NSQHS Standard 8 Recognising and Responding to Acute Deterioration
How to use the audit tool – Edition 2

Recognising and Responding to Acute Deterioration
Audit Tools Instructions

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland has developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting the National Safety and Quality Health Service (NSQHS) Standards. The audit tools have been updated to align to the second edition of the NSQHS Standards.

Purpose of the audit tools

The tools provide facilities and health services with additional supporting resources to use in conjunction with the existing NSQHS standards workbooks and guides to be able to:

- Demonstrate detailed evidence for an action by providing specific verification rather than noting the action has been met and listing the source, i.e. self-assessment

- Collect information and evidence to a further level of detail at a patient, ward and facility level, delving down into specific requirements that further support meeting the action
    - collect patient level data using a number of methods, i.e. chart documentation, observational and asking the patient/carer questions to demonstrate that the evidence has been met, and to what extent
    - observe ward/unit staff undertaking a process, e.g. use of observation charts and recording individual results

- Determine actual performance results at a ward and patient level

- Clearly identify those detailed gaps/areas that need attention, in order to target improvements and build a robust action plan at the ward and facility level

- Track and monitor audit results at the three levels over time.

The tools can be used in conjunction with other resources and directly align to the criteria in the existing NSQHS Standards workbooks and guides. Depending on the size of the facility a number of audit questions may not be applicable, it is up to each facility/health service to determine the audit questions for review. Questions and responses can be adapted to suit the requirements of each facility/health service.

NSQHS Standards Edition 2 Version 1.0
Standard 8 Recognising and Responding to Acute Deterioration – Instructions

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The suite of documents include the following:

1. A 'how to' guide on using the tools (this document)

2. A definitions guide to assist in completing the tools

3. Three specific audit tools that allow the collection and collation of information are provided that can be adapted for local use. An Excel workbook consisting of tabs with the following:

   - *Facility Collection and Results*: collects facility level responses

   - *Ward/Unit Collection Audit Tool*: collects the ward/unit level responses, the Excel spreadsheet can be used to collect up to 15 wards/units

   - *Patient Collection Audit Tool*: collects patient level responses (at a ward/unit level), the Excel spreadsheet can be used to collect up to 20 patients

   - *Results for Ward/Unit*: collates the ward/unit level responses

   - *Results for Patient*: collates the patient level responses.

4. A measurement plan for each standard that defines the goals, questions and responses in the audit tools. The plan details each audit question and its alignment to the action in the standard and can be adapted for local use. Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Scope of the Recognising and Responding to Acute Deterioration Audit tools

The audit tools incorporate audit questions on recognition and response systems, observation charts (includes Q-ADDS, CEWT, Q-MEWT and NEWT), and escalation of care.

The indicators and questions in the patient audit tool aligns to the Queensland Bedside Audit (QBA) and other statewide audits wherever possible.

How the tools were developed

An example is provided below using Action 8.4 in Standard 8

1. The NSQHS Standards workbooks and guides were used, i.e.

    a. Guide for Hospitals (November 2017) – Key tasks and Strategies for improvement

    https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-Guide-for-Hospitals.pdf

Example: Guide for Hospitals – Action 8.4 in Standard 8

Action 8.4

The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:

a. Document individualised vital sign monitoring plans

b. Monitor patients as required by their individualised monitoring plan

c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

Intent

Patients with acute physiological deterioration are identified early.

Key tasks

- Implement a system for documenting vital sign monitoring plans
- Ensure that clinicians have the necessary skills and equipment to monitor patients as required by their individualised monitoring plans
- Implement an observation chart or other mechanism for graphically documenting vital sign observations and tracking changes over time.

Strategies for improvement

Develop monitoring plans

Develop individualised vital sign monitoring plans to manage the clinical risks and needs of each patient. Work with clinicians to design systems for developing and documenting these plans, and to ensure that the systems align with workflow and effectively meet patients' needs. Include capacity to document the frequency (times per day), duration (number of days or weeks) and types of vital signs or other physiological parameters.

Monitoring plans may be included in clinical pathways for specific patient groups who have similar clinical risks and needs, but provide prompts for clinicians to consider whether the monitoring plan meets the needs of each patient, and capacity for them to review and modify the monitoring plan.

Describe the minimum expectations for vital sign monitoring in policy. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[344] identifies a core set of six vital signs, and recommends that these should be monitored at least once per eight-hour shift:

- Respiratory rate
- Oxygen saturation
- Heart rate
- Blood pressure
- Level of consciousness
- Temperature.

The frequency of required monitoring may vary between individual patients, and as a patient's clinical situation, clinical risks and goals of care change. Some patients may not need all the core vital sign observations to be monitored at the same frequency (for example, young children may not need blood pressure monitored as often as respiratory rate and oxygen saturation).

Include the core vital signs in monitoring plans for most patients. Specific groups of patients may have extra monitoring requirements (for example, pain and sedation scores, fluid balance, respiratory distress, capillary refill, or pupil size and reactivity). Patients who are at the end of life may not need their core vital signs to be monitored, but will need monitoring of symptoms associated with the dying process, such as pain, agitation, breathlessness and nausea. Paediatric patients may not be able to be monitored for level of consciousness, but accessory muscle use may be a relevant vital sign. Local guidelines may need to be developed for vital sign monitoring in specialist areas such as emergency departments, post-anaesthetic care units,

Example: Key task for Action 8.4 'Implement an observation chart or other mechanism for graphically documenting vital sign observations and tracking changes over time'.

2. The questions in the audit tools (patient, ward, facility) assess and ask for verification of the examples of evidence and outputs to collect the detailed information necessary to meet that evidence. In addition, other examples of evidence may be used. The questions may directly ask if there is supporting evidence, or may be broken down into a series of questions to delve deeper into whether the evidence has been met.

Questions and responses have been developed in consultation with content area experts.

Example: Audit tool questions for Action 8.4 in Standard 8

Documentation audit - Patient		Pt 1	Pt 2
	URN:		
1.0	Is there evidence that the patient has an observation chart for recording core vital signs? *N/A for palliative care/end of life, aged care in MPHS patient, subacute facilities. If No or N/A, go to Question 12*		
1.1	If yes to 1.0, which observation chart is present?		
1.2	Is the patient clearly identified on all pages of the general observation chart? *Includes URN, Name and DOB*		

In addition to the collection of information, the Excel spreadsheet collates data at the patient and ward/unit levels. The tab *Results for Ward/Unit* shows the number of wards/units that met the indicator and the total number audited, which are then used to calculate the percentage of wards/units that met that indicator. Subsequently, the tab *Results for Patient*, displays the percentage of patients that met the indicator. Details of the indicators can be found in the measurement plan.

3. The measurement plan details the actions and those question(s)/responses that correspond to the action.

Note: Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Example: Measurement plan for Action 8.4 in Standard 8

Actions required

Indicator name

Audit tool to find the question(s)

The question(s) that will be on the facility, ward or patient tool

The responses that will be on the tool

The numerator and denominator to assist in the collation and calculation of indicators

Action	Actions required	Goal	Indicator	Audit Tool	Question on Audit Tool	Response options	Numerator	Denominator
8.5	The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	Identify if patients have identification marked on all pages of the observation chart	% of patients who have identification marked on all pages of the observation chart	Patient	1.0 Is there evidence that the patient has an observation chart for recording core vital signs? N/A for palliative care/end of life, aged care in MPHS patient, subacute facilities 1.1 If yes to 1.0, which observation chart is present? 1.2 If yes to 1.0, is the patient clearly identified on all pages of the general observation chart? (includes URN, Name and DOB)	Yes; No; N/A combination system - Q-ADDS; combination system - CEWT; combination system - Q-MEWT; combination system - Other, e.g. MEWS; single parameter tool (track and trigger) e.g. MECC, BTF; non track and trigger, non scoring system Yes; No	Number of patients who have identification marked on all pages of the observation chart (Yes to 1.0 and Yes to 1.2)	Total number of eligible patients (Yes to 1.0 and Yes or No to 1.2)

Using the Excel tools

The audit tools are in different worksheets in the Excel document and these are accessed by the tabs at the bottom of the workbook or by clicking on the links in the Contents page.

National Safety and Quality Health Service (NSQHS) Standards
Standard 8 Recognising and Responding to Acute Deterioration
- Edition 2

Audit Tools to audit against Edition 2 of the NSQHS Standards

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland has developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting Edition 2 of the NSQHS Standards.
There are a number of tools in the workbook. The tools provide the ability to collect a number of patients and wards, and display combined results for each indicator. In addition, the measurement plan provides a high level view of the NSQHS actions and their alignment to each audit question.

Contents

Facility Collection & Results	This audit tool collects Facility level data, and the results can be printed directly from this sheet
Ward_Unit Collection	This audit tool collects Ward/Unit level data
Patient Collection	This audit tool collects Patient level data
Results for Ward_Unit	This tab presents the results of the Ward/Unit level data (that were collected on the Ward_Unit Collection tab)
Results for Patient	This tab presents the results of the Patient level data (that were collected on the Patient Collection tab)
Measurement Plan	The measurement plan outlines the NSQHS Standards Actions and the audit questions and indicators aligned to them

| ▸ | **Contents** | Facility Collection & Results | Ward_Unit Collection | Patient Collection | Results for Ward_Unit | Results for Patient | Measurement Plan |

In addition, we recognise that each facility will define when the audit will take place, how often, how many patients to audit and who will perform the audit.

Queensland Health facilities have the ability to enter their audit data online using an existing secure, electronic web-based system, Measurement, Analysis and Reporting System (MARS), available via the Queensland Health intranet. Please email mars@health.qld.gov.au for further information.

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as the audit tools are a constant **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Queensland Health facilities. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on <u>mars@health.qld.gov.au</u> for feedback or comments.