28 June 2019 (2nd Edition)

Theatres, Critical Care and Anaesthetics

Joint Critical Care Outreach Team (CCOT) and Hospital Out of Hours (HOOH) Newsletter

Working together for a safer Southend.....

We heard that you found our last Newsletter useful..... so here is the 2nd Edition. We would like to take this opportunity to also formally introduce you to the HOOH team who we work very closely with, although we have rather different roles.....

care with compassion | working together | professional & accountable

Meet the HOOH Team.....

← Rhona Hayden (HOOH and Outreach)

← Kerry Fretton

Karen Neville →

← Carys Keenlyeside

Cathy Carter →

← Anna Anthony

Sherri Bradshaw →

The team receive and allocate all electronically submitted tasks to the most appropriate Drs, considering their current workload, location and experience. This means the Drs can work more efficiently. Drs can even set tasks to alert to their teams when off duty to support patient care. HOOH also respond to emergency calls and are automatically alerted to NEWS>5 or a single parameter of 3.

The expert team have Site Manager and Critical Care Outreach Backgrounds.

HOOH and CCOT work closely together, supporting each other and communicating regularly to manage our workloads efficiently. We have a shared goal to support you to help keep our patients safe.

HOOH working hours:
19.30pm-7.30am M-F
24/7 Sat/Sun/Bank Holidays.
Nervecencre Task Management System is open for requests 7.30pm – 7.30am.
All red tasks must be bleeped through on 4400 or via the Dr on call bleep for the appropriate area.

Shaddow Opportunity: If you would like to shadow the HOOH or CCOT team to gain a better understanding of the services we offer, just email us.

Recent News, policy updates and links:

- Tracheostomy SOP (SOPC078) and Laryngectomy SOP (SOPC077)
- Outreach policy is currently being updated (CL12 [T1])
- New fluid chart criteria are being reviewed
- New and improved TEP (Order from Office Depot)
- TEP policy (CL37 [T1])
- New peri/cardiac arrest debrief tool (CCOT or HOOH will complete after every call)
- Deteriorating Patient Policy (CL37 [T2]) http://intranet/policies2/clinical/Policies%20library/CL37%20[T2]%20Deteriorating%20Patient%20Pathway.pdf
- HOOH policy + SOP (CM113 [T1] + SOPO042)
- PGD policy (MMP031 + PGD179)
- New and improved Student Nurse/Newly Qualified RN opportunities coming soon
- Regular Educational Hot Topic is every issue (Suggestions welcome!)
- NEWS 2 explained (Access the e-learning at: http://bit.ly/2AorjLw)
- Keep your eyes peeled for our revamped We're Listening Service information
- We are attending the National Patient Safety Congress so hope to bring you back lots of new ideas.

Have a great idea you would like to implement?

Our teams are well placed to help support most new innovations across the trust. If you would like our help, just ask! ☺

New Treatment Escalation Plan (TEP) (by R. Hayden, K. Neville, S. Bradshaw)

As part of an quality improvement strategy, we have re-designed the TEP form. From 3 June 2019, all adult patients admitted to hospital (excluding maternity services) should have a TEP form completed.
The form should be completed within 24 hours of admission.

Forms can be completed by any doctor, however if below ST3 they should be countersigned and/or documented discussion with responsible senior doctor who is on duty at that time. Once the form has been completed, NerveCentre must be simultaneously updated to record the TEP status (i.e. for full escalation/selective treatment/ ward based care) plus DNAR if applicable. Our aim for this revision is to improve the management of deteriorating patients. From conducting feedback during medical emergencies, one of the concerns raised was the absence of an escalation plan in the notes. We will be reviewing all wards to ensure compliance of the new TEP.

New Debrief Tool

A debrief tool has been designed which CCOT and HOOH are routinely completing following every peri/cardiac arrest. We will be reviewing these to inform future improvements.

It is understood that healthcare professionals often report feeling unsupported with having difficult conversations about death and dying; here are some useful links we have found which may be useful:

https://soundcloud.com/bmjpodcasts/talking-honestly-about-intensive-care

https://www.bbc.com/ideas/videos/dying-is-not-as-bad-as-you-think/p062m0xt

https://medium.com/death-dying-and-digital/do-not-resuscitate-waiting-for-a-blue-planet-moment-8cd8b1277fc0

On Twitter:

#TalkCPR

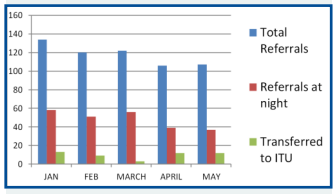
@drkathrynmannix

@kimberleystjohn

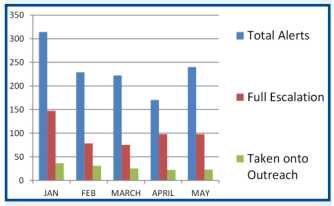
@AGoodDeath

Outreach Figures so far for 2019. (by M. Laird)

- Total number of referrals to Outreach, with number of those referred at night. Number of referrals transferred to ITU.



- Total Number of Alerts on Nerve Centre >7. How many of those for Full Escalation. How many of those were taken onto Outreach as a result of an Alert not a Referral.



- Patients reviewed following discharge from ITU/HDU = **223**

What's New with NEWS2? (Royal College of Physicians (RCP) 2017)

Following an evaluation of NEWS, the RCP have updated this to NEWS2 aiming to improve identification, urgency and response to clinical deterioration for safer and improved care.

The formally known 'low target sats' is now NEWs Sats Scale 2

Scale 1: The original score used for most patients.

Scale 2: For patients who have target oxygen saturations of 88-92%. This must be confirmed with an Arterial Blood Gas (ABG) and prescribed on JAC.

C is New Confusion: This is to identify any new confusion that is worse than the patient's baseline.
!! Please be extra-mindful of those with Dementia or Learning Difficulties as this is a red flag for sepsis screening !!

NEWS> 5 - Complete sepsis screening as a national requirement as per NICE guidelines. Nervecentre will prompt you for this. Please also consider the requirement of a fluid chart as per the Outreach policy.
NEWS> 7 - Consider CCOT referral
Please never doubt your clinical judgement and let a number take precedence. If in doubt.....shout it out!

As there is currently no local/internal training video or guide at present, a FREE dedicated online training resource aimed at professionals using NEWS2. https://news.ocbmedia.com/

The HOOH team have already provided training sheets, however for further clarification please contact them directly via bleep or approach them when they visit your area.

JUST ASK 'COULD IT BE SEPSIS?'

Remember to complete the front and back of the Sepsis Screening Tool within 1 hour for any patient NEWS>5 and document on Nervecentre. It's there to help you!

Follow Up Clinic (by Angela Meads, Outreach Nurse)

Did you know patients who are discharged from Critical Care following a period of ventilation and sedation can suffer from various psychological, as well as physical problems? These can include flashbacks, nightmares, hallucinations, depression and short-term memory loss.

In 2015, I started a monthly nurse-led follow up clinic to try to address these issues. My clinic supports the patients to access and arrange counselling or rehabilitation if required. Patients are relieved and reassured that the symptoms they are experiencing are normal, and in time will resolve. Patients are given the opportunity to revisit the Critical Care and High Dependency Units if and when they feel ready and I support them throughout this process.

Patient Group Directives (PGDs) & Medication Bundles on JAC (by Cathy Carter)

Please remember to use PGDs available on JAC for stat doses of certain medications. Drugs available paracetamol, simple linctus, senna and lactulose. Take a look on JAC and familiarise yourself with what is available. It's great learning for you and quicker for patient care and treatment. Remember to complete the NEW ilearn JAC course which takes only a few minutes. Only use IV paracetamol if necessary, it's expensive and sometimes unnecessary to wait for a prescriber if it can be administered via a PGD.

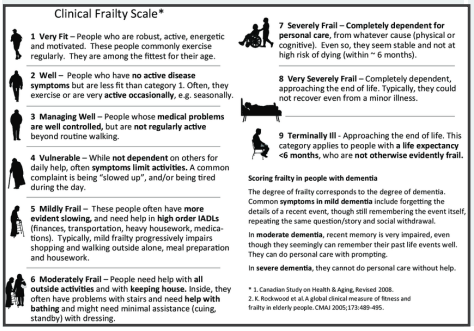
If a patient can swallow, please offer them tablet or dispersible before considering IV. Any questions, please do not hesitate to contact HOOH team with any questions concerning PGDs.

Frailty—what's it all about? (by Julie Bush, Frailty CNS)

"A distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves"
Frailty leads to reduced resilience and increased vulnerability to decompensation after a stressor event, such as minor illness, hospital admission, falls and bereavement. The presence of frailty can affect outcomes for patients and potentially mask more serious conditions. Therefore, it is essential that we are able to assess the level of frailty our patients are living with so more realistic & personalised management plans for their care and ongoing needs can be set.
There are 5 'frailty syndromes' which if present, can indicate that the person is living with a degree of frailty:

- Incontinence
- Falls
- Immobility
- Delirium
- Susceptibility to side effects of medications

It is possible that any of these syndromes can be present without frailty; however the presence of frailty is important to establish as more serious conditions such as stroke, pneumonia or myocardial infarction could potentially be masked; presenting as a sudden deterioration in mobility or a fall, in those living with some degree of frailty. The chosen tool to assess frailty at Southend, Basildon and Broomfield is the **Rockwood Clinical Frailty Scale (CFS). (see link below)**


Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail – Completely dependent for personal care,** from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months,** who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Frailty Team;
Lead Nurse: Louisa Brown.
Nurse Specialists- Julie Bush & John Radley.
Bleep: 5012
Frailty@southend.nhs.uk
Available; M-F(8am -4pm)

https://docs.wixstatic.com/ugd/2a1cfa_e5e2c60f3d3d4449bbdd5e85aeb915f3.pdf

Transfers of the Critically Unwell Patients (by Jisha Nice, Outreach Nurse)

Transfers of critically unwell patients are always a challenging task. This is one of the roles and responsibilities of our Outreach team; ensuring this is done safely. We ensure that the appropriate transfer equipment is available and is in good working condition. In 2018 we carried out **more than 130 internal transfers and 30 external transfers to other hospitals.**

In February 2018 transfer training at Southend Hospital was launched. This was organised by Sr Gillian Donohue (CNM, Critical Care) and provides a multi-professional course for anaesthetists, critical care nurses, A&E nurses and ODPs. So far we have completed 4 training days and will be arranging more later in the year. The course is backed by East of England Operational network for transfer and is conducted in our simulation suite. It includes lectures, discussions and simulation case scenarios.

Adding to our recently welcomed Mindray Transfer monitor, we are excited to have received our brand new Drager 300 plus Oxylog transfer ventilators. We will be supporting A+E to put our older ones to good use.

A gift from a patient.....

To my nurses... Thankyou.

Thankyou for being the communicator, the listener, the empath. Thankyou for translating what I don't understand. Thankyou for seeing my vulnerability and holding space for me as I reach for some control. Being a patient is scary, we're out of our depth. Your kind understanding and heartfelt connection brings trust and relief in times of angst. We may be ignorant to the colour you wear, the tasks you must complete, for that I apologise. But please know, the moments you spend checking in with us, when our souls in the dark, brings a light that heals beyond what can be seen. Hope over fear.

The angels that walk the earth... walk the wards!

Educational Hot Topic - Nervecentre Tips and Tricks

nervecentre

"To request a future HOT TOPIC, just email us and we will do our best to help"

- Ward based care is a model that can only be applied by senior nurses and should be used with caution as this removes escalations and NEWS based frequencies. This should be a decision made by a clinician.
- Treatment Escalation Plan (TEP) decisions must be updated on Nervecentre simultaneously. Please always ensure the TEP and DNAR status are ALWAYS up to date.
- Any doubts about your patients' escalation plan, clarify as a matter of urgency with their team.
- Most fields within Nervecentre have an arrow drop down ▼which allows you to view all historical entries. Using the 'revert changes' button will input previously entered data. Viewing previous TEP/DNAR decisions can help provide confidence to teams.
- High NEWS electronic alerts are not an alternative for human interaction. Policy states you must ALWAYS bleep or call CCOT to refer any patient.
- Please be mindful when you press submit..... if you have a plan in place and do not need assistance to proceed, please do not alert all teams as it makes us far less efficient. Just 'swipe left' and state your reason.
- All-electronic documentation will be upon us in the near future (or so we hope). Be safe and accountable and remember Nervecentre is an electronic form of medical notes.
- So much of Nervecentre is unused, have a look with your teams and look for new ways you can utilise it to it's fullest. Do you really need paper stool charts if you responsibly electronically document daily?
- Have a look at any patients on your ward who remain with 'Incomplete TEPS' using the list function.
- There is also a smart list which identifies any patient with a Clinical Frailty Score of 5-9.
- For a ad-hoc lesson, just ask HOOH, CCOT or Jackie Hawes.
- Any issues with permissions or status should be escalated to Jackie Hawes the Nervecentre Application Lead.
- Further information sheets will be available soon.

Follow us on Twitter:

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Want to be included in our quarterly Newsletter distribution list?
Email: Danielle Haupt
Danielle.haupt@southend.nhs.uk

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Bleeps: CCOT: 3329 HOOH: 4400,
Email: OutreachTeam@southend.nhs.uk
HospitalOutOfHours@southend.nhs.uk
Cardiac Arrest: 2222
Medical Emergency: 3333