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

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Session Title:
Early Recognition of Clinical Deterioration
Slot:
H 16: Monday, 30 October 2017: 2:45 PM-3:30 PM
Scheduled Time:
3:05 PM

Keywords:
clinical deterioration, high reliability organization and patient safety

References:

Abstract Summary:
Failure to recognize and respond to clinical deterioration is a source of preventable harm for hospitalized patients. An evidence-based, inter-professional program was implemented to proactively assess and manage risk for deterioration. Emergency transfers to the intensive care unit were reduced by 70%.

Learning Activity:

<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<tbody>
<tr>
<td>Describe the implementation of the watcher program in a children's hospital.</td>
<td>1) Discuss emergency transfers to the intensive care unit 2) Discuss the development of an evidence-based approach to identify and mitigate risk of deterioration and thus, reduce emergency transfers to the intensive care unit.</td>
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<td>Identify important structure and process.</td>
<td>1) Inter-professional team buy-in 2) Process of trigger identification 3) Inter-professional development of a plan with clear timelines 4) Twice daily watcher huddles</td>
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<td>Discuss outcomes of the watcher program.</td>
<td>1) Reduction in emergency transfer to the intensive care unit 2) Team performance</td>
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Abstract Text:
Reducing the Risk of Unrecognized Clinical Deterioration: Implementing a Watcher Program

Purpose and Background: Failure to recognize and respond to clinical deterioration is a source of preventable harm for hospitalized patients. These failures are often manifested as emergency transfers to the intensive care unit (ICU), which are defined by need for resuscitative measures within one hour before or after transfer. Emergency transfers are precursors to codes outside of the ICU which are associated with significantly increased mortality rates. The rate of emergency transfers as well as findings from event analyses at a large children’s hospital revealed failures in identifying and responding to clinical deterioration in a timely manner. Review of the literature revealed the value of watcher programs that provide structure and process for identifying risk and creating proactive, time-bound plans for interventions and ongoing assessment.

Methods: In an effort to increase situational awareness and reduce the risk of unrecognized clinical deterioration, an inter-professional team including nurses, physicians and hospital leaders was formed to develop and implement an evidence-based watcher program for inpatient medical-surgical and intermediate care units. The framework of the program incorporates the principles of high-reliability organizations through identification, communication, mitigation, and escalation of risk. The program incorporates subjective and objective triggers and empowers the entire team, including parents, to identify patients as watchers. Post identification, the inter-professional team develops a collaborative, time-bound plan with measurable outcomes. This includes an escalation plan. Further, twice daily watcher huddles provide a forum for collaborative communication about those identified as watchers and proactive planning for responding to the patient’s condition if expected outcomes are not met in the defined time frame.

Results: Over the first 8 months post implementation of the watcher program, the emergency transfer to the ICU rate decreased by 70%. In addition, nurses identify that the program empowers them to respond to changes in patient condition and reduces uncertainty around next steps. The huddles foster accountability.

Discussion and Conclusion: The program has reduced hierarchical barriers and fostered a culture of accountability while promoting organization’s core value of patient safety. Importantly, emergency transfers to the ICU were substantially reduced.