Reducing the Risk of Unrecognized Clinical Deterioration: Implementing a Watcher Program

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No disclosures
Objectives

- Describe the development and implementation of the watcher program
- Identify outcomes of program implementation
- Discuss next steps
Arkansas Children’s

- Licensed for 359 beds
- FY 17 ~ 15,000 inpatient admissions & 59,000 ED visits
- Level I Trauma Center
- 100 bed Level IV NICU
- PICU, CVICU, Burn ICU
- 80 Specialty Clinics
- 4,300 Staff Members & 500 Physicians
“Patients don’t suddenly deteriorate, healthcare professionals suddenly notice.”

-Unknown
Background

• Failure to recognize and respond to clinical deterioration – important source of preventable harm
• Failure often manifest as an emergency transfer to the ICU or a code outside the ICU
• At ACH, the emergency transfer rate and event analysis revealed an opportunity for improvement.
  – Concerning lack of situational awareness including tunnel vision, confirmation bias, false reassurance, and lack of forward planning
Project Aim

Reduce the rate of emergency transfers from IMU and Med-Surg units to the PICU by 40%, by December 31, 2016.
**SMART Aim:**
Reduce the rate of emergency transfers from IMU/Med-Surg units to the PICU by 40%, by December 31, 2016.

**Measure:**
Rate of emergency transfers from IMU and med-surg units to the PICU (measured as per 10,000 non-ICU patient days)

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**Emergency Transfers**

- Proactively identify and mitigate risks for patients who may be at an increased risk for deterioration.
- Develop and implement a model that defines subjective and objective criteria for patients who should be considered high risk for deterioration, as well as clearly defined steps for communicating, mitigating and escalating risks.
- Enhance awareness around emergency transfer events.
- Disseminate emergency transfer data to the unit level leadership, physician leadership, and quality/safety committees.
Intervention: Watcher Program

- Based on model originally developed by Cincinnati Children’s Hospital
- Proactive identification of high risk patients based on objective and/or subjective criteria:
  - PEWS score >5
  - Sepsis Screening = Yellow or Red
  - Tachycardia sustained >1 hour after intervention
  - Fluid Resuscitation (>2 boluses in previous 24 hrs)
  - MET Call within previous 24 hours
  - ICU Consult
  - Family or Staff Concern (“Gut feeling”)

Arkansas Children’s
Key Components

• Identify
  – Any staff member or parent

• Communicate
  – Standard notifications
  – Watcher Huddle
  – Organizational and departmental safety huddles
Key Components

- **Mitigate**
  - Bedside collaboration to create a plan with interventions, outcomes, and timeline
- **Escalate**
  - Pre-defined plan
- **Tools**
  - Algorithm
  - Planning tool
Discussion

• Greater than 70% reduction, sustained over time
• Key to success
  – Multi-disciplinary, cross-departmental leadership
  – Persistence, preoccupation with failure and perspiration
  – Integration of acute care leadership team
  – Twice daily huddles
Next Steps

• Evaluation of how this model may be used in other care areas or with other populations
• Sustainment through continued reinforcement, education, and data dissemination
• Maximizing EHR transition
  – Auto notifications, documentation, data extraction, etc.