

Surgical Patient Status System

Although the status of a patient is of obvious importance, a change in a patient's status during the course of his or her inpatient stay should precipitate an identifiable and predictable response.

The status at any one time of a particular patient may also be important in terms of analysing staffing and supervision requirements. It should serve to focus staff's attention on the neediest patients. This may be of value given the shift work type staffing arrangements. Whereas, nursing staff have well defined hand over procedures, this is not always the case amongst medical staff. It may therefore be of value for a covering RMO or Registrar, when visiting a ward, to know which patients may need more attention and review.

In order to be of value, the status classification of a patient needs to be constantly updated and accurate. The following classification in order of increasing severity has been created:–

STABLE	(S)
LABILE	(L)
UNSTABLE	(U)
WARD CRITICAL	(C)

Determining and Changing a Patient's Status.

Individual patients should have their status determined each morning by the Unit RMO/Registrar and at the end of each day. Any person may change a patient's status to a more severe category, eg ward nurse, Allied Health Professional, RMO etc, but the Unit RMO should be notified immediately of any change in a patient's status to a more severe category.

Changing a patient's status to a less severe category can only be done by the Unit RMO/Registrar or the Ward Nursing Manager (or deputy).

A patient's status and when last updated should be maintained with surgical ward patient lists.

Definitions:-

STABLE

- Patient whose observations have been within normal limits for > 24 hours;
- Patient receiving maintenance fluids only (IV or oral);
- Patient whose biochem/haematology is normal (Typically a patient who is awaiting elective surgery or who underwent operation more than 24 hours previously and who is experiencing an uneventful recovery).

LABILE

- Patient who has undergone operative or other invasive procedure within last 24 hours but whose recovery is proceeding as expected;
- Patient who requires more than routine observations eg with epidural catheter;
- Patient who has been unstable less than 24 hours ago;
- Patient who has developed an abnormal observation which is explainable and unlikely to require intervention or deteriorate;
- Patient who has developed an abnormal biochem or haematology result.

UNSTABLE

- Patient who has undergone operative or other invasive procedure within last 24 hours but whose recovery is not proceeding as expected;
- Patient whose observations became abnormal but responded to corrective measures;
- Increasingly abnormal biochem or haematology results;
- Patient who has required 'abnormal, unexpected' intervention in last 24 hours.

WARD CRITICAL

- Patient who has persisting abnormal observations despite corrective intervention;
- Patient who has qualified as unstable more than once in the last 24 hours;
- Patient who has abnormal observations and diagnosis remains unclear;
- Patient in whom further deterioration is deemed a likely possibility.

Nursing Observation Protocols according to Patient Status

These should be developed in conjunction with the RMO/Registrar/Fellow/Surgeon. The nature of observations and reportable levels should be agreed upon and recorded. The required observations will vary with each patient.

The following should be regarded as minimum guidelines: -

STABLE PATIENT

4 hrly obs	BP, Pulse Temp Resp rate.
------------	---------------------------------

LABILE PATIENT

1-4 hrly obs	BP, Pulse Temp Resp Rate
Consider	fluid balance chart CVP pressures O2 Sats FBE, U&E's

UNSTABLE PATIENT

30 min – 1 hrly	BP, Pulse Temp Resp Rate
Consider	fluid balance chart CVP pressures O2 Sats FBE, U&E's

WARD CRITICAL PATIENT

30 min or more frequently	BP, Pulse Temp Resp Rate
Consider	fluid balance chart CVP pressures O2 Sats FBE, U&E's

Medical Staff Actions

Any patient moving to a more severe category – RMO notified.

Any patient who moves to Unstable or Ward Critical Status –

1. should be reviewed at earliest possible time by Unit or Covering Registrar (<1hr);
2. surgeon responsible for patient should immediately be contacted;
3. differential diagnostic list created and contingency planning initiated;
4. 'worst case' scenario identified;
5. nursing observation plans and reportable levels reviewed;
6. should be individually and specifically handed over to covering RMO and Registrar before unit management staff leave hospital.

REMEMBER!

The major causes of adverse patient outcomes are: -

1. Failure of communication with other medical and nursing staff;
2. Failure to involve senior staff in timely fashion;
3. Failure to detect signs of further deterioration;
4. Tendency to attribute the abnormal to common, benign events without preparation for the uncommon catastrophic event.

VSCC Approved: July 2004