

# Implementation of an Early Warning System

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### Background

- >200,000 in-hospital cardiac arrest each year
- Clinical deterioration is often undetected or ignored
- Early Warning Systems have been shown to identify patients at risk up to 20 hours before a significant event
- Early identification decreases deaths (2.5 – 30%) and transfer to higher levels of care (11 – 46%)

### Purpose Statement

- Develop a plan and implement an Early Warning System on medical/surgical units
- Assess effectiveness:
  - Mortality rate
  - Cardiac arrests
  - Transfers to higher levels of care

#### Methods

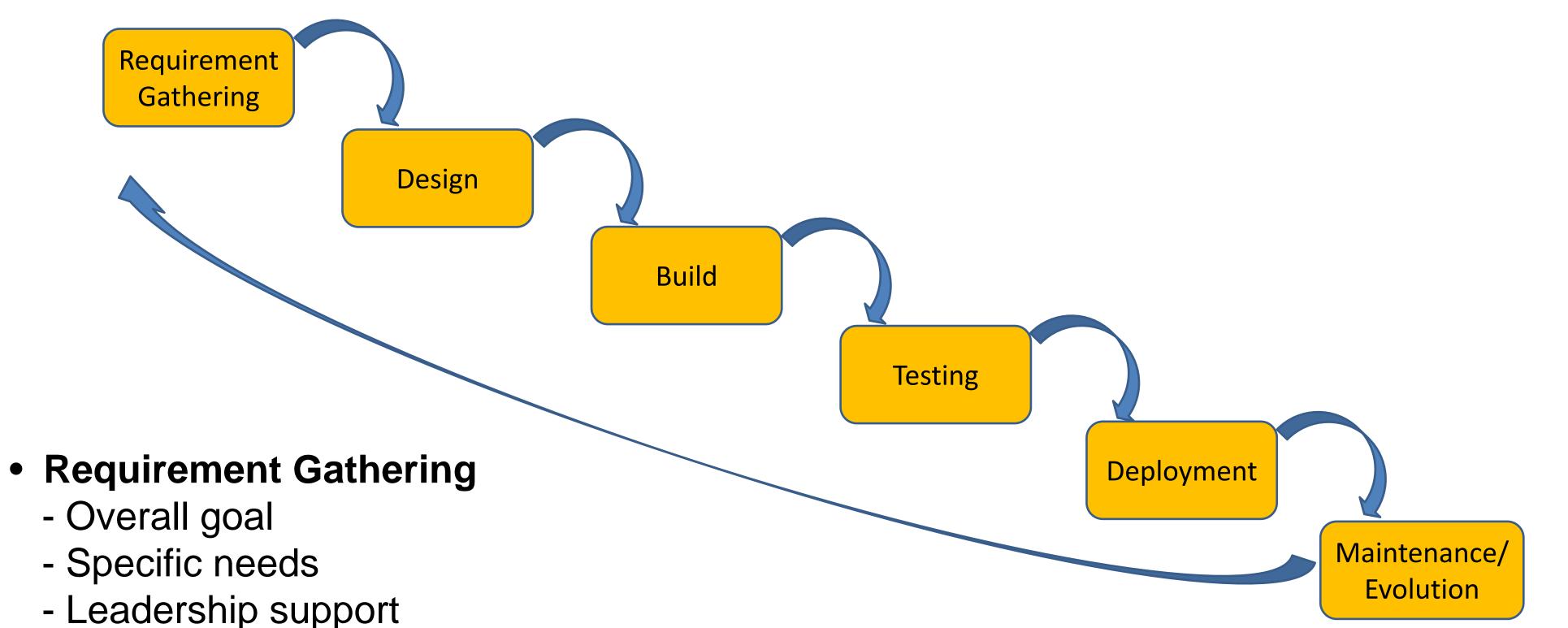
- Literature review to define data and training needs
- NEWS2 kick-off meeting
- Clinicians reviewed design
- Feedback provided to the build team
- Implementation Playbook developed for users/leaders
- Baseline data reviewed

### Setting

- 207 bed medical center
- Southern California health system
- 132 med/surg beds
- No out-of-staffing Rapid Response Team

#### Donabedian's Framework Structure Outcome Process RN/Provider Applications of Decreased Mortality Rate **Monitoring Tool** Availability Cardiac Arrests RN/Provider Communication Skills Transfers to Higher Level of Design of Response of Care Electronic Tool Team

## Royce's System Development Lifecycle



- Define scope
- Available resources

#### Design

- Existing tool available
- Include clinicians
- Active/passive notification
- Expected response
- Document workflows
- Create plan

#### Build

- Monitor progress
- Escalate to clinicians for questions
- Create training plans
- RRT
- General floor staff
- Hospitalists

### Testing

- Technical team
- User acceptance

#### Deployment

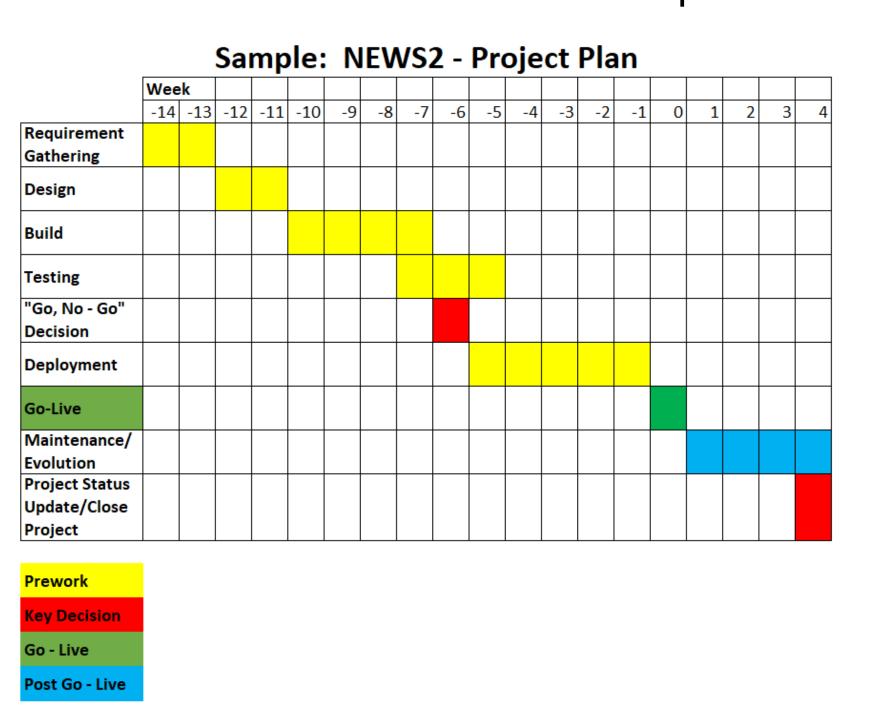
- Internal marketing
- Provide training
- Go-live support
- At-elbow
- Superusers
- Monitor process measures

#### Maintenance/Evolution

- Address any breaks
- Monitor outcomes
- As needs change, start back at the requirement gathering step

### Implementation Plan

14 Weeks Pre- and 4 Weeks Post - Implementation



### **Evaluation Plan**

- Potential measures
- Mortality rates
- Cardiac arrests
- Transfers to higher level of care
- Length of stay
- Rapid Response Team use
- 90 day post go live and ongoing

### Challenges/Outcome

- This implementation was aborted due to a system leadership decision.
- Failed IT implementation occurs in 40% of projects and is costly.
- Prevention of failed IT projects requires a sound basis for system selection.

#### Resources

Implementation Playbook and references



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