Service specifications for Critical Care Outreach Services
Introduction
The quality requirements for critical care in Wales published in 2006 set out the foundation for the establishment of critical care outreach services to augment the care given in critical care areas:

Role and function of critical care outreach
Outreach is aimed at augmenting the effectiveness of critical care units by enabling critical care expertise to be utilised at all stages in the evolution of a patient’s critical illness, both within and outside the critical care unit.

Outreach is a collaboration and partnership between the critical care department and every ward. A multi-disciplinary outreach team should be utilised following the identification of deteriorating health to provide advice, support education and a link to the critical care facility.

The outreach team should support and facilitate the ability of ward staff to:

• Identify patients who are at risk of developing life threatening acute illness using simple risk assessment tools based on vital sign observation.
• Initiate immediate resuscitative action.
• Make appropriate referral, documentation and communication.
• Provide psychological and physiological surveillance to patients post critical care discharge.
• Provide outpatient clinics to provide psychological and physiological surveillance following discharge from hospital.
• Educate and train ward staff in the identification of deteriorating physiological signs, the use of appropriate early warning scoring systems and institution of appropriate treatments.

These were later supplemented by the NICE Guidelines on the care of the acutely ill patient in hospital (CG50).

The South East Wales Critical Care Network (SEWCCN) commissioned a group to write service specifications for outreach services that will enable Trusts to establish such services in accordance with current guidelines and advice.

The following document sets out the service specifications and includes relevant appendices as a blueprint for a safe and effective Critical Care Outreach Service. The specifications are intended to instruct individual hospitals how to provide this service in a consistent way across the Network, whilst allowing the continuation of already existing practices whenever possible.

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Service specifications for Critical Care Outreach Services to comply with NICE Guidance
CG50

General
- An outreach service should provide a universal, consistent ‘safety net’ to all patients in all areas of a hospital.
- The outreach service should be under the ownership of the critical care service. This will ensure the transition between ward and critical care areas is smoother. Involvement of other specialties such as acute medicine may be arranged locally.
- Network guidance should ensure a consistent standard and model for outreach and provide a basis for funding applications within individual trusts.
- Its staffing should be ‘self sufficient’ and not draw on resources from critical care areas so as to affect nurse: patient ratios. Leave requirements should be covered by the service itself. There must be resources for study leave to maintain and update the skills of the staff.
- Individual hospitals may implement network guidance in a way that suits their own structures and personnel, providing that a safe, consistent standard of care is provided.
- Ward clinical responsibility for patients referred to outreach remains with the admitting team or their deputies.
- The outreach team can be nurse led with immediately available medical support as required. Medical staff with critical care training must be available to support the outreach team.
- There must be a named clinical lead for the service in each hospital.
- An advanced Nurse Practitioner should lead the outreach nursing team.
- A range of Senior Registered Practitioners with a minimum of 4 years experience in critical care nursing should deliver the outreach nursing service on a continuous basis.
- Outreach nurses must be competent to prescribe in emergency situations in accordance with local policies and procedures.
- Involvement with non-critical care nursing staff is essential to ensure inclusiveness with the service and avoid unnecessary perception of ‘us and them’. This will also provide a teaching interface to cascade skills to the wards.
- Outreach must receive experienced input from other specialties e.g. dietetics, speech and language therapy, psychology and physiotherapy (see appendix 1.), as required and access to this resource should be adequately funded by Trusts in line with the Quality Requirements.
- Following referral to outreach, the treatment plan devised should be implemented by the ward staff immediately with support from outreach as agreed.

Pre-Admission and Ward Care
- Access to the service should be available to all staff (clinical, AHP and ancillary) via the nurse looking after that patient.
- The service should be consistent 24 hours a day, 7 days a week. Any ‘At night’ service should be the same as the daytime provision.
- There should be a clearly defined communication pathway for patients being identified as at risk. This should be site specific with named contacts.
- A Trust-specific scoring system should be used to identify at risk patients. Its use must be backed up with training for all users. Any local modifications must be agreed with the site outreach service.
- A site-specific clear protocol should be followed upon triggering outreach referral.
- Outreach should be called within a maximum of 15 minutes of a patient score ‘triggering’ and outreach should respond within 30 minutes of receiving the referral.
Post-Discharge from Critical Care

- Patients deemed ready for discharge should be discharged to ward care between the hours of 07:00 and 22:00. Outside these hours a critical incident form must be filled in.
- The outreach team should continue follow up of critical care discharges until they are deemed physiologically and psychologically stable enough for discharge from outreach. Longer term care may be provided by critical care rehabilitation services.
- Issues such as tracheostomy care, special nutritional requirements etc. should be coordinated by the team until handed over to ward based services to reduce the probability of preventable readmission. These should be covered by well-defined guidelines with appropriate resources to ensure their provision.
- Each discharged patient should have a discharge document with a summary of their stay on critical care and a statement of the patient’s continuing care needs. This form should be of a standard design across the network which combines ease of completion and clarity of information and it should be put in the patients notes. A multidisciplinary form(s) would be most appropriate.
- Discharges should be backed up with phone call to a designated recipient whenever possible (designated recipient being a member of the patient’s consultant’s team or the middle grade medical staff taking responsibility for the patient). This should ensure that immediate matters are addressed and handed over. This handover should be documented in the patient’s notes.

Education

- The outreach service should act as the source of education and support to facilitate ward staff caring for potentially unstable patients.
- Guidance on the acquisition and assessment of the necessary skills and competencies can be obtained from the DoH document ‘Competencies for Recognising and Responding to Acutely Ill Patients in Hospital’ (see attachments). This document also lists a number of courses that can be considered to facilitate critical and acute care service provision within health boards.
- Regular updating of training should be available and ward staff given the time and resources to attend this
- Teaching of medical staff may need a more formal arrangement and be placed within locally based programmes. The content of this teaching should be standardised across the network.

Equipment

- There should be a basic level of equipment and capabilities expected of a general ward such as the ability to give measured oxygen, measured IV fluids, suction and drug infusions etc. This should be formalised and endorsed by Trusts with appropriate resources allocated where necessary.
- All staff must receive training in the use of bedside equipment with which they are expected to work and this must be recorded.
- Equipment must be maintained and in working order.
- The outreach team will need access to a transfer monitor for managing unstable patients outside critical care until admission can be arranged.
- Individual hospitals may decide to produce a ‘kit bag’ of equipment/drugs that can be brought to the bedside to ensure a constant standard of resource provision, independent of individual ward conditions.
- There should be a review of nurse patient ratios on general wards that reflect that ward’s patient dependency levels. This may require an authenticated audit tool to measure this ‘care load’.
Audit

- There should be an agreed audit system of the service in place to measure outcomes and activity using a dataset consistent across the network.
Appendices

Appendix 1

The Role of the Critical Care Physiotherapist in supporting the Critical Care Outreach Team

- To act as a supporting member of the Critical Care Outreach Team [CCOT] in providing enhanced critical care assessment and monitoring skills in a ward based environment enabling prompt detection and effective management of emergency problems.
- To follow up patients discharged from Critical Care ensuring the early recognition of new and recurring problems.
- Provide highly specialist advice, teaching and training to other members of the Multi Disciplinary Team [MDT] to optimize their management of patients with Musculoskeletal and respiratory problems.
- Provide highly specialist advice to physiotherapy colleagues working within other clinical areas on:
  i. The care of the patients after discharge from Critical Care
  ii. The management of specialist interventions or procedures not routinely encountered on the ward such as the management of a tracheostomy.
  iii. The recognition of changes in a patient’s clinical status and condition.
- In conjunction with other members of the MDT to provide ongoing rehabilitation needs and goals in an inpatient and outpatient setting as part of an intensive care follow up service.

Appendix 2

The Role of the Clinical Psychologist within Critical Care Outreach Service

- To act as a member of the CCOT to ensure that psychological aspects of the patient’s rehabilitation are considered at each stage of the pathway.
- To advise on screening/short clinical assessment to identify patients at risk of psychological problems (most notably Post Traumatic Stress, Anxiety and Depression) and Cognitive dysfunction.
- To offer training, advice and consultation on the development and appropriate use of psychological first aid as a preventative intervention for a variety of psychological presentations including early PTS and distress from hallucinations.
- To advise on ‘comprehensive assessment’ of psychological rehabilitation needs and take referrals when screening carried out by CCOT indicates significant risk of psychological difficulties.
- To provide specialist consultation, training and advice to ward staff and other members of the CCOT on psychological aspects of care post critical. To include signposting to relevant psychological services post discharge for those identified through comprehensive assessment as having ongoing psychological difficulties.
- To work with the multidisciplinary team to ensure continuity in the provision of a comprehensive rehabilitation approach to critical care patients (on critical care, on ward and in the community)
Appendix 3

Minimum dataset for MEWS:
Eight variables that should be included as a minimum in any MEWS system used by units:
- Heart rate – in beats/min.
- Systolic blood pressure – in mmHg.
- Respiratory rate – in breaths/min.
- CNS assessment – using the AVPU scale.
- Urine output – in ml, preferably hourly but this will not be possible in non-catheterised patients.
- Temperature – in degrees Celsius.
- Inspired oxygen concentration – in litres/min or as %.
- Arterial oxygen saturation – in %.

Appendix 4

Measuring Outcomes

The aim of the audit will be to determine if the Critical Care Outreach Service is implementing and is in compliance with the NICE guideline (CG50).

- Physiological observations:
  - % of patients who have had their physiological observations recorded at the time of their admission or initial assessment
  - % of patients for whom a clear written monitoring plan that specifies which physiological observations should be recorded and how often is present within the health record.
- Identifying patients whose clinical condition is deteriorating or is at risk of deterioration:
  - % of patients monitored using a physiological track and trigger system
- Identifying patients whose clinical condition is deteriorating or is at risk of deteriorating:
  - % of patients whose physiological observations were monitored at least every 12 hours
  - % of patients for whom there is evidence of increased frequency of monitoring in response to the detection of abnormal physiology
- Graded response strategy:
  - There is an agreed and locally delivered graded response strategy in place for patients identified as being at risk of clinical deterioration
  - For patients admitted to Critical Care, the % of patients for whom there is evidence that the decision to admit was made by Consultant to Consultant referral
- Transfer of patients from Critical Care to general wards:
  - The % of patients transferred between 22.00 and 07.00hrs
  - The % of those transferred between 22.00 and 07.00hrs documented as an adverse event
- Care on the general ward following transfer:
  - % of patients for whom there is a formal structured handover of care from Critical Care staff to ward staff (both medical and nursing) supported by a written plan
  - % of patients for whom a formal structured handover of care (supported by a written plan) includes:
    - summary of Critical Care stay including diagnosis and treatment
    - a monitoring and investigation plan
    - a plan for on-going treatment including drugs and nutrition plan infection status and any agreed limitations of treatment
- physical and rehabilitation needs
- psychological and emotional needs
- specific communication or language needs

Calculation of compliance where % compliance can be measured can be calculated as follows:

\[
\text{Number within the population group whose care is consistent with the criterion} \times 100
\]
\[
\text{Number within the population group to whom the measure applies (that is the total population group less any exceptions)}
\]

As well as reporting the % compliance, it will often be useful to report the actual numerator and denominator figures to give an idea of scale.

**Attachments**

**NICE Guidance**

[Image]

**DoH Competencies**

[Image]