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South of England Improving Safety in Mental Health Collaborative

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# **Reducing harm through early detection of clinical deterioration and timely and competent clinical response**

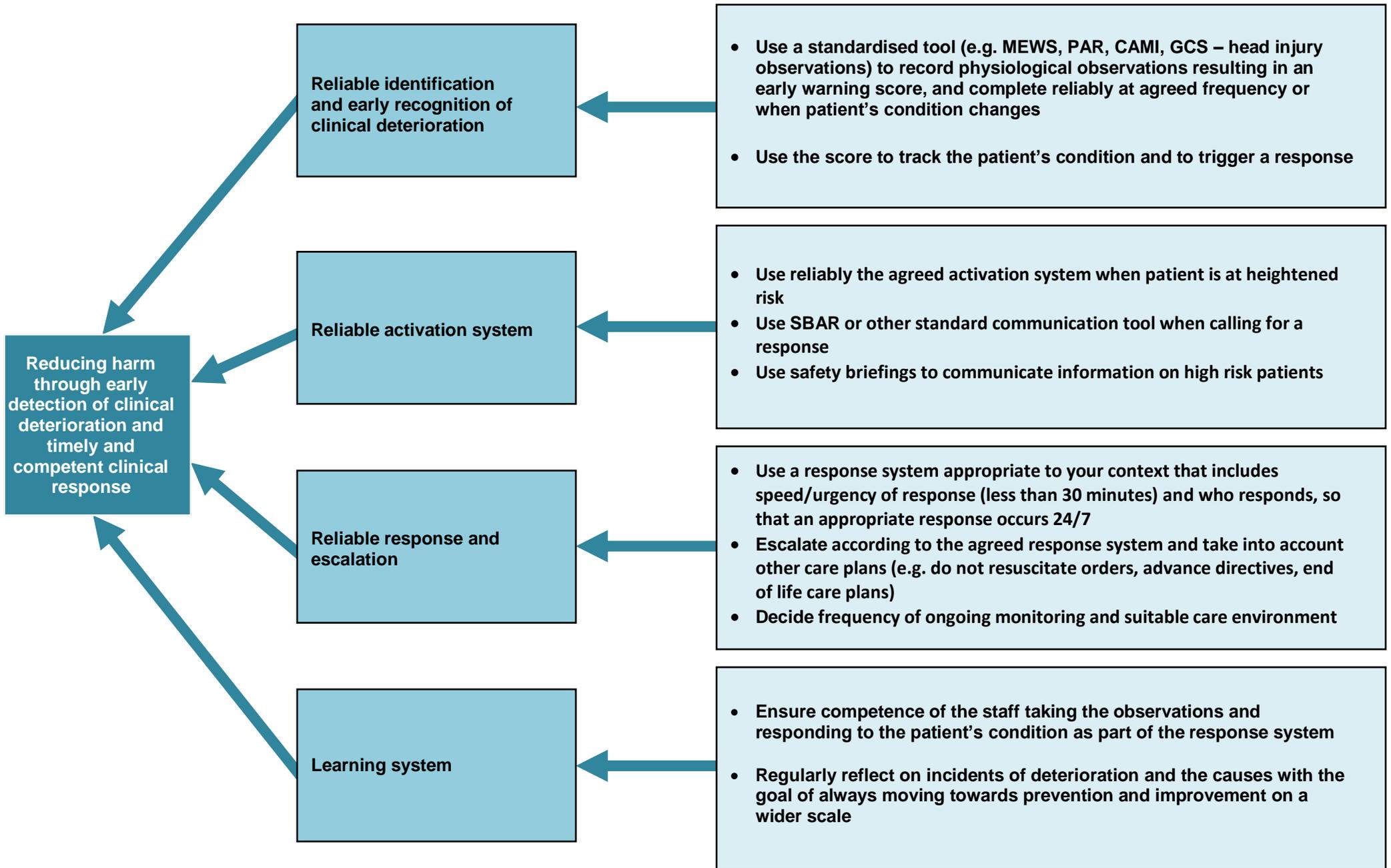
## **Driver Diagram and Change Package**

A driver diagram is used to conceptualize an issue and to determine its system components which will then create a pathway to achieve the goal. Primary drivers are system components which will contribute to moving the primary outcome. Secondary drivers are elements of the associated primary driver. They contain change concepts that can be used to create projects that will affect the primary driver.

**Outcome**

**Primary Drivers**

**Secondary Drivers**



Secondary Drivers	Key change concepts and change ideas for PDSA testing
<ul style="list-style-type: none"> <li>• Use a standardised tool (e.g. MEWS, PAR, CAMI, GCS – head injury observations) to record physiological observations resulting in an early warning score, and complete reliably at agreed frequency or when patient’s condition changes</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a chart for routine recording of clinical data including early warning scoring mechanism. Consider colour coding to provide visual prompt as well as a numeric score of illness severity.</li> </ul>
	<ul style="list-style-type: none"> <li>• Take a full set of observations on admission – pulse rate, respiratory rate, systolic blood pressure, level of consciousness, oxygen saturation and temperature</li> </ul>
	<ul style="list-style-type: none"> <li>• Calculate and record early warning score</li> </ul>
	<ul style="list-style-type: none"> <li>• Specify the physiological observations to be recorded and how often taking into account diagnosis, comorbidities and agreed treatment plan</li> </ul>
	<ul style="list-style-type: none"> <li>• Monitor physiological observations according to the plan specified but usually at least every 12 hours</li> </ul>
<ul style="list-style-type: none"> <li>• Use the score to track the patient’s condition and to trigger a response</li> </ul>	<ul style="list-style-type: none"> <li>• Agree when scores should trigger a response e.g. extreme variation in an individual parameter or an aggregate score</li> </ul>
	<ul style="list-style-type: none"> <li>• Record when patient’s condition requires variation in score and trigger thus avoiding unnecessary response</li> </ul>
	<ul style="list-style-type: none"> <li>• Engage with patients and families to recognise when the symptoms of their condition changes and when they need to initiate action</li> </ul>
<ul style="list-style-type: none"> <li>• Use reliably the agreed activation system when patient is at heightened risk</li> </ul>	<ul style="list-style-type: none"> <li>• Take action to trigger the required response.</li> </ul>
	<ul style="list-style-type: none"> <li>• Record in the chart when response required is activated</li> </ul>
	<ul style="list-style-type: none"> <li>• Consider equipment, and it’s reliability e.g. mobile phone reception, needed to activate a response</li> </ul>
	<ul style="list-style-type: none"> <li>• Engage with patients and families about how to initiate action when deterioration is detected in their condition</li> </ul>
	<ul style="list-style-type: none"> <li>• Communicate to appropriate clinical staff in the team and consider visible means (e.g. patient status at a glance white boards) as a way of communicating acuity of patients</li> </ul>
<ul style="list-style-type: none"> <li>• Use SBAR or other standard communication tool when calling for a response</li> </ul>	<ul style="list-style-type: none"> <li>• Agree standard communication tool within the organisation</li> </ul>
	<ul style="list-style-type: none"> <li>• Incorporate SBAR into any appropriate training</li> </ul>
	<ul style="list-style-type: none"> <li>• Consider SBAR visual reminders e.g. stickers on phones</li> </ul>
<ul style="list-style-type: none"> <li>• Use safety briefings to communicate information on high risk patients</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporate into the beginning of the shift handover process</li> </ul>
	<ul style="list-style-type: none"> <li>• Consider using SBAR format for safety briefings</li> </ul>

Secondary Drivers	Key change concepts and change ideas for PDSA testing
<ul style="list-style-type: none"> <li>• <b>Use a response system appropriate to your context that includes speed/urgency of response (less than 30 minutes) and who responds so that an appropriate response occurs 24/7</b></li> </ul>	<ul style="list-style-type: none"> <li>• Develop a graded response system (adaptable to patient condition, comorbidities and situation) organised round graded scores and triggers</li> </ul>
	<ul style="list-style-type: none"> <li>• Respond with the required speed/urgency based on the level of trigger</li> </ul>
	<ul style="list-style-type: none"> <li>• Have personnel with the competences to respond to the level of trigger</li> </ul>
	<ul style="list-style-type: none"> <li>• Response mechanisms agreed to ensure 24/7 cover</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Escalate according to the agreed response system and take into account other care plans (e.g. do not resuscitate orders, advance directives, end of life care plans)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Take appropriate action to escalate in line with the graded response system</li> </ul>
	<ul style="list-style-type: none"> <li>• Communicate any care plans e.g. do not resuscitate orders, advance directives, end of life care plans, to avoid inappropriate responses being taken</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Decide frequency of ongoing monitoring and suitable care environment</b></li> </ul>	<ul style="list-style-type: none"> <li>• Decide appropriate care setting for patient based of clinical condition</li> </ul>
	<ul style="list-style-type: none"> <li>• Agree process for transferring patient to a changed care environment</li> </ul>
	<ul style="list-style-type: none"> <li>• Include early warning score in handover to any changed care environment</li> </ul>
	<ul style="list-style-type: none"> <li>• Record frequency of monitoring required in the chart</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Ensure competence of the staff taking the observations and responding to the patient's condition as part of the response system</b></li> </ul>	<ul style="list-style-type: none"> <li>• Agree competences required to take observations and assess staff</li> </ul>
	<ul style="list-style-type: none"> <li>• Agree competences and develop multidisciplinary training in recognition and response to deterioration and assess staff</li> </ul>
	<ul style="list-style-type: none"> <li>• Ensure staff required to respond have the competences required to deliver the required response</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Regularly reflect on incidents of deterioration and the causes with the goal of always moving towards prevention and improvement on a wider scale</b></li> </ul>	<ul style="list-style-type: none"> <li>• Organise regular and frequent multidisciplinary reviews of circumstances surrounding patient deterioration – outcomes can inform future PDSA cycles for improvement</li> </ul>
	<ul style="list-style-type: none"> <li>• Use process compliance data to demonstrate where systems failure exists</li> </ul>