NCEPOD: Time to Intervene?

A review of patients undergoing cardiopulmonary resuscitation as a result of an in-hospital cardiac arrest

Dr Mark Temple
Consultant Physician & Nephrologist

Acute care fellow
Royal College of Physicians
A review of patients undergoing cardiopulmonary resuscitation as a result of an in-hospital cardiac arrest

Failings:
• Quality initial assessment (JD)
• Time to 1st consultant review
• Documentation (38% - time 1st cons review)
• Decision making: CPR status

• Recognition severity of illness
• Deteriorating patients
  – Escalation of care/ ceilings of care
Key: increased consultant delivered care

**report uncertainties**
Relative performance locations/services

Admission area/ Location of arrest
- Med Wd 38% / 27%
- ED 20% / 8%
- Surg Wd 14% / 28%
- CCU 9% / 12%

AMU Performance?

**Objectives**
- Consultants seeing pts earlier
- Consult review consistent 7/7
- Consultant continuity
- AMU Follow up review – 2xWR
- Med (Surg) wards enhanced consultant review by team delivering ongoing care
- Organisation of patient care
- Deteriorating pt/ consultants

Royal College of Physicians
Setting higher standards
## RCP initiatives: consultant delivered care/organisation of care

<table>
<thead>
<tr>
<th>Initiative</th>
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<tr>
<td>Consultant care: AMU</td>
<td>Acute Care toolkit 2 (2011)</td>
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<td>Consultant care: wards</td>
<td>Evaluation consultant working 2011</td>
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<tr>
<td>Deteriorating patient detection / escalation</td>
<td>Acute Care Toolkit 2</td>
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<td>Prompting CPR decisions</td>
<td>NEWS (Launch 7/2012)</td>
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<td>The productive Ward Round</td>
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<td>Mortality Review</td>
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<td>Future Hospital Commission</td>
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Benefits of consultant delivered care. Academy Royal Medical Colleges 2012

- Rapid, appropriate decision making (endorse DNACPR where CPR futile)
- Improved outcomes
- More efficient use of resources
- GP access to fully trained Dr
- Pt expectation of access to appropriately skilled clinician & info
- Benefits to training junior doctors
Benefits of consultant delivered care
Academy Royal Medical Colleges

• Increased Mortality & morbidity delay in consultant involvement in care – range of fields (acute medicine)

• Increased mortality at w//es attributed to decrease consultant input in care

• Studies designed to improve pt care incorporating earlier consultant involvement – improved outcomes
Enhancing consultant delivered care – what progress has been made?

Acute Physicians and the AMU

2004 Acute medical unit – hub for care acutely ill pts
2007 RCP Acute Medicine Task Force report: right person, right setting – first time
– recommendations: operation and staffing
• AIM Consultant presence acute floor (3 per AMU)
• Standards of care
• Benefits: Supervision, handover, communication
  – Patient flow, education, training

• Acute Physicians (AIM) fastest growing specialty 2009/10 – [currently 415]
Concern quality patient care (OOH):
RCP Position statement November 2010

• Hospitals undertaking the admission of acutely ill medical patients should have a consultant physician on site for at least 12 hours per day, seven days a week, at times relating to peak admission periods. The consultant should have no other duties scheduled during this period.

• RCP Survey 2010 “Evaluation of Consultant Input into Acute Medical Admissions” average cover gap:
  - Weekday 4.4 hrs - requires 35% increase cons hrs
  - Weekend 7.3 hrs - 60% increase consultant hours
RCP Acute Care Toolkit series

- Recommendations
- Best practice
- Practical solutions

- July 2011  Handover

- Oct 2011  High quality acute care
  - 14 principles for high quality care
  - Recommendations: consultant working
Consultant physicians are at the forefront of delivering care to patients presenting to hospital with medical emergencies. Delivering this care depends on competent and expert clinical staff, organised with optimal working arrangements to match patient demand, supported by the right level of resources and facilities. The pressures on acute medical services are relentless and intense. Factors that may compromise timely, high-quality care to patients largely relate to staffing, casemix and the organisation of care (see Box 3).
ACT 2: High quality care for acutely ill patients

AMU (1)

- Consultant on site 12 hours day without conflicting duties
- At least 2 consultant WRs during 12 hrs
- In period AMU staffed by consultant all newly admitted patients should be seen within 6-8 hrs.
- Patients admitted overnight seen within 12 hrs
- The staffing, resources and specialist support services involved in the care of medical emergencies should be organised on the basis of 7 day working
AMU: Support for patterns consultant working:
RCP survey Feb-April 2010: Association pattern of cons cover acute medical admissions & patient outcomes:

- Admitting cons > 4hrs/day, 7/7 lower 28/7 re-admissions rate

- Consultant on call no other fixed commitments lower adjusted case fatality rate

- Consultants conducting ≥2 WRs / day on AMU lower adjusted mortality pts LOS > 7days

- Consultant on call works blocks of >1 day, < 7days lower overall week-end mortality

Clin Med 2011 (11) 1: 17-19
ACT 2: High quality care for acutely ill patients

AMU (2)

• The assessment, documentation and treatment of acute medical illness should be standardised across the NHS.

Clerking/Prescription/Prompts : CPR

• NEWS
Simple things done well : potential huge impact
Key: escalation of clinical response
Reluctance to call consultant
ACT 2: High quality care for acutely ill patients

Medical and surgical wards

Particular risk
• Pts transferring AMU to medical ward
  – Within 48hrs admission (evolving acute illness)
  – Medical outliers on surgical wards

• Moving to different landscape: AMU – med ward (enhanced staff, cons, organisation)
  – Staff unfamiliar with pt and acute care
  – Uncertainties diagnosis / ceilings of care
  – detection & response to clinical deterioration
• Transfer Friday pm – break continuity of care
  – next scheduled cons review 72 hrs+
ACT 2: Pts transferred out of AMU – receive a consultant review within 24 hrs – 7/7

- Enhanced review Consultant of team responsible for continuing care
  - Priority cons duty 1st working hour “Golden Hour”
  - Template cons physician working 7/7 all wards
    - Buddy arrangements: medical teams – surgical wards
    - W/day: reschedule conflicting duties 8.30-10
    - W/end: cons rota for shared bed patch

Facilitates:
- Reliable cons review critical time acute illness
- Confirm: Diagnosis, Rx, discharge, ceilings of care,
- Support ward nurses and covering med staff
Enhanced consultant review – what does it mean in practice? (Heartlands Hospital)

Before: 2 o/c physicians safari ward rounds

Now
• AMU: 8am: 2 Consultants review pts

• All Medical and Surgical Wards:
  8.45am - 6 Consultant Physicians reviewing patients (new and/or sick)
How to change consultant working
The Physicians story - Paul Woodmansey (2011)

• AMU consultant cover 12hrs w/d, 6-8hrs w/e
• W/E Troubleshooting Consultant visits all med wards: sick & quick d/c
• Increase early discharge
• Coincided reduction mortality (all and w/e)
• Major change working life: introduced with relative ease
• Consultant proposed tried & accepted
• Good for pt care
• “Greatest challenge is cons delivered (not led) service required”
• “Pace .. in hospital .. pts need daily senior input”

Clin Med 2011 (11) 1: 17-19
RCP Acute Care Toolkit series

- July 2011  Handover
- Oct 2011  High quality acute care
  - 14 principles for high quality care
- April 2012 Acute medical care for Frail older people.
  - identify pts needing palliative care
  - AMU attendance – advance care planning

- (July 2012) Delivering 12hour 7 day consultant working on the AMU
Quality and safety at the point of care. How long should a ward round take? [The checklist] Caldwell, Worthing (2011)

<table>
<thead>
<tr>
<th>Date</th>
<th>Checker's name</th>
<th>Checker's status</th>
<th>Signed</th>
<th>Clinical team</th>
<th>Type of round</th>
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<td>Caldwell</td>
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<td>Routine/Post-take</td>
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- **pt review** mean 12 min
- 14’ post take/10’ review

- Review more systematic
- **Prompt: CPR decisions**
- Less tests (planned)
- Provides assurance QoC
- Participation pt/MDT
- Aid Teaching (revalid’n)

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<thead>
<tr>
<th>Start time</th>
<th>Finish time</th>
<th>Number of patients</th>
<th>Number of doctors on team</th>
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<td>Patient’s Initial</td>
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<tr>
<td>Discharge team?</td>
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<td>Write IT0’s now?</td>
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<th>Ceiling of care</th>
<th>And CPR status</th>
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<th>Planning</th>
<th>Agree blood tests, radiology, consider need for senior advice or referral</th>
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<tr>
<td>Agree nurse tests</td>
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<tr>
<td>Referral or senior help?</td>
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RCP Future Hospital Commission.
To report March 2013
Place & Process worksteam (Hospital activity)

Core topics:
– Interface with primary care
– The deteriorating patient
– Continuity of care
– Clinical decision making
– Safe patient care
NCEPOD Hospitals – audit CPR attempts and pts who should have had DNACPR

INDIVIDUAL CASE MORTALITY REVIEW

Proforma Completed by: [Name]
(should be the Consultant responsible for the patient’s care at the time of death or named deputy)

| Patient’s name and PID | Consultant’s name | Date of review | Type of review (tick one below):
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<td>Directorate Multidisciplinary Mortality Meeting □</td>
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<td>Directorate Mortality Meeting (Doctors only) □</td>
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<td>Individual Case Note review □</td>
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Presentation and significant events in hospital stay/medical and nursing issues arising

Was need for palliation □ Yes

Directorate Mortality review

- All deaths
- Open discussion peers
- Multi - professional
- Checklist
- Record findings
- Share learning points
- Learning for all!