22 May 2017

Ms Emma Forbes
Senior Project Manager
Patient deterioration programme
NZ Health Quality & Safety Commission
PO Box 25 496
Wellington 6146

**Via email:** Emma.Forbes@hqsc.govt.nz

Dear Ms Forbes

**Proposed national recognition and response system**

Thank you for the opportunity to comment on HQSC's proposed national recognition and response system for acute physical deterioration for adult inpatients.

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates. It also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. RACS represents nine surgical specialties in New Zealand and Australia being: Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head-and-Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery. As part of its commitment to standards and professionalism, RACS strives to take informed and principled positions on issues related to surgical care in New Zealand including matters such as this proposed system.

HQSC has posed a number of questions on the proposed system and these have been responded to below.

*1. The summary document outlines components of an effective and sustainable recognition and response system. Are there any components missing?*

The document has been circulated to members of the RACS New Zealand National Board which includes representatives of the nine surgical specialties of the College. Feedback has been received from a number of surgeons and the overall impression is that the proposed process, the vital signs chart and early warning score and the escalation mapping tool are all appropriate. There were no missing components identified.

*2. In what ways does your organisation currently support implementation, sustainability and/or improvement of hospital recognition and response systems?*

RACS would support the introduction of a universal Early Warning Scoring (EWS) system and documentation process to all District Health Boards and private hospitals across New Zealand. The universal introduction would be more acceptable than having different systems and documents in different facilities. This would also reduce confusion and the risk of error where practitioners work across different facilities. RACS is cognisant of instances where there has been failure to notify the deteriorating patient and failure to rescue

*3. Does your organisation have any plans to implement training requirements for clinicians working as part of recognition and response systems?*

RACS supports surgical safety programmes and we would actively encourage New Zealand surgeons and surgical trainees to be aware of, and use, agreed processes.

*4. Are there other tools and guidance you believe would be useful for your members to support implementation of changes to current recognition and response systems in hospitals?*

RACS would support a comprehensive communication and implementation plan, similar to that used in the introduction of the surgical safety checklist.

*5. Do you have any further comments about recognition and response systems?*

Feedback from cardiothoracic surgery representatives indicate that this process of monitoring and an early warning system is an important part of patient care, but that it will also be important to allow specialised services to adapt this scoring system after reference to the relevant unique patient characteristics. For example, in cardiothoracic surgery the heart rate triggering can be too sensitive with patients in rapid AF. Representatives believe that the current ability to adapt the scores is accepted practice and experience overall has been positive. A side effect of many more codes is there may be many more successful outcomes given they are being called in patients less sick.

Feedback from our general surgery representatives supports the process in that there will be improved communication, juniors would be empowered to report to their seniors if they have concerns and that the process provides a 24 hour cover system whereby nurses who are concerned, but cannot get hold of junior staff are empowered to call the next level up. However, the system needs overrides under certain circumstances where the vital signs are expected to fall outside the reportable limits e.g. known bradycardia, hypertension.

RACS notes that the vital signs chart allows for modification of the triggering scores and is supportive of this addition.

The reporting levels may not be applicable to high dependency units and intensive care units where expensive monitoring is already in place. The process is certainly applicable to normal adult ward patients

RACS thanks you for this opportunity to comment on the proposed national recognition and response system. If you should require any further information please don't hesitate to contact me.

Yours sincerely

Richard Lander FRACS
Executive Director for Surgical Affairs (NZ)