The Deteriorating Patient

CISS Education 2018
Objectives

- Identify the systems which support and promote the recognition and response to clinical deterioration within the CISS
- Identify the key concepts of critical thinking and graded assertiveness, and discuss the importance of these in the recognition and response to clinical deterioration
- Discuss the appropriate action required to escalate care in the deteriorating patient
- Identify the means by which patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care
The deteriorating patient

Many patients who suffer adverse events have some anomaly in their vital signs / conditions up to 6-8 hours prior to the event.
Barriers to escalation

- High stress & workloads - resident condition being overlooked
- Nervousness & anxiety of possible ridicule or reprimand - procrastination & late notification
- Fear of being viewed negatively – desire to manage problem internally / reluctance to seek assistance
- Drs not easily accessible
Issues

• **D**ocumentation – often partial or incomplete

• **I**nterpretation – frequently not even attempted

• **E**scalation – Communication predominant

    barrier
How can we improve patient safety: Measuring vital signs is not enough!

To identify the deteriorating patient earlier, the following principles have to be implemented:

- Communicate more effectively
- Educate ourselves on best practice
- Have emergency protocols in place
- Practice those protocols regularly
- Use track and trigger observation charts, i.e. QADDS
How is this tool different?

- It is a visual tool – easy to spot trends
- Order of vital signs changed in order of importance regarding patient deterioration
- Blood pressure and pulse have separate graphs for clarity
- ‘sedation score’ changed to ‘consciousness’
- Score instructions/ actions are on the same page as vital signs
Clinical Deterioration
(Escalation Pathway)

Commence BLS Algorithm

Are they responsive?

- Yes
  - Are they breathing normally?
    - Yes
      - Manage underlying cause of deterioration eg pain COPD
    - No
      - Medical Emergency
        - Send for help
        - Notify team leader and Medical officer
        - Inform Nurse Manager
        - Position patient
        - Provide oxygen if clinically indicated aiming for Oxygen Saturation of 94%
        - Monitor oxygen saturation continuously
        - Monitor vital signings and record on Q-ADDS tool every 5 minutes
  - No
    - Are they breathing normally?
      - Yes
        - Medical Emergency
          - QAS
          - Provide oxygen
          - Place patient in recovery position if clinical appropriate
          - Monitor Vital signs on Q-ADDS tool
          - Record Vital signs every 5 minutes
          - Monitor oxygen saturation continuously
          - Notify medical officer/ team leader and Nurse Manager
        - No
          - Code Blue
            (Continue DRSABSD)
Critical Thinking

• What is it?

• Why is it important?
What does it all really mean?

• What **skills** does the critical thinking nurse display and what **action** does a critical thinking nurse take?
Definition

• critical thinking for clinical decision-making is the ability to think in a systematic and logical manner with openness to question and reflect on the reasoning process used to ensure safe nursing practice and quality care

Heaslip 2008
How can we improve our critical thinking?

• Didactic versus *self-directed learning*
• Don’t “pigeonhole” patients, be open to alternative diagnoses
• Utilise case reviews
• Engage reflective practice
• Practice evidence based practice
• Promote professional development sessions
• Questioning and group discussions
NMBA Competency Standards for the Registered Nurse

• Four Domains

  • Professional Practice
  
  • Provision and co-ordination of care
  
  • Collaborative and therapeutic practice
  
  • Critical Thinking and Analysis
Communicating Clinical Concerns

- **S** – Situation: What is happening at the present time?

- **B** – Background: What are the circumstances leading up to this situation?

- **A** – Assessment: What do I think the problem is?

- **R** – Recommendation: What should we do to correct the problem?

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<td>S</td>
<td>- Introduce self / designation</td>
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<td>- Give name of patient</td>
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<td>- The problem is ...</td>
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<td>- Come to see patient</td>
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<td>- Tests ...</td>
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<td>- Change in treatment</td>
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3 Modes of Communication

• Aggressive
• Passive
• Assertive

• Which one do we want?
Assertion: What is it?

• Express your own position – ‘I’ statement
• State your position clearly but unemotionally
• Maintain moderate tone of voice
• Actively listen to the other person’s position
• Verbal & non-verbal messages are in agreement
• Focus on the problem, not the person
• Use tactful responses
• Take responsibility for consequences of actions/inactions
Graded Assertiveness

Probe
I need to know what’s happening

Alert
I think something bad is happening

Challenge
I know something bad is happening

Emergency language
I’m not going to let it happen
Assertiveness Process

**PROBE** – Seek Clarification

“I was wondering what your management plan is for Mr K as his BP is 92/55 and he has decreased urine output”

**ALERT** - Offer Options or Alternatives

“Would you like me to give extra fluids to increase Mr K’s blood pressure and call you back in 5 minutes?”

**CHALLENGE** - Express concern

“I am concerned that we have not addressed Mr K’s hypotension, he is monitoring in the yellow section of the obs form and he will continue to deteriorate if we do not manage his blood pressure now.”
“You Must listen!”

“Mr K is continuing to deteriorate. I think he is at risk of cardiac arrest if this continues and I do not want to let that happen. If you are not going to initiate a management plan for Mr K I am going to call an ambulance.”
Practical Documentation Tips

- Use black ink
- Date & time on each entry (use a 24 hour clock)
- Objectivity rather than subjectivity
- Legibility
- Do not obliterate
- Sign with name & designation
- Only use acceptable abbreviations, preferably avoid
When to document

- Minimum of 1 entry every 24 hours
- Significant event occurs
- Decisions
- Test or investigation ordered
- The patient’s condition improves or deteriorates
- Consultations
- Observations of the patient’s condition
- Decision makers/family members/others are consulted in relation to the care and treatment of the patient
Documentation

- Care plans should be individualised for the patient
- The Post Fall Clinical Pathway to be initiated and documented following the fall incident
- If a patient is having regular visual observations (or any other strategies) the clinical documentation should reflect this
- The details of the fall and the immediate actions taken are to be documented
- The care plan is to be updated to describe any new care required with regards to the post fall injuries
- **The team leader must take responsibility to make sure documentation has been completed before the patient is transferred to QAS**
Documentation Systems

SOAPIE

• S — Story (subjective)
• O — Observations
• A — Assessment
• P — Plan
• I — Implementation
• E — Evaluation

SAO

• S — Situation
• A — Action
• O — Outcome
Other avenues for family/patient

• Provides an additional safety net

• Engages patients, families and carers as part of the broader health care team

• Improves communication between the patient, family, carer and the health care team

• Patients, families and carers are encouraged and supported to use the system
Process

• Talk to the nurse looking after you about your concerns
• Ask to speak to the shift co-ordinator if you still are concerned
• Ask to speak to the duty nurse manager (via phone) if you are still concerned
• The message – ‘We are listening and want to work with you to provide safe care’
In summary

- It is our duty of care to recognise and manage deterioration appropriately.
- Using graded assertiveness facilitates clear, concise and prompt communication of deterioration.
- Ensure patient and family know they can approach their nurse, the shift co-ordinator, the NUM/DNM if they have concerns about deterioration.
- Documentation is essential to provide ongoing safe care and provide evidence of our care.