

Acutely ill patients in hospital

# Implementation advice

2007



This implementation advice accompanies the clinical guideline: 'Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital' (available online at: [www.nice.org.uk/CG050](http://www.nice.org.uk/CG050)).

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**This implementation advice is aimed at the person responsible for implementing NICE guidance in the organisation (NICE manager) and the overarching lead for the topic.**

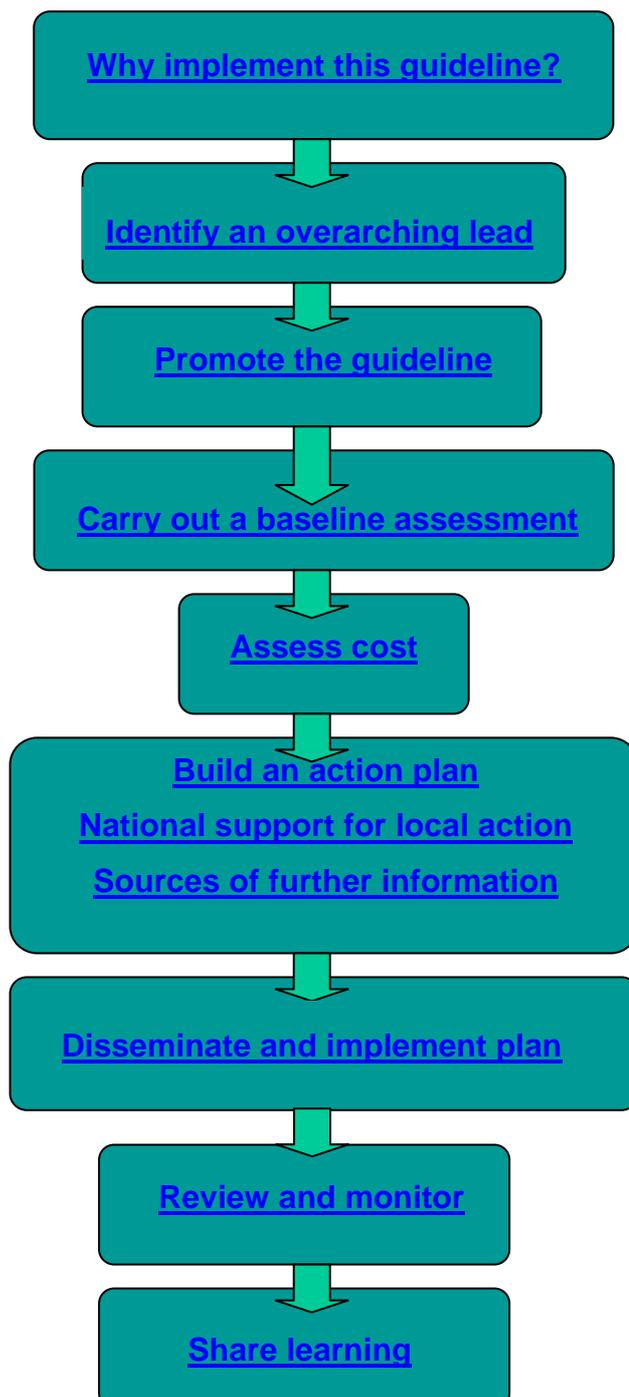
**This is a support tool containing suggested steps towards implementing our guidance informed by your local baseline assessment.**

**It is not NICE guidance.**

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## Steps to implementing NICE clinical guidelines

The algorithm below outlines the process for implementing NICE clinical guidelines. When using this advice online, hold down the 'Ctrl' button and click on the hyperlinks in the boxes to go directly to the advice you need. The advice has been developed in consultation with a range of experts from patient and professional groups. A list of these contributors is available [here](#).



## Why implement this guideline?

Any patient in hospital may become acutely ill. However, the recognition of acute illness is often delayed and its subsequent management may be inappropriate. This may result in late referral and avoidable admissions to critical care, and may lead to unnecessary patient deaths, particularly if the initial standard of care is suboptimal. A level 3 intensive care unit bed costs approximately £1716 per day. Monitoring patients (checking them and their health) regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems. Implementation of this guideline will help improve patient safety.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2005) identified delayed recognition, inappropriate therapy and late referral as prime causes of the substandard care of acutely ill patients in hospital. Poor communication between acute medical and critical care medical teams and a lack of awareness by medical consultants of their patients' deteriorating health and subsequent admission to critical care were identified as aggravating factors. For patients who have been treated in a critical care area, the transfer back to the general wards and the step down from 'one-to-one' to 'one-to-many' nursing care can provoke anxiety. Responding to the psychological and emotional needs of the patient, as well as their physical needs, is critical during this period.

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health'. The implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that nationally agreed guidance should be taken into account when NHS organisations are planning and delivering care.

If the guidance is not relevant to your organisation, remember to record it.

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## Identify an overarching lead

If you are responsible for implementing NICE guidance (NICE manager) you should identify an overarching lead from critical care to support the clinical leads in this area to begin putting the guidance into practice. The overarching lead might be a consultant from critical care or a medical director. Clinical leads who support the overarching lead should include consultants in medical, surgical and critical care settings and nursing staff from:

- general medical and surgical wards
- critical care areas
- emergency departments
- ward-level and high-dependency-unit service providers such as critical care outreach teams, hospital-at-night teams or other locally agreed response teams.

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## **Promote the guideline**

The NICE manager should ensure that all relevant groups are aware of the guidance and have copies of the quick reference guide.

The [slide set](#) provided by NICE should help you raise awareness of the guideline.

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## **Carry out a baseline assessment**

Using the published guidance, the overarching lead should work with the relevant identified clinical leads to compare current activity with the recommendations. This information could be gathered through local discussions or by using a more formal questionnaire. This baseline assessment will help identify exactly what your organisation and others are doing now and what needs to change in light of the guideline.

Consider, for example, how the recommendations will have an impact on:

- local care pathways and existing early warning systems
- appropriate care settings and transfer
- training and competencies of staff
- communication.

The NICE [audit criteria](#) may help you with this process.

### ***Who should be involved?***

Once the baseline assessment has identified what needs to change, the next stage is to identify which groups will need to alter their current way of working and to consider the best way to engage them in the development and implementation of the action plan. These groups are likely to include:

- general medical and surgical ward doctors and nurses
- critical care doctors and nurses
- emergency care staff
- staff from outreach services, hospital-at-night teams or other locally agreed response teams
- patient safety managers
- education and training representatives
- patient representatives.

In most cases there may be existing groups or networks, such as critical care delivery groups that could fulfil this function.

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## **Assess cost**

The NICE manager should work with the overarching lead and the clinical leads to assess how much it will cost to implement the guideline using the [costing template](#) provided by NICE. It might be possible to make some of the required changes using existing resources, and there may be potential for savings to be achieved, or capacity freed up to be used for other things.

Click here to view NICE's [costing report](#).

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## **Build an action plan**

If your organisation is not meeting the recommendations, the NICE manager, the overarching lead, the clinical leads and identified staff should work together to develop an action plan. The details of your action plan will depend on the results of your baseline assessment and your local circumstances.

In consultation with a range of [experts](#) in medicine, surgery and critical care we have identified three key areas to help implementation:

- appropriate care settings and transfer
- training and competencies
- communication.

### ***Suggested actions***

#### **Appropriate care settings and transfer**

All staff should use physiological track and trigger systems to inform their decisions if a patient's condition deteriorates. Appropriate use of a locally agreed graded response system can ensure that patients are managed in the appropriate setting, with only those at most need of critical care being admitted to these areas.

Critical care area discharge planning should aim for a safe and efficient transition from the critical care area to general medical and surgical wards. If possible, patients should not be transferred from critical care areas to the general ward between the hours of 22.00 and 07.00.

- Use the NICE [slide set](#) and the [quick reference guide](#) to raise awareness of guideline recommendations among all staff in the acute setting (including emergency care).
- Use your baseline assessment to ensure that any track and trigger systems used are multi-parameter or aggregated weighted scoring systems.
- Work to determine local thresholds for track and trigger systems to inform the graded response strategy.

- Put in place systems for regular review of local thresholds to optimise sensitivity and specificity.
- Use the care pathway in the NICE quick reference guide to work with local teams to develop and agree a graded response strategy for patients identified as being at risk of clinical deterioration.
- Ensure that the graded response strategy is communicated to all staff at induction, in ongoing professional updates and on mandatory training days.
- Consider establishing links between hospital-at-night teams and other locally agreed response teams, such as critical care outreach teams, to ensure continuous effective and coordinated implementation of the graded response strategy.
- Consider embedding your graded response strategy into local observation charts.
- Ensure that policies and protocols include appropriate transfer timings and that any transfer made between 22.00 and 07.00 is recorded as an adverse incident.
- Consider a regular review process for adverse incidents relating to [discharge timings](#) from critical care to identify avoidable issues and take appropriate action.
- Use the [audit criteria](#) to inform progress against the critical care discharge recommendation.

### **Training and competencies**

The Department of Health is currently developing a competency matrix for staff who care for acutely ill patients in hospital. Education and training of ward staff, and subsequent assessment against any competencies, is of key importance in ensuring that staff can correctly measure the appropriate physiological variables, correctly use the track and trigger system agreed locally, and identify and enact the correct response to a patient at risk of clinical deterioration.

Staff working with acutely ill patients on general wards should also receive education and training that helps them to recognise and understand the

physical, psychological and emotional needs of their patients following discharge from critical care areas.

- Use existing team meetings and network meetings to ensure that the agreed local track and trigger system is communicated to staff and that staff have the necessary [competencies](#) to implement the graded response effectively. Consider developing a training package for the agreed track and trigger system and placing on your local intranet.
- Work with general ward staff and other locally agreed outreach teams (including hospital-at-night teams) to ensure that any difficulties with enacting correct responses to a patient showing clinical deterioration are identified and resolved.
- Review current [education and training](#) programmes for staff working within critical care areas and general medical and surgical wards to reflect the guideline recommendations relevant to providing information to patients, and work with local education and training providers to ensure that future programmes are designed to reflect recommendations.

## **Communication**

Effective communication between staff working in critical care areas and those in the general wards is vital to ensure that staff are able to implement any written care plan and to minimise patient anxiety on transfer from critical care areas to the general ward.

Transfer from the critical care area back to a general ward causes anxiety for many patients. This is exacerbated if staff on the general ward are not made aware of the patient's physical, emotional and psychological state. Effective communication with both patients and their carers/families may alleviate some of this anxiety.

- Consider using a [structured communication programme](#) when transferring a patient if there is identified clinical deterioration.
- Review the processes used locally to support handover of care from critical care to the general wards. This should be formal and accompanied by a

written care plan. The NPSA/BMA document '[Safer Handover](#)' might inform this work.

- Make it clear in handover and documentation who, in both the critical care area and the receiving ward, has responsibility for the patient.
- Consider how any handover of care can incorporate details of a patient's psychological and emotional needs, and review care plans to encourage and document participation of the patient in decisions that relate to their recovery. The [DIPEX](#) website can help you learn from the patient experience.
- Ensure that action initiated from implementation of the graded response strategy is communicated quickly and effectively to relevant staff, patients and their carers/families.

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## National support for local action\* [[Back to 'Build an action plan'](#)]

Over the past 5 years there have been a number of developments in policy on critical and emergency care. These developments have focused on enhancing the quality of critical care by:

- proposing a modernisation programme based on the comprehensive critical care concept
- providing professional development activities
- providing examples of good practice
- developing a minimum data set
- building on information from the 'Confidential Enquiry into Patient Outcome and Death' (NCEPOD).

| Document/organisation  | Relevance  |
|--|--|
| <a href="#">Clinical indicators for critical care outreach services</a><br>Critical Care Stakeholders Forum and National Outreach Forum, with support from the Department of Health 2007 | <ul style="list-style-type: none"> <li>• Describes the role of critical care outreach services in supporting patient care and provides indicators of effectiveness for outreach services.</li> </ul>   |
| <a href="#">Safer care for the acutely ill patient: learning from serious incidents</a><br>National Patient Safety Agency (NPSA) 2007  | <ul style="list-style-type: none"> <li>• A report that outlines and identifies some of the key areas of risk, as well as actions that NHS organisations can take immediately to ensure that acutely ill patients are monitored and managed effectively.</li> </ul>         |
| The <a href="#">critical care minimum data set</a> (CCMDS)<br>Department of Health 2006  | <ul style="list-style-type: none"> <li>• Provides key administrative and clinical data approved for collection by NHS trusts that admit adult patients who require level 2 or 3 critical care.</li> </ul>  |
| <a href="#">An acute problem?</a><br>National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2005  | <ul style="list-style-type: none"> <li>• Presents the key findings and recommendations of the 'Confidential Enquiry into Patient Outcome and Death'.</li> <li>• Links the provision of critical care facilities with the care of severely ill medical patients.</li> </ul> |

[Quality critical care: beyond 'comprehensive critical care': a report by the Critical Care Stakeholder Forum](#)

Department of Health 2005

- Provides examples of good practice in the delivery and organisation of adult critical care services.
- Describes features of a high-quality patient-focused service, with examples of how this can be achieved.

[Acute medicine: making it work for patients. A blueprint for organisation and training](#)

Royal College of Physicians 2004

- Aims to further strengthen the specialty of acute care by setting out new conditions for practice, and assessing how many specialists are and will be needed, how much time should be allocated to patient care and how care can be organised across departments and disciplines.
- Details training requirements at undergraduate and postgraduate level, together with plans to establish a firm teaching base for the future.

[Reducing avoidable deaths in hospital](#)

NHS Institute for Innovation and Improvement

'Hospital at night' initiative

- Has launched a patient safety initiative related to reducing avoidable deaths in hospital.
- Website details the activity currently being undertaken.

[Releasing time to care: the productive ward.](#)

NHS Institute for Innovation and Improvement

- Aims to redefine how medical cover is provided in hospitals during the out-of-hours period.
  - Website highlights the initiatives being undertaken by this team as part of the working time directive and includes a library of good practice.
- 'The Productive ward' is an innovative and practical programme of work that aims to:
- allow for the safe and reliable delivery of care, helping patients to get better more quickly and reducing their length of stay
  - increase the proportion of time that nurses spend providing direct care to patients
  - improve the experience of both staff and patients
  - organise wards so that space works for rather than against staff – saving time and effort.

## Sources of further information\* [[Back to build an action plan](#)]

### Document/organisation

### Relevance

#### Appropriate care settings and transfer [\[back to action plan\]](#)

[Faster access: bed management demand and discharge predictors](#)

Department of Health 2004

- Provides links to and an overview of the functionality of software for bed management demand and discharge predictors.
- Supports the guidance given in the Department of Health's 'Wait for a bed checklist' and the 'Bed management

[Intensive Care National Audit and Research Centre \(ICNARC\)](#)

## **Training and competencies** **[\[back to action plan\]](#)**

[DH competency matrix](#)

Department of Health 2007

[Competency in action – hospital at night and nurse coordinators competences](#)

Healthcareworkforce 2007

The [national education and competence framework for advanced critical care practitioners](#)

Department of Health 2006

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[Adult critical care: specialist pharmacy practice](#)

Department of Health 2005

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[Critical care nursing competencies](#)

London Health Sciences Centre

[Acute care undergraduate teaching \(ACUTE\) initiative](#)

Resuscitation Council (UK) and Intercollegiate Board for Training in Intensive Care Medicine 2005

[ALERT \(acute life-threatening events – recognition and treatment\) course](#)

[www.alert-course.com](http://www.alert-course.com)

toolkit'.

- Provides a dataset that considers bed occupancy rates and records time of transfer from critical care.
  - The dataset may be able to help identify delayed discharges that should be assessed in conjunction with occupancy data.
  - Due to be published in late 2007.
  - This link takes you to the DH homepage
  - Accredited set of nursing competencies – a resource for acute NHS trusts implementing the 'Hospital at night' initiative (see above).
  - Support for using the 'Hospital at night' model in the evenings and weekends, and for trusts starting to implement 'Hospital by day' or 'Hospital 24/7'.
  - Shares progress that has been made within the National Practitioner Programme – Critical Care Project.
  - Details a proposed National Education and Competence Framework.
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- Guidance on good practice, skills and experience relevant to pharmacists who wish to specialise in critical care areas.
  - Supports the new and emerging role of pharmacists in critical care.
- 
- Competencies based on those of the Canadian Association of Critical Care Nurses.
  - Developed by Critical Care London Health Sciences Centre.
  - The ACUTE project used consensus techniques to identify competencies in the care of acutely ill patients, or those who have had a cardiac arrest, that medical students should possess at the point of graduation.
- 
- Includes information on the aims of the ALERT training course and details of centres across the UK.

## Communication

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[Critical Care Patient Liaison Committee](#)  
(CritPaL)

[ICU steps](#)

[DIPEX](#)

[Structured communication tool: SBAR](#)  
National Patient Safety Agency

[SBAR technique for communication: a situational briefing model](#)

Institute for Healthcare Improvement  
[NPSA risk assessment resource pack](#)  
National Patient Safety Agency

[Safe handover: safe patients](#)  
[Guidance on clinical handover for clinicians and managers](#)  
NPSA/BMA 2004

- Remit includes making recommendations on providing information and improving communication with patients and their relatives, friends and carers, as well as the general public, and advising and participating in activities to increase awareness and knowledge of critical care among the general public.
- Support group set up by ex-patients and family members to help those who have had a life-threatening injury or illness to come to terms with their experience and find support and reassurance in the recovery period.
- A website detailing personal experience of patients relating to admission to intensive care and receiving information from doctors.
- SBAR stands for Situation, Background, Assessment and Recommendation. It is a structure to be used when nurses, doctors or any members of the clinical team need to communicate about a patient's condition.
- A downloadable tool to facilitate use of the SBAR technique in practice.
- You will need to register as a user before being able to access the tool; registration is free.
- Includes a handover template and risk assessment guide for use by hospital-at-night teams.
- This document provides guidance to doctors on best practice in handover
- It provides examples of good models of handover that doctors and hospital managers can learn from
- It aims to drive further developments in standardising handover arrangements in UK hospitals

Please note that the Institute is not responsible for the quality or accuracy of any information or advice provided by any other organisation.

## Related NICE guidance [[Back to build an action plan](#)]

| Document   | Relevance  |
|--|--|
| <ul style="list-style-type: none"><li>• <a href="#">Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition.</a> NICE clinical guideline 32 (2006).</li><li>• Prevention of ventilator-associated pneumonia</li></ul> | <ul style="list-style-type: none"><li>• Covers the care of patients with or at risk of malnutrition, whether they are in hospital or at home.</li><li>• Part of the NICE and the National Patient Safety Agency (NPSA) pilot project to produce <a href="#">guidance</a> addressing patient safety in the NHS.</li><li>• Publication expected December 2007.</li></ul> |

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## **Disseminate and implement plan**

Once the action plan and assessment of cost have been approved by the NICE manager the work of implementing the action plan begins. To ensure effective implementation, all relevant clinical leads should sign up to the action plan – for example, via a local area agreement.

The [slide set](#) provided by NICE should help you.

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## **Review and monitor**

Implementation of the guideline should be reviewed and monitored, with results fed back to the relevant trust board.

One way to monitor implementation of the guideline is to audit current practice against the NICE guidance. The guideline is accompanied by [audit criteria](#) to help you with this.

### ***Implementation and uptake of NICE guidance***

The [ERNIE](#) (Evaluation and review of NICE implementation evidence) database is a source of information on the implementation and uptake of NICE guidance.

ERNIE will provide:

- a bank of guidance-specific NICE implementation uptake reports
- references to external literature
- a simple classification system summarising the uptake of NICE guidance.

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## Share learning

Have you got some tips to share with other organisations on implementing NICE clinical or public health guidance? Or would you like to learn from other people's experiences? If so, the Institute's ['shared learning' database](#) can help.

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## Acknowledgements

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