Alison Hunter

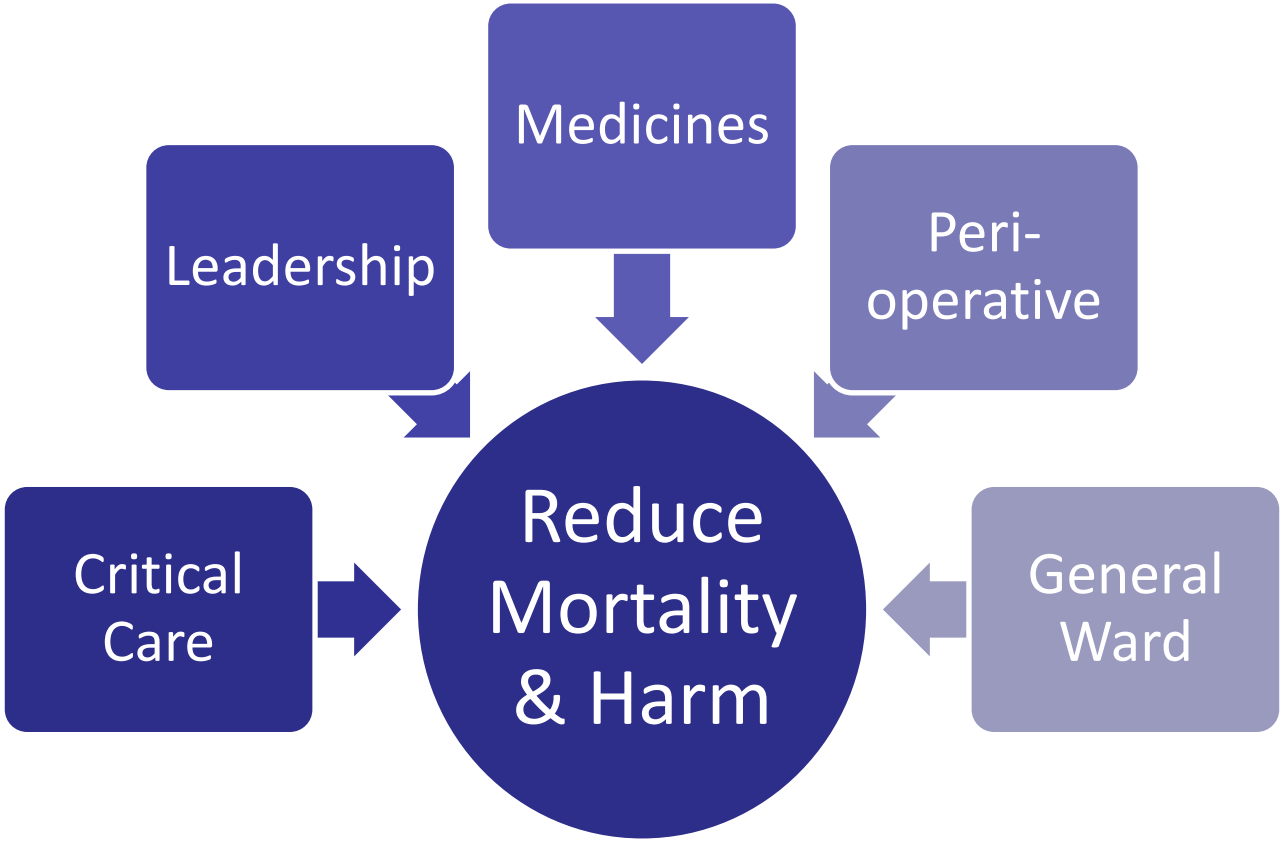
Improvement Advisor, Acute Adult Safety Programme

Healthcare Improvement Scotland

NHS SCOTLAND

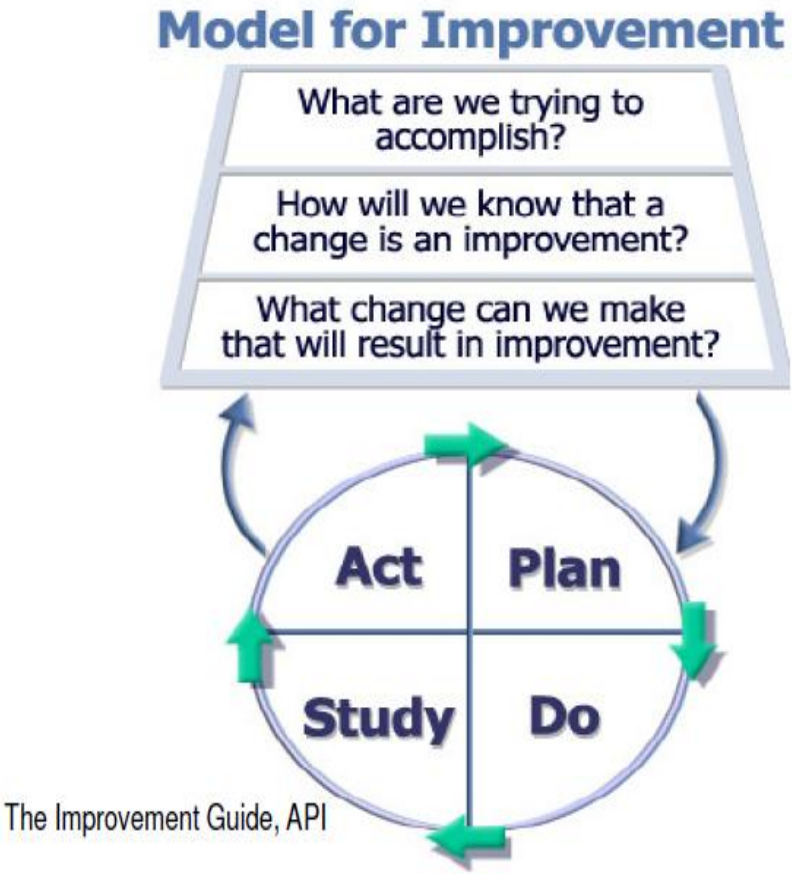
Healthcare Improvement Scotland

Acute Adult 2008 – what we did

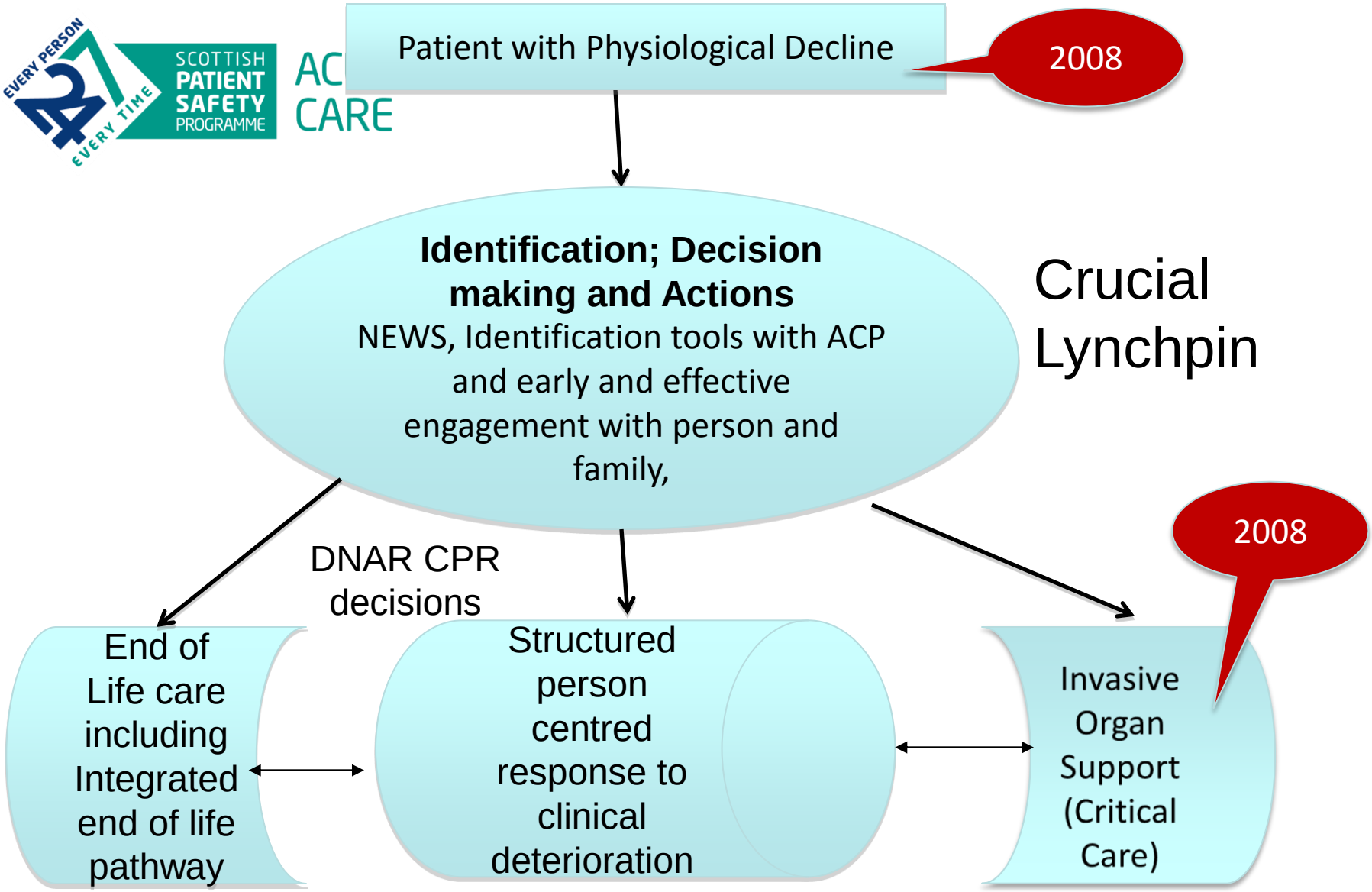


How we do it

- Have a method of delivery
- Setting an aim
- Connect with front line staff
- Define the what, not the how
- Connect people with each other



Acute Adult 2013 – what we are doing now


Patient with Physiological Decline
2008
Identification; Decision making and Actions
NEWS, Identification tools with ACP and early and effective engagement with person and family,
Crucial Lynchpin
DNAR CPR decisions
2008
End of Life care including Integrated end of life pathway
Structured person centred response to clinical deterioration
Invasive Organ Support (Critical Care)

AIM	PRIMARY DRIVER
95% of people with physiological deterioration in acute care will have a structured response and plan A reduction of inappropriate interventions 50 % reduction in CPR attempts (with chest compressions and/or defibrillation) in general ward setting by December 2015	Early Anticipation, collaborative planning and decision making
	Scottish Structured Response Processes Reliably Implemented
	Infrastructure

Reducing Harm

New aim that 95% of people experiencing acute care (in general ward) be free from avoidable harms by the end of 2015

Cardiac Arrest is one of the harms
Cardiac arrest (out with ITU, CCU, Front Door) can be seen as a surrogate marker for failed recognition, anticipatory care and rescue of the deteriorating patient

Script the Critical Moves

SCOTTISH PATIENT SAFETY PROGRAMME — ACUTE CARE

Physiological deterioration: early warning score trigger or of concern to staff

↓

Inform Nurse in Charge Increase frequency of observations	
Screen for Sepsis & treat as appropriate Deliver Sepsis 6 within 1 hour	

↓

Nurse and Doctor meet at or near the p
document a plan together using the

↓

Person Centred Team Based Decision M

Access information from Primary Care – (admission wards only)	
Nurse and Doctor discuss the plan toge	
Active problems, working diagnosis and recorded in case notes	
Review & increase frequency of observa	
Escalation ceiling recorded: Level 1, 2, 3	
Early referral to critical care or rapid resp care would include level 2 or 3 care	
DNACPR considered and completed if	
A structured response has occurred only ticked (or key processes occurred) with	

Person Centred Structured Review
A regular process of communication between multi-disciplinary team, patient & family

Risk of deterioration reviewed & documented	
Limited reversibility assessed (e.g. with SPICT tool)	
Written management plan reviewed & updated	
Anticipatory Care plan required?	
DNACPR status considered - National DNACPR patient information leaflet provided if appropriate	
Communication with person (patient) and family about management plan documented	
A structured review has occurred only if all boxes have been ticked (or key processes occurred)	

Person Centred Structured Review
A story of opportunities/missed opportunities?

Evelyn Paterson
Palliative Care Clinical Nurse Specialist
NHS Forth Valley

The deteriorating palliative care patient in Acute Care

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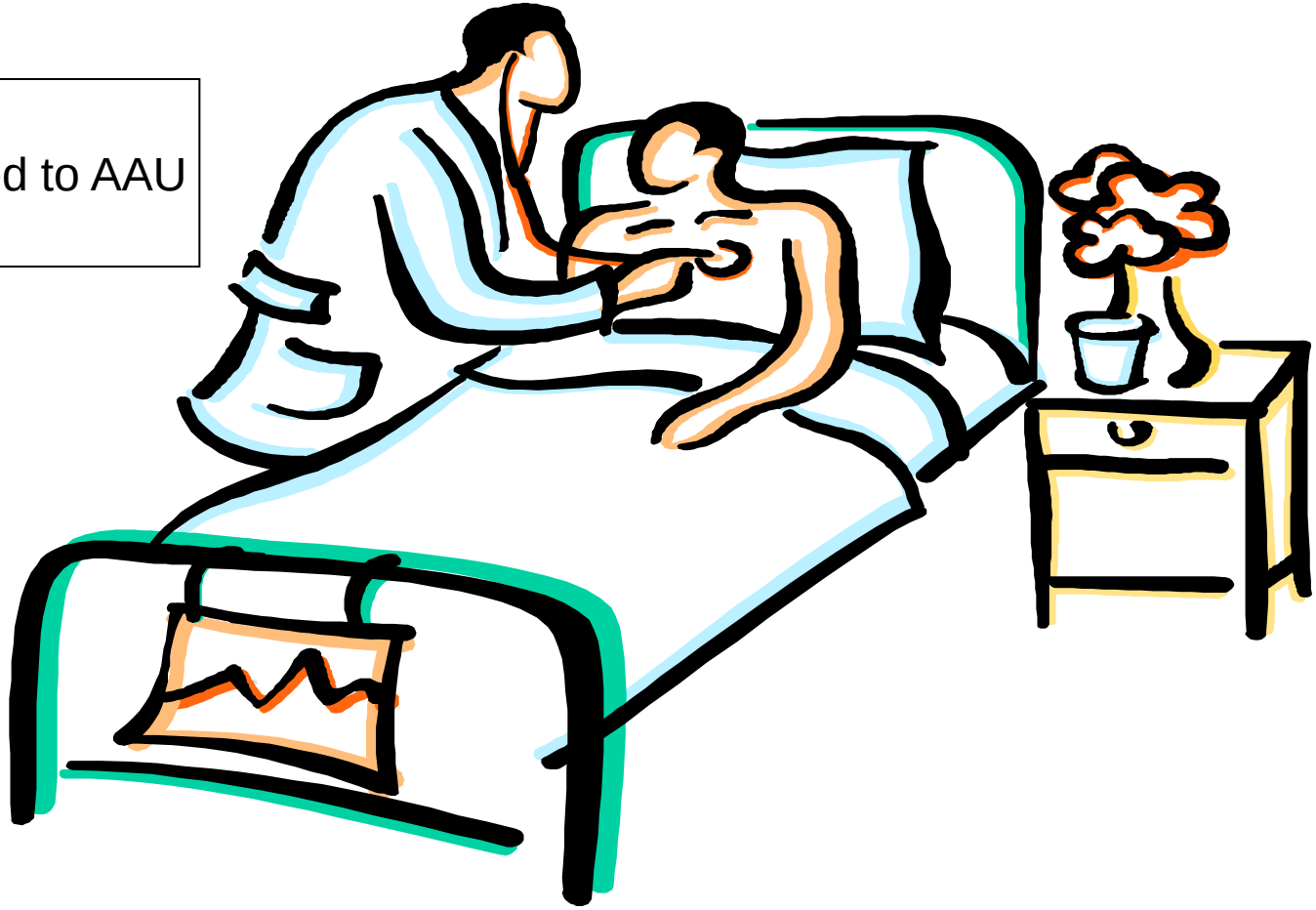
- Mrs “Casper” (Based on real patient story)

Admitted to AAU



- 3rd hospital admission in a 10 week period to AAU with chest infection and exacerbation of her COPD.

- Discharged from hospital 17 days before following a 48 hour admission. Previous admission was also a short stay.

A missed opportunity ?

What factors will influence the management plan for Mrs Casper?

Where are the opportunities/missed opportunities? (historic and current)

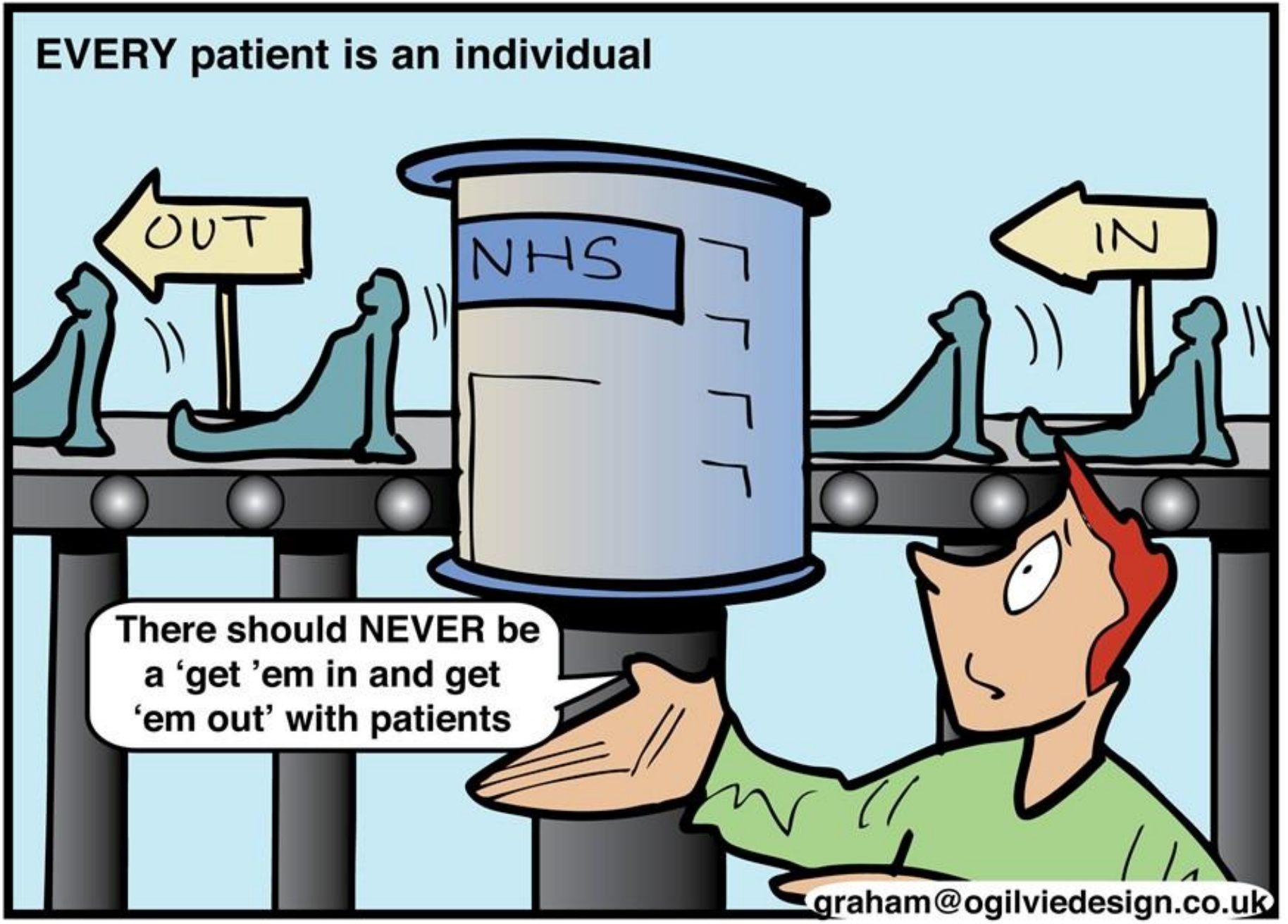
What should happen for Mrs Casper in the AAU?

Challenges of care (1)

- Little continuity with the medical staff or nursing staff looking after her on each episode of care in AAU or in downstream wards.
- Information out of hours may be limited.
- Case notes not immediately available. Rely on information that can be obtained electronically.
- Bed pressures.
- Volume of work. Mrs Casper is one of many admissions that day.

Challenges of care (2)

- Mrs Casper was admitted at 11pm. 2 previous admissions have been at similar times
- Family report an overall decline in health over past 6 months.
- Full social care package in place but Mrs Casper feels very lonely, frightened and vulnerable especially at night.
- Family feel strongly that she is not able to return home.


EVERY patient is an individual
OUT
NHS
IN
There should NEVER be a 'get 'em in and get 'em out' with patients
graham@ogilviedesign.co.uk

Challenges of care (3)

- Antibiotics have been commenced in the AAU.
- Mrs Casper improves significantly in first 24 hours.
- The aim is for discharge home but given family concerns a move to downstream ward is arranged.

Challenges of care (4)

- New team taking over care in a down stream ward.
- Documentation does not reflect family concerns and the management plan includes active discharge planning.
- Discussions with patient and family - team now aware of fears and vulnerability, pattern of decline and recent episodes of care.

What opportunities/missed opportunities exist to ensure there is a thinking ahead approach to care in the future?


Teamwork is all important
Daily Goals
Briefings
SAFETY
We're ALL linked in this TOGETHER
Hey! We have traction here!
graham@ogilviedesign.co.uk

Advance Care Planning

Planning for end of life care; can be done at any stage of life from well to dying. Usually through facilitated conversations that will incorporate patient/carers choices.

Anticipatory Care Planning

Planning for situations including a change in health status we ***expect*** or ***anticipate***.

May happen to patients with chronic conditions throughout the illness trajectory

The components of advance and anticipatory care planning

- It is important to acknowledge that uncertain but predictable patterns may emerge with chronic conditions and other life limiting conditions. Recognizing this presents an opportunity to provide more appropriate care based on a changing health picture. SPICT can help professionals predict increasing palliative care needs and therefore influence decision making and care.

What next for Mrs Casper?

- She returned home after 8 days with additional support from health and social services and from her family.

- Mrs Casper wanted an opportunity for further discussion re future place of care in a few months time.

- DNACPR in place with information on KIS to support decision making out of hours.

- The immediate discharge letter provided essential information to the GP.

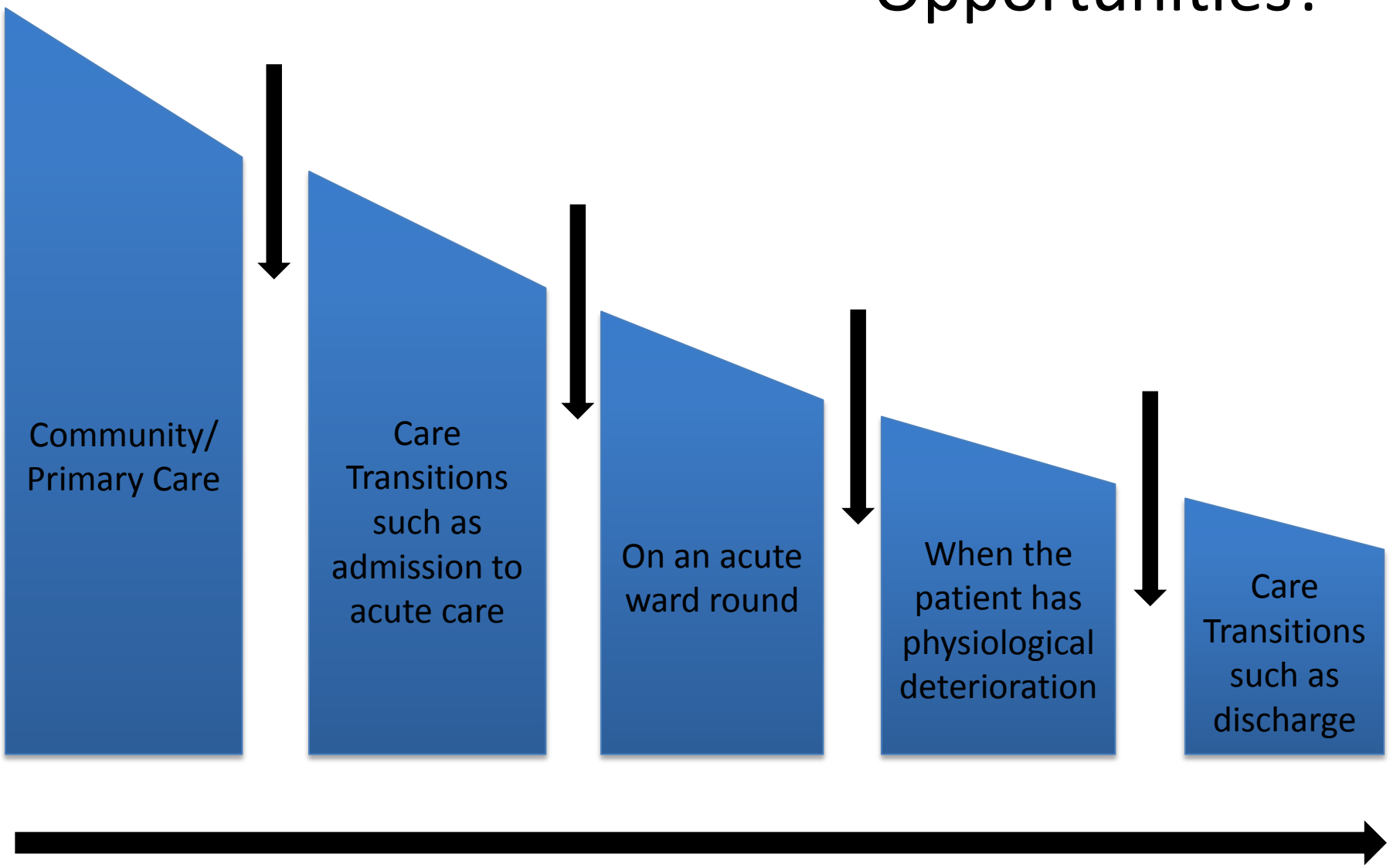
- A prompt for GP to add information to Key Information Summary (KIS).

- Anticipation of anxiety and distress and worsening breathlessness was important to consider.

- AAU staff would be able to access KIS in the event of unscheduled care. This would improve decision making and care provision based on changing health picture.

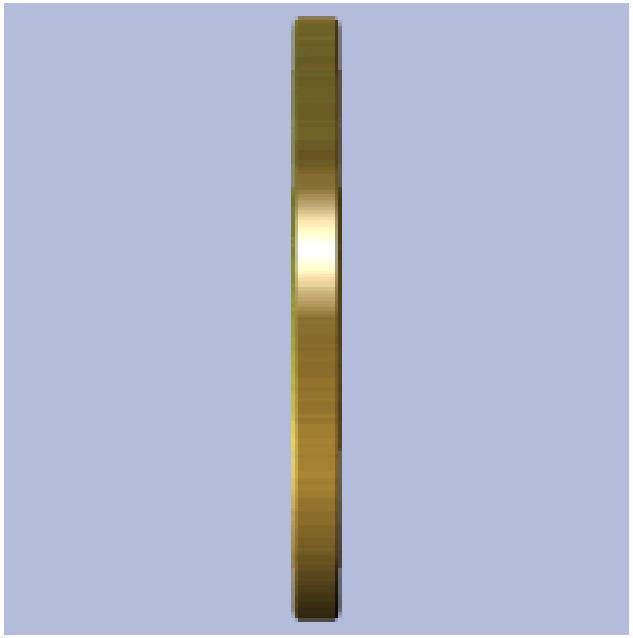
“MRS”

Missed Opportunities?



TWO SIDES OF THE SAME COIN

“RESCUE”



PALLIATIVE CARE

RECOGNITION ⟷ RESPONSE ⟷ PLANNING ⟷ ESCALATION

MISSED OPPORTUNITY?

MISSED OPPORTUNITY?

HOME

HOSPITAL (1)

MISSED OPPORTUNITY?

HOSPITAL (2)

HOME

MISSED OPPORTUNITY?

?

HOME

APPROPRIATE DISCHARGE

HOSPITAL (3)

MISSED OPPORTUNITY?

PLANNING & COMMUNICATION

JOINT EVENT

DNACPR

DETERIORATING PATIENT

9 JANUARY 2014
GLASGOW


KEEP
CALM
AND
ENJOY
HALLOWEEN