Balancing risk and empowering patients

Ben Owens
Clinical Director, Sherwood Forest Hospitals NHS Foundation Trust

Bharath Lakkapa
Clinical Director, Northamptonshire Healthcare NHS Foundation Trust
Balancing Risk and Empowering Patients
“She’s not safe!”
Questions

• Is speeding safe?

• Would you jump out of a 3rd floor window?
Behaviours we see that cause harm

- Unnecessary admissions
- Delayed discharges
- Home if bloods normal
- OT/Physio reflex
- The “reasureogram”
- Refusal to do a hot week/review patients
- Refusal to board/sit out/use the discharge lounge
- Refusal to offload ambulances
“I'm not happy for you to go home”
“But you might fall”
“She's not safe”
“I'm not happy to sign him off for the stairs”
“I'm not risking my PIN”
“The relatives might complain”
Drivers for these

My Patients
I'm not responsible for ED/Ambulances
Might be sued
Might be called to the coroner
Its not my job
But I cant see them and I can see the patient in
front of me
What we measure – falls IC rates
Playing it safe for patients

Dr. Bharath Lakkappa
Figure 1: Vulnerability of frail elderly people to a sudden change in health status after a minor illness

Healthy Elders:

- 10 Days of bed rest and healthy Elders

- >12% loss in aerobic capacity is equivalent to a decade of usual physiologic decline

10 days in hospital

acute, sub acute or community

leads to the equivalent of 10 years ageing in the muscles of people over 80

relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

Functional Decline

- After hospitalisation

- Decline in ADLs during hospitalization is common

- Independence in specific ADLs declined 40-75% when studied in a general inpatient geriatric population

Imminence of death among hospital inpatients

• 48% of people over 85, die within one year of hospital admission

David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*
Risk in life
Real risk for the patients

- If you are admitted through an overcrowded ED you have a 43% mortality increase if admitted for 10 days or more.

- If you are 77 you have a mean of 1000 days of life left — How many would you choose to have in hospital?

- Bed rest — 10-20% muscle strength lost per week — admission for > 3 days can convert an independent frail person to a dependant one.
Why do we see process and behaviour differently to clinical treatment?
Logic

• The single most expensive thing to do with a patient is to put a patient in an ambulance (£250) and drive them to hospital and keep them there (£300 a night)

• Hospitals are buildings full of ill people and admitting increases the risk to each patient and to other patients

• Therefore only those that are too unstable to be treated at home/are high risk of serious harm if discharged should be admitted and all others should be managed somewhere else
Patient stories
Review of frail patients – for what outcome?
Juniors

• It starts early
• Most medical schools invite the MDU/MPS in to speak to students
What can we learn from elective care?

Consent for bypass and give a choice
Why not for admission/discharge?
For surgery we accept it documented in the notes why not in emergency care
Phrases to Ban

“I’m risk averse”
“My risk” or “I’m not taking the risk of discharging them”
“Back to baseline”
“Medically fit for discharge”
“Not Safe to go home”
“Failed Physio” or “failed stairs assessment”
“I’m not happy to sign them off as fit”
“I’m here for my patients”
Risk and safety

- There is risk in whatever we do
- There is risk in all of the outcomes of our decisions
- We want autonomy for ourselves but safety for our family!
- Risk averse for one person usually increases or moves the risk elsewhere!
- It belongs to the patient.
Balance

There is no “no risk” or “safe” just “safer” or lower risk”
Ownership and a system view

• Every decision we make about a patient has a risk to them but also a direct effect on others and the system as a whole and that extra test or delay harms/delays another patient
• Examples in real life we all accept – litter, recycling, car emissions,
How do we change this?

We need to encourage staff to change the language they use, the approach to decision-making and the concepts of risk and who owns it and to empower patients. We should be giving the patient the information about the risks, empowering and supporting them to make the decision they want. Liberating the clinicians from the false perception of personal risk they believe they have.
Review of frail patients – for what outcome?
Appropriate for Discharge from A & E / Assessment units – ASK

- Is ADL baseline stable or can ADL independence be recovered easily at home?
- Are there sufficient/willing caregivers available to assist transition?
- Are meals and medication(s) supervision available, if needed?
- Is the home a safe environment?
- Is primary care available for follow-up?
- Is any home nurse monitoring, services (PT, OT, social care) needed?
Monitoring:

- To decrease Risk
- Promote recovery at home
- Early identification of deterioration
- Decrease readmission
- Back to independence quicker
- One example – in use currently
Community Early Warning System (CEWS)  
Northamptonshire

There is evidence that acute illness is exacerbated by “failure to act” on recognised changes (Hillman et al, 2001).

Analysis of serious patient safety incidents revealed that 11% of deaths were related to “deterioration not recognised or not acted upon” (NPSA, 2007).

Points where the process can fail include: not taking observations, not recognising early signs of deterioration, not communicating observations causing concern and not responding to concerns appropriately (NPSA, 2007).
CEWS:

- Needed modification from acute hospital
- Traffic light guide to help focus
- Admission suggested
- When admission suggested, can be discussed with GP to help with decision to admit (if advanced care plan in place?)
- If admitted to acute, track patient when admitted and try to pull out
Score

• Trialled in 2010, Parameters adjusted with Audits (3 months)
• Score became a priority (no NEWS locally)
• Than, the parameters triggering the change
• Changed to a system from score
• Traffic light system
• More focused on the physiological parameters
Chart / Visual

• Similar to NEWS paper chart
• Ease of use
• In patients home
• For Staff coming from acute to community services (vice versa)
• Action suggested and reminder
• Training – based on Physiology of Aging
• CEWS; on every visit, by all staff members of team
# Observation Chart for CEWS (Community Early Warning System)

## Northamptonshire Healthcare

**NHS Foundation Trust**

**Version 3 (Feb 2018)**

### Data Time

<table>
<thead>
<tr>
<th>Time</th>
<th>3-4</th>
<th>4-5</th>
<th>5-6</th>
<th>6-7</th>
<th>7-8</th>
<th>8-9</th>
<th>9-10</th>
<th>10-11</th>
<th>11-12</th>
<th>12-13</th>
<th>13-14</th>
<th>14-15</th>
<th>15-16</th>
<th>16-17</th>
<th>17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17-20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04-07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01-04</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Vital Signs

#### B.P.

- **Systolic**
- **Diastolic**

#### Sp O₂

- **90-100**
- **85-90**
- **80-84**
- **75-79**
- **70-74**
- **65-69**
- **< 65**

#### O₂ sat%

- **96-100**
- **91-95**
- **86-90**
- **81-85**
- **76-80**
- **71-75**
- **< 71**

#### Temp °C

- **36.0-36.5**
- **35.5-36.0**
- **35.0-35.5**
- **34.5-35.0**
- **34.0-34.5**
- **33.5-34.0**
- **< 33.5**

### Additional Observations

- **Pulse**
- **Drops < 10**
- **Drops ~ 10 - 19**
- **Drops ~ 20 - 29**
- **Drops > 30**

### Levels of Hypoxaemia

- **None**
- **Mild**
- **Moderate**
- **Severe**

### Blood Sugar

- **< 3.9 mmol/L**
- **3.9 - 6.1 mmol/L**
- **> 6.1 mmol/L**

### Diabetic

- **< 14 Mmol/L**
- **14 - 16 Mmol/L**
- **> 16 Mmol/L**

### Non Diabetic

- **< 10 Mmol/L**
- **10 - 12 Mmol/L**
- **> 12 Mmol/L**

### Monitoring Frequency

- **Every 4-6 hours**
- **Every 6-12 hours**
- **N/A**

### Escalation Plan

- **V**
- **P**
- **U/A**

- **Ventilator**
- **Fenestra**
- **Inotropic Support**

---

**In Emergencies, Please Use NCHFT**
<table>
<thead>
<tr>
<th><strong>CEWS</strong></th>
<th><strong>Customer</strong></th>
<th><strong>Response</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
<td>Normal observations</td>
<td>No further action required regarding observations</td>
</tr>
<tr>
<td></td>
<td>Use clinical judgement to determine frequency of CEWS</td>
<td>Unplanned care - Use clinical judgement regarding discharge if appropriate</td>
</tr>
<tr>
<td></td>
<td>Planned care - continue to complete CEWS as scheduled</td>
<td>Consider repeat</td>
</tr>
<tr>
<td><strong>Green</strong></td>
<td>Observations not in normal range</td>
<td>Use clinical judgement to determine frequency of CEWS</td>
</tr>
<tr>
<td></td>
<td>Suggested plan is to increase frequency to once daily for 5 consecutive visits</td>
<td>Unplanned care / Planned care - Use clinical judgement regarding condition of patient</td>
</tr>
<tr>
<td></td>
<td>Discuss with senior if concerned or after 5 visits patient remains green (SEAR)</td>
<td>Consider re-assessment</td>
</tr>
<tr>
<td><strong>Yellow</strong></td>
<td>Observations significantly deteriorating, patient is unwell</td>
<td>Consider SEPSIS flag</td>
</tr>
<tr>
<td></td>
<td>Increase frequency of visits to minimum twice daily</td>
<td>Screen for infection, this should include broad investigations in form senior staff and escalate at appropriate (SEAR)</td>
</tr>
<tr>
<td></td>
<td>If remains yellow for 48 hours - senior review of patient is warranted</td>
<td>Need to ensure plan and ensure safety netting advice given to patient</td>
</tr>
<tr>
<td></td>
<td>Consider referral to Unplanned Care - for close monitoring and must be discussed with an Unplanned Care 5 and 7 Nurse / Matron (SEAR)</td>
<td></td>
</tr>
<tr>
<td><strong>Red</strong></td>
<td>Patient is acutely unwell and requires immediate admission (SEAR)</td>
<td>If patient refuses, admission document mental capacity and rationale</td>
</tr>
<tr>
<td></td>
<td>Needs robust plan and ensure safety netting advice given to patient</td>
<td>If patient is for palliative care or end of life care, ensure DNAR, Do Not Transport to Acute Hospital documentation is in place, inform and involve palliative care services</td>
</tr>
</tbody>
</table>

### SEAR - Handover tool

**Situation**
- State reason for visit and current situation

**Background**
- Give reason for current referral
- Give background information on the patient

**Assessment**
- Give / record set of CEWS
- Give any findings or concerns from assessment

**Recommendation**
- State clearly what you want the person you are calling to do and your plan for the patient (e.g. to visit or to give advice about patient management)

### The Patient can have an agreed variance following a discussion with an appropriate professional

- Unplanned care: CEWS in hours / or out of hours / Specialist Nurses
- Planned Care: AHP / Specialist Nurses / GP

Example: "As discussed with Dr Smith due to COPD, respiratory rate 22 - 25 is the patient normal."

- The range never becomes 'White', it stays the agreed colour but has to be clearly documented that this is the patient's normal requiring no further action
- If the observations leave the agreed variance will require the response of that colour triggered

### If the patient is unwell and has signs / symptoms of infection consider SEPSIS flags

#### Is the Amber Flag Present?

**New deterioration in CCS / AVPU or acute confusion**
- Systolic Bp 20-40mmHg below normal
- Heart rate > 120 per minute
- Respiratory rate > 25 per minute
- Nasal Oxygen saturation (SpO2) 80-85% (85% 90% in COPD)
- Non-blanching rash unmoistened / ashen / cyanotic
- No urinating within 8 hours
- Urine output less than 0.5ml / kg / 12 hours
- Recent Chemotherapy (within last 6 weeks)
- Seizure / Status Epilepticus
- Recent Neutropenia
- Relative’s worried about mental state / behaviour
- Acute deterioration in function / ability
- Immunocompromised
- Trauma, surgery or procedure in last 5 weeks
- Respiratory rate 25-30 OR dyspnoeic
- Systolic BP 90-100mmHg
- Heart rate 61-90 OR new dysrhythmics
- Tympanic temperature > 36°C

**Clinical signs of wound device or skin infection**
Falls:

- Majority of patients in community intermediate care
- Decreased mobility (95%)
- At home (30% - live alone)
- Needed a measure to prevent falls
- Orthostatic blood pressure check introduced
Lying and standing  Systolic BP

- Drop in BP from lying supine for 5 minute
- Standing for 3 minutes or 1-3 minutes and if patient complains of dizziness
- $>30$ – admission
- 20-29
- 10-19
- Baseline $<10$
- Drop $>10$
- Usually systolic drop is also seen.
Blood sugar

<3.0
3.0 – 4.0
4.1 – 10
10.1-14
Blood sugar /urine

Diabetic
> 14 no Ketones
> 14 & ketones

Non Diabetic
> 10 no Ketones
> 10 & ketones
Level of Consciousness

- Is confused/agitated
- Any change in baseline
- Is alert and oriented
- Responds to voice commands
- Responds to pain stimulation
- Unresponsive - Admission
Traffic Light

- **GREEN** On CEWS, pt at risk of admission to acute care without monitoring ...
- **Yellow** on CEWS, pt at high risk of admission to acute care...
- **RED** on CEWS. Admission
GREEN / yellow On CEWS:

- Action is required to prevent Deterioration
- **Green** - minimum one daily nursing visit to follow the initial medical management plan.
- Unwell adult assessment to be carried out
- **Yellow** - Minimum 2 nursing visits a day to follow the initial medical management plan
- ANP Urgent Unwell adult assessment to be carried out
- Discuss with consultant / Doctor/ Matron - Management plan
Assessment ..

- Blood for baseline investigations (FBC, U&E’s, CRP, MSU when appropriate) need to be taken, results reviewed
- Sputum sent if productive cough
- Prescribe and commence essential treatment (antibiotics, furosemide, pain relief etc..)
- Safety-netting and medical management plans need to be in place
GREEN/Yellow

- Monitor patient’s oral intake with strict input (and output when available). Minimum 1.5 Lts per day (exceptions CCF, Hyponatremia ..)

- Daily weight (heart failure) and action if >2lbs weight gained within 24 hrs

**Delirium prevention**

- Monitor bowel action

- Monitor for oral thrush

- Manual handling/mobility
  Plan needs to be detailed

- Pain control

- Fluid chart in patients home

- Vison and Hearing
GREEN On CEWS

- Discuss DNAR status with patient and family
- Clearly state mobility plan for RH/NH staff to prevent deterioration in mobility
- ECG following a fall and review with consultant
- Keep GP informed of medical management plan
- If patient’s condition does not improve in 72 hrs, discuss and review patient with consultant /matron( ANP)
- Monitor for 48 hrs once CEWS returns to normal (for discharge)
Yellow on CEWS:

- Keep GP up to date with medical management plan
- No change in 24 hrs
- Discuss with matron / consultant / doctor
- Plan home visit
- Monitor for 48 hrs once CEWS returns to normal
- If admitted to acute hospital, state reasons and inform ICT to track patients
RED on CEWS

- Admission should be discussed with Matrons (ANP)/ consultant

Exceptions will be

- Known COPD, palliative care, etc..
- If Observation are normal for that patient and documented before.
- Refusing admission (ANP visit)
- Document, Mental capacity of patient
- Decision discussed with family and documented
Consider.. Palliative care

In patients with

• Advanced dementia
  
  Patient bedbound more than 3 months, non communicative with poor oral intake previously

• Advanced heart failure
  
  Diagnosed and known to Heart Failure Nurse with palliative measures already discussed with patient

• DNAR in place
  
  With patient’s wishes known, and does not want to be transferred to acute hospital

• Advanced frailty
  
  Patient has capacity and does not want further treatment i.e. not to be transferred to acute hospital
RED – not transferred to acute - Document

- ANP visit and after review with Matron/consultant
- Document / Discussion with
- Patient
- Family
- GP
- And clearly state Advanced care plan
- Escalation plan
Risk - definition

Risk perception is the subjective judgment people make about the severity and probability of a risk is the potential of gaining or losing something of value. Values (such as physical health, social status, emotional well-being, or financial wealth) can be gained or lost when taking risk resulting from a given action or inaction.
Informed consent for all decisions
This is about people
First Steps

• Have to understand the problem?
• Guide to Reducing Long Length of Stay
• Review weekly on the wards of all patients 21 days and over
• Focus on frailty
  • Identify at the front door (frailty screen)
  • Diagnose and manage delirium
  • Track through the hospital those at risk of increased stay (PARIS)
  • Ask every day ‘why not home, why not home today’?
What does good like for over 65’s?

- Discharged NFA 700
- Admitted to Hospital 1,000
- Discharged requiring further support 300
  - “Low-level” support (e.g., follow-up from therapist or District Nurse) 50
  - Intermediate Care
  - Domiciliary Support (e.g., Reablement based) 225
  - On-going Domiciliary Support 86
  - Short-term Reablement based residential care bed with therapeutic and nursing support 25
- Residential Care 8
This is about people
First Steps

• Have to understand the problem?
• Guide to Reducing Long Length of Stay
• Review weekly on the wards of all patients 21 days and over
• Focus on frailty
  • Identify at the front door (frailty screen)
  • Diagnose and manage delirium
  • Track through the hospital those at risk of increased stay (PARIS)
  • Ask every day ‘why not home, why not home today’?
What does good like for over 65’s?

Discharged NFA 700 → Admitted to Hospital 1,000 → Discharged requiring further support 300

- "Low-level" support (eg follow-up from therapist or District Nurse) 50
- Intermediate Care
  - Short-term Reablement based residential care bed with therapeutic and nursing support 25
  - Domiciliary Support (eg Reablement based) 225
  - On-going Domiciliary Support 86

Residential Care 8