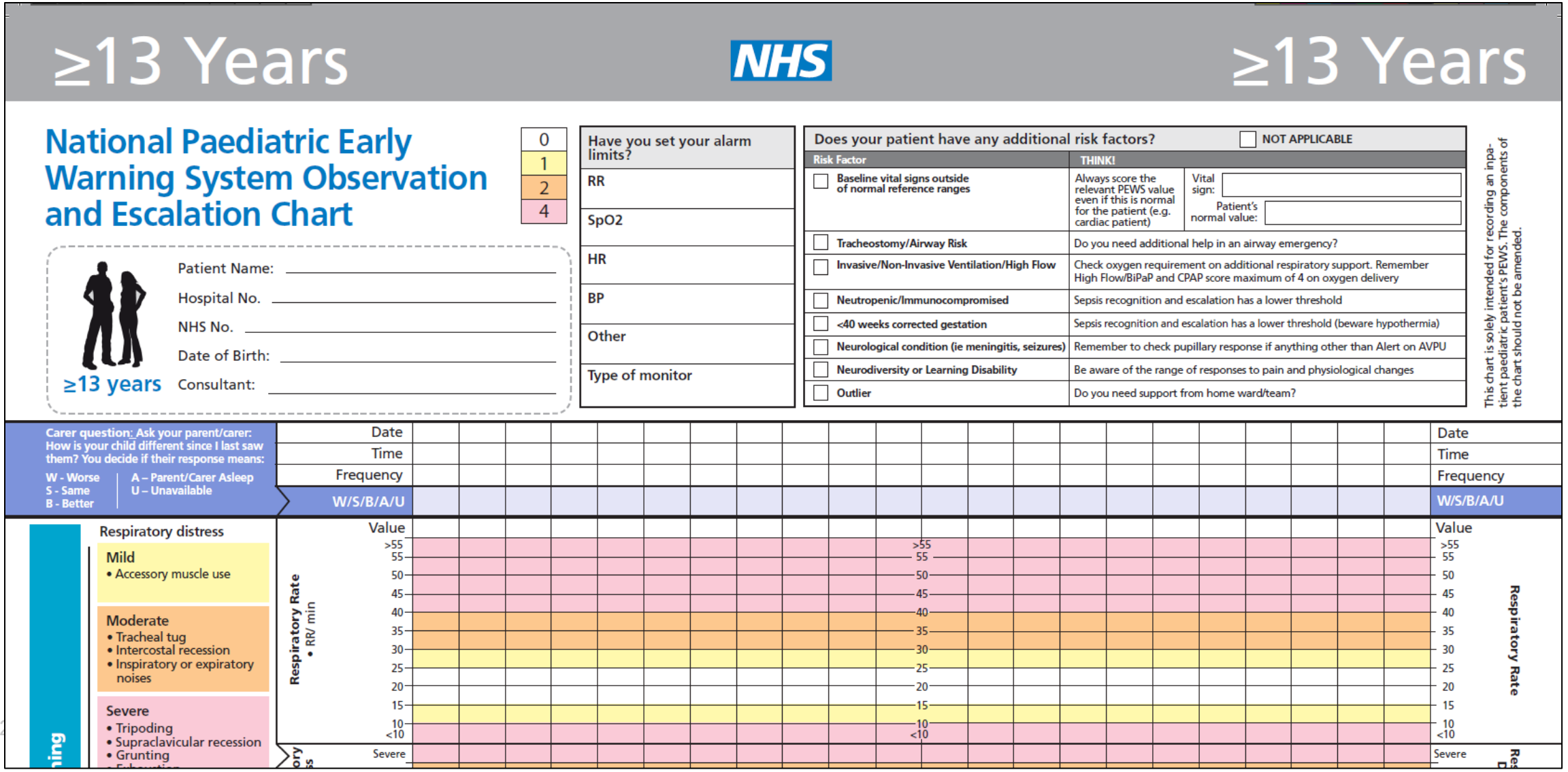
I called the 'Call 4 Concern' number and was greeted with great reassurance from the nurse who answered the call, the nurse came to review my dad and when she arrived the doctor was present, they worked together as a team and treatment began.

The outreach nurse reviewed my dad, informed him and us of the plan and reassured my dad as a patient and us as a family that he would be monitored overnight and someone from outreach would come down to check on him throughout the night.

At a time of panic, worry and uncertainty the 'Call 4 Concern' service gave us back control as service users and we believe genuinely saved a life.

excellence

How is your child different – worse, the same, or better?



≥13 Years NHS ≥13 Years

National Paediatric Early Warning System Observation and Escalation Chart

0
1
2
4

≥13 years

Patient Name:
Hospital No.
NHS No.
Date of Birth:
Consultant:

Have you set your alarm limits?
RR
SpO2
HR
BP
Other
Type of monitor

Does your patient have any additional risk factors? ☐ NOT APPLICABLE

Risk Factor	THINK!
☐ Baseline vital signs outside of normal reference ranges	Always score the relevant PEWS value even if this is normal for the patient (e.g. cardiac patient) — Vital sign: / Patient's normal value:
☐ Tracheostomy/Airway Risk	Do you need additional help in an airway emergency?
☐ Invasive/Non-Invasive Ventilation/High Flow	Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery
☐ Neutropenic/Immunocompromised	Sepsis recognition and escalation has a lower threshold
☐ <40 weeks corrected gestation	Sepsis recognition and escalation has a lower threshold (beware hypothermia)
☐ Neurological condition (ie meningitis, seizures)	Remember to check pupillary response if anything other than Alert on AVPU
☐ Neurodiversity or Learning Disability	Be aware of the range of responses to pain and physiological changes
☐ Outlier	Do you need support from home ward/team?

This chart is solely intended for recording an inpatient paediatric patient's PEWS. The components of the chart should not be amended.

Carer question: Ask your parent/carer: How is your child different since I last saw them? You decide if their response means:
W - Worse | S - Same | B - Better | A – Parent/Carer Asleep | U – Unavailable

Date / Time / Frequency / W/S/B/A/U

Respiratory distress
- Mild: • Accessory muscle use
- Moderate: • Tracheal tug • Intercostal recession • Inspiratory or expiratory noises
- Severe: • Tripoding • Supraclavicular recession • Grunting

Value: >55, 55, 50, 45, 40, 35, 30, 25, 20, 15, 10, <10

Respiratory Rate • RR/ min

Severe

Influencing and Informing Martha's Rule

- Family campaign - meetings with family
- SoS commitment
- Patient Safety Commissioner – leading a series of sprint events
  - **Sprint 1 -** defining problem to be solved – Oct 9th
  - **Sprint 2 -** feedback from NHS England pilots – Oct 10th
  - **Sprint 3 -** what already exists and how does this fit with wider work – Oct 11th
  - **Sprint 4 -** developing the solutions for successful implementation – Oct 18th

What is Martha's Rule?

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.

2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition

3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Bradford Teaching Hospitals
NHS Foundation Trust

Improving recognition and treatment of deterioration: Incorporating patients' worries & concerns in the assessment of acute illness

NHS England 'Worries and Concerns' Pilot 2023/24

Liz Tomlin *(Head of Quality Improvement and Clinical Outcomes)*
Bradford Teaching Hospitals NHS Foundation Trust

Together, putting patients first

NHS E 'Worries and Concerns' Pilot

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

10 miles, 10 years less life.

10 miles, 20 years less healthy life.

Life expectancy (in years)*	Female	87.6	84.7	83.8	79.9	78.1
	Male	84.3	80.8	77.7	77.8	73.3
Healthy life expectancy (in years)**	Female	72.1	68.9	64.3	58.1	48.5
	Male	71.1	67.4	62	60	50.6

RIC Reducing Inequalities in Communities

*Data source: Office of National Statistics, 2017 – 2019
**Data source: Office of National Statistics, 2009 – 2013

Closing the health gap in central Bradford

Collaborative Team Checklist

Bradford Teaching Hospitals NHS Foundation Trust

Role	Our People
Exec Lead / Sponsor	Dr Ray Smith – Chief Medical Officer Karen Dawber – Chief Nurse Officer
Project Lead	Liz Tomlin – Head of Improvement & Clinical Outcomes
Clinical Leads – nursing and medical	Dr Brian Wilkinson – Consultant Anaesthetist Maggie Molloy & Karon Todd – Senior Sisters Critical Care
Patient Safety Partners/Patient Representatives	Yorkshire Quality & Safety Patient Reference Group (YQSPR)
MDT members of Ward / Department / Speciality areas where work will be progressed	Ward Staff from ward 21, ward 7, ward 9 and Virtual ward Clare Nandha – Sepsis Specialist Nurse
Quality Improvement Lead	Lisa Jamieson – Quality Improvement Manager
Patient Experience Lead Patient Safety Lead	Ruth Tolley – Patient Experience Lead

The programme of work has two aims:

1. To develop, test, implement and evaluate reliable methods for patients (or their families/carers) to escalate worries and concerns about acute illness and deterioration when standard care is not meeting their needs.

2. To develop, test, implement and evaluate reliable methods for patients (or their families/carers) to routinely input their views regarding their wellness/illness and trajectory, and any worries and concerns into the health record, with evidence that those views and worries and concerns are considered and acted on by the healthcare team.

Method: Patient Wellness Questionnaire*

'A measure that can be used to routinely collect patient-reported wellness during observation in hospital and may potentially improve early detection of deterioration.'

*Albutt, A., O'Hara, J., Conner, M., & Lawton, R. (2020). Involving patients in recognising clinical deterioration in hospital using the Patient Wellness Questionnaire: A mixed-methods study. Journal of Research in Nursing, 25(1), 68-86.

Patient Wellness Questions

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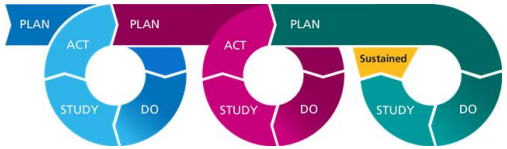
How are you feeling?

Patient Wellness Score Decision Matrix

2	3	4	5	6
3	4	5	6	7
4	5	6	7	8
5	6	7	8	9
6	7	8	9	10

Action based on PW Score	
2-5	Continue to monitor
6-7	Talk to the nurse in charge
8-10	Call Critical Care Outreach Team #6775

How are you feeling compared to the last time we asked (or since you arrived in hospital or on the ward)?



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Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Aim:
To actively engage with patients (or carers/families) in the acute care setting to routinely input their views regarding their wellness/illness and trajectory into their health record, with evidence that any worries and concerns are considered and acted on by the healthcare team by 31 March 2024.

Measures for Improvement :
- Number of PWQs completed per day
- Percentage of PWQ's completed that are documented in the electronic health care record
- Number of Critical Care Outreach Team referrals
- Qualitative: Patient feedback and Staff feedback

Change Idea: 'Patient Wellness Questionnaire' (PWQ)
It is anticipated that we may detect earlier 'soft signs' of deterioration by listening and involving patients, carers and families, to escalate concerns to a specialist team (CCOR) and acting on those concerns.

Ward 21 Planned Surgery PDSA cycles:
- HCAs PWQ at the same time of observations
- Completed paper forms
- Bay 2 plus side room – 5 beds
- Bay 3 plus side rooms – 5 beds
- Whole ward – 20 beds

Ward 7 Infectious Diseases PDSA cycles:
- RNs completing PWQ
- Not linked to observation time
- Whole ward (12 beds - all side rooms
- Removed paper forms – sustained and routine recording in patient notes

Ward 9 Stroke rehab PDSA cycles:
- RNs
- HCAs added
- Reported directly into electronic health care record – nursing notes
- Whole ward -12 beds

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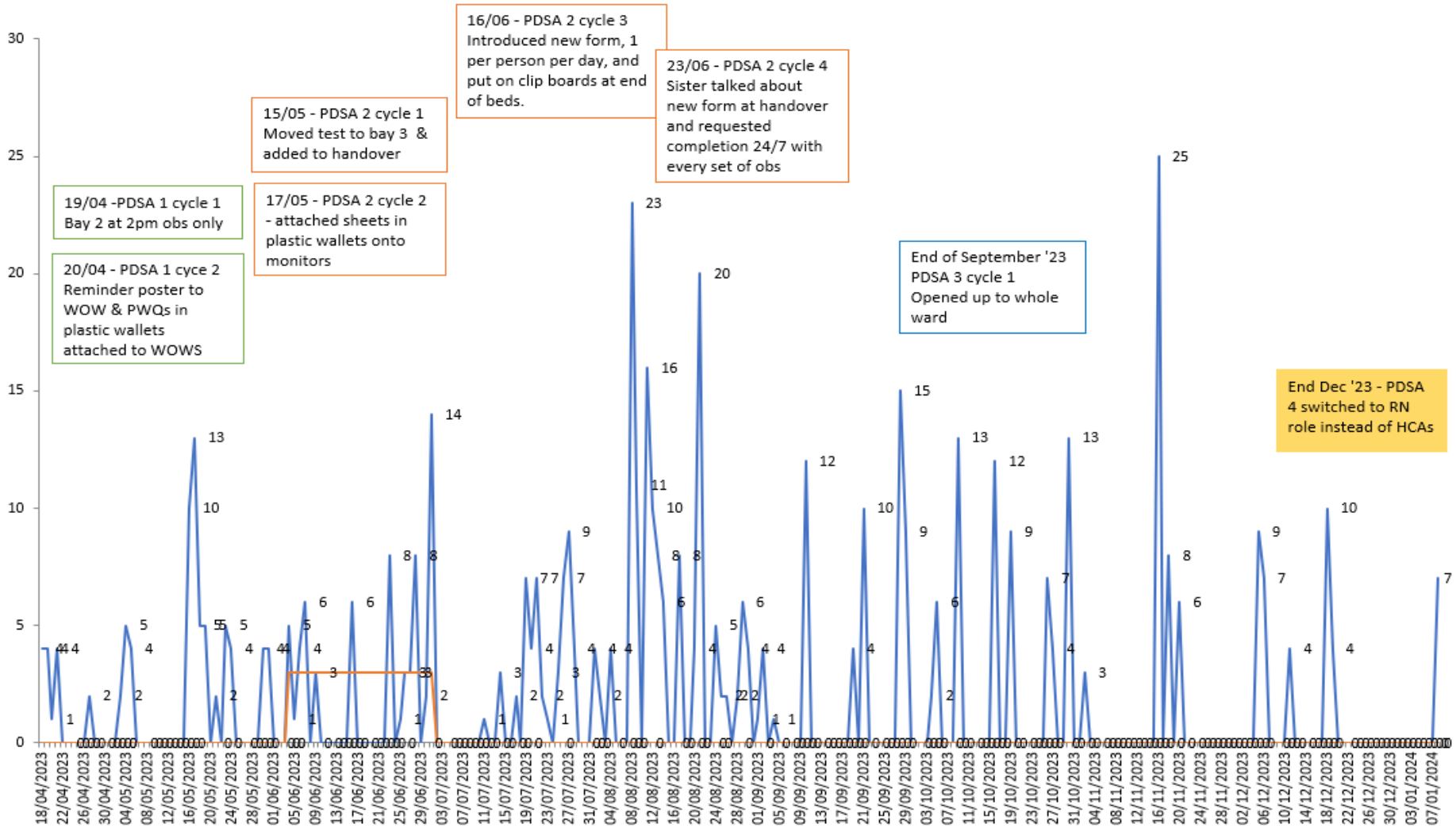
Ward 21: Number of completed PWQs per day - paper based



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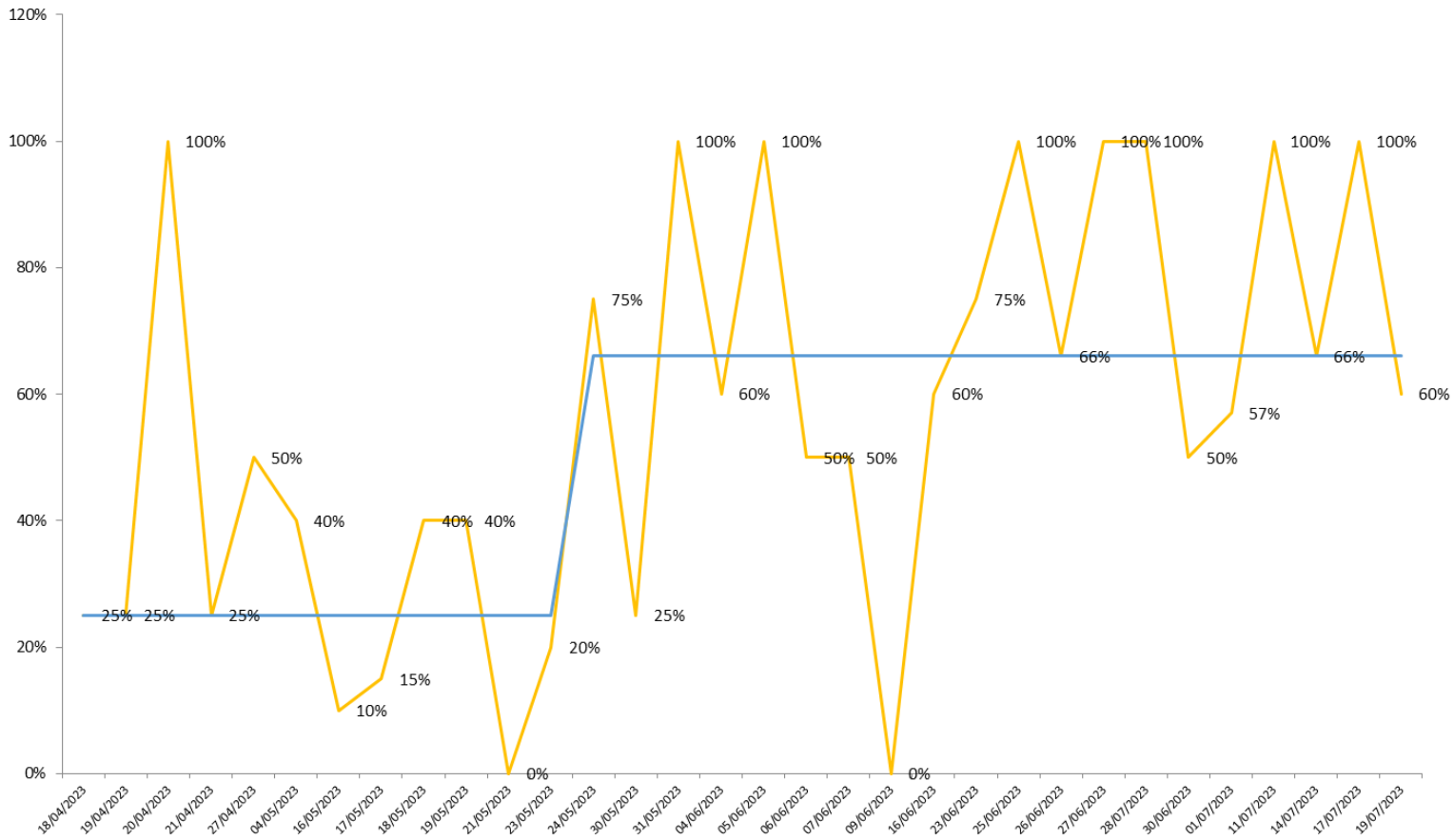
Ward 21 - % of times PWQ used outside of NEWS2 observations



Together, putting patients first

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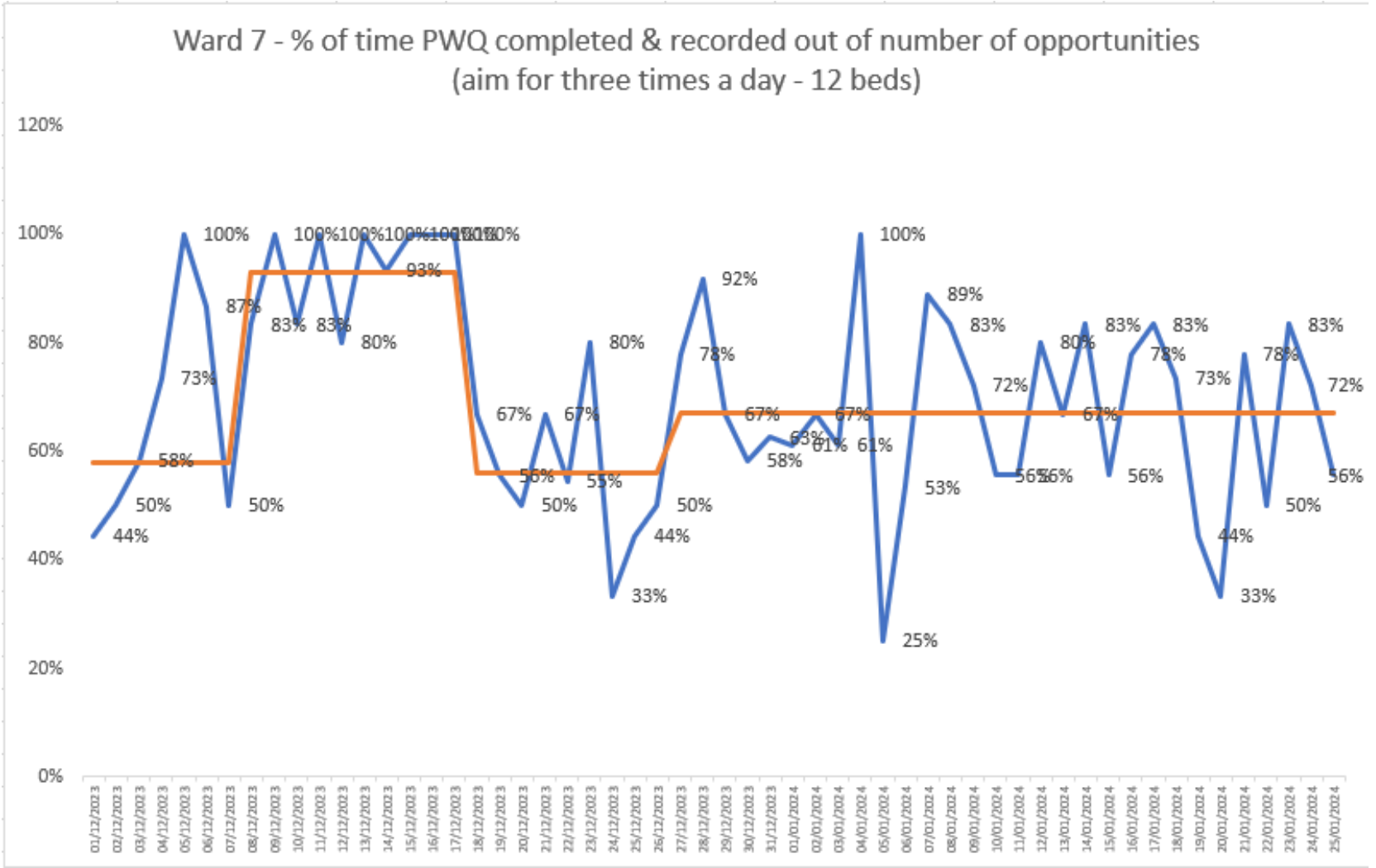

Together, putting patients first


PLAN
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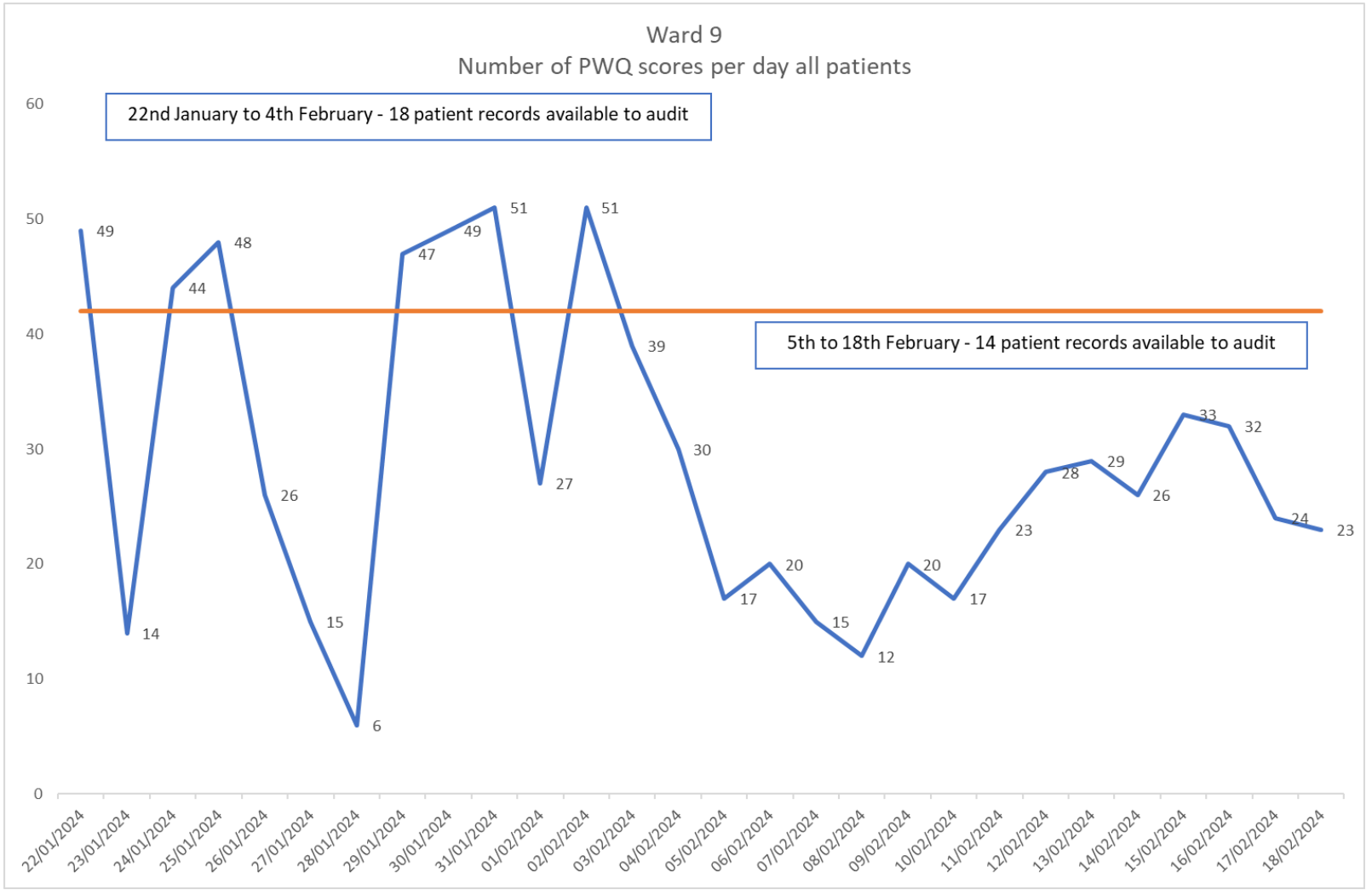
Ward 9
Number of PWQ scores per day all patients
22nd January to 4th February - 18 patient records available to audit
5th to 18th February - 14 patient records available to audit
60
50
40
30
20
10
0
49
14
44
48
26
15
6
47
49
51
27
51
39
30
17
20
15
12
20
17
23
28
29
26
33
32
24
23
22/01/2024
23/01/2024
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09/02/2024
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11/02/2024
12/02/2024
13/02/2024
14/02/2024
15/02/2024
16/02/2024
17/02/2024
18/02/2024

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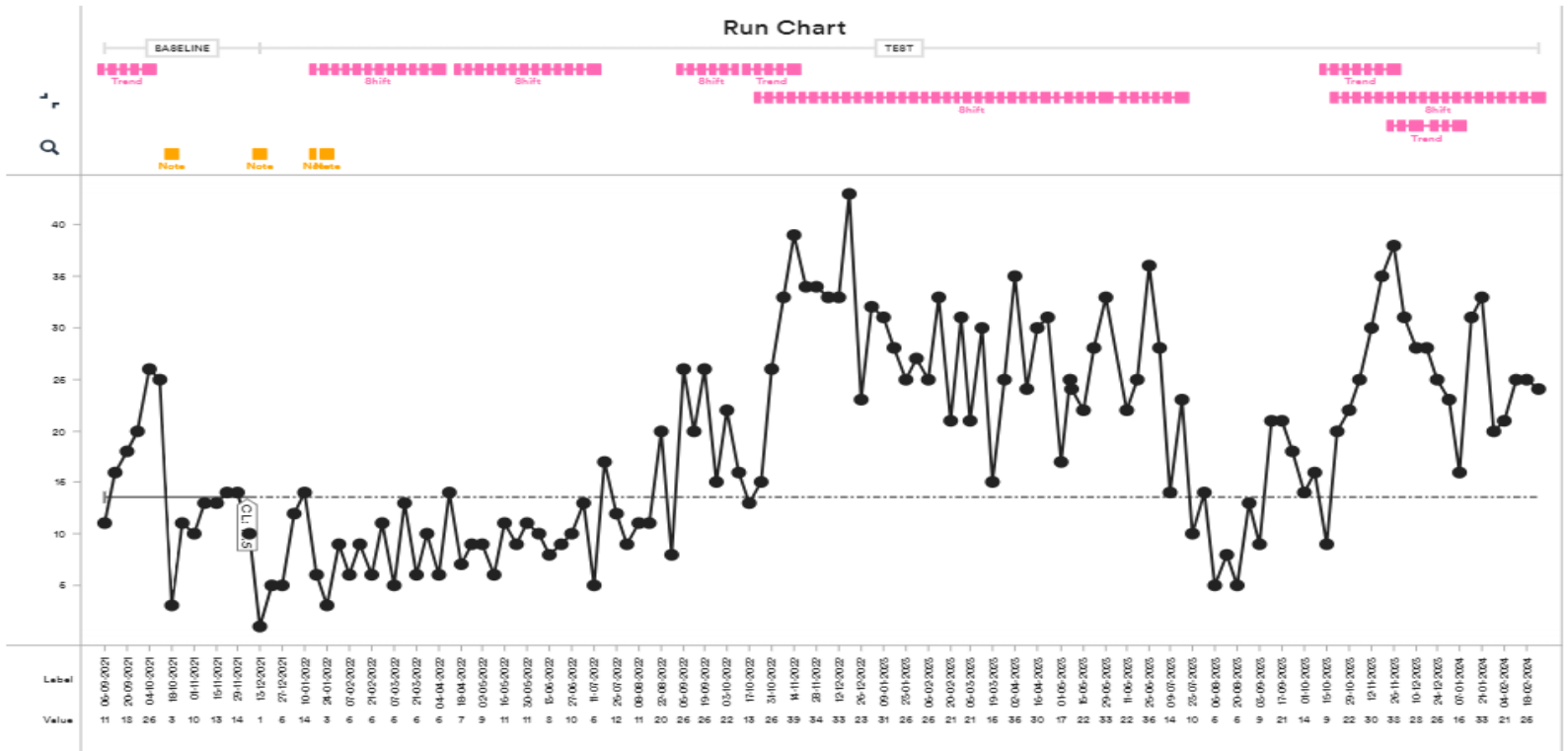
Run Chart – Number of referrals to critical care outreach team (Number of referrals to CCOR team)

Chart

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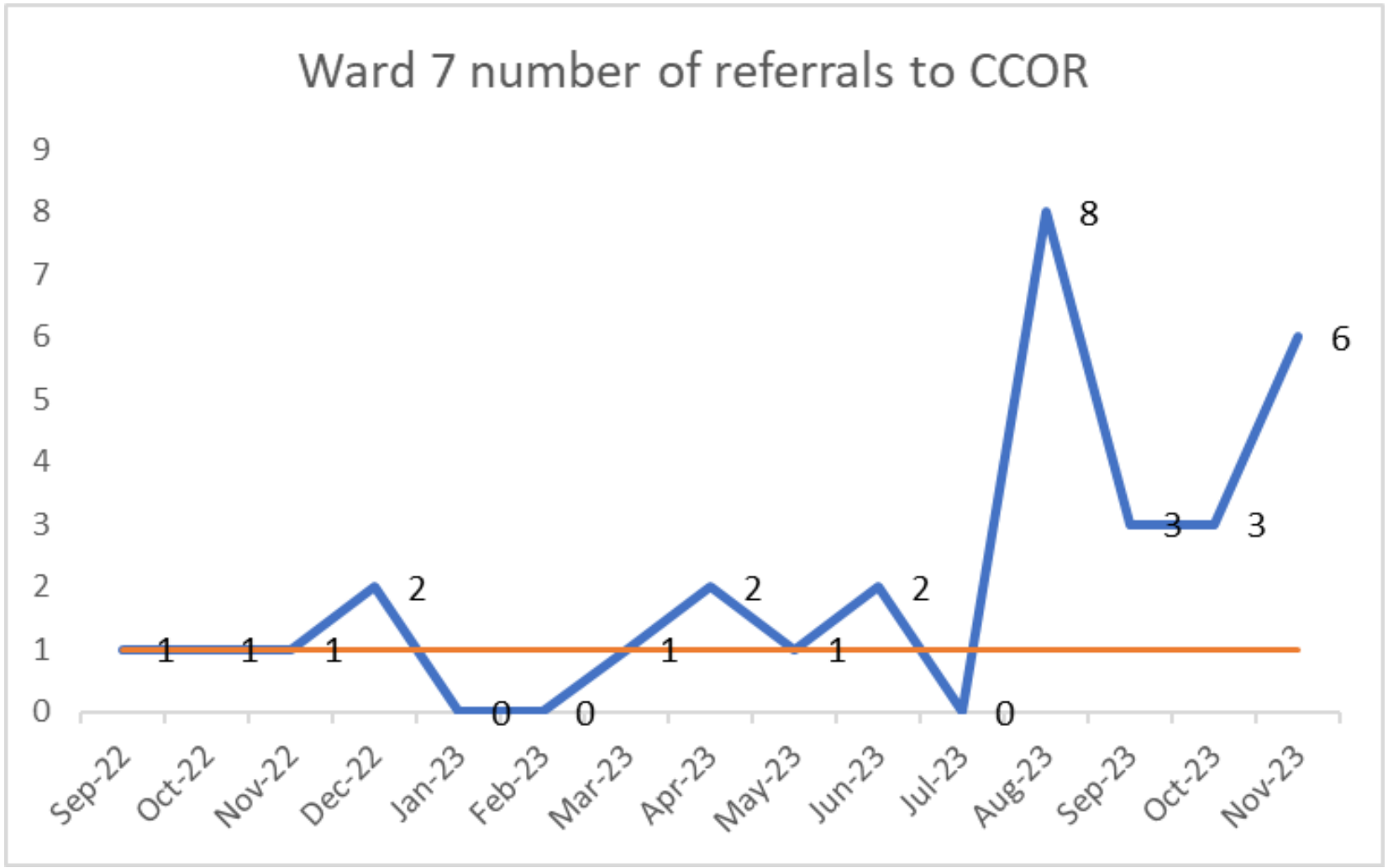
Ward 7 number of referrals to CCOR
9
8
7
6
5
4
3
2
1
0
1
1
1
2
0
0
1
2
1
2
0
8
3
3
6
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23

Patient Story – Ward 7

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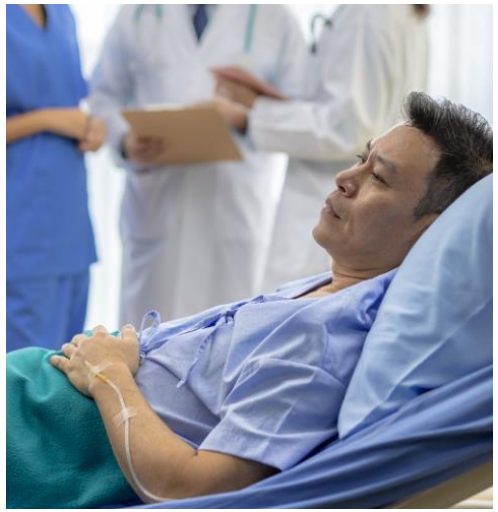

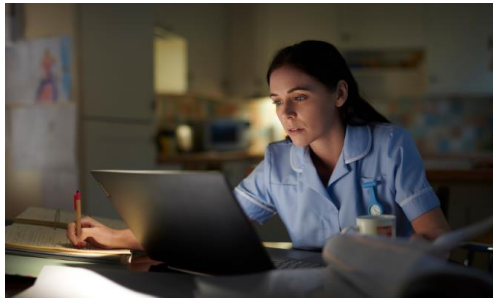

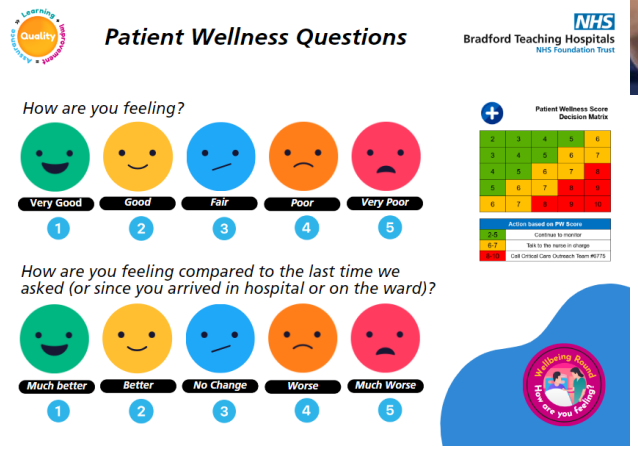

Together, putting patients first

STUDY – what have we learnt?

- Leadership – ward leadership significantly impacts the success
- Staff feedback: Ownership – RNs used the PWQ as a time to talk, language was not seen as a barrier to use
- Not completed at the time of observations - as suggested by research
- Adaptation for individual wards /cohort of patients
- Buy-in and support from the Critical Care Outreach Team (CCORT)
- Support from Quality Improvement specialists
- Patient feedback: Received well

ACT – what we are going to do …

- Continue working with the three ward areas – embed and sustain the use of the PWQ
- New areas - Virtual ward, Accident & Emergency and Paediatrics
- Learning Disabilities and Autism – adapted the PWQ for patients and families
- Health Inequalities – explore and measure
- EPR – looking to record within Vital Sign section
- **Martha's Rule** – co-design our approach to provide a service for staff, patients and families to have 24/7 access to a rapid review from our CCORT

How are you feeling today?

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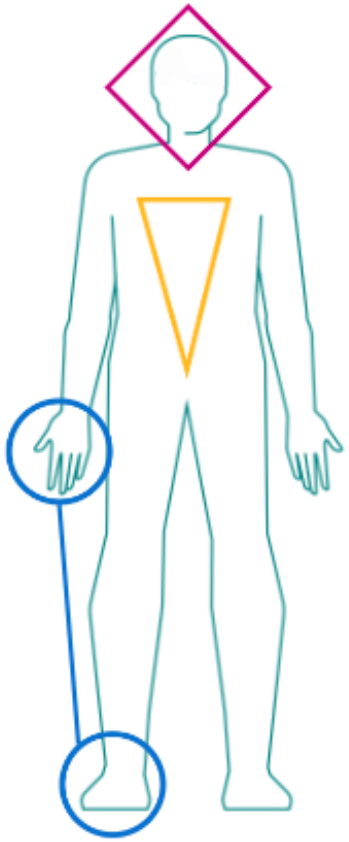
Does your patient show any of these signs of deterioration?



- New or increased confusion / agitation / anxiety / pain
- Changes to usual level of alertness / consciousness / sleeping more or less

- Increasing breathlessness or chestiness
- Change in usual drinking / diet habits
- 'Can't pee' or 'no pee', change in pee appearance
- Diarrhoea, vomiting, dehydration

- A shivery fever – feel hot or cold to touch
- Reduced mobility – 'off legs' / less co-ordinated

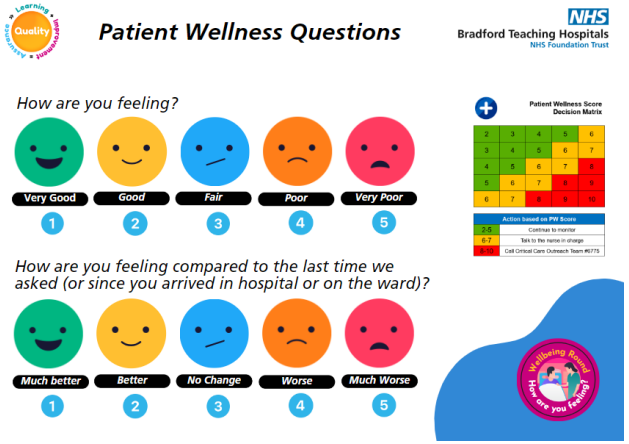
If YES to one or more of these triggers, take action!

- *Document response on EPR (Electronic Patient Record)*
- *Take a full set of observations*
- *Speak to nurse in charge*

Any concerns from family, friends or carers that the person in not as well as normal?

RESTORE2 Recognise Early Soft Signs, Take Observations, Respond, Escalate

Use this for patients unable to respond to the Patient Wellness Questions (PWQ) and use your judgement to allocate a score.



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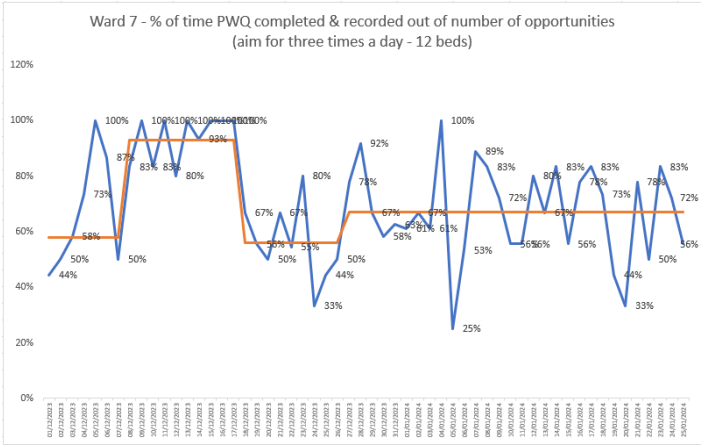
Thank you for listening
Any questions?



Q&A

Thank-you online audience

Keep in touch

his.acutecare@nhs.scot

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Breakout session round 2

Sessions begin at 14:25

- **Falls:** ‘Building on the momentum: the next step forward’ (main plenary room **Arcoona**)
- **Deteriorating Patient:** ‘Find your game changers’ (**Inspiration Suite**)
- **Wellbeing:** ‘Avoiding burnout and supporting wellbeing’ (**Creation Room**)
- **QI:** ‘Scale and spread’ (**Innovation Centre**)

Professor Brian Dolan

Professor Brian Dolan OBE

Director of Health Service 360,

Honorary President of AGILE

Evaluation

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