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HSIB report reinforces national approach to tackle preventable deaths from deterioration

A new report published today recommends tackling the recognition and response to deteriorating patients with the same national approach driving improvement in identifying and treating sepsis.

Problems in recognising and responding to patients who are deteriorating continues to be a major source of severe harm and preventable death in hospitals. Previous research has shown that up to a quarter of preventable deaths are related to failures in clinical monitoring. *

In their report, the Healthcare Safety Investigation Branch set out one recommendation to NHS England /NHS Improvement to extend the remit of their successful cross-system sepsis programme board to include deterioration from conditions other than sepsis. This comes after they launched a national investigation based on the case of a 58-year old woman who deteriorated and died, less than 24 hours after presenting at the Emergency Department with a potentially treatable condition.

The investigation examined the context of the Emergency Department and various models of patient assessment used, as well as the factors that influence decision making. This includes communication tools, how information is delivered, environmental pressures (noise, interruptions etc.), time constraints and a focus on meeting performance standards.

Dr Stephen Drage, Director of Investigations at HSIB said: “Our investigation very much highlighted that it is not easy to improve situation awareness and decision making. The emphasis has to be on designing an effective system to make sure the right information is getting to the right place at the right time, creating a holistic picture of the patient.

“This is why we have made the recommendation to extend the remit of the national programme board. They have already had great success with their work, and there has been an increase in the identification and timely treatment of sepsis. We felt it would be beneficial to bring together experts and leaders in the field, so that there is a more unified approach taken in tackling the recognition and response to critically unwell patients.

“Recognising and treating deterioration in patients is something clinicians have to deal with every day in busy hospitals and ultimately our safety recommendations are designed to reduce the devastating impact this has on staff, patients and their families.”

Dr Matt Inada-Kim, Consultant Acute Physician and a national lead in sepsis and deterioration, who worked with the team throughout the investigation commented: “This independent HSIB report shines a light on the

benefits that healthcare will gain through learning what other industries have done when tackling similar problems.

“Though healthcare is unique, in its complexities and situation, there are some key transferrable human factors lessons such as standardisation to a common language (NEWS2), communication (spoken, non-verbal, written and electronic), situational awareness and mental modelling; all ideas that can make healthcare safer.

“We have such a wonderful opportunity to build upon the findings of this report at scale and develop a sustainable vision of how we can address and improve outcomes within the condition that is the largest cause of avoidable harm in healthcare.”

The report also sets out a second recommendation focused on the use of NEWS (National Early Warning Scores). The investigation found that there was research to suggest that the way it was escalated places a high demand on staff resource. The work done on NEWS and the feedback incorporated into NEWS2 was recognised by the investigation. HSIB have recommended to the Royal College of Physicians to continually evaluate the implementation and use of NEWS2. The team also observed that NEWS2 shouldn’t be used as a stand-alone tool and should be combined with other patient information.

The report is now available on the HSIB website and responses to the recommendations will be published later this year.

ENDS

Notes to Editors

- National Early Warning Scores (NEWS) is based on a simple aggregate scoring system in which a score is allocated to physiological measurements when patients present to or are being monitored in hospital.
- *Reference in section 1.2.2 Page 16 of report: a 2012 study[i] of hospital deaths found that 26% of preventable deaths were related to failures in clinical monitoring. These included failures to act upon abnormal test results, failures to establish monitoring systems and failures to respond to such systems.

Recommendations, observations and safety actions in full

Safety recommendations

1. The Royal College of Physicians NEWS advisory group continues to evaluate the implementation and use of NEWS2, including but not limited to:
    - The use of NEWS2 in practice, in particular the consistency of recording, the consistency of response, and the communication of patient measurements between healthcare professionals.

- The effectiveness of NEWS2 in identifying a patient's level of acute illness in different care settings and patient groups.
- The presentation of NEWS2 information and how this supports clinicians to identify trends, particularly in electronic records.
- The guidance and training on the use of NEWS2 as part of clinical assessment and patient monitoring.

2. NHS Improvement/NHS England should expand the remit of the Cross-System Sepsis Programme Board to include physical patient deterioration, involving additional stakeholders as required.

Safety observations

- NEWS2 is not intended to be a stand-alone tool. Instead, it is intended to be combined with other relevant charts, clinical investigation results and notes together with clinical observations of the patient. There may be benefits to staff being trained in this approach and systems being designed to support bringing relevant information together.
- There may be benefits to including the historical data from NEWS2 graphs and charts, together with other key information, during a patient handover.
- There would be benefits to Trusts ensuring they are using the latest version of the NEWS2 observation chart and protocols. Any recommended changes to early warning scores, documentation or use would benefit from being tested in practice before widespread implementation.

About HSIB

The formation of HSIB is a world-first and represents a landmark moment for the NHS in England. HSIB's purpose is to help improve safety in the healthcare system by developing recommendations and sharing lessons from investigations. HSIB will improve patient safety through effective and independent investigations that do not apportion blame or liability.

More details can be found www.hsib.org.uk

Media contacts

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