

# Why don't nurses call for help: results of a systematic review.

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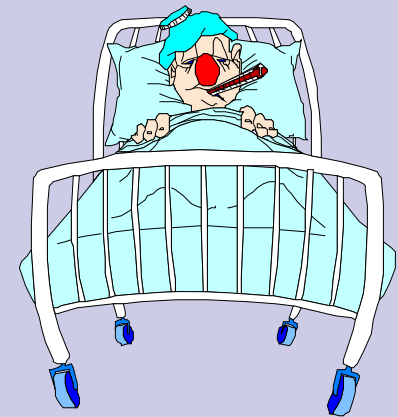


# Aims of the session

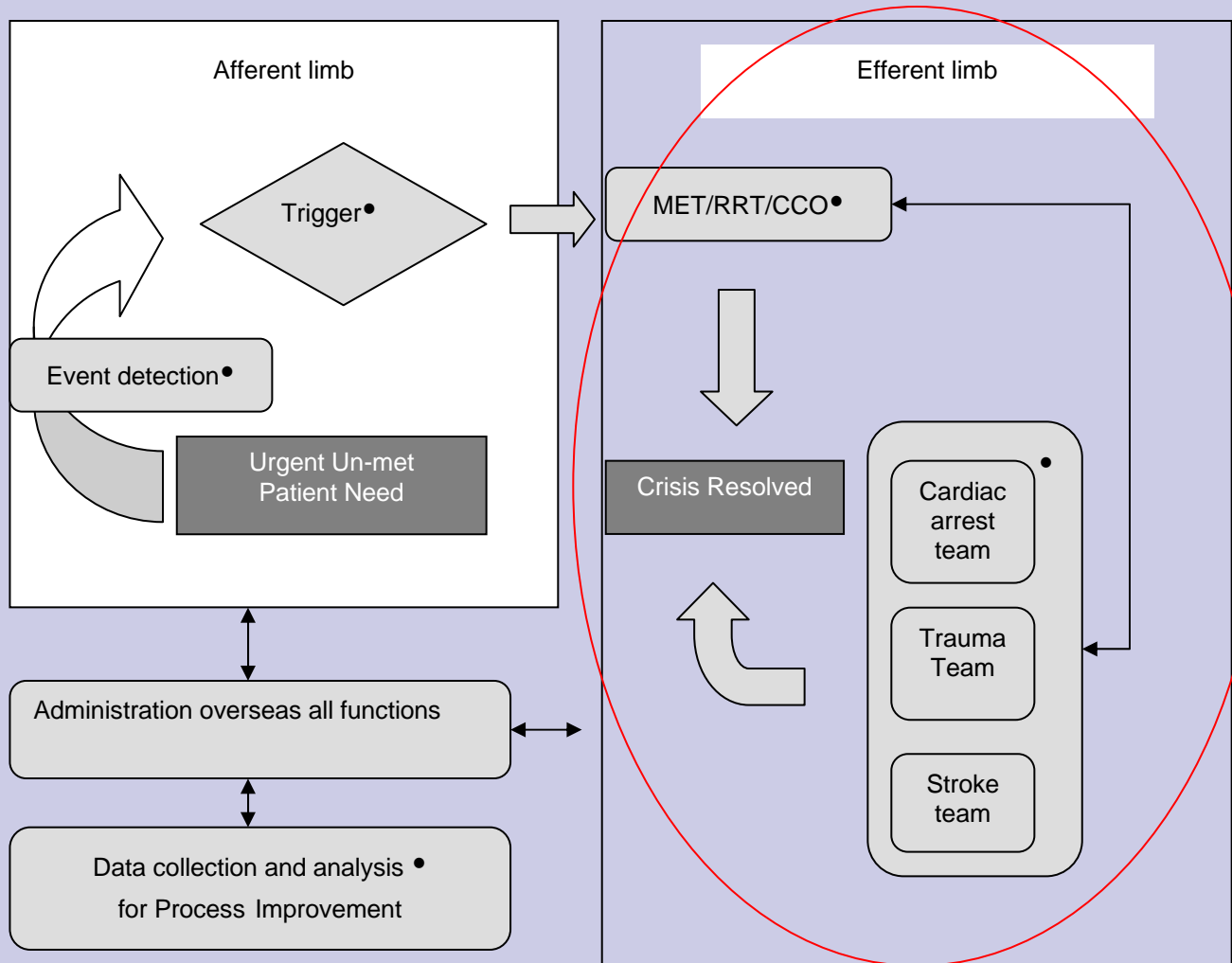
- To briefly describe a systematic literature review that looked at how nurses observe ward patients to detect deterioration
- To discuss some of the findings of the review
- Suggest how we might improve practice

# Background to the review

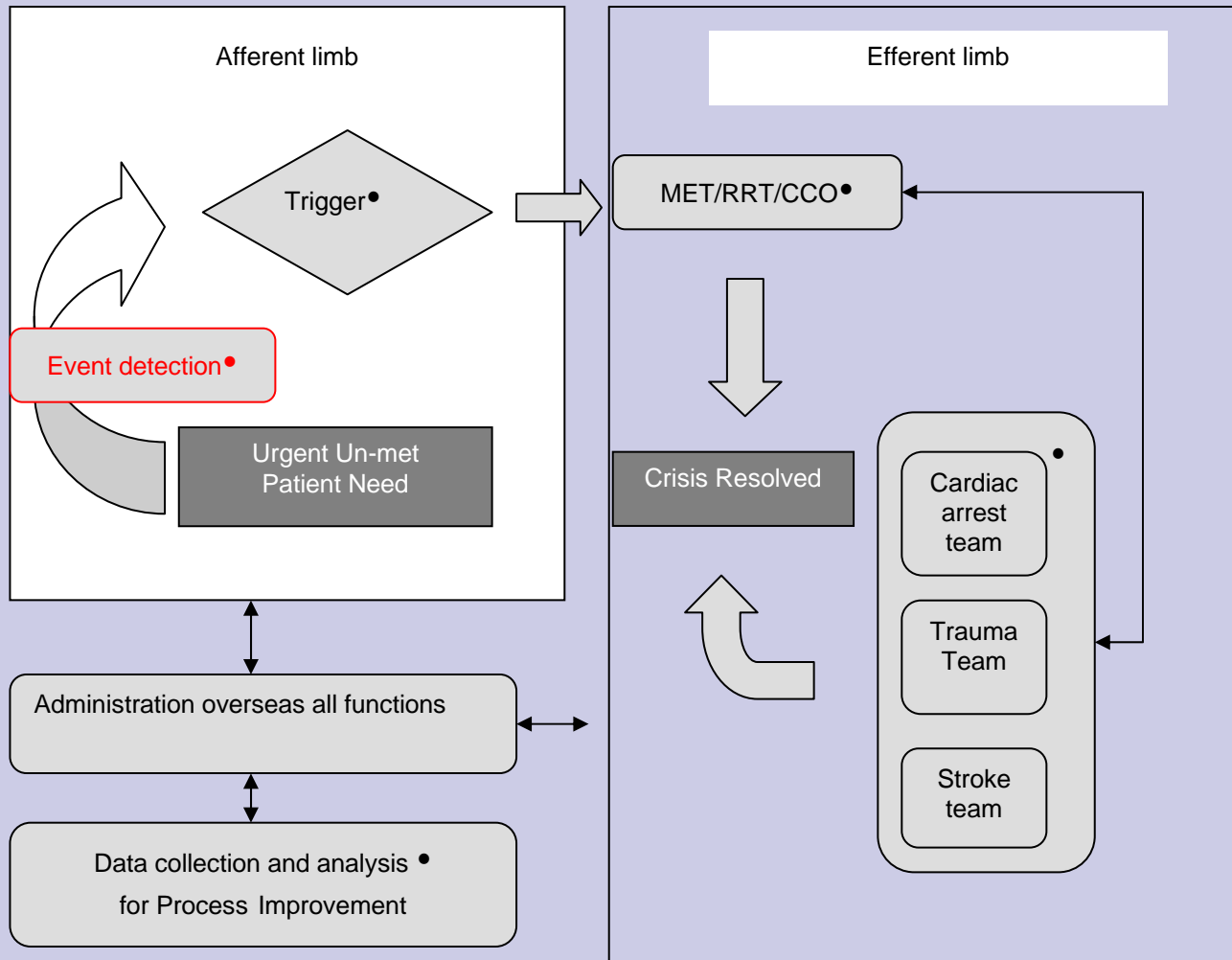
- Concerns that deterioration of ward patients was not being recognised or acted upon.
- Implementation of Rapid Response Systems have not solved the problem.  
(NCEPOD 2005; NPSA 2007)
- Personal experience: why don't nurses recognise the acutely unwell patient, or follow rescue protocols?



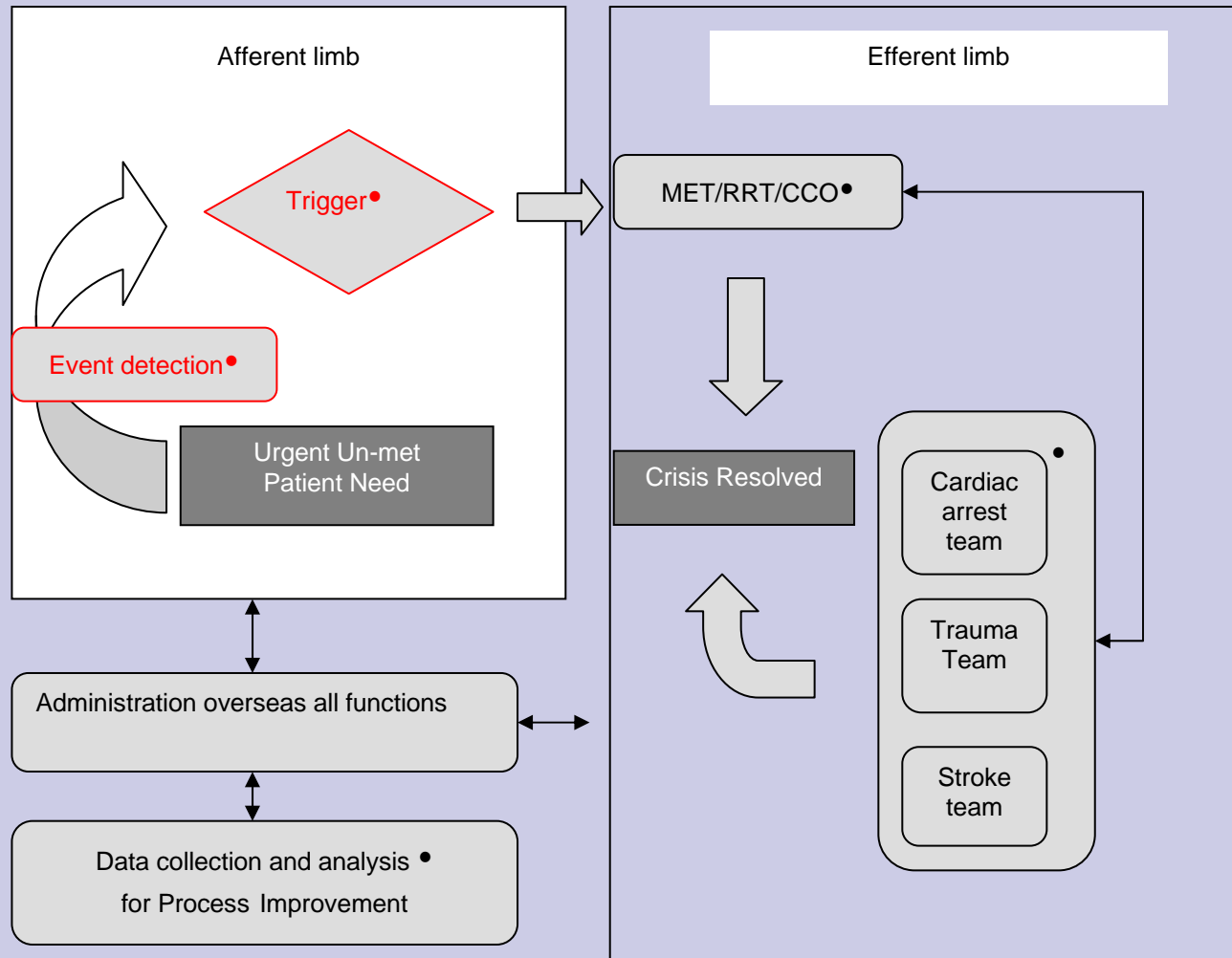
# Rapid Response Team Structure (DeVita et al, 2006)



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# Aims of the literature review

- To investigate, describe and critically evaluate the current state of knowledge around the nursing practice of observations to detect deterioration in the ward patient.

## Method

- Four sources
  - Electronic data bases (8)
  - Reference lists
  - Key reports
  - Experts in the field
- Inclusion criteria
  - All research designs and languages
  - From 1990 to April 2007
  - General ward areas

## Results

- Total of 740 citations
- 16 selected for full review
- 14 included in final narrative





# Systematic literature review: Research studies' findings

## 1. **Recognition of the at-risk or deteriorating ward patient**

- Intuition
- Physiological changes
- The patient and their family

## 2. **Patient assessment**

- Assessment process
- The role of the nurse
- Recording vital signs
- Equipment

## 3. **Reporting deterioration**

- The decision about calling
- Early warning score
- Communication and language

## 4. **Managing deterioration**

- Initiating treatment
- Making treatment decisions

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# Recognition of the at-risk or deteriorating ward patient

1. Intuition

Knowing the patient

Pattern recognition

2. Physiological changes

'Coming across the patient'

Further assessment

3. The patient and their family

# Recognising deterioration and calling for help

Unskilled

Skilled

Feeling concerned and anxious

- Unsure what to do
- Concern with 'looking stupid'
- Check with other nurses

Checking vital signs

- Unsure what to do if observations are 'normal'
- May wait for obs to deteriorate before calling for help

Conduct advanced assessment

- Describe physiological findings that are both objective and subjective

# Problems with reporting: Fears

- Nurses are **nervous** and **anxious**, and feel **uncertain about calling** and wondered if they were **doing the right thing** (Cioffi 2000b)
- **Fears** about what would be expected of the nurses once the medical team arrived (Cioffi 2000b)
- **Concern about looking stupid** (Cioffi 2000b, Andrews and Waterman 2005)

# Problems with reporting: Nurse/doctor interface

- Nurse/doctor interface a **source of conflict** (Cutler 2002)
- Getting action from doctors was a **concern for nurses** (Cutler 2002, Cox et al 2006)
- Doctors often **failed to review patients** in a timely way (Cutler 2002)
- Nurses have to be **persuasive with doctors** to get them to review the patient (Minick and Harvey 2003, Andrews and Waterman 2005)
- **Persistence and risk taking** were associated with early recognition of patient problems (Minick and Harvey 2003)

# Problems with reporting: Communication

- Nurses find it **difficult to articulate** subtle changes in the patient's condition (Minick and Harvey 2003, Andrews and Waterman 2005)
- Nurses felt **unable to say** what was wrong (Cioffi 2000b)
- Nurses were conscious that they had to use **medical language** that included **quantifiable evidence** of the patient's deterioration to **get the doctors attention** (Andrews and Waterman 2005)

# Suggestions to improve detection of the deteriorating patient in the future

- Properly resource wards to deliver skilled assessment of patients by experienced and trained staff
- Value intuition, but teach analytical skills that include both subjective and objective data
- Concentrate on improving the inter professional communication process (the use of SBAR)
- Supply front line staff with tools that support clinical decision making (electronic data capture)
- Involve and empower patients and their families in the process





# In summary...

Detecting the deteriorating patient and calling for appropriate help is a highly complex process.

It not only requires skill and training, it also calls for wisdom, confidence and bravery.



# Thank you

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