# ***Original Research Article***

## Poor Responses to Patients' Deteriorating Physiological Parameters in Hospital:The Roles of Modified Early Warning Scoring System and Rapid Response System

***"A stitch in time saves nine"***


## ABSTRACT

**Background**. Most adverse events in hospitalised patients are often preceded by documented progressive deterioration of physiological parameters without appropriate responses. Modified Early Warning Score (MEWS) is a simplephysiological score that was developed to aid early recognition of patient at risk of deterioration and assist in timely response.

**Aim**:To document and determine how earlyhealth care workersresponse to physiological parameters 72 hours preceding death and to sensitise and convince nurses and doctors about this simple scoring system.

**Methodology**: We reviewed case notes of 264 patients discharged alive and 243patients who died in LadokeAkintola University of Technology Teaching HospitalOgbomoso. Patients less than 18 years old and obstetrics and gynaecological patients were excluded. The Patients' relevant data and vital signs were gotten from case notes and were used to calculate Mean MEWS for each patient over 72 hours preceding outcome.

**Results**. One hundred and fourteen (79.72%) of 143 patients with MEWS of above six were classified to be critically ill and managed in general wardsinstead of higher care unit. Mean MEWS among the patients discharged alive was statistically significant lower than the dead patients (2.7±0.7 vs. 8.0±2.6, *P*<.001). Mean MEWS for pulse rate (0.2±0.63 vs. 2.1±1.0*P*<.001) and respiratory rate (1.2±0.01 vs. 2.3±0.75, *P*<.001) were statistical significantly lower for the patients discharged alive. The main reason for calling attention of clinicians to deteriorating patients was gasping in 52.6% of caseswhich is a late sign. Responses of house officers when called upon to review critically ill patients were to inform registrars in 44.03% of cases. There was a mean delay of 131(±66.28) minutes between house officers' review and consultants' inputs.

**Conclusion**: Our study showed delay in recognition of patients at risk of deterioration and significant delay innurses response and decision making process, we thus suggest use of MEWS and introduction of rapid response system.

**Keywords**:*Poor response, deterioration, physiological parameters, modified early warning score, Rapid response system*.

## INTRODUCTION

National Early Warning Score (NEWS) is a simple physiological score that consists of six physiological parameters: pulse rate (PR) in beat per minute, systolic blood pressure (SBP) in millimetres of mercury,respiratory rate (RR) in breath per minute, temperature(T) in degree Celsiusand arterial oxygen saturation ($SpO_2$) and level of consciousnessusing AVPU system: (A alert, V for responding to voice, P responding to pain and Ufor unresponsive). This scoring system requires simple monitoring devicesthat are readily availablefor duringroutine monitoring of vital signsat bed side. The scoring system was developed by the Royal College of Physicians (RCP) to aid early recognitionof patients at risk of adverse events, through tracking of patients' physiological parameters[1].A variant of NEWS called Modified Early Warning Score(MEWS) excluded SpO2 in its parameters, which makes it more easily scored as SpO2 is not routinely monitored during vital signs assessment, a modification making it more feasible to use in low and middle income countries where pulse oximeter may not be readily available.Deterioration of patients' conditions are often preceded by progressive derangement of physiological parameters several hours prior to adverse events in about 80% of cases[2]which are often documented[3, 4, 5, 6, 7,8,9] without corresponding early competent clinical response and intervention [10].Failure of early response and appropriate interventions from physicians with appropriate clinical competencies has been termed "*failure to act*" by Hillman et al and was associated with exacerbation of acute illness[11]with increased risk of cardio-respiratory arrest and death[12,13]with a study quoting about 11% mortality[14]. Sub-standard care received by most of patients prior to presentation,due to poor health care services in low and middle income countries, are often associated with poorer prognosis and outcomes. This coupled with delayed initiation of definitive treatment, delayedrecognition of progressive derangement of vital signs, lackof continuous automated monitoring devices in most of the wards and lack of dedicated acute medical teams for 24 hours coverage in a day in many hospitals in most low and middle income countries, further escalatethe poorer outcome seen in our patients. Early recognition of at risk patients makes it easier to manage such patients with simple measures such as oxygen support, fluid support, review of medications such as early commencement of antibiotics in patient with sepsis, with minimal cost on scarce health care resources.

The triad of early detection, timeliness of response and activation of clinicians with appropriate clinical competency has been shown to improve the outcomes of patients at risk of adverse events in hospitals. In other to achieve this triad many hospitals have introduced Rapid Response System (RRS) that consists of two limbs; the afferent limb that utilises a track and trigger systems (TTS) by using a scoring system such as National Early Warning Score or its modification called Modified Early Warning Score (MEWS) that will assist early recognition of patients at risk and the efferent limb system known as Rapid Intervention Team (RIT) that respond to afferent limb activation. This study was borne out of recognition of the advantages and effectiveness of compliance to triad of early detection, timeliness of response and competent clinical response in patients' care. We thus investigated our compliance to the triad, by documenting responses of health care workers to patients'physiological parameters 72 hours precedingdischarge or death, to compare MEWS between dead patients and patients discharged alive, and to sensitise and convince health care workers that are directly involve in patients' care about this simple scoring system (MEWS) and it s value in achieving the triad.

## METHODS

### Setting

The study was carried out in LadokeAkintola University of Technology Teaching Hospital Ogbomoso.LadokeAkintola University of Technology Teaching hospital Ogbomoso is a new tertiary health care centre with facilities for primary, secondary and tertiary health care services. The hospital receives referral from local peripheral hospitals and neighbouring teaching hospitals. The hospital admits an average of about 2150 patients per year with mortality rate of about 5.60% per year on the average. The hospital has about 300 beds, an intensive care unit (ICU): with four functioning ventilator, two consultant anaesthesiologists, six anaesthetic specialist registrars in training and eight-non-specialist nurses. The hospital has minimal facilities for managing critically ill patients; making many critically ill patients to be managed in general wards by the managing team with or without contributions from the anaesthetist, a finding comparable to Bhagwanjee study, who found outthat critically ill patients are often managed in general wards in low and middle income countries due to few numbers of available ICU beds[15]. No ward in the hospital has facility foreither continuous monitoring of patients physiological parameters orfunctioning defiribilator.

**Patients**

We retrospectively reviewed randomly selected case notes of 264 patients discharged alive and243patients who diedbetween July 2011 and June, 2016. The exclusion criteria included patients less than 18 years, pregnant patients because pregnancyis associated with hyperdynamic circulationon its ownand NEWS and MEWS are yet to be validated in pregnant women andcase notes that lack necessary parameters for calculating MEWS on six occasions preceding outcomes.

**Data**

The data collected included patients' socio-demographic characteristics, clinical diagnosis, patients' wards,and six-sets of each patients'vital signsat 12 hours interval over 72 hours preceding outcome (discharged alive or death). The obtained vital signs were used to calculate six sets of modified early warning score and mean score for each patient. Modified Early Warning Score offivewas taken as critical value based on previous finding which showed that MEWS of 5 and above was associated with increased need for ICU admission (OR 5.4, 95% CI 2.8-10.7) and adverse outcome[16]. The mean score for patients that were discharged alive was compared to that of dead patients. The other data retrieved from the case notes included documented nurses' responses to abnormal vital signs, evidence of escalation of treatment or intervention either by the nurses or house officers when called upon, reason(s) for calling the attention of clinicians by nurses prior to patients death, house officers responses and treatment plans, time difference in minutes between house officers' documentation and registrars' documentation, registrars' documentation and consultants' input; time of death and duration of hospital stay.

**Modified Early warning Score (MEWS)**

Modified Early Warning Score is a modification of the National Early Warning Score developed by the Royal College of Physicians (RCP) with the aim of achieving a universal and objective scoring system that will allow early recognition of patients at risk of adverse events. National Early Warning Scoring system scores seven physiological parameters that include PR,SBP, RR, $SpO_2$,T,level ofconsciousness and urine output (which is excluded from score calculation),whereas Modified Early Warning Scoring system excluded SpO2 and Urinary Output (table 1) that are not routinely monitoredand charted invital signs charts. MEWS has minimum and maximum values of 0 and 14 respectively with higher score signifying physiological instability.

Table1: showing the component of Modified Early Warning Score and grading.

| | 3 | 2 | 1 | 0 | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|
| Systolic blood pressure (mmHg) | 70 | 71-80 | 81-100 | 101-199 | | >200 | |
| Pulse rate (beats per minute) | | 40 | 41-50 | 51-100 | 101-110 | 111-129 | 130 |
| Respiratory rate (breaths per minute) | | 9 | | 9-14 | 15-20 | 21-29 | 30 |
| Temperature ($^{o}$C) | | 35 | | 35-38.4 | | 38.5 | |
| AVPU score | | | | A | V | P | U |

AVPU: A, alert; V, responding to voice, P, responding to pain; U, unresponsive

Adapted from Subbe et al, 2001.doi:10.1371/journal.pone.0151408.t001 [16].

**Statistical analysis**

Results were presented in form of tables and charts. Socio-demographic characteristics were analysed using descriptive statistics, categorical variables were presented in form of both frequencies and percentages, and mean and standard deviation were used for continuous variables. Chi-square and t- test were used for test of significance for categorical and continuous variables respectively. *P*-values less than .05were considered to be statistically significant.

**RESULTS**

Case notes of 264 patients discharged alive and 243 dead patients were reviewed. The mean age of the patients was 49.6 (±26.7)withinterquartile range (IQR) of 34 (Q1=37 and Q3=71).Two hundred and eighty nine (57.0%) of the patients were males. Table 2 shows the socio demographic characteristics of the patients.

Table 2: Showing the socio-demographic characteristics of the patients

| **Parameters** | **Alive (n=264)** | **Dead (n=243)** | ***P value*** |
|---|---|---|---|
| **Age (mean SD)** | 48.33(±28.2) | 50.80(±26.2) | *.3080* |
| **Sex M:F** | 153:111 | 136:107 | *.7175* |
| **Wards** | | | |

| | | | |
|---|---|---|---|
| **Medical** | 91 | 88 | |
| **Surgical** | 101 | 83 | *.5782* |
| **ICU** | 13 | 18 | |
| **Emergency** | 59 | 54 | |

Mean modified early warning score for patients discharged alive (PDA) was 2.7 (± 0.6)as compared to mean score of 8.0 (± 2.6) for the dead patients(*p <.001*). Further assessment revealed that modified early warning score of 5 and above were significantly associated with higher risk of mortality (RR 21.24,*P<.001*) (Fig. 1)

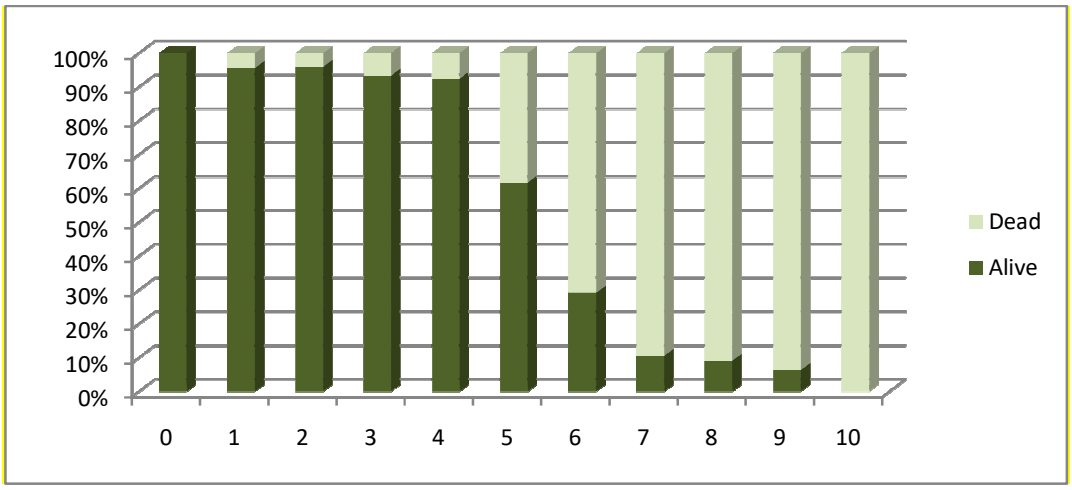


Fig.1: Showing the outcomes in percentages for different modified early warning score values.

Assessment of vital signs revealed that pulse rate, respiratory rate, temperature and consciousnessscores were statistically significantly higher in dead patients, while systolic blood pressure shows no statistical significant difference when dead and alive patients were compared.

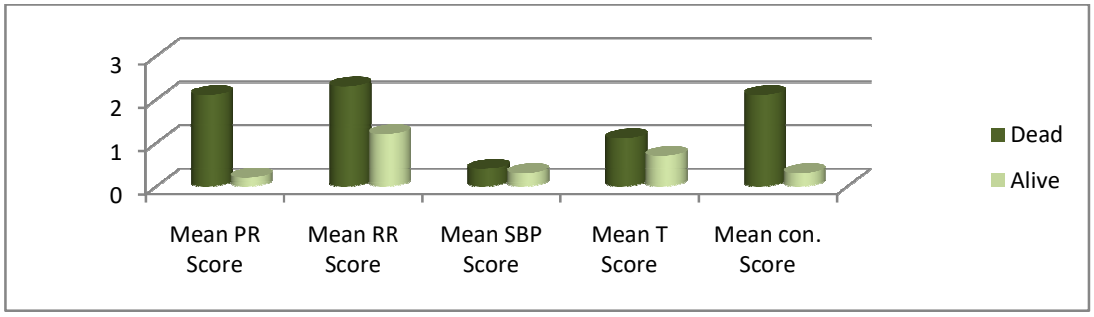


Fig.2:Showing the mean scores for each parameter of MEWS between dead and alive patients.

Ninety-four (26.2%) out of 361 patients that have MEWS of 6 and below had documented evidence of escalation of treatment or increased in frequency of monitoring of their vital signs as compared to 139 (95.2%) out of 146 patients with MEWS of greater than seven.Decreased blood pressurein 65(30.4%) occasions was responsible for escalation of treatment based on the vital signs andfollowed by decreased $SpO_2$in49(22.9%) occasions (Fig. 3).

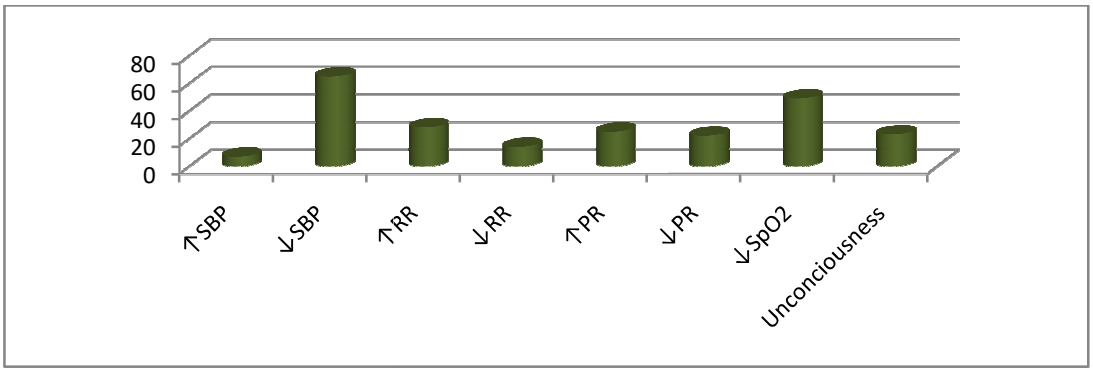


Fig. 3: Showing changes in vital signs that were associated with escalation of treatment.

↑*Increased* ↓ *Decreased*

There was a mean delay of 83 minutes between house officers' documentation and registrars' review following recognition of patients' deterioration by ward nursesand mean delay of about 48 minutes before consultants' input, making a total delay of 131minutes before final decisions were taken. Analysis of indication for notifying clinicians prior to patients' demise revealed that in 52.6% of times attentions of clinicians were not drawn to patients until patients startedgasping. (Fig. 4)

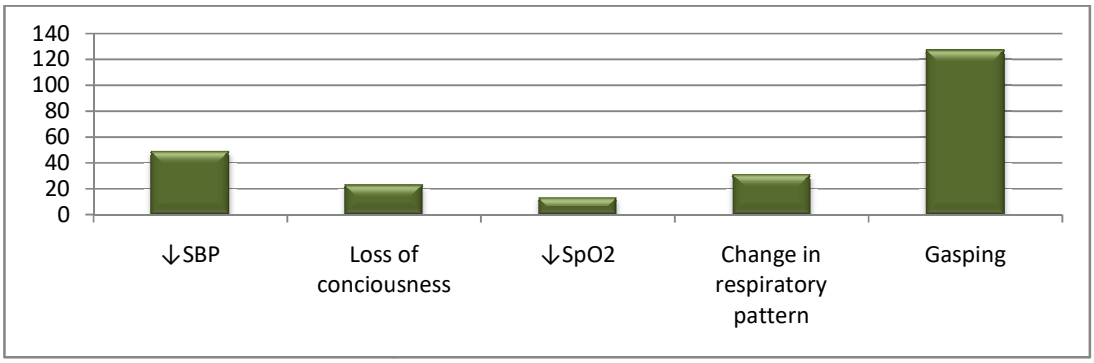


Fig.4: Reasons for notifying managing team preceding patients' death by nurses

Review of the case notes revealed that in 179 (73.7%) out of 243 occasions clinicians met patients gasping and breathless in 40 (16.5%) occasions. (Fig. 5)

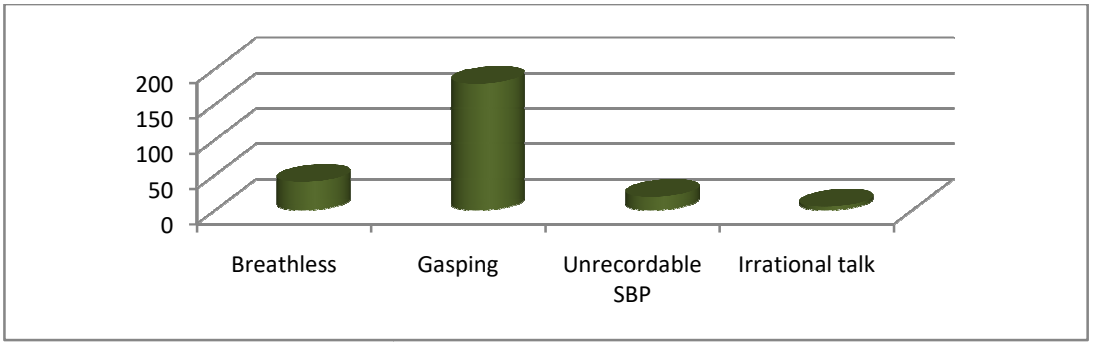


Fig.5: Showing patients' condition at point of review by clinicians following notification of patients' deterioration by the nursing staffs

When house officers were informed to review patients following recognition of patients' deterioration; in 107(44.03%) occasions the responses were to inform their unit registrars. (Fig. 6)

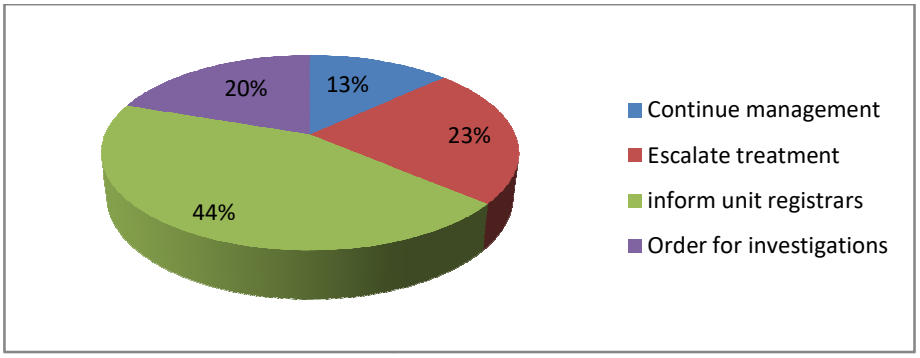


Fig.6:Showing the pattern of house officers' responses to deteriorating patients.

Admission pattern revealed that 311 (61.3%) out of 507 patients had MEWS of 5 and above. Of 311 patients with MEWS of 5 and above 280 (90.0%) were managed in generalwards. Only 29 (20.3%) out of the 143 patients with MEWS of 7 and above were managed in ICU.

In none of the case notes was there cleared documentation byclinicians on what to do in case of patients' deterioration or specific value of vital signs thatclinicians should be informed.

**DISCUSSION**

This study confirmed previous reports findings on MEWS as a predictor of patients' outcome; and that progressive deterioration of patients' physiological parameters often precede patients' death, which are often documented without appropriate corresponding competent clinical responses. Thisstudy showed that modified early warning scores of 5 and above was associated with clinical and statistical

significant mortality. No patients in this study with mean modified early warning score of above eight and those with MEWS of above twelve at any pointsurvived, as compared to one study where some patients with such values survived [17]. Possibleexplanation for poor outcome in this study is probably due to lack ofadequate critical care facilities in our centre such as: all round functioning ICU, high dependency unit (HDU)and complete lack of coronary-cardiac unit compared to hospitals in developed countries where modern critical care facilities are readily available and accessible. Other factors that may be responsible for better outcomes in developed countries are: availability of services of emergency medical team (EMT) and activation ofrapid response system (RRS) following recognition of patients' deterioration[18]. This study also found out that there was appreciable mean delay of about 131 minutes before consultants' inputs into patients' management following recognition of deterioration by nursing staffs. A non documented observation revealed that in about 56% of cases randomly reviewed, consultants' input were often verbal communications over the phone, this rose up to about 95% during the call hours. This time delay becomes more worrisome as it was revealedthat house officers' responses in most cases were inadequate and sub-optimal due to lack ofadequate knowledge and experiences on management of critically ill patients. In majority of the cases house officers rarely escalate treatments when called upon to review patients at risk of deterioration, but rather waited for their registrars to take decisions who in turn would further need to inform managing consultants before major decisions are taken such as: need to transfer patients to higher care unit or refers to other centre with better facilities.

This study revealed that common reasons for escalation of treatment were decrease in blood pressure (un-recordable) followed by decreased SpO2; these two changes are late signs as initial compensatory mechanism of cardio-respiratory system would have maintained systemic blood pressure and SpO2 by increasing HR, force of contraction, peripheral vasoconstriction and RR due to activation of sympatho-adrenergic response. This shows lack of basic understanding of pathophysiological changes and physiological compensatory mechanism associated with haemodynamic instability among health care workers.

The study showed poor compliance to the triad of early detection, timeliness of response and activation of appropriate clinicians with competent clinical responses which are important factors that influence patients' outcomes. This study alsofound out that about 62% of patients in medical and surgical wards wereconsidered to need at least an hourly monitoring of vital signs based on the

221 expected response for MEW score of 5 as in the Royal College of Physicians (RCP) guidelines
222 (Table3). The study further showed that less than one-fifth of patients with MEWS of seven and above
223 weremanaged in intensive care unit (ICU). This showed that significant percentage of patients that
224 were managed in conventional general wards were patients that required higher care units. The main
225 reasons for this pattern of admissions and management of “potentialcritically ill patients” in
226 conventional general wards were due to: (1) failure of recognition for need to transfer such patients to
227 higher care units with better monitoring facilities such as high dependency unit or ICU (2) lack of such
228 higher units. Similar reasons were reported from studies from some other low income countries[1920].
229 In none of the case notes was clear documentation of what to do in case of patient’s deterioration of
230 vital signs or change in patient’s clinical condition. If the clinicians clearly stated critical/specific vital
231 sign values that clinicians’ attention should be sought and possibly what to do while waiting
232 forclinicians’ review, some adverse events would have been prevented. A similar approach is being
233 used in management of head injured patients when decrease in Glasgow Coma Score(GCS) is
234 considered as an indication to call clinician’s attention who has core clinical competency in managing
235 head injured patients; a similar approach is also embraced when writing blood transfusion orders
236 which include what to do when signs and symptoms of transfusion reaction are observed. The main
237 objective of this approach is to avoid inherent danger of delay interventions in such two
238 aforementioned clinical scenarios. This approach can be borrowed in management of patients at risk
239 of adverse eventin the general wards.
240 Current evidence has shown that the triad of 1) early detection and recognition, 2) timeliness of
241 response and 3) competency of medical response arefactors that determine patient’s response and
242 outcome to medical interventions[16,21,22,23,24,25].Early detection and timeliness of response are
243 possible/feasible through monitoring and early recognition of patients’ vital signs deterioration. This
244 triad is essential for good patients’ management and outcomes. Failure to monitor vital signs, coupled
245 with delay in recognition of patients’ vital signs deterioration have been shown to delay the rapid
246 response system/emergency medical teams[26]with resultant failure to act. Failure to act was
247 reported to be responsible for about 11% of avoidable hospital mortality by National Patients Safety
248 Agency(NPSA)report in 2007[14].
249 Vital signs are complex physiological parameters that are often affected by so many factors other than
250 the clinic-pathological conditions of the patients. Thus holistic approach in the interpretation of vital

sign values in context of other vital sign values rather than interpretation of a particular value in isolation may likely predict patients' outcome as derangement of vital signs rarely occur in isolation. When combined and weighted values are used to calculate a single score value it will likely make the interpretation much easier and better. Recognition of this has led the RCP to developed a colour coded scoring system called National Early Warning Score(NEWS) that will help nurses, clinicians and member of emergency medical team or Rapid Response System bridge the gap to recognise and detect early a deteriorating patient through simple bed side physiological parameters. The scoring system also states clearly the expected responses based on the calculated-weighted scores thus allow timely notification of clinicians with appropriate clinical competency as shown in tables 3 and 4. A similar observational track and trigger chart was developed for children use in Victorian Hospital which guides the clinicians whether to escalate patients care based on the vital sign values[27].

Table 3: National Early Warning Scoring System

| Parameters | 3 | 2 | 1 | 0 | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|
| Resp. Rate | ≤8 | | 9-11 | 12-20 | | 21-24 | ≥25 |
| O2 Sat | ≤91 | 92-93 | 94-95 | ≥96 | | | |
| Supp O2 | | YES | | NO | | | |
| Temp | ≤35.0 | | 35.1-36.0 | 36.1-38.0 | 38.1-39 | ≥39.1 | |
| Systolic BP | ≤90 | 91-100 | 101-110 | 111-219 | | | ≥220 |
| Heart Rate | ≤40 | | 41-50 | 51-90 | 91-110 | 111-130 | ≥131 |
| Level of conciseness | | | | A | | | V,U,P |

Table 4:Clinical response to NEWS triggers

| Scores | Clinical risk | Monitoring | Response |
|---|---|---|---|
| 0 | Low | Minimum 12hourly | Continue routine NEWS monitoring |
| 1-4 | Low | 4-6 hourly | Inform registered nurse to determine if need for Escalation of care |

| | | | |
|---|---|---|---|
| Individual parameter scoring 3<br>(Red score) | Medium | Increased to a minimum of 1 hourly | Registered nurse to urgently inform managing team<br>With core competencies<br>Clinical care in environment with monitoring facilities |
| Aggregate 5-6 | Medium | Increased to a minimum of 1 hourly | |
| Aggregate 7or more | High | Continous monitoring of vital signs | Need specialist review from managing team<br>Clinican with critical care competencies assessment<br>Consider transfer to higher unit |

Adapted from Royal College of Physicians National Early Warning Score

This study utilised a modified form of NEWS which has been previously validated and aimed to meet the need of patients in various clinical settings[16, 28]including Africa [29. 30, 31].Modified Early Warning Scoring system excluded patients SpO2 and hourly urinary output in its scoring. The authors opted forMEWS as SpO2 are not routinely monitored nor charted in patients' vital signscharts and hourly urine output were not documented in most of the case notes, a common occurrence seen in most low and middle income countries.

In order to avoid delay in patients'management as pointed out in this study we suggest introduction and use of modified early warning score, which score patients based on the derangement of vital signs and consciousness level and expected response without delay based on the patients score on colour coded NEWS triggers chart; as many hospitals have no trigger point nor escalation policy.Modified early warning score is highly favoured because of its simplicity, as estimation of peripheral oxygen saturation and oxygen supplementation are not readily available in significant number of time in low and middle income countries..However National Early warning Scoring system which take patients SpO2 , and oxygen supplementation into consideration to calculate NEWS may be a better predictor of patients outcome in places where facility for $SpO_2$ is readily available

Determination of MEWS for each patient following assessment of vital signs will assist attending

health care worker to make a better decision based on the warning score protocol guidelines(table 4) rather than subjective opinion of the observer who may as well be deficient in interpreting the implication of observed values. Though several other scoring systems have been designed, none of themissuitablefor bedside scoring and universal as MEWS and NEWS. ModifiedEarly Warning Score can also help inallocation of patients to different level of care especially in low and middle income countries were health care resources are limited in supply. Modified early warning score has also been shown to assist nurses, doctors and other health care professionals that are involved in patients' care to have a protocol based guidelines for frequency of monitoring vital signs. This becomes advantageous in situations where there is low nurse to patient ratio thus avoiding the traditional routine of monitoring vital signs for every patients whether at risk or not thus allowing concentration and more focused attention to patients at risk of deterioration that may need more frequent monitoring and escalation of treatment.

Though introduction of MEWS will aid in early detection of patients at risk of progressive deterioration and possibly timely response, the authors still believed that for the third component of the triad to be effective hospitals need to introduce a dedicated acute medical team unit in the form of Rapid Response System (RRS) whose afferent limb will make use of MEWS to activate the efferent limb. The efferentlimb will consist of clinicians with core competency in acute care management and trained ICU personnel that will offer immediate response to activation and commence immediate treatment in the ward and plans further escalation of treatment based on patient's MEWS and response.

## CONCLUSION

This study showed delay in recognition of patients at risk of deterioration despite obvious documentation of progressive derangement of vital signs and significant delay in nurses response anddecision making process, we therefore suggest and recommend the use of MEWS assessment for each patients at leasttwice a dayor more depending on patients clinical and haemodynamic stability with expected corresponding response and introduction of acute medical team in the form of rapid response system (RRS) in our hospitals.

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