“Packaging” information about patient deterioration in terms of vital signs and the Early Warning Score facilitated nurses’ communication with doctors


Q How do nurses use vital signs and the Early Warning Score (EWS) to report physiological deterioration in patients to ensure successful referral to doctors?

DESIGN
Grounded theory.

SETTING
A surgical ward and a general medical ward in an inner city university teaching hospital in the UK.

PARTICIPANTS
30 nurses, 7 doctors, and 7 healthcare support workers.

METHODS
Participants were interviewed for 30–80 minutes with open ended questions that were modified using the process of theoretical sensitivity and theoretical sampling. Data were also collected from conversations with staff and observations of on-duty staff (3–8 h). Interviews were tape recorded, transcribed, and thematically coded. 83 conceptual categories and subcategories were generated and integrated by the process of constant comparison.

MAIN FINDINGS
Nurses ensured successful referral of patients to doctors by providing credible evidence about patients’ physiological deterioration—making credible requests for referrals. In turn, it was easier for doctors to contextualise the information (in terms of importance of symptoms and severity of deterioration), make judgments on patients’ conditions, and prioritise care, facilitating faster diagnosis and treatment.

CONCLUSION
“Packaging” information about patients’ physiological deterioration in terms of vital signs and the Early Warning Score enabled nurses to effectively communicate this information to doctors.

Commentary
For positive patient outcomes in today’s healthcare environment, excellent communication must occur between healthcare providers. In the grounded theory study by Andrews and Waterman, the EWS promoted early intervention for deteriorating patients by providing an objective score based on vital signs that nurses could easily relay and doctors could easily understand. Acuity scoring systems such as the EWS are popular because they objectively communicate assessment findings, although their accuracy is dependent on sensitivity and user knowledge. However, they are not without drawbacks, such as inattention to detail, incorrect charting, calculation errors, and misinterpretation of scoring rules, all of which can result in inaccurate scores.1 If nurses solely rely on the EWS (a tool with unclear diagnostic sensitivity) to identify patient deterioration,2 it may lead to the omission of other key assessment parameters such as urine output, an early indicator of vascular compromise when subtle changes occur. Other EWS systems being implemented include indicators such as urine output in the past 4 hours, but have unknown sensitivity and specificity. Moreover, all EWSs, like all screening aids, have different predictive values as a function of the changing prevalence of critical event risks in different clinical environments. Variables such as length and quality of clinical experience among nurses, nurse-patient ratios, the nature of professional preparation and training, and the unit or organisational environment3 also need to be considered when planning ways of reducing delayed emergency intervention.

Gina Maiocco, RN, PhD, CCRN, CCNS
School of Nursing, West Virginia University
Morgantown, West Virginia, USA


For correspondence: Dr T Andrews, School of Nursing and Midwifery, University College Cork, Cork, Ireland. t.andrews@ucc.ie

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