Minutes (New Directions: 26th June 2015)

Thank you to all attendees for making the trip to Wellington, for what turned out to be another fantastic national outreach meeting. I would like to personally thank our two sponsors again for providing us with a vast spread of delicious treats (VitalPAC Geneva Health & ANZICS) that kept us going for the whole day. Thank you also to the Life Flight Trust who kindly hosted us in their Meeting Room, and kept the coffee flowing freely.

The day was chaired by Anne Pedersen (Clinical Nurse Specialist Patient at Risk, Wellington Hospital) and focused on new developments that are challenging critical care outreach services in New Zealand hospitals.

Presentations 1&2 are available at:
http://www.nzno.org.nz/groups/colleges/new_zealand_college_of_critical_care_nurses/outreach_nurses

Speaker 1: Alex Psirides "NZ MET study; Rapid Response & MET Training"
Dr Alex Psirides works as an Intensive Care Specialist at Wellington Hospital and is a keynote speaker at international ICU and Rapid Response conferences. Alex kindly shared some of the key findings from his latest study 'Characteristics and Outcomes of Medical Emergency Team calls in New Zealand hospitals – a prospective observational study.'

For those interested to learn more about the 'NZ MET' study, you can hear Alex present the results at the Safety Quality ANZICS meeting in the Gold Coast 6th & 7th July 2015.

Alex then explored the training needs of rapid response teams, the impact of silos and system failures within acute care hospitals to deliver better early recognition and response systems.

Speaker 2: Gabrielle Nicholson "Health Quality & Safety Commission & Quality Improvement Programmes"
Gabrielle is a senior portfolio manager at the HQSC, and presented on how the HQSC approaches quality improvement. The HQSC leads and coordinates work across the health and disability sector with an aim to improve health equity for all populations; improve quality, safety and experience of care; and provide better value for public health resources. Improvement projects focus on a specific area for improvement, build on sustainability and require process and outcome measures to demonstrate impact on quality and safety markers.

In terms of the **deteriorating patient**, the HQSC has:
1. scoped a new improvement programme with Sapere Research Group (experts in health economics)
2. held a national workshop December 2015 with clinical experts from all around the country
3. reviewed national and international approaches to rapid response and clinical outcomes
4. Presented an advisory report to the HQSC Board

The Board agreed to proceed with further scoping and planning for an improvement programme for the deteriorating patient. The three main work streams that are being considered are:

1. Provide a 'gold standard' early warning score and vital sign chart & promote rapid response teams
2. Develop an approach to improve patient and family involvement
3. Develop an approach to ensure that patients have a 'Goals of Care Plan' to avoid unwanted treatment, such as futile CPR

From July 2015, an implementation plan will be scoped with support from clinical experts, which will be presented to the HQSC Board for approval April 2016.

Speaker 3:Bronwyn Farnell "VitalPAC automated EWS & IT solutions"

Bronwyn from Geneva Health presented on the latest developments with the UK VitalPAC system. The VitalPAC product has advanced considerably from its earlier days as an automated hand-held device for reporting vital signs, calculating Early Warning Scores; then triggering an automated response.

The VitalPAC suite now includes organisational and management systems (e.g.VitalFlo) which help locate 'at risk' patients; and links patients to their clinical record.

To date no New Zealand hospitals have implemented VitalPAC; Canterbury DHB is due to launch an alternative system this year (Patient Track). Although there is considerable interest from hospital clinicians and some IT departments, there are no plans (yet) to adopt these kinds of IT solutions into clinical practice, at a national level. It was acknowledged that standardising the NZ EWS would be an important first step, to then being able to look at the implementation of hand-held automated EWS systems.

Speaker 4: Jo Wailing & Teresa Thompson "Developing a regional approach to the deteriorating patient"

Apologies accepted for Jo who was unable to attend. Teresa is Charge Nurse Manger of ICU at Hutt Hospital and has been integral in supporting developments with the critical care outreach team. Hutt Valley, Wairarapa and Capital & Coast DHBs formed a 'Critical Care Network' in 2013. The purpose was to align critical care practice and develop a 3DHB approach to policy and practice. The key areas for the 3DHBs were: establish a governance framework, explore inter-hospital resources for the critically ill patient (including transport), establish a 3DHB EWS and vital sign chart; and set up telemedicine between the 3 hospitals. Some of the driving forces behind the need for a critical care network included:

- Critical care capacity in the sub-region
- Inequality in access to critical care specialists (resulting in delayed transfer to ICU)
- Work force gaps
- Inter-DHB communication

The network found that there were no NZ critical care networks to learn from, therefore they identified other countries with similar geographical challenges and populations instead: Wales and Norway.

Progress to date:

- Support obtained from Clinicians in all 3 DHBs
- Reduction in clinical incidents and improved recognition and intervention in critical illness at Wairarapa hospital.
- Telemedicine agreed across all 3DHBs, for roll-out with IT support end 2015
- National project for flight retrieval has gained Ministry of Health approval for a scoping document
- CCDHB is collecting data regarding the wider critical care network
- Support for the Critical Care Network from COOs across multiple DHBs in the lower North Island catchment area
- Hutt Valley were first to launch the new EWS and Vital Sign Charts (June 2015) – note that the EWS is standardised but the escalation pathway has been tailored to each hospital's resources

Roundtable

Nelson Marlborough DHB

Nelson Hospital currently has no CCO service. A business case in support of developing a CCO role is going to be submitted end 2015.

Capital & Coast DHB

The Patient At Risk (PAR) team is a 24/7, seven days a week service,resourced with 3.9FTE (previously 4.2). We have between 6-12 vacant shifts per roster, most of which are picked up as extras by the PAR nurses. We have record levels of sickness calls. The role of the PAR nurse remains the same - supporting patients, families and healthcare professionals by: responding to clinical emergencies and acute referrals; monitoring patients recently discharged from ICU; and providing education and advice in the management of acutely ill ward patients. In 2014 we had record numbers of referrals (3452) including: 1117 MET calls & 216 paediatric referrals. This is on a back drop of hospital mortality decreasing from 2.05 – 1.42% (2009-2014); which reflects well on the PAR, EWS and MET systems we have in place at CCDHB.

Counties Manukau (Middlemore)

The PAR team continues to have 2 PAR nurses on duty 24/7, seven days a week (12.6 FTE). The service is due to trial Call And Respond Early (C.A.R.E) patient & family escalation on 2 wards soon. There have been a number of publications in critical care journals form the Middlemore team, and Lesley Kazula will be applying for Nurse Practitioner at the Nursing Council in the next few months. The team is supported by a Clinical Psychologist (as part of ICU).

Whanganui

Waitemata

The PAR team have 7.2FTE (of which 2.8 is CNS) and cover two campuses: North Shore and Waitakere. North Shore is the larger hospital and provides cover 7am-10:30pm; Waitakere has

cover 2pm-10:30pm. The focus of the team is prevention through education, and they do not attend clinical emergencies. Waitemata run an acute care training course called 'ACT' for which they have 20-30 attendees per month. ACT is a scenario-based course. An automated EWS system is being looked at this year.

Waikato DHB
Waikato runs its CCO service on 5.2FTE. They have developed a comprehensive E-Learning package that focuses on early recognition and response, and EWS.

Hutt Valley DHB
Hutt continue to operate a CCO team with 1.4FTE, covering afternoons and evenings, 7 days per week. The CCO nurses roam the wards to identify at risk patients. They are also involved with teaching the ALERT course, when time permits. The CCO team provide quarterly EWS compliance reports to Clinical Director & CNM of ICU.

Lakes (Rotorua)
Lakes are trialling a new CCO role for 6 months. The CCO nurse operates Thursday – Sunday afternoons and nights, using 2.3FTE. This is in addition to a Clinical Resource Nurse role (0.6FTE). The CCO focus on supporting ward staff and team building.

Wakefield
Wakefield continues to run a PAR service 24/7, seven days a week from rostered ICU staff (i.e. off the floor). Their workload is evenly split – 50% ICU follow-up reviews and 50% acute referrals.

Meeting closed