



## Patient Safety Alert

*Resources to support safer care of the deteriorating patient (adults and children)*

12 July 2016

Alert reference number: NHS/PSA/RE/2016/005

Alert stage: Two - Resources

Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely or effective manner. This is a clinical issue contributing to death and severe harm.

Research has shown that 26% of preventable deaths were related to failures in clinical monitoring. These included failure to set up systems, failure to respond to deterioration and failure to act on test results (Hogan et al, 2012).<sup>1</sup> In 2015 around 7% of patient safety incidents reported to the National Reporting and Learning System (NRLS) as death or severe harm were related to a failure to recognise or act on deterioration.

Many acute hospitals have developed programmes to improve the recognition and response to deterioration. These have included Early Warning Scores (EWS), initiatives and technology for improving the accuracy of taking and recording observations, and the timely escalation of care. However, it is those organisations and teams that have placed the EWS within a **whole safe system of care** that are producing better outcomes for patients.

This resource alert is supported by the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Physicians (RCP). We have brought together a range of resources to help NHS organisations to take a whole system approach to reducing the harm caused by a failure to recognise and respond to patients of all ages at risk of deterioration. This includes working with patients and families; providing education and training; open and consistent reporting and learning; and improving patient safety culture.

Our resource collection for the **adult deteriorating patient** <http://improvement.nhs.uk/resources/detection-and-management-deterioration-adult-patients> includes analyses of NRLS data and learning from Serious Incident investigations, and signposts a range of resources, toolkits and eLearning from organisations including the RCP. These resources support the timely recognition and initiation of treatments for the deteriorating patient, including patients deteriorating through sepsis.

Building on ReACT (The Respond to Ailing Children Tool),<sup>2</sup> NHS Improvement has been working with the RCPCH to support clinicians, teams and organisations to capture the core components required for a **Paediatric Early Warning System**. The interactive document 'A safe system framework for recognising and responding to children at risk of deterioration' [www.rcpch.ac.uk/safer-system-children-risk-deterioration](http://www.rcpch.ac.uk/safer-system-children-risk-deterioration) lists the needs and responsibilities within the system for families, clinical teams and organisations, and includes a wide range of resources developed and tested in practice.

## Actions

**Who:** All organisations\* providing NHS-funded care

**When:** To begin as soon as possible and to be completed by 31 January 2017

- 1** Identify a senior clinical leader in the organisation to take forward the response to this alert.
- 2** Using these resources, assess whether any areas of your organisation's overall system of recognising and responding to the deteriorating adult and child can be strengthened.
- 3** If the assessment identifies any areas that require improvement, develop and begin delivery of an action plan.
- 4** Make sure staff in your organisation are aware of any of these resources that are relevant to their roles and responsibilities.

**See page 2 for technical notes and links to the resources**

\*The majority of these resources are for acute care providers, however some resources are relevant and valuable in all settings, including primary, community and mental health care.

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## Technical notes

### Patient safety incident reporting

See 'The adult patient who is deteriorating: sharing learning from literature, incident reports and root cause analysis investigations', within the adult resource set for details of NRLS and Serious Incident review [improvement.nhs.uk/resources/shared-learning-and-resources-prevent-deterioration-adult-patients](http://improvement.nhs.uk/resources/shared-learning-and-resources-prevent-deterioration-adult-patients)

### Resources

- Resources for the detection and management of the **adult patient** who is deteriorating [improvement.nhs.uk/resources/detection-and-management-deterioration-adult-patients](http://improvement.nhs.uk/resources/detection-and-management-deterioration-adult-patients)
- A safe system framework for recognising and responding to **children** at risk of deterioration [www.rcpch.ac.uk/safer-system-children-risk-deterioration](http://www.rcpch.ac.uk/safer-system-children-risk-deterioration)

### References

1. Hogan H et al. Preventable deaths due to problems in English acute hospitals: a retrospective case record review study. BMJ Quality & Safety 2012; 21:737-45 <http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159.full>
2. ReACT (The Respond to Ailing Children Tool) [www.england.nhs.uk/patientsafety/re-act/](http://www.england.nhs.uk/patientsafety/re-act/)

### Stakeholder engagement

- The Royal College of Physicians Patient Safety Committee
- Medical Specialties Patient Safety Expert Group
- Infant Children and Young People's Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see [www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/](http://www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/)