Topic Guide: Outreach Team Staff

- Any systems in place to help monitor patients in order to detect those at risk prior to any changes clinically? e.g. Frailty assessments.
    - How are these recorded?
- How are deteriorating patients identified?
    - What cues are used most to identify deteriorating patients?
    - Changes in which vital signs do you feel are most indicative of a deteriorating patient?
    - Are lab results available quickly enough to be used to identify deteriorating patients and do you feel they are a good indicator?
    - Views on the benefit of electronic automated vital signs monitors rather than just relying on handwritten charts?
- Does your hospital policy/protocol include the use of NEWS (or similar)?
    - Do staff use it?
    - How often is it recorded for patients? How is this decided?
    - Do you find it useful?
    - Availability of senior staff?
    - Do you feel comfortable and supported in deciding to call the outreach team based on just a feeling something is wrong with a patient, even if they do not meet the Track and trigger criteria?
- Calling Criteria (Once they are identified, what happens next?)
    - What observations are measured as key to alerting the outreach team?
    - Single vital sign triggers or NEWS?
    - Is any form of technology used for automatic alerts?
    - If trigger occurs, is it then voluntary or mandatory to call the outreach team?
    - Who calls the outreach team (nurse/Dr/pt/family)?
    - Who is contacted and how (eg. Bleep)?
    - How quickly should they then respond?
    - Are they utilised appropriately?
    - What are the main barriers to calling the outreach team?
- How many RRT does your hospital have (e.g.MET/outreach)?
    - Who's in it - How many people?

- o Who leads it - nurse/physician?

- o Does it include a specialty staff eg. pharmacist or respiratory therapist?

- o Is there a sepsis response team in addition to this?

- What do the outreach team do?

  - o Actions/treatments?

  - o Follow-up of pts who don't go to ICU?

- Views on the effectiveness of the outreach team

  - o Do they respond quickly enough?

  - o Do you feel they are beneficial to patient care?

  - o How could it be improved?

- Is there any formal handover structure used?

  - o Written/verbal…

- What triaging system is used by the outreach team /how do they decide if a patient should be transferred to ICU or can stay on the ward?

  - o Does the outreach team use proactive rounding (going through ward patients to pre-empt those who seem like they may deteriorate)? Do you feel this would be useful?

  - o Does the team work well together? What aspects do you feel are important to ensuring a successful outreach team?

  - o Do you feel well received by the ward staff?

- Is there any follow up of patients? How? By who?

- Potential problems of an outreach team?

  - o "deskilling" of ward staff

  - o Decreased level of attention to patients not at risk of deteriorating

  - o Staff conflict/communication errors

  - o Diversion of outreach team members away from ICU

- Do you feel that the change in European working time directives has had an effect on the identification and care of deteriorating patients?

  - o Prompts relating to handover

- Communication and strong leadership is coming up as an important factor to enable critical care to be done effectively throughout the hospital, at every level.

- o Is it still very hierarchical or is there more collaborative working, especially with the creation of more roles for nurses, eg. Nurse practitioner, that sees nurses working alongside doctors more now.

Higher level organisational systems Background info

- o What was the motivation behind setting up strategies to improve identification and treatment of deteriorating patients?
- o Any local/national guidelines that were particularly helpful?
- o Where does the funding come from?
- o How did you decide to use an outreach team /Track and Trigger?
- Implementation of an outreach team
  - o Was a specific tool kit used?
  - o What type of education/training was given to staff? Information only or simulation-based?
- Networking/exchanging info
  - o Do you have any system/forum (eg. Local or regional meetings) for information sharing of good/bad practice with other hospitals?
  - o Websites used for info?

- Audit and evaluation
  - o Have you done any sort of audit of your outreach team/ Track and Trigger/handover/education systems to assess how effective they've been?
  - o Are results fed back to staff?
  - o What are the goals/aims of having implemented the outreach team?
  - o Has it been cost-effective?
  - o What effect has it had in terms of bed management in the hospital?
  - o How is the data on deteriorating patients collected?
  - o Is the trust participating in the National Cardiac Arrest Audit?
  - o Any idea of the stats for the hospital?
- Education
  - o What educational opportunities are required/available to staff? Eg. ALERT.

- o Mortality and Morbidity meetings?
- o Does the induction for new starters involve anything specific to deteriorating patients?
- o Any educational information available to patients or their relatives?

Outliers, HDU/step down.

DNACPR/ceilings of care- who puts in place? Standard policy on this? Way of flagging this to staff out of hours?

Any tools used for predicting severe adverse events following patient discharge from ICU to a ward?

Uniformity across the hospital?

Resources

- Financial incentives such as CQUINS
- Impact of critical care bed availability on approach towards deteriorating pts?
- Staffing on the wards impact on deteriorating patients?
- Electronic patient record
- Flag bloods, observations, etc if patient deteriorating?
- Timeline of high level interventions eg Reports from NICE, RCP etc
- Where are the weak links in the chain- where do patients fall through the gaps?
- What makes the biggest impact?