NSQHS Standard 9 Clinical Deterioration

How to use the audit tools

Recognising and Responding to Clinical Deterioration in Acute Health Care Audit Tools Instructions

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, have developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting the National Safety and Quality Health Service (NSQHS) standards.

Purpose of the audit tools

The tools provide facilities and health services additional supporting resources to use in conjunction with the existing NSQHS standards workbooks and guides to be able to:

- Demonstrate detailed evidence for an action by providing specific verification rather than noting the action has been met and listing the source i.e. self-assessment
- Collect information and evidence to a further level of detail at a patient, ward and facility level, delving down into specific requirements that further support meeting the action
    - Collect patient level data using a number of methods i.e. chart documentation, observational and asking the patient/carer questions to demonstrate that the evidence has been met, and to what extent
    - Observe ward/unit staff undertaking a process eg clinical handover and recording individual results
- Determine actual performance results at a ward and facility level by rolling up data i.e. auditing all patients in a ward for a ward result, auditing all wards for a facility result
- Clearly identify those detailed gaps/areas that need attention, in order to target improvements and build a robust action plan at the ward and facility level
- Track and monitor audit results at the three levels over time

The tools can be used in conjunction with other resources and directly align to the criteria in the existing NSQHS standards workbooks and guides. Depending on the size of the facility a number of audit questions may not be applicable, it is up to each facility / health service to determine the audit questions for review. Questions and responses can be adapted to suit the requirements of each facility / health service.

The suite of documents include the following:

1. A ‘how to’ guide on using the tools (this document)
2. A definitions guide to assist in completing the tools
3. Three specific audit tools that allow the collection and collation of information are provided that can be adapted for local use:
    - *Patient audit tool*: collects patient level data (at a ward/unit level), use one audit tool for each patient audited
    - *Ward/Unit audit tool*: collects ward/unit level data and collates the patient level responses
    - *Facility audit tool*: collects facility level data and collates the ward/unit level responses
4. A measurement plan summary for each standard that defines the goals, questions and responses in the audit tools. The plan details each audit question and its alignment to the action/criteria in the standard and can be adapted for local use. Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Scope of the Clinical Deterioration Audit tools

The audit tools at this stage incorporate audit questions on recognition and response systems, observation charts (includes QADDS and CEWT), escalation of care and Advance Health Directive.

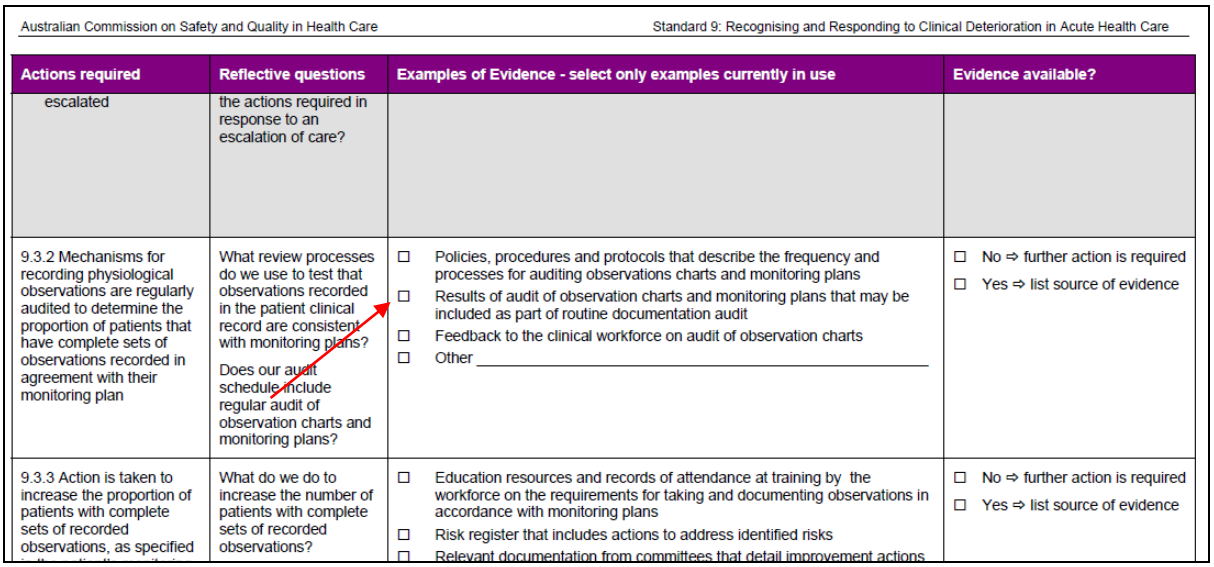
The indicators and questions in the audit tools align to the Queensland Bedside Audit (QBA), Productive Series and other statewide audits wherever possible.

How the tools were developed

An example is provided below using action 9.3.2 in Standard 9

1. The NSQHS standards workbooks and guides were used i.e.:
    a. Hospital Accreditation Workbook - In particular the 'Examples of Evidence' for each action required. (October 2012)
    http://www.safetyandquality.gov.au/publications/hospital-accreditation-workbook/

Example:
Hospital Accreditation Workbook – Standard 9 Action 9.3.2(October 2012)



Australian Commission on Safety and Quality in Health Care — Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care

Actions required	Reflective questions	Examples of Evidence - select only examples currently in use	Evidence available?
escalated	the actions required in response to an escalation of care?		
9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	What review processes do we use to test that observations recorded in the patient clinical record are consistent with monitoring plans? Does our audit schedule include regular audit of observation charts and monitoring plans?	☐ Policies, procedures and protocols that describe the frequency and processes for auditing observations charts and monitoring plans ☐ Results of audit of observation charts and monitoring plans that may be included as part of routine documentation audit ☐ Feedback to the clinical workforce on audit of observation charts ☐ Other _____	☐ No ⇨ further action is required ☐ Yes ⇨ list source of evidence
9.3.3 Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified	What do we do to increase the number of patients with complete sets of recorded observations?	☐ Education resources and records of attendance at training by the workforce on the requirements for taking and documenting observations in accordance with monitoring plans ☐ Risk register that includes actions to address identified risks ☐ Relevant documentation from committees that detail improvement actions	☐ No ⇨ further action is required ☐ Yes ⇨ list source of evidence

Example of Evidence for 9.3.2 Results of audit of observation charts and monitoring plans that may be included as part of routine documentation audit'

    a. Safety and Quality Improvement Guides (one per standard) – in particular under each action and key task there are 'Outputs' suggested. In addition, the suggested strategies may assist the facility in providing options for how an action can be improved.
    (October 2012)
    http://www.safetyandquality.gov.au/publications/safety-and-quality-improvement-guide-standard-9-recognising-and-responding-to-clinical-deterioration-in-acute-health-care-october-2012/

Example:
Safety and Quality Improvement Guide - Standard 9 Action 9.3.2 (October 2012)

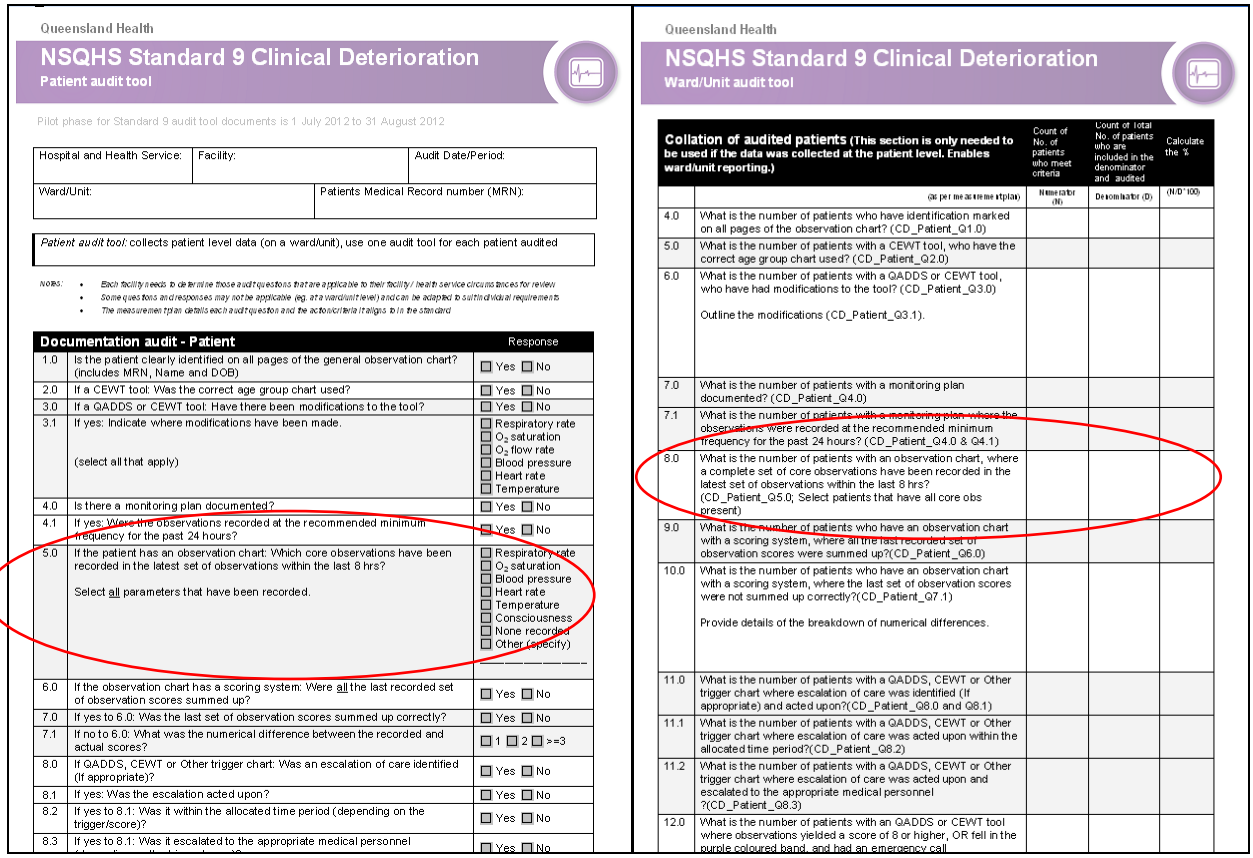
Actions required	Implementation strategies
9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	**Key task:** • **Conduct regular audits of completed observation charts to evaluate compliance with policy and/or the monitoring plan** **Suggested strategies:** Audits should occur as part of the health service organisation's audit program or through quality improvement activities in individual clinical areas. Continuous audits of observation charts are not required. Intermittent audits of a sample of observation charts allow 'snapshots' of compliance which can be tracked over time. A standardised audit tool should be used throughout the organisation so that data can be collated centrally. Two types of audit are useful. Observational audit can provide information about clinicians' practices regarding the techniques of physiological observation measurement. Documentation audit measures compliance with policy regarding minimum frequency (number of times per day) and duration (number of days or weeks) of core physiological observations. Audits should be based on the area's observation policy or policies, and should evaluate whether: • core physiological observations are being measured accurately • they are measured according to the minimum frequency and duration specified in the monitoring plan. **Outputs of improvement processes may include:** • policies, procedures and protocols regarding audits of observation charts • evaluation plans and audit schedules that describe the frequency and processes for auditing observation charts • reports on the evaluation of observation chart audit results. **Further reading and resources:** See Appendix C for a summary of data collection and audit requirements. Relevant sections of the *Guide to Support Implementation of the National Consensus Statement*:

An output for 9.3.2 'Reports on observation chart audit results'

2. The questions in the audit tools (patient, ward, facility) assess and ask for verification of the examples of evidence and outputs to collect the detailed information necessary to meet that evidence. In addition, other examples of evidence may be used. The questions may directly ask if there is evidence to support, or may be broken down into a series of questions to delve deeper into whether the evidence has been met. In addition, questions may require the auditing of patients in order to demonstrate that the evidence has been met, and to what extent.

   Questions and responses have been developed in consultation with content area experts.

Example: Audit tool questions for Standard 9 Action 9.3.2



Queensland Health

NSQHS Standard 9 Clinical Deterioration

Patient audit tool

Pilot phase for Standard 9 audit tool documents is 1 July 2012 to 31 August 2012

Hospital and Health Service:	Facility:	Audit Date/Period:
Ward/Unit:	Patients Medical Record number (MRN):	

Patient audit tool: collects patient level data (on a ward/unit), use one audit tool for each patient audited

NOTES:
- Each facility needs to determine those audit questions that are applicable to their facility / health service circumstances for review.
- Some questions and responses may not be applicable (eg, at a ward/unit level) and can be adapted to suit individual requirements.
- The measurement plan details each audit question and the action/criteria it aligns to in the standard.

Documentation audit - Patient		Response
1.0	Is the patient clearly identified on all pages of the general observation chart? (includes MRN, Name and DOB)	☐ Yes ☐ No
2.0	If a CEWT tool: Was the correct age group chart used?	☐ Yes ☐ No
3.0	If a QADDS or CEWT tool: Have there been modifications to the tool?	☐ Yes ☐ No
3.1	If yes: Indicate where modifications have been made. (select all that apply)	☐ Respiratory rate ☐ O_2 saturation ☐ O_2 flow rate ☐ Blood pressure ☐ Heart rate ☐ Temperature
4.0	Is there a monitoring plan documented?	☐ Yes ☐ No
4.1	If yes: Were the observations recorded at the recommended minimum frequency for the past 24 hours?	☐ Yes ☐ No
5.0	If the patient has an observation chart: Which core observations have been recorded in the latest set of observations within the last 8 hrs? Select all parameters that have been recorded.	☐ Respiratory rate ☐ O_2 saturation ☐ Blood pressure ☐ Heart rate ☐ Temperature ☐ Consciousness ☐ None recorded ☐ Other (specify) _____
6.0	If the observation chart has a scoring system: Were all the last recorded set of observation scores summed up?	☐ Yes ☐ No
7.0	If yes to 6.0: Was the last set of observation scores summed up correctly?	☐ Yes ☐ No
7.1	If no to 6.0: What was the numerical difference between the recorded and actual scores?	☐ 1 ☐ 2 ☐ >=3
8.0	If QADDS, CEWT or Other trigger chart: Was an escalation of care identified (if appropriate)?	☐ Yes ☐ No
8.1	If yes: Was the escalation acted upon?	☐ Yes ☐ No
8.2	If yes to 8.1: Was it within the allocated time period (depending on the trigger/score)?	☐ Yes ☐ No
8.3	If yes to 8.1: Was it escalated to the appropriate medical personnel	☐ Yes ☐ No

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Ward/Unit audit tool

	Collation of audited patients (This section is only needed to be used if the data was collected at the patient level. Enables ward/unit reporting.) (as per measurement plan)	Count of No. of patients who meet criteria Numerator (N)	Count of Total No. of patients who are included in the denominator and audited Denominator (D)	Calculate the % (N/D*100)
4.0	What is the number of patients who have identification marked on all pages of the observation chart? (CD_Patient_Q1.0)			
5.0	What is the number of patients with a CEWT tool, who have the correct age group chart used? (CD_Patient_Q2.0)			
6.0	What is the number of patients with a QADDS or CEWT tool, who have had modifications to the tool? (CD_Patient_Q3.0) Outline the modifications (CD_Patient_Q3.1).			
7.0	What is the number of patients with a monitoring plan documented? (CD_Patient_Q4.0)			
7.1	What is the number of patients with a monitoring plan where the observations were recorded at the recommended minimum frequency for the past 24 hours? (CD_Patient_Q4.0 & Q4.1)			
8.0	What is the number of patients with an observation chart, where a complete set of core observations have been recorded in the latest set of observations within the last 8 hrs? (CD_Patient_Q5.0; Select patients that have all core obs present)			
9.0	What is the number of patients who have an observation chart with a scoring system, where all the last recorded set of observation scores were summed up?(CD_Patient_Q6.0)			
10.0	What is the number of patients who have an observation chart with a scoring system, where the last set of observation scores were not summed up correctly?(CD_Patient_Q7.1) Provide details of the breakdown of numerical differences.			
11.0	What is the number of patients with a QADDS, CEWT or Other trigger chart where escalation of care was identified (if appropriate) and acted upon?(CD_Patient_Q8.0 and Q8.1)			
11.1	What is the number of patients with a QADDS, CEWT or Other trigger chart where escalation of care was acted upon within the allocated time period?(CD_Patient_Q8.2)			
11.2	What is the number of patients with a QADDS, CEWT or Other trigger chart where escalation of care was acted upon and escalated to the appropriate medical personnel ?(CD_Patient_Q8.3)			
12.0	What is the number of patients with an QADDS or CEWT tool where observations yielded a score of 8 or higher, OR fell in the purple coloured band, and had an emergency call			

The patient audit tool allows you to collect the specific question/s that can be used for 9.3.2 in auditing patient identification bands.

The ward/unit audit tool allows you to collate all the patient results for a ward/unit level view.

In addition to the collection of information, the ward/unit and facility tools include the ability to be able to collate data i.e.: collate the data collected at a patient level for a ward/unit view, collate the data collected at a ward/unit level for a facility view. Where this is the case, the collation questions refer to where the information can be found eg. CD_Patient_Q8.0 refers to Q8.0 in the Patient audit tool where the responses to collate the data will be found.

The last three columns in the collation sections i.e.: Num/Den/% allows for the calculation of the % result at a ward/unit and facility level (for reporting). Details of these can be found in the measurement plan. Future plans for the electronic capture of information will allow the collation of data to be automatic.

3. The measurement plan details the criteria / action and those question/s / responses that correspond to the action.

   Note : Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Example: Measurement plan for Standard 9 Action 9.3.2

Actions required | **Audit tool to find the question/s** | **Indicator name** | **The question/s that will be on the facility, ward or patient tool** | **The responses that will be on the tool** | **The numerator and denominator to assist in the collation and calculation of questions (ward and facility tool)**

Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator
9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	Patient	Identify patients in the ward/unit who have a monitoring plan where the observations were recorded at the recommended frequency	% of patients who have a monitoring plan where the observations were recorded at the recommended frequency	4.0 Is there a monitoring plan documented? 4.1 If yes: Were the observations recorded at the recommended minimum frequency for the past 24 hours?	Yes; No Yes; No		
	Ward			7.0 What is the number of patients with a monitoring plan documented? (CD_Patient_Q4.0) 7.1 What is the number of patients with a monitoring plan where the observations were recorded at the recommended minimum frequency for the past 24 hours? (CD_Patient_Q4.0 & Q4.1)		Number of patients who have a monitoring plan where the observations were recorded at the recommended frequency	Total number of patients audited
	Patient	Identify patients in the ward/unit who had an Observation Chart where a complete set of core observations is recorded in the latest set of observations within the last 8 hrs	% of patients who had an Observation Chart where a complete set of core observations is recorded in the latest set of observations within the last 8 hrs	5.0 If the patient has an observation chart: Which core observations have been recorded in the latest set of observations within the last 8 hrs? Select all parameters that have been recorded.	Respiratory rate; O2 saturation; Blood pressure; Heart rate; Temperature; Consciousness; None recorded; Other (specify);		
	Ward			8.0 What is the number of patients with an observation chart, where a complete set of core observations have been recorded in the latest set of observations within the last 8 hrs? (CD_Patient_Q5.0; Select patients that have all core obs present)		Number of patients who had a complete set of core observations is recorded in the latest set of observations within the last 8 hrs	Total number of patients audited with an observation chart
	Patient	Identify patients in the ward/unit who had an observation chart with a scoring	% of patients who had an observation chart with a scoring system where all the	6.0 If the observation chart has a scoring system, were all the last recorded set of observation scores summed up?	Yes ; No		

In addition, we recognise that each facility will define when the audit will take place, how often, how many patients to audit and who will perform the audit.

Queensland Health facilities have the ability to enter their audit data on-line using an existing secure electronic web-based system, Measurement Analysis & Reporting System (MARS), available via the Queensland Health intranet. Please email mars@health.qld.gov.au for further information.

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.