Auckland District Health Board Patient at Risk (PaR) Team

Governance, development & delivery

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ADHB: Background

ADHB pre-2017 (Adults):

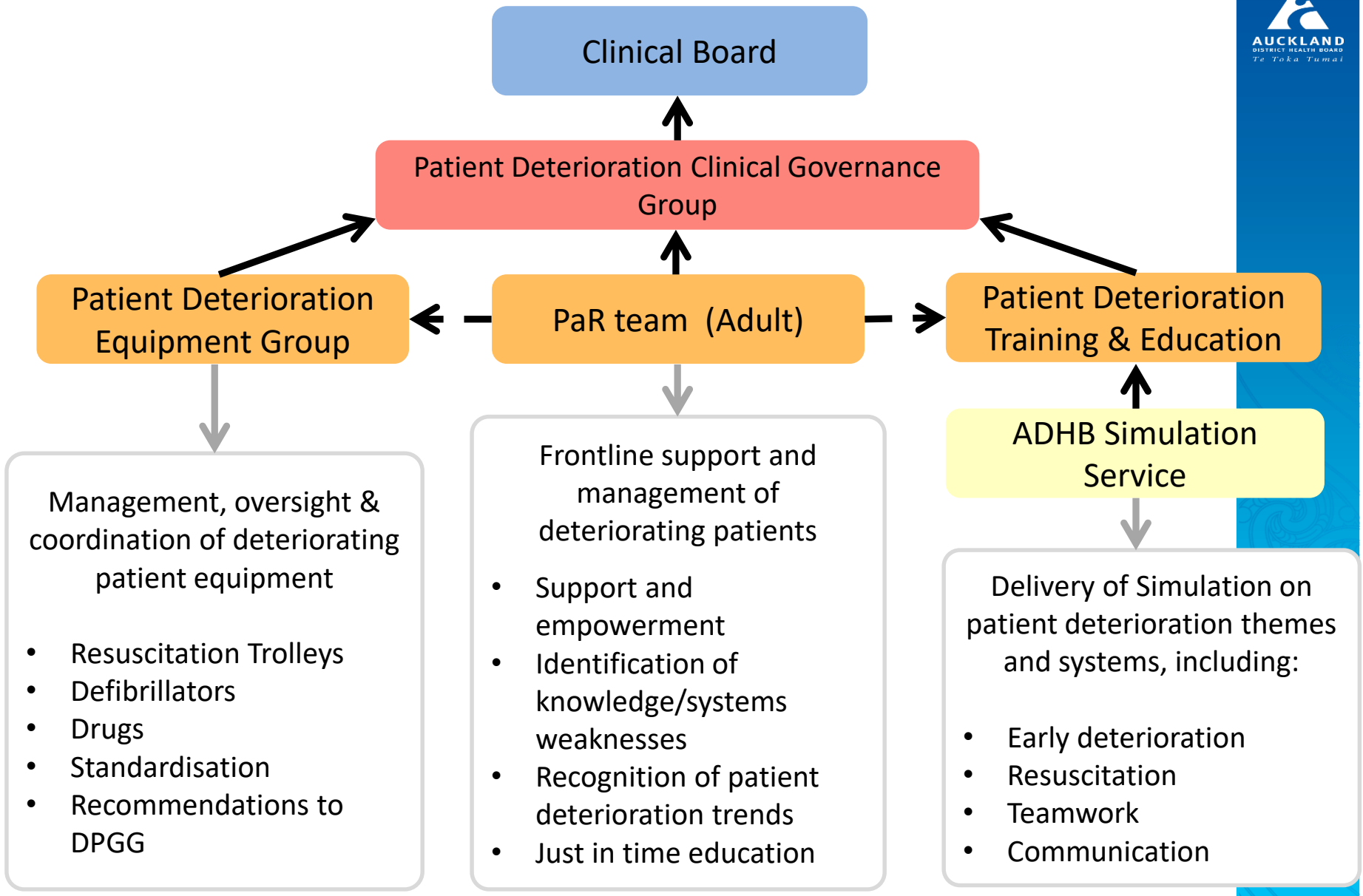
- Local EWS-based vital signs chart
- No dedicated patient-at-risk nursing team
- No overarching clinical governance of patient deterioration
- Low quality data collection
- Adverse events & failures to escalate
- 2016: Provider-group level directive
- 2017: 24/7 re-structure

24/7 Restructure

- CNA role disestablished
- Patient at Risk (PaR) team introduced
  - PaR Nurse Specialists (10.3 FTE)
  - PaR Charge Nurse (1.0 FTE)
  - PaR SMO (0.5 FTE)
  - Team administration support (0.4 FTE)
- Patient Deterioration Clinical Governance Group

Governance

Auckland District Health Board



Deteriorating Patient Clinincal Governance Group (DPCGG)

Membership:

- Director, Clinical Quality & Safety (Chair)
- Lead SMO PAR – Adult & Child
- Director, Adult Medical
- Director, Child Health – Medical
- Nurse Director, Cardiovascular & Surgical Directorates
- Resuscitation Coordinator
- Leader, Nurse Consultant – Safe Care Programme
- Chief Medical Officer
- Service Improvement Manager
- Charge Nurse PAR – Adult & Child Health
- Service Clinical Director, Department Critical Care Medicine
- SMO- Women's Health
- SMO- Emergency Care
- SMO- Anaesthetics

PaR team (Adult)

Team Vision:

" Best possible outcomes for at risk and deteriorating patients"

WELCOME Haere Mai	RESPECT Manaaki	TOGETHER Tuhono	AIM HIGH Angamua
• Leadership	• Teamwork	• Communication • Support & Empower	• Professionalism • Organisation knowledge

New Zealand Early Warning Score (NZEWS)

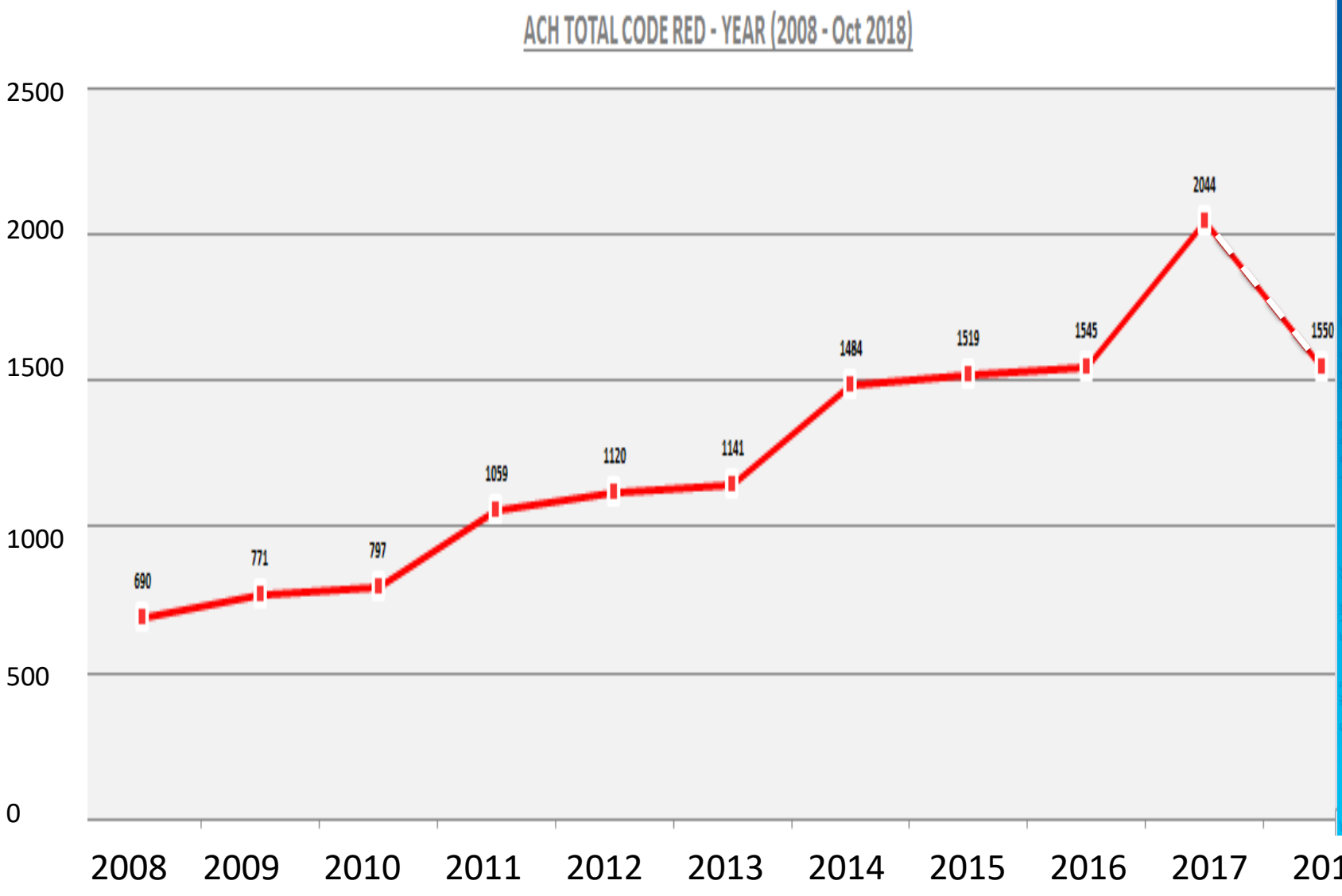
- PaR team features throughout ADHBs NZEWS response pathway
- Phased rollout started November 2017
- Mixed methodology engagement & delivery
- Database, auditing and feedback

ADHB: Patient deterioration data

- Pre-2017 data and sources
- Database development and revisions
- Database reporting and HQSC
- Feeding back to the wards

National patient deterioration programme performance for 01 Dec 2017 to 30 Nov 2018

Rapid Response Team escalations 2008-2018



IC-26 (2017)

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MINIMUM STANDARDS FOR INTENSIVE CARE UNIT BASED RAPID RESPONSE SYSTEMS

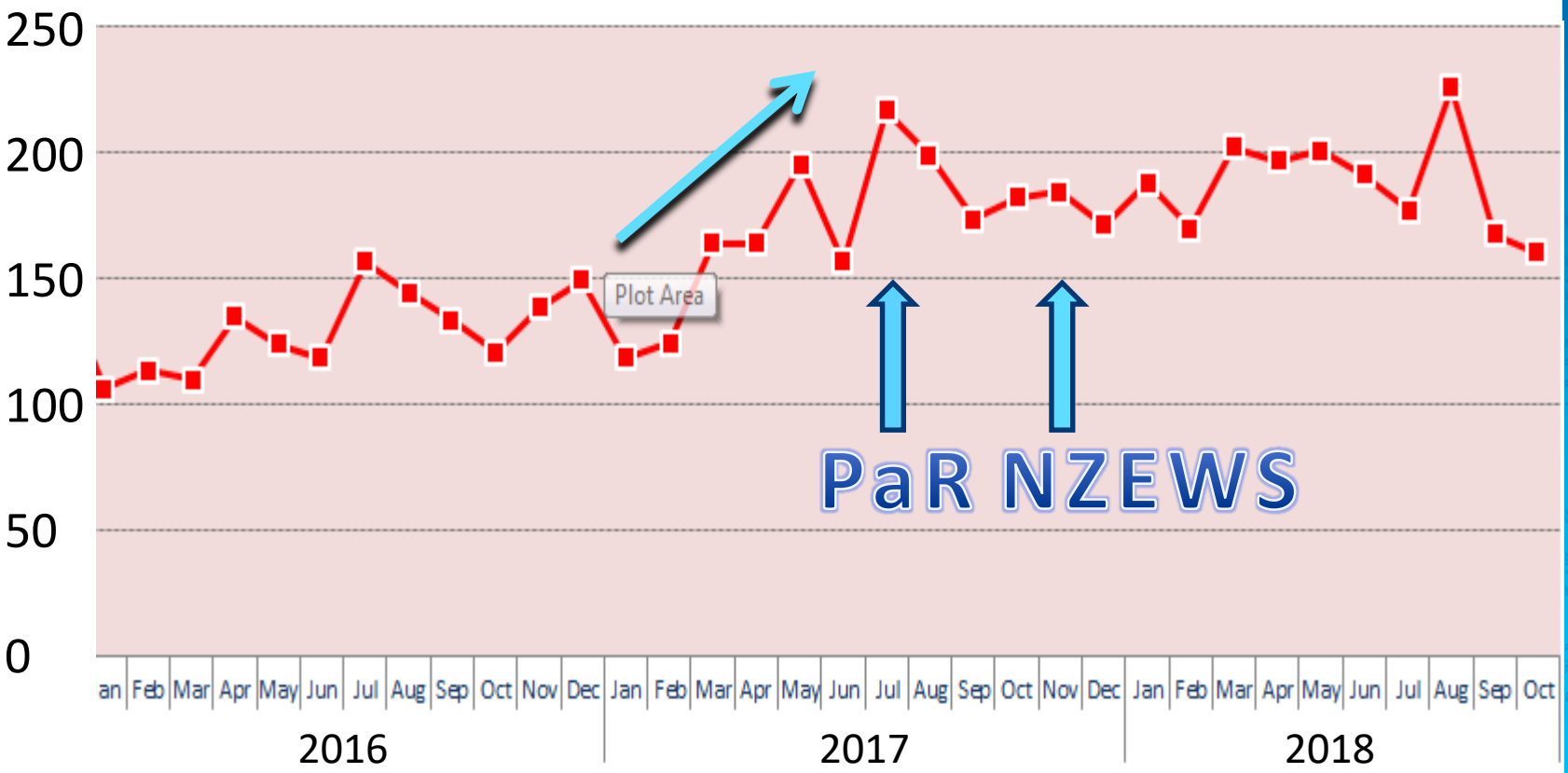
The ICU staff should be immediately available to attend RRT activations. However, the appropriateness of the system's capacity to attend simultaneous activations is the institution's responsibility to determine. Where a team is immediately available, the institution should define minimum standards for response times appropriate to that institution. A response time of less than ten minutes would be typically expected from an ICU team in a large hospital.

Once RRS calls reach a volume of more than 2000 per annum average a separate ICU medical officer and nurse to the ICU treating team should be rostered for the RRT.

ICU trainees must not be rostered for RRT shifts for more than 25% of their clinical time. At least 75% of their clinical time must be spent managing patients within the ICU.

The RRT should be overseen by an intensive care specialist who is immediately available for advice to the ICU medical officer and to attend to the RRS call where specialist expertise is required. In large tertiary ICUs with RRS calls of >2000 per annum a separate specialist roster for RRS oversight is recommended.

Rapid Response Team escalations: 2016- Oct 2018



ADHB Governance: What helped us……

- Absolute support and buy-in from the top down
- Patient Deterioration Clinical Governance Group
- Resource to get the job done
  - Experienced mix of nurse specialists
  - SMO and Charge Nurse
  - Team administration
  - Performance improvement
  - Business intelligence support
- Data to guide service development