

# Recognise, Respond & Record



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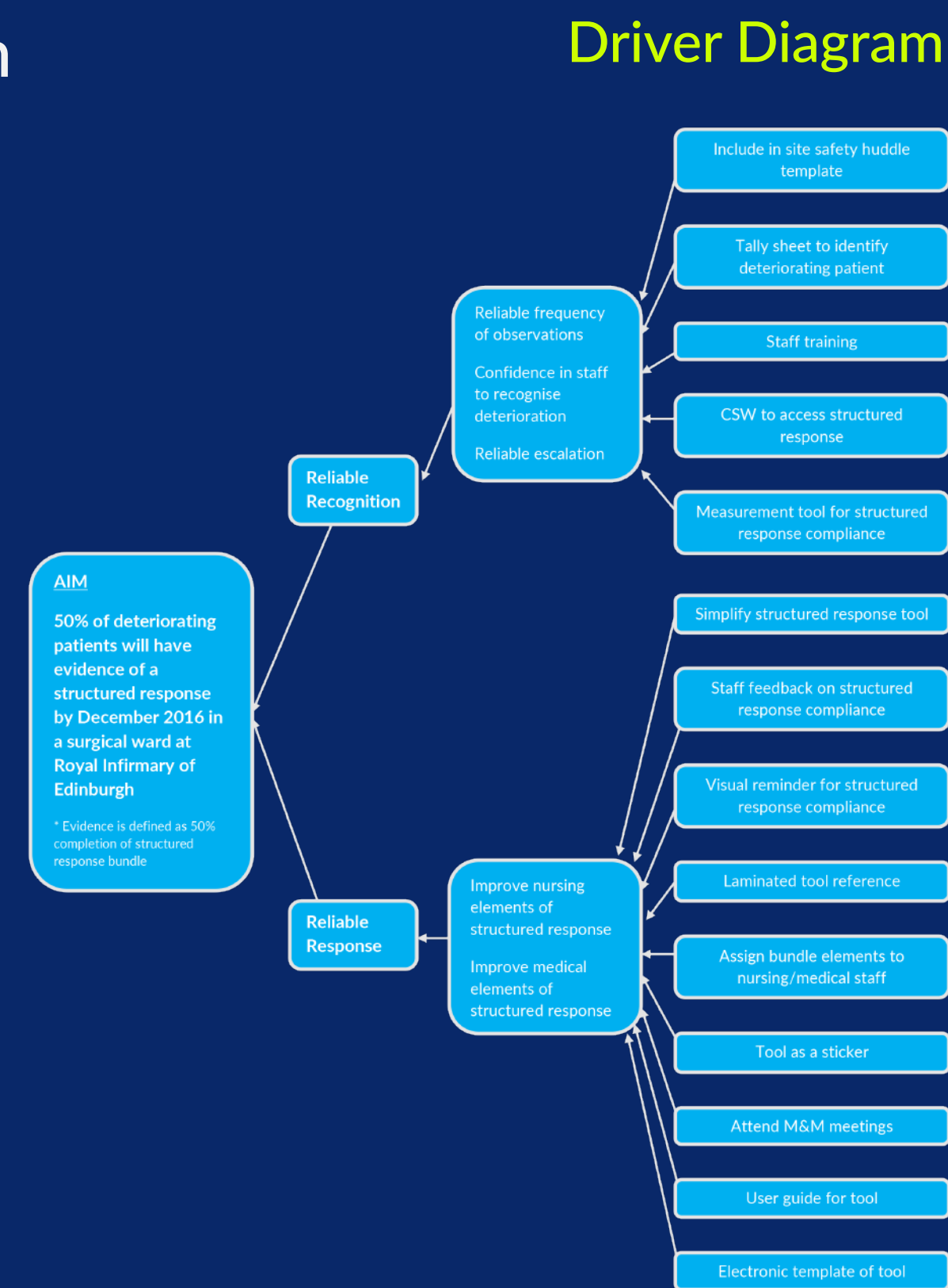
Acknowledgments: **Kirstie Tinkler** Clinical Nurse Manager **Louise Fegan** Charge Nurse

## Background



Failure to recognise patient deterioration can result in fatal cardiac arrest. Early recognition of - and response to - the deteriorating patient using the National Early Warning Score (NEWS) and an appropriate structured response can improve patient outcome.

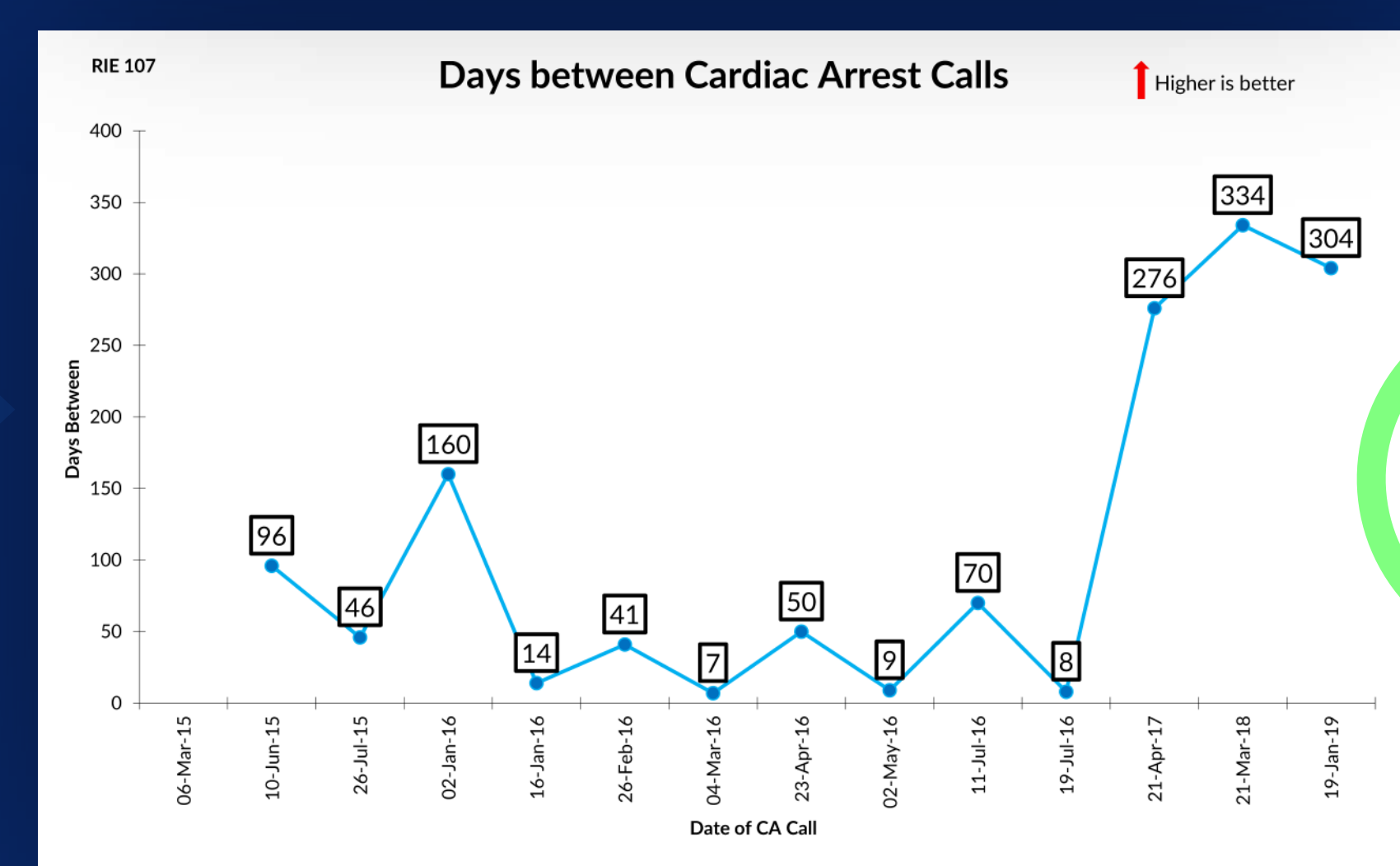
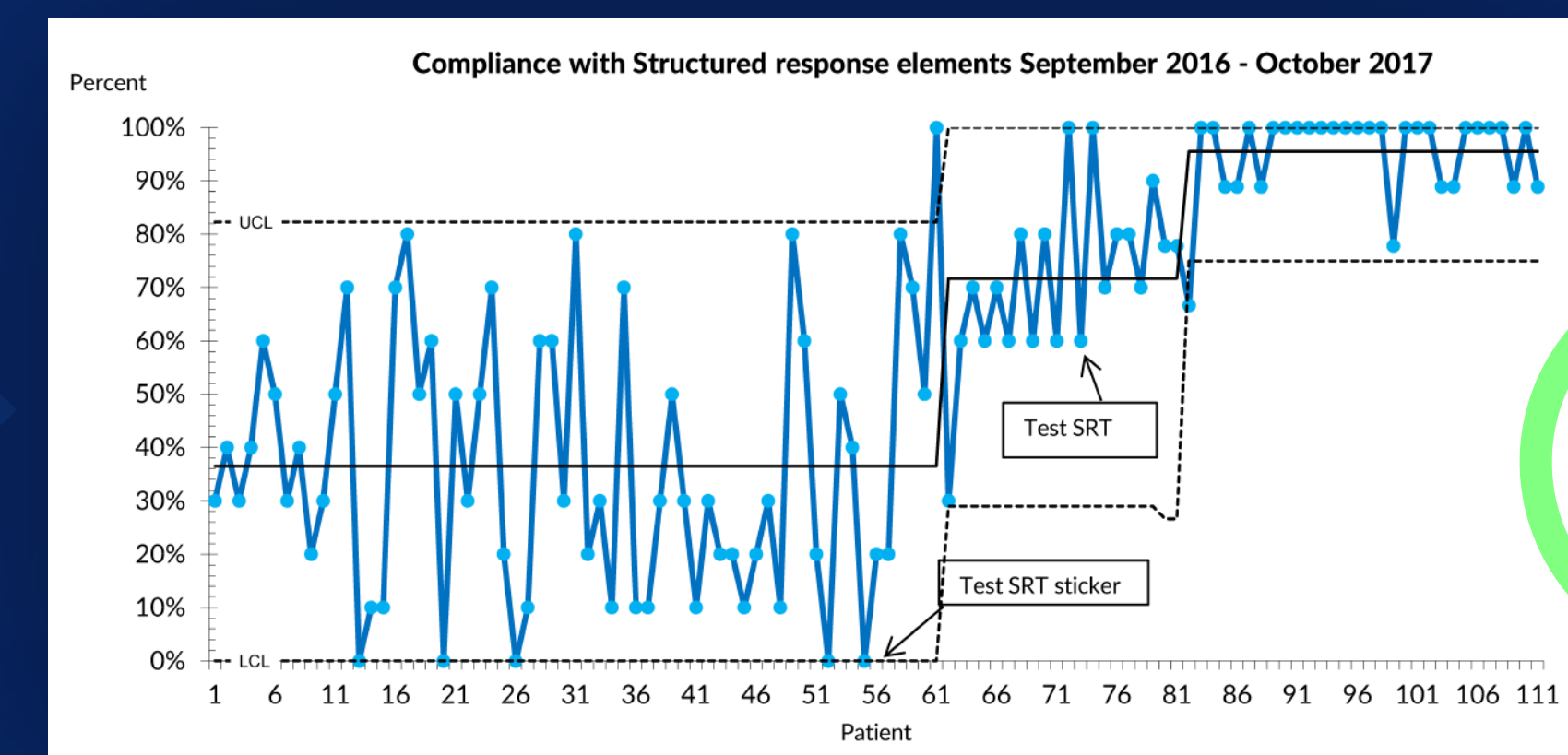
This project aligns with the NHS Scotland target to reduce Hospital Standardised Mortality Rates (HSMR) and Cardiac Arrest.



## Results



There have been no cardiac arrests during the project period (276 days) and the improvement has been sustained until January 2019. Since introducing the test of a Structured Response “sticker”, compliance with elements of the structured response bundle has improved.



## Aim



50% of deteriorating patients will have evidence\* of a structured response by December 2016 in a surgical ward at the Royal Infirmary of Edinburgh

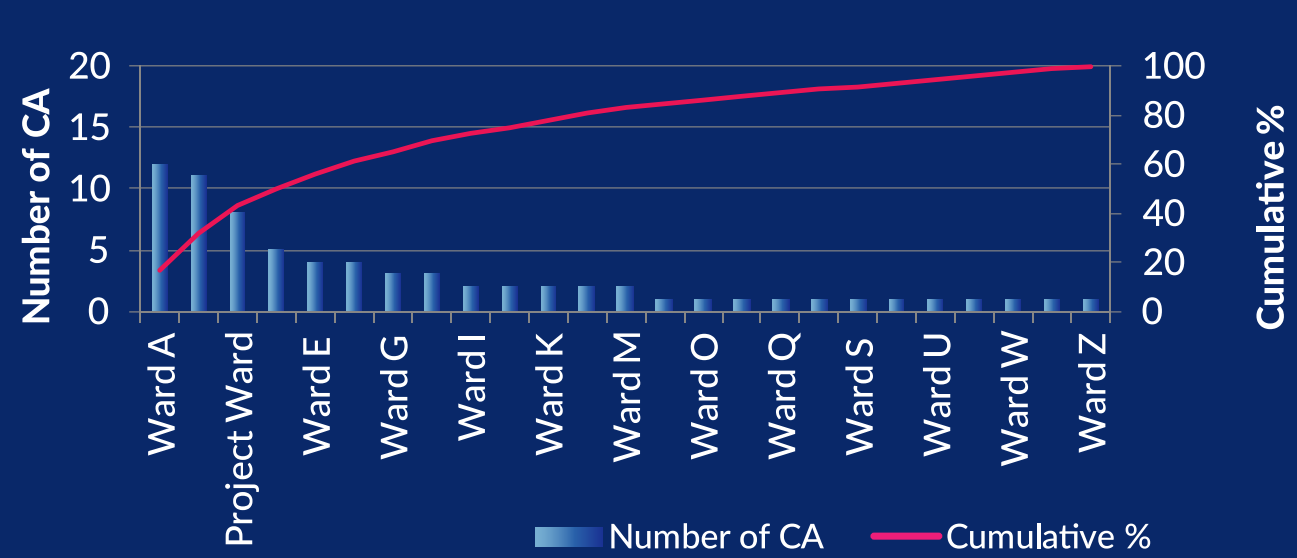
\*Evidence is defined as 50% completion of structured response bundle

## Method

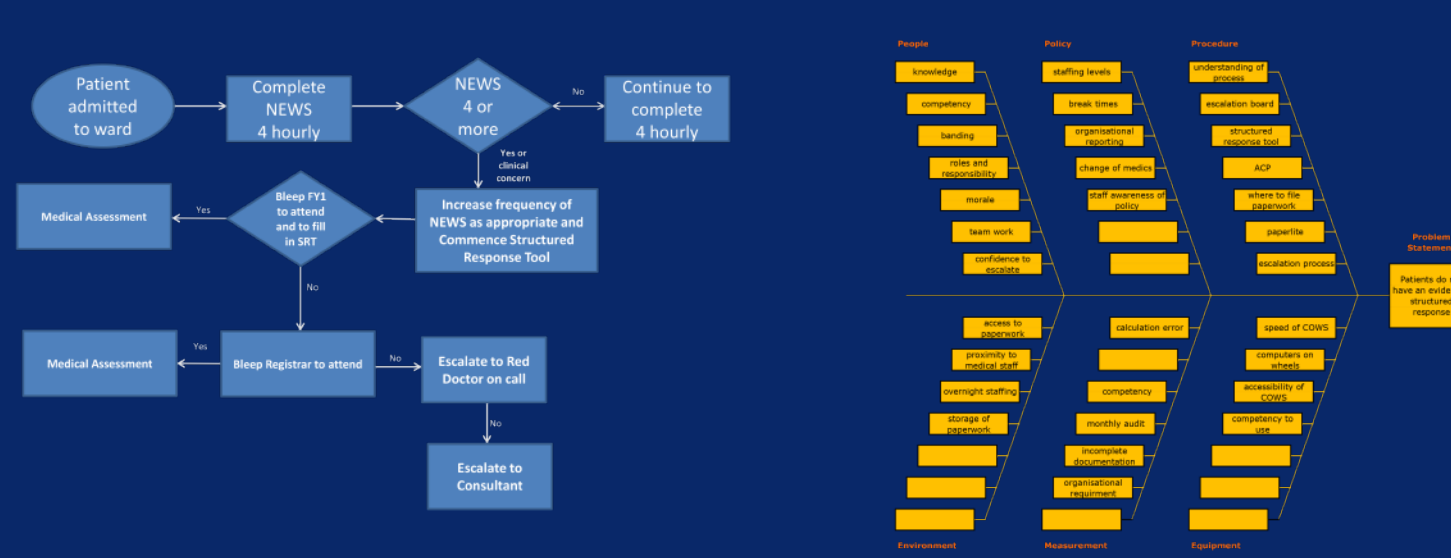


1 Various QI diagnostic tools were used to prioritise the clinical area and understand the problem:

Pareto of Cardiac Arrests between 1/1/2016 and 31/7/2016 to prioritise clinical area



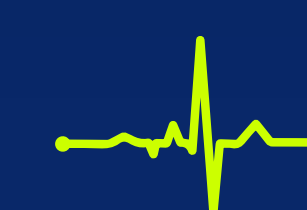
Process Map Cause & Effect Diagram



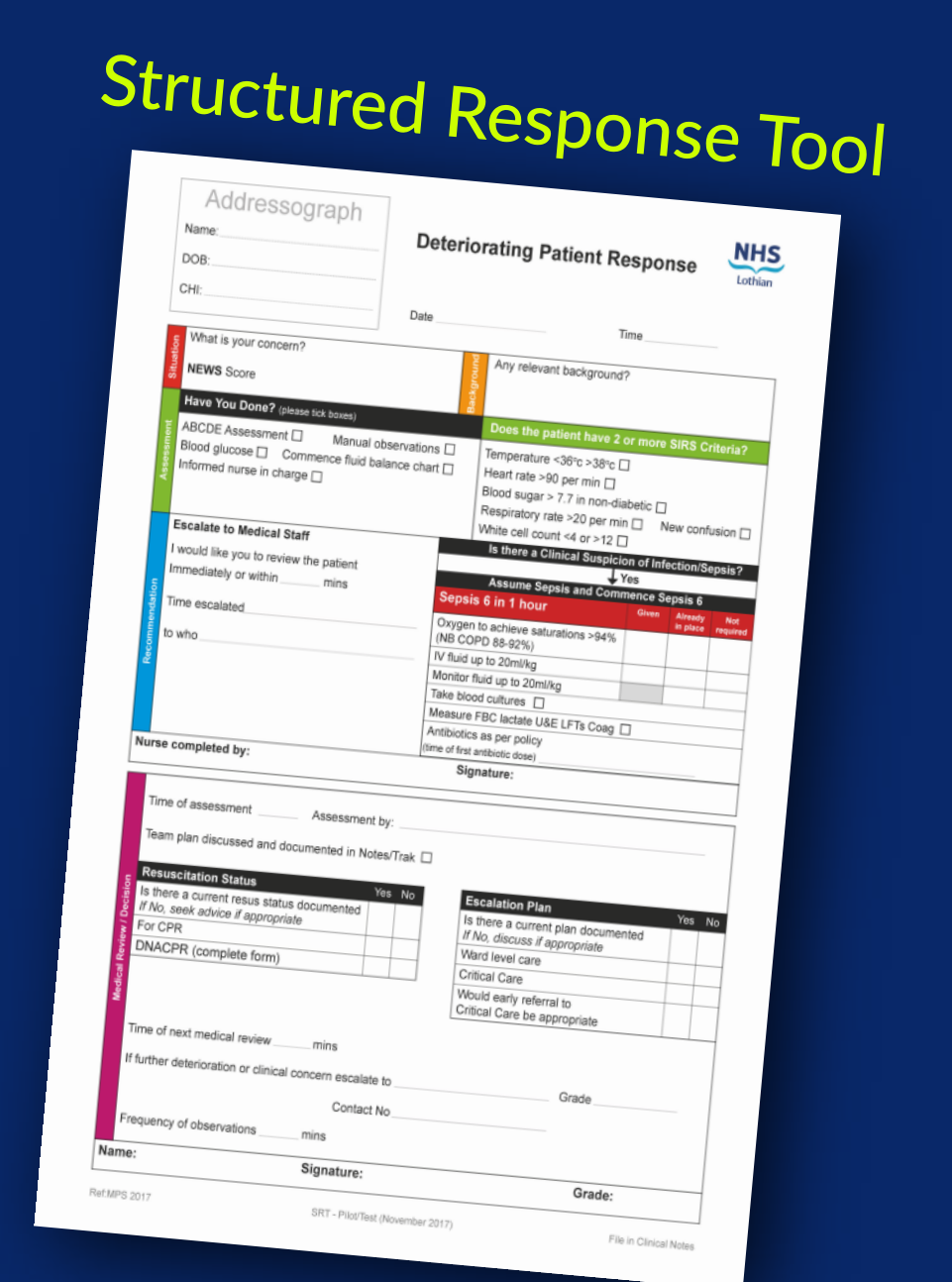
2 From these diagnostics, various tests of change were developed and carried out, the following of which were successful:

- Data collection tool to count deteriorating patients
- Visual Aids to prompt staff to use Structured Response Tool (SRT)
- Simplified version of SRT/sticker
- Attending ward safety briefs to inform and engage with staff

## Conclusions



- An invaluable amount of time was spent on diagnostics and understanding the system before any change ideas were tested.
- Increasing engagement in the project.
- Robust use of PDSA structure to test many changes.
- Being able to demonstrate change by using meaningful data.
- The project aligns with the 2020 vision to make healthcare safe and timely and to reduce avoidable harm.
- The tool developed is multidisciplinary, improves communication, and makes “the right thing easier to do”. A robust reliable process is in place showing measurable improvement.



## References



- Scottish Intercollegiate Guidelines Network. SIGN 139 Care of deteriorating patients. Consensus recommendations. Edinburgh: SIGN 2014
- NHS Scotland Quality Strategy - Putting people at the heart of our NHS. May 2010.
- CEL19 (2013) Next steps for acute adult safety - patient safety essentials and safety priorities



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