Identification of high risk patients through effective recognition of early warning signs and reduces mortality and morbidity of orthopedic patients in a tertiary care hospital.

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Abstract

Background:

Identification of early warning signs plays an essential role in patient safety and recognizing further deterioration. Analysis of serious patients' safety incidents revealed that 11% of deaths were related to "Deterioration not recognized or not acted upon" (NPSA, 2007). According to NPSA 2007 where the process can fail include: not taking observations, not recognizing early signs of deterioration, not communicating observations causing concern and not responding to concerns appropriately. A similar scenario happened in a tertiary care hospital where a full code patient expired and after root cause analysis it was identified that the cause was failure to identify early warning signs.

Objective:

The objective of this project is to identify high risk patients through effective recognition of early warning signs and reduce mortality and morbidity of orthopedic patient.

Methodology:

The project was conducted at The Aga Khan University Hospital from September 2016-august 2017. It was a multidisciplinary approach where a team of health care providers were involved to ensure identification of high risk patients and its interventions. The strategies employed for quality improvement were to give the awareness to nurses regarding the importance of risk assessment in every patient, reinforcement to do focused assessment to act on early warning signs. In addition to that in the daily rounds the priority of head nurses, nurse instructor, clinical nurse coordinator and team leader is to visit the high risk patients first. Multiple sessions were conducted on modified early warning signs and its action plan. Multiple mock drills and rhythm analysis sessions were conducted to ensure proper code management and resuscitation. Teachings were given regarding proper interpretation of clinical findings. During the weekend, the nurse

team leader on coverage performs the role of checking the high risk patients. Data was collected from January 2017 to august 2017 regarding high risk patients.

Result:

A total of 49 patients were identified as high risk and managed accordingly. Out of which, 14 patients were recognized, managed and remained on the same ward bed. Whereas 32 patients, were managed on same bed and moved to high dependency unit for further management. However 2 patients were electively intubated according to the need of the patient's condition and moved to ICU. 1 patient expired as was on DNR(Do not resuscitate) and comfort care. No full code expiries occurred in this whole period of the quality project.

Conclusion:

It has been observed that we can really make a difference by early identification of deteriorating patients and by efficient team approach.