Does the introduction of a new Acute Observation Unit (AOU) chart improve escalation and quality of high dependency care given in a High Risk Maternity Unit?

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1. BACKGROUND AND ABSTRACT

A local snapshot audit of the current early warning chart currently in use when caring for maternity patients who are significantly unwell at PHT was undertaken. This audit demonstrated that the chart was poorly understood and rarely completed correctly. This was identified as a patient safety issue in relation to early identification and escalation of the deteriorating maternity patient.

The chart was not maternity specific. It was based on the nursing ‘early warning system’ (EWS) and Glasgow Coma Scale (GCS) assessment. Locally midwives use Alert, Voice, Pain, Unresponsive (AVPU) scoring and are not familiar with EWS or GCS systems.

It was felt that the service would benefit from a maternity specific chart. Recommendations from confidential enquiries suggest utilising a RAG rating system in keeping with the locally modified Early Obstetric Warning System chart (MEDOWS), which was already embedded in practice.

It was felt that this would improve identification and escalation of the deteriorating maternity patient and increase midwives’ confidence in using the chart and escalating from it.

2. PROJECT AIMS AND OBJECTIVES

To design a new maternity specific AOU chart with a clear and simplified trigger and escalation process.

• To audit it’s use for completion, escalation and timely review.

This change should:

• Improve completion of the chart
• Reflect the ABCDEF approach to assessment
• Improve ‘totally’ of the trigger scores
• Improve identity and escalation of the deteriorating maternity patient
• Clearer audit trail of the identifying, escalating and medical review process when the chart is ‘triggered’
• Include a system for planning investigations/care.

3. ACTIONS TAKEN AND METHODS USED

The methodology used was in line with NHS Improvement’s recommendations of using a Plan, Do Study Act approach to Quality Improvement.

• A local draft was created
• The draft was distributed for comment
• Face to face surveys with staff were carried out to discuss the charts design
• Mind mapping meetings to discuss the charts design
• The chart was adopted and implemented at PHT
• The chart was shared with neighbouring Trusts and within SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) Local Maternity System (LMS)
• The chart was piloted for use in real time (test of change).
• Feedback from pilot study used to update the chart. The chart was subsequently updated.
• The use of the chart was audited.

4. EFFECTIVENESS OF CHART AUDITED

Audit of HDU Chart completion

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5. CONCLUSIONS

• Introduction of the new RAG rated HDU Chart improved completion, recognition of triggers, escalation and timely review of the unwell maternity patient.
• The chart improved documentation and subsequent review/audit of care.
• Multi-professional design ensured that the document addressed the analytical needs of all staff involved in caring for the unwell maternity patient.
• The taskbar improved handover of planned investigations and care (eg Blood tests, removing pressure dressings).
• The chart was poorly countersigned by medical staff, although documentation of these reviews could be identified in the patient’s notes.
• Following training, midwives expressed a preference for using the new chart and it is now embedded in practice.
• The chart is now being shared across the SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) Local Maternity System (LMS) for consideration and use in neighbouring Trusts.

REFERENCES


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