Denise Kivell, Director of Nursing at Counties opened the day.

Denise began with a challenge –

- Do you know your brand?
- Who are you?
- What are you in the organisation?
- Who are the future leaders? Are you thinking about leadership? Is there a National appreciation of our roles?

Denise commented that there are a multitude of challenges out there and wanted us by the end of the day to …

- Be informed on how the advanced nursing role adds value.
- Have an understanding of what is needed.
- Have a national appreciation.
- Have a reality check.
- Look at our leadership
- Have time out to think and challenge.
- Refocus on safer patient care.
- Know our brand.

Complexities of

- Increasing patient acquity.
- Faster through-put.
- Financial restraints.
- Increasing use of protocols. (Challenge protocols as we don't want tick-box nurses!).

- Risk of losing critical thinking.
- Impact of poverty – Refocus and challenge our healthcare system.
- Nutrition – obesity rate now 39% (33% in 2006)
- Long term/chronic conditions.
- Expectations – public/society.

Status of nursing

- Entering a time of considerable financial restraint through-out the country as government aims to reduce spending.
- What is the best workforce to utilise?
- Important to think about how we keep ourselves safe (i.e. workload) and still function effectively and efficiently.
- Be mindful of organisational expectations.
- Challenge and then fix **the system** as we need the system to run smoothly.

We need to Inspire Leadership and look at the big picture.

Leaders are not all the same and we have a lot of under-cooked leaders.
Nursing has got really good at managing and not leading! Re-address Leadership.
Take risks – have a vision.

Our Challenge …

To think of something different!
We cannot solve problems by using the same kind of thinking we used when we created those problems.

With that in mind…

- We need visionary leaders who realise the value of education – nurses not good on business savyiness!

- We need leaders prepared to fight for that education.
- We need to take into account factors such as the patient experience, population health and financial restraints.
- We need to look at strategies/policies – are we all on the same page?
  What does family/patient focused mean?
  Are the ex-patients/families involved in designing the services?
  Are we really family focused?

So in conclusion…

Are you involved in and/or leading?

Challenge ourselves to be Ambassadors of what is happening in our own organisations. (Nurses are not more special because they work in a certain area – they are in fact all the same, providing the same service)

Advocate for improved technology – ask questions - is it necessary to document something and then data enter that same thing?

Important that we don't take away from patient contact.

Promote ourselves. Sing our own praises.

We do add value and we need to articulate this! By writing, teaching and mentoring.

Alison Pirret – Nurse Practioner, PhD candidate and Nurse Practitioner for ICU Outreach presented on her PhD topic: Comparing Nurse Practioner Diagnostic reasoning with that of Registrars.

Alison kindly gave us her power-point. Please find enclosed.

Jo Soldan – Clinical Psychologist, Critical Care Complex presented on Developing Resilience – interventions in outreach roles.

Jo has also kindly given us her power-point. Please find enclosed.

Round Table Updates.

We asked the question of where everybody was at and where they felt they were going.

Northland.

Provide a nurse led service and on the Cardiac Arrest Team. – changing to Outreach so will have an Outreach focus.
2 FTEs (.5 down currently) - 7 days a week - 2.30pm-11.00pm. Hand over to ICU Registrar overnight.
Involved in House Surgeon handover.
Lead Consultant in place when help needed.

Currently...
Getting an orientation and competency document developed.
Getting busier.
Reviewed and tweaked EWS.

Waitemata.

Critical Care Outreach service.

7 years in operation. Initially started with one person – now 9. 1x Team Leader and 3x CNS's
Service expanded across two sites since February – North Shore 7.30am – 10.30pm. (Late shift goes to Medical Handover)
Waitakere 2pm – 10.30pm. – Pager to ICU co-ordinator after 10.30pm who will hand onto ICU Registrar for follow-ups overnight and the Registrar will hand over in the morning.
Part of MET Team.
Designated Medical back-up is ICU Medical Team.
Have an ACT (Acute Care Training) Course once monthly for junior doctors, nurses, allied health and Southern Cross staff.
Run a weekly teaching programme in Waitakere and North Shore called 'All Systems Are Go' which teaches the basics of assessment skills.

Currently…
Challenging. Busy.
Orientation programme done.
Quality plan in KPI's
Lots of focus on Waitakere currently.
Developing technical competencies.

Auckland.

Outreach Team (only follow-up patients who have been in DCC)
All from ICU – 7x RN's. Team Leader is a CNS who identifies patients in the unit and then liaises with the ward.
7.00am-3pm Monday – Friday.
7.00pm-11.00pm weekends.
Then hand over to CNA's – nil formal hand-over of patients from DCC to CNA's

CNA's
24/7 group. 15 staff (approx 12FTE's) with differing levels of experience. (5 have Clinical Masters)
Part of Code Team at Auckland, Starship and National Woman's.

Attend 10.00pm Medical Handover.
Referrals through EWS, nurse concerns, travelling road show (visible, accessible and well known), doctor's referrals, relationships with ICU Registrars (mutual respect).

Currrently…
Concerns re sitting under Operational as opposed to Medical Umbrella.
Varied ideas as to where to go as a team.
Need supportive guidance and growth.
Worried about lack of formal training/education and anyone to guide/mentor this.
Nil data collection so unable to formally validate/justify the role.
Everyone doing things differently/view role differently.
Differing competencies.

Starship.

24/7 service with a senior PICU nurse dedicated to MET (code pink) calls and following up children discharged from PICU to wards.
Lots of data collection.
Twice yearly education and simulation training of ward nurses in how to manage the deteriorating patient

Currently…
Trialling Paediatric EWS for past year – thought to be a positive move with improved compliance around staff completing a full set of observations, provides another tool to assist with the recognition of deteriorating children and works as a track and trigger system when escalation of care required. – As this is a part of an International Research Project, another 2 years of data collection is required to be able to assess viability.

Counties

24/7 Team. 11 FTE's, most of who are not ICU trained – so mostly run external to the Critical Care Complex.
Offer a 9 month internship programme which allows a little 'give' in the team for study days and for Critical Care Nurses to experience the role.
2x Nurse Practioner interns currently.
Modes of referral are from EWS + MET (attend all MET calls except in the Emergency Care Department), medical staff concerns, nurse concerns and follow up of patients discharged from ICU and HDU.
Attend medical handovers morning and night (8.am and 10.00pm)
Attend ICU/HDU medical handovers. Discuss the patient/family in full and look at areas like rationale as to why a patient might/might not be for readmission to ICU/HDU.
Data collection which is made available hospital wide.
Work closely with CTEC (Clinical Training and Education Centre) with simulation training on the wards. This has the additional benefit of providing a view of how we work in/with teams on the wards in MET calls.
Part of patient at Risk Governance Group – constantly looking at what is happening on the wards.

Currently…
Just beginning a Cardiac Arrest data study to determine whether EWS's are being utilised properly on the wards and study of staff perception of EWS and MET.

Waikato.

Now a PAR Team who for the past 2 years have been under the Critical Care Complex.
6 nurses with a FTE of 5.2
Commence at 2pm and mostly work 10 hour shifts.
Hoping for ICU Consultant to be attached soon.
ICU/HDU follow-ups.
Attend Medical handover at 10pm - felt this is of variable quality and Surgical not attending as yet.

Referral is from EWS's and calls from staff.

Currently…
Busy!
Looking at documentation – frustrations with IS. Starting to develop a data-base.
Hoping to commence formal education in August.
Looking at Paediatric EWS – feel earlier intervention may be necessary.
Feel there is a need to look at succession planning for sick leave/annual leave.
Looking at developing education around MET calls.

Capital and Coast.

PAR Team. 4.5 FTE's providing a 24/7 service.
Follow up all ICU discharges.
EWS referrals.
Attend all clinical emergencies. There are now 4x the number of MET calls daily and reduced Cardiac arrest calls secondary to increased use of EWS's. ICU Registrars attend all MET calls.
Attend ICU handover mane.
Level 2 senior nurse pathway.
PEWs utilised.

Currently…
Very passionate Intensive Care Specialist (Alex Psirides) developing a National EWS chart.
Developing an Outreach model.
Winter 2013 – creating more HDU and physical beds.

Central. (Taupo/Rotorua)

CRN at Rotorua (200 beds)
No HDU. ICU work under the belief that patients need to be tubed to be admitted (to ICU) so somewhat bed-blocked from a progression perspective.
Stand-alone role. 2.30 pm–11.00pm Monday – Friday.
Works with Duty Managers.
Doesn't work under an Intensivist however carries a Resus Pager.
Works along-side junior doctors, guiding, mentoring and helping with cannulations and 'basics'.
Cross over of boundaries i.e. cannulating, attending MET calls, trouble-shooting i.e. PICC lines.

Currently…
Commenced Post-Grad study this year. (5 years in role)

Wellington. (Private Sector)

24/7 service. PAR service since 2009.
Lots of change/new developments now out of ICU.
Reducing staff numbers in ICU adding to workload.
Collecting lots of data but unsure if it is correct data.
Changed EWS charts. EWS's system triggers calls.

Currently…
Recently commenced follow-up of ICU discharges.

Christchurch.

24/7 Intensive Care and Outreach Service. Senior nurses in ICU share the role/rostered to role out of a pool of 30 (senior) ICU nurses and a CNS. Registrar available 24/7.
18 bed ICU – 95% of patients intubated.
Christchurch has approximately 400 beds. Also have acute Medical beds off-sight.
Attend all emergencies.
Paediatric + Maternity EWS in place for past 2 years.
Modes of referral – clinical concerns, EWS and clinical emergencies.
Data collection shows approximately 330 patients being seen monthly.

Currently ……
Data Collection is being used to plan a new ICU as current ICU often overflowing.

Invercargill

180 beds at Invercargill.
No official MET Team or PAR service. Calls are triggered from an UPS (unstable patient score) which is a guideline only at this stage but is sensible and widely used. Unfortunately it isn't necessarily always followed through. What tends to happen currently is a nurse speaks with a house surgeon who will then refer up the chain as he/she sees fit.
Co-ordinator presently trying to grow everybody on the Duty Manager Team with a Clinical Care background.

Just merged with Dunedin to become Southern District Health – lots of restructuring currently so a general feeling of "wait and see'.
Major financial restraints.

Lesley Kazula & Meghan Kelly – NP interns at Middlemore presented on Preparing NCNZ NP in an internship programme.

Lesley and Meghan have kindly given us their power-point. Please find enclosed.

Richard Matsas; Paediatrician Kidz First and Shirley Lawrence: Research Nurse, Kidz First presented on Bedside Paediatric Early Warning Scores (BPews)

It was recognised that there should be a system for recognising deterioration in children (physiologically unstable) so a bed-side early-warning score chart (BPews) was developed with an education package for staff.
Richard did point out that

- It isn't meant as a substitute for clinical acumen.
- Nil temp or GCS – Emphasis on Early Warning – not just a trigger tool.
- Emphasis also on getting more senior input at an earlier stage.
- Gives the most junior doctor and nurse something to work with.
- Education and review is essential.

Anne Pederson gave an update on NZews.

The HQSCNZ (Health Quality Safety Commission of NZ) have given a verbal indication that they are very keen to pursue however not formalised as yet.
Anne reminded us that all 20 DHB's have an EWS of some description. And that clinical staff remain very good at documenting deterioration. But that patients are quite robust and somewhat difficult to kill!
Cardiac Arrests shouldn't be happening. Target Zero = No in-patient should ever receive CPR.

Dr Maureen (Mo) Coombs presented on NCCOM – advancing for the future. This was followed by a group discussion.

Mo discussed the evolution of the Critical Care Outreach under a UK model which was introduced in 2000.
Function was to..

– Avert Admission.
– Enable discharge by supporting continuing recovery.
– Share critical-care skills with non critical-care staff.

Service Models –

- Critical Care education and training for wards.
- Track and Trigger for wards (EWS Systems)
- Telephone Hot-Line for ward staff.

There then followed follow-up clinics – bring patients in post ICU and subsequent hospital discharge and provide physiological and psychological support.

This led into a Group Discussion chaired by **Debbie Minton – Nurse Manger Middlemore Critical Care Complex.**

Debbie reiterated those things required to move forward.

- A National Forum.
- Patient Safety – EWS/PEWS.
- Leadership.

Early recognition of deterioration done poorly when we consider the thousands spent on ACLS.
A forum is required to spread the word and provide political clout.
We have amazing ideas but need to work together to move forward. What's needed to achieve this?

Alison suggested that Critical Care Outreach could be a sub-website attached to NZNO.

Mo asked do we want more contact as an Outreach forum?
How do we develop a site with NZNO? Do we need ongoing development?

Canterbury feel they are struggling with nurses getting on-board with EWS (patient observations and accuracy). They feel there is no follow-up post audits. They also feel that the hospital does not acknowledge Outreach services and EWS.

Counties discussed a new Governance Group that has EWS under their umbrella and is now looking at education around EWS.

We need to work as a Collective to influence policy. I.e. developing NZews.
Important to keep informed, educated. Need people at the top of the game – professionalism, behaviour, education.

Mo suggested we think outside of the box and look at our own professional updating. What are our own key learning needs? Research, anatomy and physiology, assessment skills?
Look at key opportunities and collectively work to support each other.

So to ponder...
What does this group want?
How formal do we want it to be?
Who drives it all?
Does a more formal sub-group need to be established?
Continue to communicate through group e-mail.
Need a structure for NZews – we want to be involved in the Consultation process.

Thank you to all who participated in the day. It was great to catch up with you all.