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P065 -Impact on urine output monitoring of its removal as a trigger from a track and trigger system

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Introduction

NICE guidelines for in-hospital track and trigger systems do not require hourly urine output monitoring but recommend that it should be considered in specific clinical circumstances.

The first widely used track and trigger system, the EWS system, did not include urine output. However modified versions of this system (MEWS) were implemented in a variety of settings sometimes including urine output as a trigger. The need for a national standard has led to NEWS2. NEWS2 now has formal endorsement from NHS England to become the early warning system for identifying acutely ill patients in hospitals in England. It does not include urine output as a trigger. This marks a change for some trusts who previously utilised MEWS systems. The removal of urine output as a trigger raises the possibility of a reduced emphasis on urine output and a consequent decline in monitoring.

Method:

The aim of this study is to evaluate the impact on urine output monitoring of its removal as a trigger from a track and trigger system. A retrospective comparison will be made of fluid balance chart completion between January 2018 and January 2019 after a change in November 2018 from a MEWS system (which included urine output as a trigger) to NEWS2.

Monitoring on two 'standard-bearer' wards will be reviewed, the urology and renal wards. These wards were selected for their emphasis on urine output monitoring. They also provide a contrast between a medical and a surgical ward, and between a ward using electronic recording and a ward using paper charts. Fluid charts for all patients who activated a MEWS/NEWS2 score escalation during the study period will be reviewed. Charts for each 24 hour period during which they activated will be reviewed starting from the time of the first activation. Fluid balance charts will be rated as completed, absent, or incomplete (nothing recorded for more than 6 hours).

Results:

92 patients have been identified for the year 2018 for review.

Patients for year 2019 will be identified at the end of January 2019.

Comparison will be made between 2018 and 2019 for both ratio of absent to completed charts as well as ratio of incomplete to completed charts.

Limitations:

Establishing a framework for evaluating fluid chart completion is complex. Differentiation between an incomplete chart and one, for example, that reflects an oliguric condition requires context. The schema presented here can therefore only give a very raw evaluation of quality.

The choice of cohort was specifically made to encompass wards which we might hold to a higher standard in terms of urine output monitoring. The implication being that if they have seen a decline in standards others are likely to have done so too. However 2 wards is a small sample group and these results might not be reflected more broadly.

This study considers only two points in time, before and after the change. The impact of change may diminish over time.