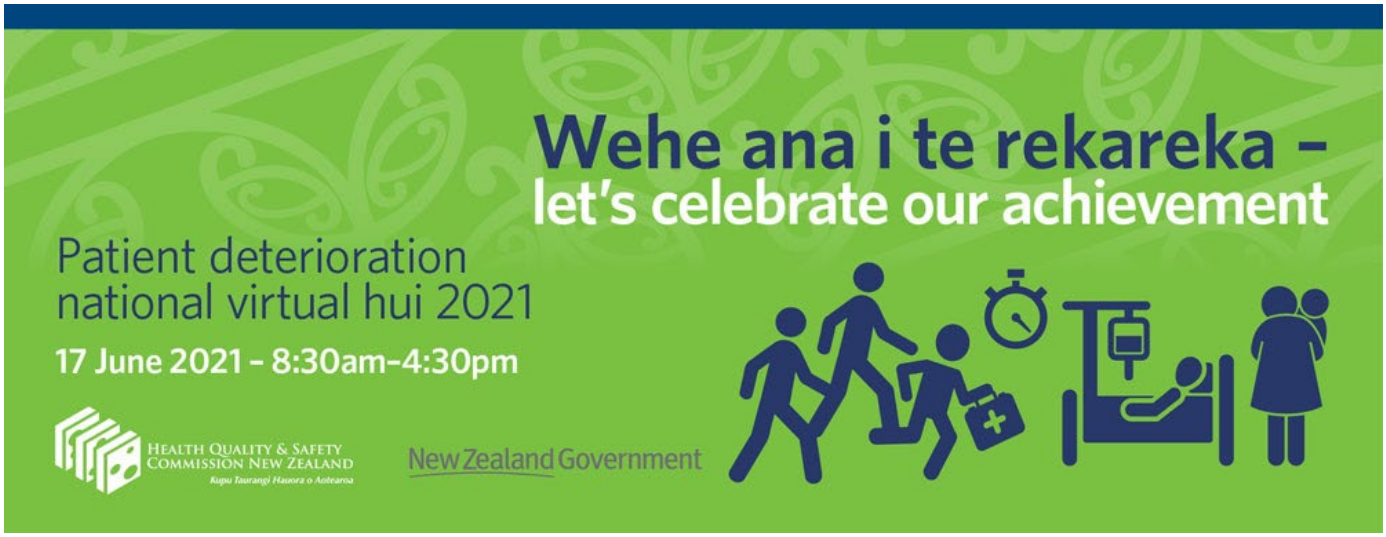

Final programme

Time	Session
8.30am – 10.20am	**Morning Sessions**
8:30am	**Karakia and welcome from the mana whenua**
8:35am	**Welcome from the Health Quality & Safety Commission** Dr Alex Psirides, clinical lead, national patient deterioration programme, Health Quality & Safety Commission
8:40am	**The wrong type of care** Felicity Goodyear-Smith, Postgraduate Goodfellow Chair MBChB, MD, FRNZCGP (Dist), FFFLM (RCP), Department of General Practice & Primary Health Care, University of Auckland *Ninety-seven year old Marie ended up in hospital in her last few days of life, and received acute care rather than the palliative care she wanted. In this presentation, Marie's daughter Felicity talks about their experience.* *Followed by 10 minutes live Q&A*
9:05am	**Celebrating the patient deterioration programme** Dr Alex Psirides *The five-year national patient deterioration programme began in 2016 with the aim of improving the recognition of and response to adult hospital inpatients who deteriorate. As the programme moves from implementation to business as usual, Alex will discuss how this was achieved, and how the work streams were designed and adapted for the complex and diverse conditions of 20 Aotearoa New Zealand district health boards (DHBs). Programme sustainability will be discussed – how do we maintain the changes we have achieved when teams move on?*

9:30am	**Embedding Te Tiriti o Waitangi into our work** Stephanie Turner, director of Ahuahu Kaunuku (Māori health outcomes), Health Quality & Safety Commission *Exploring the importance of Te Tiriti and its role in preventing patient deterioration and improving whānau experience will be discussed. How can we establish and nurture mutually beneficial partnerships with Māori? How do we facilitate tino rangatiratanga and why would we want to? How does this relate to patients deteriorating in our care? Stephanie will explore our current health system norms and challenge us to think about how matauranga might inform and improve health practice for all. How might we better design our system to ensure whānau and patients actively partner at all levels of the system, be it governance, direct-care, or policy? Te Tiriti o Waitangi is central to determining actions to resolve the health inequities between Māori and non-Māori, and advance Māori health. Understanding inequity and how daily health care may be increasing inequity of outcomes for individuals and their whānau will be explored.* *Followed by 10 minutes live Q&A*
10:20am	**Morning tea**
10.35am – 12.30pm	**Mid-morning sessions**
10:35am	**Establishing and sustaining Kōrero mai** *This session will include a range of DHB approaches to Kōrero mai and a consumer perspective.* **Creating urgency for change – Kōrero mai** David Price, director of patient experience, Waitematā DHB *Waitematā DHB rolled out its Kōrero mai programme at pace and within three months it was embedded across all inpatient wards at North Shore and Waitakere hospitals, including maternity, paediatrics, special care baby unit and older adults mental health. Two-and-a-half years on, this presentation will focus on how to engage your organisation for a rapid roll-out, lessons learnt from the process, key statistics and the ongoing evaluation and promotion of the service.* **Co-design the way forward** Sarah Imray, CNS PAR nurse and Laura Ellis, consumer engagement manager – quality improvement and patient safety, Capital & Coast DHB *Kōrero mai was launched in 2019 following a successful co-design project. The Co-design team consisted of medical, nursing and two consumers working together to ensure that consumers could freely voice any concerns about their condition. Working with consumers is a humbling experience and it is the only true way we can develop services that keep our patients at the core of everything we do, Kōrero mai is a prime example of this. This talk is a reflection on how we developed Kōrero mai with consumers and how continual evaluation of a service will lead to improvements for all patients.* *Followed by 20 minutes live Q&A*

11:10am	**Supporting clinicians, patients and whānau with shared goals of care** **He manako te koura o kore ai – 'Wishing for crayfish won't bring it': Creating cultural change around shared goals of care in Nelson Marlborough** Tammy Pegg, cardiologist, Nelson Marlborough Health *Tammy lead a shared goals of care culture change at Nelson Marlborough Health starting from the case for change through roll-out, revision, refinement, and now system improvement, although she acknowledges much work is still needed.* **Shared Goals of Care – our journey at MidCentral DHB** Janine Kereama – Associate Director of Nursing, Acute and Elective Specialist Services / Chair, Deteriorating Patient Governance Group, Steve Jenkins – Nurse Consultant, Resuscitation and Lee Welch – Improvement Advisor *An overview of MidCentral DHB's journey as a pilot site, with establishing Shared Goals of Care, the third work stream in the Health Quality Safety Commission's Deteriorating Patient Programme* *Followed by 15 minutes live Q&A*
11:45am	Five-minute break
11:50am	**Implementation of a national maternity early warning system – does this make a difference?** Matthew Drake, specialist anaesthetist and deputy service clinical director, National Women's Health, department of anaesthesia, Auckland DHB *National Women's Health was one of the pilot sites for the then newly-developed standardised maternity early warning system (MEWS), which has now been implemented nationwide. At this session, Matthew will discuss the pilot and rare outcomes such as cardiac arrest and admission to ICU, as well as presenting data on alternative outcome measures – code red (very unwell women) and code blue (cardiorespiratory arrest) – which were used to determine the impact of MEWS implementation.*
	Maternity early warning score in other DHBs Michelle Thomas, director of midwifery/maternity quality and safety coordinator, Wairarapa DHB and Matthew Drake *Live panel discussion*
12:30pm	**Lunch**
1.10pm – 2.20pm	**Afternoon sessions**
1:10pm	**Learning from implementing electronic vital signs systems** **A Cog in a wheel, lesson learned from implementing an electronic vital signs system** John Hewitt, nurse specialist, corporate quality and patient safety, Canterbury DHB Iidil Merlini, midwife educator and quality coordinator, Hauora Tairāwhiti *Followed by 15 minutes live Q&A*

1:40pm	**Sustaining nurse-led outreach teams** **Patient at risk (PaR) under the maunga** Amy McDonald and PaR Clinical nurse specialists, Taranaki DHB *Our presentation is an outline of our journey from recruitment to the present day. As a fairly new service, we have compared the number of calls and referrals types in March 2020/21 a year apart to show how the service has grown, developed or changed within that time.* **Coming of age** Kate Smith, nurse practitioner from the critical care department, Waikato DHB, Lesley Kazula, nurse practitioner, critical care complex, Counties Manukau Health, and Sarah Imray *Critical care outreach services were introduced in New Zealand in response to a growing concern that ward patients, who were either critically ill or had the potential to deteriorate, were not being identified and appropriately treated in a timely manner. These services extend beyond the boundaries of critical care by taking specialist critical care/acute care nursing knowledge and skills to other clinical areas within the hospital. In New Zealand these services have developed in an adhoc manner and often quite diverse in terms of the service provided. Often the service is adapted to meet local demand and resources available. These outreach services have increased since the introduction of the Commission's patient deterioration programme.* *This session will discuss development of the New Zealand Critical Care Outreach Forum, which was started several years ago by nurses working in critical care outreach services, with the aim of providing support and guidance.* *Followed by 20 minutes live Q&A*
2:20pm	**Afternoon tea**
2.40pm – 4.15pm	**Late afternoon sessions**

2:40pm	**Validating the New Zealand early warning score** Dr Alex Psirides and John Hewitt *The New Zealand early warning score has now been tested using 14 million vital signs from the Canterbury DHB electronic database. The presenters will discuss the results of this massive study, particularly around the ability of the early warning score to predict serious adverse patient events. Comparisons with the UK National Early Warning Score will be presented for the first time, with discussions on the implication for Aotearoa New Zealand practice, as well as what the future of early warning score systems may look like here.* *Followed by 10 minutes live Q&A*
3:20pm	**Sustaining beyond the programme** **Where to from here? Sustainability and maintaining momentum** Jan Dewar, clinical advisor, Health Quality & Safety Commission *The Health Quality & Safety Commission has created a guide for auditors and health services. The aim of the guide is to increase awareness about essential components of a fully implemented patient deterioration programme within health systems. This presentation will discuss the components of the patient deterioration programme included in a tracer audit process. It is intended to support process and programme improvement to enhance patient and whānau experience and outcomes.* **The continued oversight of the maternity early warning system (MEWS) through the maternity quality and safety programme (MQSP)** Amanda Rouse, senior advisor, maternity, community health system improvement and innovation, Ministry of Health *Amanda will discuss the background to the MQSP, current reporting requirements and why it is well placed to monitor and support the ongoing use of MEWS at district health boards.* *Followed by 15 minutes live Q&A*
3:55pm	**Reflections on the day**
4:15pm	**Hui closing – acknowledgments and karakia**