

BMJ Open Quality Targeted communication reduces the inappropriate use of Early Warning Scores in patients with treatment limitations

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INTRODUCTION

Early Warning Scores (EWSs) use physiological parameters to create an aggregate score alerting medical teams to patient deterioration, triggering referrals to critical care regardless of chronic health issues and physiological reserve.^{1 2} Consequently, in some patients with persistently altered physiology or patients who are not deemed suitable for escalation to critical care, EWS can be inappropriate resulting in the overmonitoring of patients and inappropriate contact of critical care.^{2 3} Guidelines state that in such circumstances routine recording of EWS can be stopped.²

In our trust, end-of-life care patients were monitored according to EWS resulting in the inappropriate call out of critical care. For example, critical care teams were called to assess patients where a decision not to escalate to critical care had previously been documented. Nursing staff reported that monitoring according to EWS increased workload limiting their ability to achieve other tasks resulting in patient stress.

We, therefore, sought to determine the proportion of patients with treatment limitations in place who had these limitations documented on their EWS chart.

METHODS

We performed two snapshot audits on acute medical (control) and general medical wards (intervention) to obtain the percentage of patients with treatment limitations in place who had this documented on their EWS charts before and after improvement measures. First, a paper prompt on the EWS chart. Second, targeted communication interventions to general medical wards only. Targeted communication was not repeated after the second audit. A third snapshot audit was completed a year after improvement measures

in order to identify whether improvements were sustained. As the decision to use a paper prompt was initiated by the trust and the second intervention was communication to follow existing guidance² this study did not require ethical approval but was registered at our Trust as an audit (registration no. 4474).

Setting

Acute medical (control) and general medical (intervention) wards in a large District General Hospital between 2018 and 2020.

Target population

Patients with treatment limitations identified through review of notes.

Interventions

First intervention (control and intervention wards): paper prompt on the EWS chart. Second intervention (intervention ward only): targeted communication consisting of announcements at departmental meetings and emails to consultants and senior ward nurses. Nurses were asked to highlight patients during ward rounds that might be inappropriate for EWS. These interventions had previously been shown to be effective.^{4 5}

Outcome

The proportion of patients with treatment limitations that were monitored appropriately by EWS. (Monitoring includes recording observations on the EWS chart and the response to this including observation frequency and contact of other health professionals.) We considered patients were being monitored appropriately if their limitations were documented on their EWS charts. This documentation varied between patients. Some patients at the end of life were not suitable for EWS monitoring. Other patients required alteration of response to EWS score; for example, to not call critical care.

Three audits

2018 (preintervention), 2019 (directly postintervention), 2020 (1 year follow-up—intervention ward only). Targeted communication was not repeated after 2019. Medical and nursing staff were not informed about audit timing.

All patients on the target wards were reviewed during each audit. Audit 2018 occurred over 3 days in November–December. Audit 2019 occurred over 8 days in June–September. Audit 2020 occurred over 2 days in August–September.

We obtained qualitative feedback from nurses and physiotherapists by discussion at departmental meetings throughout the study.

χ^2 test was used (SPSS V.24) for statistical analysis. Results were considered significant when $p < 0.05$.

RESULTS

Audit results

There was no significant difference in the proportion of patients with treatment limitations that had these documented on the EWS chart between 2018 and 2019 (12/21 (57.1%) vs 12/32 (37.5%), $p = 0.160$) in the ward where only a paper prompt was used. However, where targeted communication was used, there was a statistically significant improvement (16/43 (37.2%) vs 55/93 (59.1%), $p = 0.017$).

In 2020, 10/27 (37%) patients with treatment escalation limitation decisions in wards where targeted

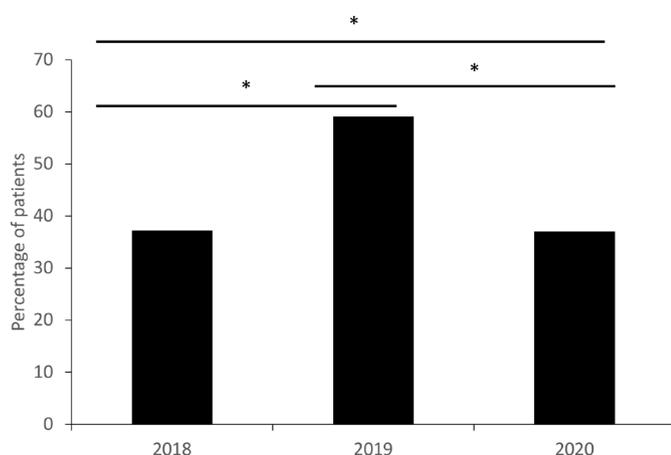


Figure 1 Patients with treatment limitations in place on general medical wards (where targeted communication was used) who had these limitations documented on their EWS charts in 2018, 2019 and 2020. There was a significant difference in the percentage of patients with treatment limitations documented on their EWS chart across the three audits. Significantly more patients with limitations in place had this documented on their EWS charts in 2019 in comparison with 2018 and 2020. Horizontal lines are used to illustrate which groups were compared in the chi squared test. *There was a significant difference between the proportion of patients with treatment limitations documented on the EWS chart between groups where $p < 0.05$. EWS, Early Warning Score.

communication had been used had these documented on their EWS charts (figure 1). This was significantly ($p = 0.042$) worse than the previous (2019) audit.

Qualitative feedback

September 2019

Nursing staff identified that multiple patients were over-monitored and they offered to help by prompting doctors to think about appropriateness of EWS.

November 2019

Band 5 physiotherapists and ward nurses overwhelmingly welcomed stopping inappropriate EWS.

October 2020

Ward managers and matrons stated that nurses feel it aids their communication with patients and families when treatment escalation limitation decisions are made and documented.

DISCUSSION

Our results indicate that the proportion of inpatients with treatment escalation and limitation decisions in place that have their EWS amended can be improved by targeted communication. Paper prompts alone are not sufficient. These findings are in contrast to a Cochrane review that concluded that manually generated paper reminders have a small but significant effect on outcomes.⁴

Other studies have demonstrated the effectiveness of targeted communication.⁵ It is likely that an effective tool in our study was nursing team involvement who frequently prompted medical staff. Nurse-driven prompts have previously been demonstrated to be effective at improving concordance of physicians to guidelines.⁶ However, our results demonstrate that sustained change requires continuous education, communication and reminders consistent with previous studies.⁵

In this study, the nursing team were positive about the improvements in workload when EWS was reviewed. High nursing workload prevents optimal patient care by reducing time to communicate.⁷ This is particularly relevant in patients receiving end-of-life care.⁸ Furthermore, restricted visiting policies during the COVID-19 pandemic make it important that stretched NHS resources of time and personnel required for inappropriate EWS scoring should be better utilised in providing palliative support.⁹ Previously, nurses' pattern recognition has been shown to detect acute deterioration.¹⁰ Therefore, nursing impressions may be a less disruptive way to monitor patients with treatment limitations than EWS.

Limitations

This study was small and was carried out in a single centre which might limit generalisability. However, data were collected on general medical wards found in most hospitals and the interventions could be replicated in most healthcare settings.

Data were collected using ‘snapshot’ style audits and represents three points in time. Nevertheless, this enabled us to collect data quickly and we were able to limit bias as staff were not aware of audit timings.

Conclusions

A large proportion of patients with treatment escalation limitations are still regularly being assessed using EWS despite not being suitable for escalation to critical care. This places unnecessary workload on staff and distresses patients. Targeted communication is an effective tool to prompt staff to address EWS measuring but this needs regular repetition.

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Patient consent for publication Not applicable.

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