

Intensive Care Unit

Annual report 2012 -2013



RESPECTFUL
KIND **SAFE**
EXCELLENT

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INTRODUCTION

2012 was a wonderful year to be in London. The main reason for this was the brilliantly hosted Olympic Games. The Game Makers were pivotal to this success. The game makers made people feel welcome, they took a personal interest in making the vast crowds feel special, they had up to date and accurate information, they demonstrated professionalism in their work and pride in what they stood for. Perhaps this is what we should all try and emulate in delivering our services to patients and their relatives.

2012 was a busy year on the unit and in the Trust. The trust had to prepare staff, patients, and visitors for the disruption caused by having the Olympic Cycle race pass by the front doors. This was executed within the trust with precision and excellent team work .Everyone knew their roles so that they were able to enjoy this historic event. In fact one of our patients on a ventilator was taken down just outside the main doors to see the ladies race!

2012 was also the year when the trust, through consultation with staff, patients and governors voted on the values that would represent Chelsea and Westminster as an organisation. These values would be Kindness, Respect, Excellence and Safety. This year's annual report has been divided into these four sections.

We demonstrate respectfulness in this issue by the work on our patient diaries, end of life care and organ donation.

We demonstrate kindness by all the work and feedback we receive from our relative satisfaction survey and focus groups.

We demonstrate safety by our work on infection control, and learning from our morbidity and mortality meetings, clinical incidents etc.

We demonstrate excellence by our project work, development programmes and multidisciplinary working.

This annual report does take a lot of work and expertise to pull it all together (special thanks to Amanda Dixon who has been editing and formatting and organising this annual report for the last 4 years). It is written and produced by the staff to showcase and market the continuous commitment everyone has to continually develop the unit. The hard work is worth it when the finished product is produced, so on behalf of the unit; we hope you will enjoy reading it.

**Jane Marie Hamill
Head Nurse Critical Care**

FOREWARD



In January 1985 when I started as a Consultant the critical care services at Westminster Hospital consisted of a small converted ward with 6 beds in the main building and a 3 bedded cardiac unit in the Page Street block.

Equipment was primitive with very old ventilators, including a Cape and several Manley Ventilators. Invasive monitoring was 'brought in' by a special clinical measurement team and looked like the stage set for Quatermass and the Pit. Dialysis could be provided in extremis by the RAF mobile dialysis team. The speciality of ICU did not even exist officially in the UK then and has only been formally recognised relatively recently. As a new product of state of the art Australian Intensive Care training it was beyond my imagination to see how this could possibly function at all, let alone well.

To my astonishment within a few days I knew it worked and within weeks I knew it worked well. It was a road to Damascus moment to realise that the secret of good high quality effective ICU is good conscientious nursing and it is that which makes the difference. Proper care of the individual and their needs, with bedside

attention to their physical condition and awareness of the needs of their relatives are the basis of good intensive care. High tech equipment and the medical skills will only fulfil their potential if there is a solid nursing capability and even then is only a small part of the delivery of critical care. It was the most important lesson an Intensivist can learn.

Over the next few years the ICU caught up with state of the art ventilators, bedside monitoring, access to dialysis and proper medical staffing. Even the Royal Colleges eventually recognised the burgeoning speciality of Critical Care and formalised or is formalising training and qualifications. At Chelsea and Westminster we have a unit that ranks alongside the best in the World. My personal view is that while many things have changed over the years the one common element that has been fundamental to our successful evolution is the one thing that has not changed at all, and that is the attitude and professionalism of our nursing staff who maintain the standards of their predecessors and who have kept the well-being and care of the patient and their relatives sacrosanct. This ethos is also seen in the physiotherapists,

dieticians, speech therapists and pharmacists who are part of the elite team that constitutes our Intensive Care. That is not to say that there has not been considerable developments in training, education and professional development across the board, but they have not been at the expense of the fundamental ethos. In the papers one reads of new innovations like bedside care of the patient, cleanliness and hygiene in the wards and care and consideration of relatives but all of these have been standard since before 1985 in our unit. Interestingly these were the basic tenets of Florence Nightingale over 100 years ago.

So what is new in 2013? We have once again the Customer Service Excellence award but I am reminded that we were, in the 90's, one of the first units in the UK to be given the then coveted Charter Mark. For me these awards are indicators not of new behaviours, but evidence of sustained good practice. Our Foundations of Critical Care Course, and ITU course at King College hospital are a tremendous asset; and we also successfully recruit high calibre nurses. We have a strong on going professional development program and we have industrious and engaged patient focus groups. We are developing new guidelines such as the new delirium guidelines. We train a new generation of intensivists and have considerable research activity, some like

Drs Vizcaychipi and Sinha, culminating in PhDs but with several more at various stages. One of our physiotherapists, Eve Corner, has developed a new rehabilitation scoring system that we hope will improve considerably our ability to help the vitally important, but previously neglected, rehabilitation process following critical illness not just here but across the UK. These are all the kinds of exciting developments that come from a dynamic cohesive and progressive unit.

What does the next year hold? We have just appointed Alex Li who will complement the existing Consultant team as well as being a major potential asset to the evolution of Intensive Care, in his own right. Expansion of burns will be a challenge for which we are ready and I suspect in the future the main ICU may also need further structural development but that is for the future. The main change is the one that will not happen. That is, I am sure that there will be no change in the fundamental ethos of our nursing in its aims and aspirations and it will continue to be the solid foundation on which good ICU can be practised to the benefit of our patients and their relatives.

Neil Soni
Consultant Anaesthetist and Intensivist

VALUES

In February 2012 the trust devised our four key values: safe, respectful, excellent and kind under the banner “**Our values—'It's who we are'**”.

More than 900 patients, members of the public and staff voted during the consultation and the values were launched in May 2012 during our Open Day.

They were designed to ensure the highest quality care for those being treated here and the highest quality experience for staff working here. These values and behaviours guide everything we do as a Trust and as individual members of staff. They define the quality of care that patients should expect at Chelsea and Westminster and how we as staff can help meet those expectations.

In the intensive care unit we were delighted to have these values, as we felt they matched the philosophy of care that we have worked with for a number of years. Since the launch of the trust values we, as a unit, decided to update our philosophy using the trust values, and have undertaken some work with our staff to identify how we demonstrate the trust values in our practice. This work was done by undertaking some values-clarification focus groups. This involved groups of our staff working through some prompting questions and gathering their own thoughts to identify what was important to them (see table below)

Values clarification exercise

This exercise is designed to help focus us what is important to us as an ICU team to help us update our philosophy.

I believe the purpose of ICU is

I believe my purpose in ICU is

I believe that critically ill patients need

If I was a critically ill patient I would like

I believe families/ friends of ICU patients' value

I believe I can help an ICU patient

As a member of the ICU team I feel valued when

After the focus groups we identified themes that were emerging from the focus groups and how they linked to the values of Safe, Excellent, Respectful and Kind and developed some photo boards describing our values and how people will see that we demonstrate them. See below. These

photo boards now line our corridor for all visitors to our unit to see.

Elaine Manderson
Clinical Nurse Specialist – Intensive Care

How do we demonstrate **EXCELLENCE** on the intensive care unit?

We provide education and training for all our staff to improve our performance and deliver the best care for critically ill patients and their relatives.



We have daily MDT (multidisciplinary team) ward rounds to ensure a holistic plan of care is developed and implemented.



'We will do what we say we will do, e.g., if we say we will get the doctors to speak to relatives we will organise it.'

How do we demonstrate **SAFETY** on the intensive care unit?

We will maintain safety by regularly checking and auditing our clinical practice.



We will provide continuity of care so that you will get to know the staff that look after you.



'We will challenge each other about infection control prevention'

How do we demonstrate **RESPECTFULNESS** on the intensive care unit?

We will keep the curtains closed when carrying out care.



We will find out what your likes and dislikes are through our patient profiles.



'We will treat all patients and relatives as individuals'

How do we demonstrate **KINDNESS** on the intensive care unit?

We will ask you how you are and if you need any help, support, advice we will help you.



We recognise that it is important that your loved ones are near so we will provide overnight stay rooms and have limited visiting restrictions.



'We will treat you how we would like our relatives to be treated'

Our Values

RESPECTFULNESS

PATIENT DIARIES

The ICU team continue to develop the Patient Diaries. We write these diaries for some of our ICU patients in order to fill in the gaps for them, so that they can have a better understanding of their ICU experiences and perhaps make sense of some of their memories. It is hoped that reading the diaries also helps patients make achievable recovery goals.

Over the past year, there have been a number of achievements:

- The number of diaries written for patients has been steadily increasing as we have involved all the primary nursing teams; in 2011, there were 13 diaries completed, and this was improved to 34 in 2012. Up until May 2013, we have started 13 diaries in 2013.
- We have improved the process for returning the diaries.
- I am trying to give lots more feedback to the nurses once I have returned the diary – both from the patients and also from what I have read. I hope that feedback will help to demonstrate the value of the diaries, so that staff remain motivated.
- More teaching/promoting diaries. This is now focused on the content of diary entries, so we read anonymous extracts from diaries and discuss what has been written. I also use this opportunity to try to reiterate various issues I have encountered: reminders about the diary staying on ICU, when to start the diary, and how to get help.
- I have had some teaching sessions with other multi-disciplinary team (MDT) professionals including our pharmacist and the physiotherapists, so that the patient can gain a more comprehensive picture of his/her ICU experience. Eve Corner (Lead Physiotherapist) also suggested including the CPAx information

in the diaries, and including the diaries on the Rehab Round every Monday.

- Updating the Shared Drive. I keep records of my letters to former patients or bereaved relatives, as well as GPs. It also has the current teaching records and templates for some of the paperwork.

I am aiming to get feedback from patients and bereaved relatives. So far, the feedback has all been really positive, with the only concerns being the fact that the diaries were started late, and that the writing was sometimes illegible. One patient worried about the fact that there were days when nothing was written; he was concerned about what was so wrong on those days.

Some patients' opinions include:

- 'I was very glad to read it. Thrilled. This was my life. I couldn't believe that people cared that much, and wrote the diary out of the goodness of their hearts.'
- The diary showed that the nurses were 'dealing with a person here, not a medical statistic. With the technicality of the job, the diary makes the nurses think about who the patient is as a person. Engaging.' The diary showed the 'human qualities that the nurses gave' in writing in it.
- 'I will use the diary as a tool to discuss my ICU stay with my family; I am still finding it difficult to adjust to everyday life.'
- 'I had a lot of unanswered questions and wanted to know what happened. The diary mostly answered my questions.'

A bereaved relative 'actually felt much better after reading it, because it showed how well he [her dad] was looked after.' Another one said that 'it showed that everyone did absolutely everything that they possibly could have done. I liked reading the diary; it brought me a lot of comfort.'

Plans for the future include getting more of the MDT involved, hopefully using photographs in the diaries, and encouraging patients' families to write

in the diary (pending clinical governance approval). I am also in the process of helping other ICUs with starting diaries.

Rose Le Cordeur
Sister – Team D



donation because they feel it is what their relative would have wanted.

Careful deliberation of all of the ethical and moral dilemmas has made this a particular facet of medical care that must include calm consideration of all the various needs. Whilst our sole obligation is to the dying patient – the involvement of other medical teams in multiple locations makes it doubly important that this obligation is at the forefront of all that we do.

It is fair to say that since the committee began its work the process of approaching families with sensitivity, identifying potential organ donors and enabling transplants to go ahead has improved. As with most intensive care units, the consistency of care comes from the nursing staff who have embraced this as another part of our obligation to the care of patients and the relief of suffering. But a special mention must go to James van der Walt, our specialist nurse for organ donation and to Caroline Heslop who chairs the organ donation committee

Whilst most families mourn their loss and would have wanted things to turn out differently, I am happy to say that we have had nothing but positive feedback from the bereaved families. The thanks of grateful individuals whose lives have been given a new lease by the humanity of the donor does go some way towards alleviating the grief for those remaining. For all of us involved the altruism and magnanimity of such a gift is humbling.

ORGAN DONATION

It is a sad fact that we are not able to help everyone who comes to the intensive care unit. A proportion of our patients will die whilst under our care and, for those, we do our utmost to treat them and their families with kindness, respect and dignity. Every death is poignant but there is one last duty of care we owe to the dying and that is to respect all of their wishes – including any wish they may have had to donate organs in the event of their death.

Until a few years ago, like most countries, the supply of donor organs had continued to fall behind the number of people requiring organ transplantation. Increasing numbers of people were dying or languishing on organ donor waiting lists as this gap widened. NHS Blood and Transplant (NHSBT) was charged with trying to reverse this trend. It concluded that setting up Organ donation committees, appointing clinical leads and embedding specialist nurses within every trust to raise the profile and centrally coordinate the national effort was the best strategy. Which is how I came to be a CLOD – clinical lead for organ donation. Not a very pretty title, but a necessary job nevertheless.

There are significant challenges, not least in broaching this to families who had not imagined themselves ever being in this situation. It helps if we are able to identify that our patient had expressed their wishes by putting their name on the organ donor register in the past but often the family will agree to exploring the option of organ

And there is good news from such dark moments - for the first time ever the gap between donors and recipients narrowed last year.

Dr Richard Keays
Director ICU
Clinical lead for organ donation

The number of people on the NHS Organ Donor Register has now gone over a record 18 million. This means that in the UK as a whole, more than 30% of people have registered their willingness to help others live in the event of their own death.

During 2012, more than 1,200 people donated their organs after death, allowing over 3,100 organ transplants to take place. However, with more than 10,000 people in need of a transplant and three people dying every day while waiting for an organ, NHS Blood and Transplant (NHSBT) is urging more people to join the Organ Donor Register and to make their family and friends aware of their wishes.

Chelsea and Westminster Hospital has an active multidisciplinary Organ Donation Committee whose aim it is to raise awareness about organ donation. Over the last year we have worked tirelessly to achieve not only the Department of Health and NHSBT's goals, but also Chelsea and Westminster's objectives. I am very proud to say that we have achieved what have set out to do and this makes me very proud to work within such a motivated and inspiring team. I would like to thank everyone within the multidisciplinary team that has contributed their knowledge, support and time. I am looking forward to the next year to continue building on these achievements.

James Van Der Walt
Specialist Nurse for Organ Donation - London Team

END OF LIFE CARE

In October 2012 we commenced using the official Liverpool Care Pathway (LCP) – ICU Version 12 document in order to be audited by Liverpool just as the rest of the Hospital. Unfortunately, a few weeks after this happened the LCP became viewed as a controversial tool after concerns were expressed by the media and public. The LCP was viewed as a 'backdoor form of euthanasia' rather than a 'pathway used to care for patients who are dying and to ensure their dignity and comfort at end of life'. Sadly, this had tainted the LCP and led to a reluctance to use the document for patients who are deemed at the end of life.

The LCP is based on core principles transferred from hospices, such as, good communication, assessment, symptom management, reassessment and caring for the person in a holistic manner. Thus, it is worth examining why the LCP received the criticism it did at the end of last year. A possible reason is the lack of education and experience when using the pathway resulting in confusion and distress for the families involved. The LCP needs to be applied with clinical common sense and good communication skills grounded in knowledge of the pathway and how to initiate and use it.

Another reason could be the difficulty in identifying the patients who are at end of life; this is particularly pertinent to the ICU environment, a setting where technology and active treatment reign. This lack of certainty of a patient's prognosis, illness progression and of death can act as a barrier to the use of the LCP. The traditional paradigms that separated palliative care from intensive care no longer suffice, instead they overlap in a complex manner resulting in blurred boundaries surrounding living and dying.

However, ICU does have a relatively high mortality rate suggesting there is a place for a palliative tool in the ICU arena. Hence, we have adopted the Palliative Care Guideline which has been approved as a document to use when our patients are at the end of their life to ensure their

death is dignified, peaceful and comfortable, and there is support for their families at this difficult time. Over the forthcoming year we shall be auditing the use of this guideline.

Ann Sorrie
Sister – Team H

SAGE AND THYME – COMMUNICATION COURSE *Dealing with people in distress*

One of the most essential responsibilities of healthcare workers in ICU is communication with patients and their families.

I was pleased to be given the opportunity to attend the SAGE and THYME communication skills course. My hope being that this will be of benefit to myself and my colleagues; enabling me to feel more confident in dealing with patients and families, recognising their emotional concerns and anxieties as well as providing support for my colleagues who may experience difficulties in dealing with people in distress

The key word for this course is to *listen* to the patient and family rather than feel intimidated by their concerns and anxieties.

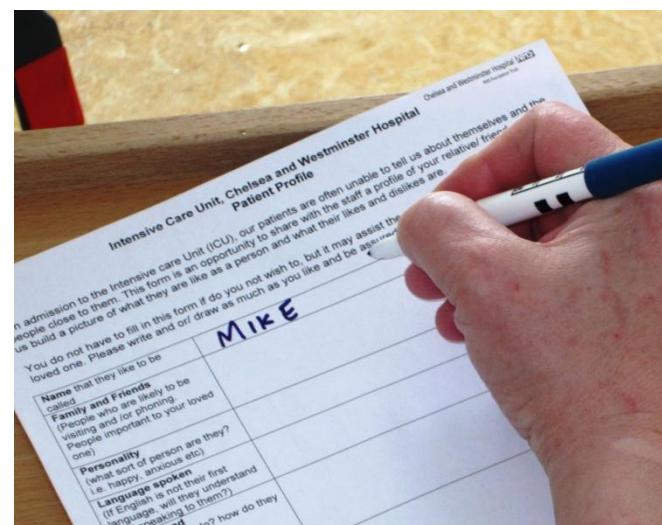
In ICU there are several factors that act as barriers to communication. Some of these factors include demands on the doctor's time, involvement of the multi-disciplinary team and procedures in the care of a patient and sometimes cultural and language difficulties which can make a family feel isolated therefore increasing their anxiety.

Our unit at Chelsea and Westminster offers an open visiting policy allowing informal meetings to occur spontaneously at the bedside. We also have a relative's waiting room which offers privacy for formal meetings, and an environment for the families to express their concerns and anxieties

This structured training has helped me to recognise emotional concerns early and respond effectively to patients and their relatives

Since completing this course, I feel my confidence has improved within my role as senior staff nurse. I am able to support my colleagues appropriately and feel more equipped to deal with challenging situations.

Saowanit Kampinij
Senior Staff Nurse – Team C



RELATIVES SATISFACTION SURVEY



Visitors to ICU can experience lots of emotions but initially these can be anxiety, stress, fear, anger, boredom or relief. As healthcare professionals it is important that we understand these emotions, we provide the right information and try to limit the stress visitors may be experiencing.

On Chelsea and Westminster ICU, providing an excellent patient and visitor experience is extremely important to us. We may not be able to change the outcome but we can influence the experience. One of the ways we ensure that we are meeting the needs of visitors/relatives is to conduct a relative satisfaction survey.

The ICU had conducted a Relatives Satisfaction Survey (RSS) for the past 14 years. During this time the RSS has constantly been evaluated and audited by our volunteer (an ex-relative). The results have been presented at the Quality Group so that we can action what has been suggested and celebrate what we have done well. A large part of the process has been reactive in waiting for relatives / visitors to fill them in as they wait in the overnight rooms or in the waiting room. Last year we saw a drop in responses and as a result decided to do a number of things.

We completely revamped the questionnaire so that it is slick, easy to fill in and more professional looking. We also changed our strategy from reactive to proactive in encouraging visitors to fill it in. Now, twice a year we will send out 50 questionnaires in the post with a letter and stamped addressed envelope. We will then collate the answers, present them to the staff and send a report to any of the visitors who have indicated they would like one.

The questionnaire

The questions have been broken down into 3 sections; "Care and Communication", "How Did We Treat You" and "Facilities". As before the respondent is asked to circle the appropriate answers to the questions.

In Section 1 “Care of the Patient and Communication” we want to find out about how well we treated the patient and how well we dealt with their pain and agitation. It is also important that we know how easy it was to get answers to questions, speak with a consultant and be able to participate in care if possible. Primary nursing is the way we deliver care on the unit so we need to know if relatives are aware that this takes place.

In Section 2 “How did we Treat You? our aim is to find out how well we treated the patient’s relatives/friends. Since most patients in ITU are going to be dependent on their relatives/friends it is of vital importance that they are looked after.

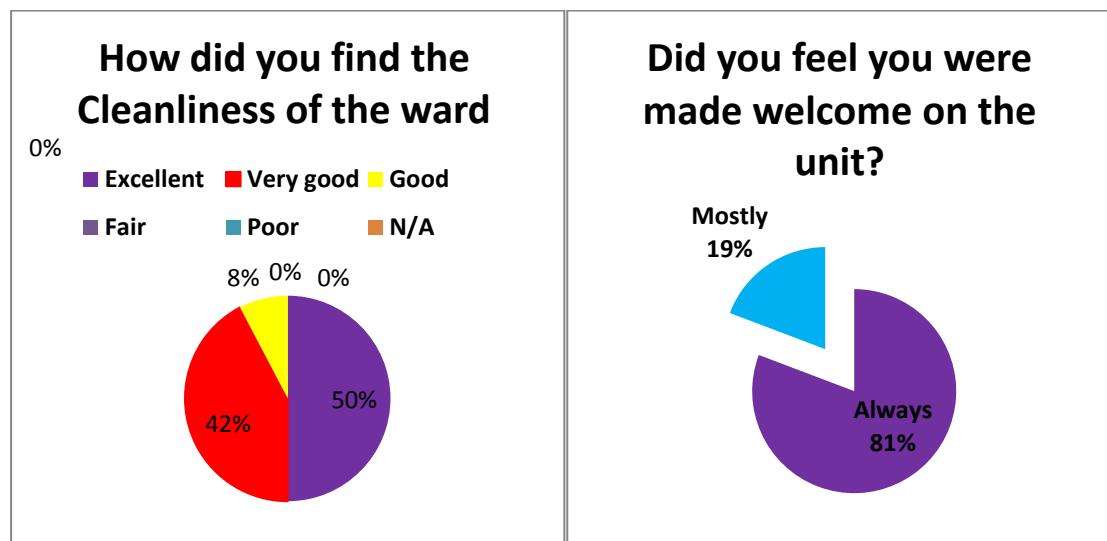
In Section 3 “Facilities” we want to find out if relatives are aware of the facilities available, and what standard they consider them to be.

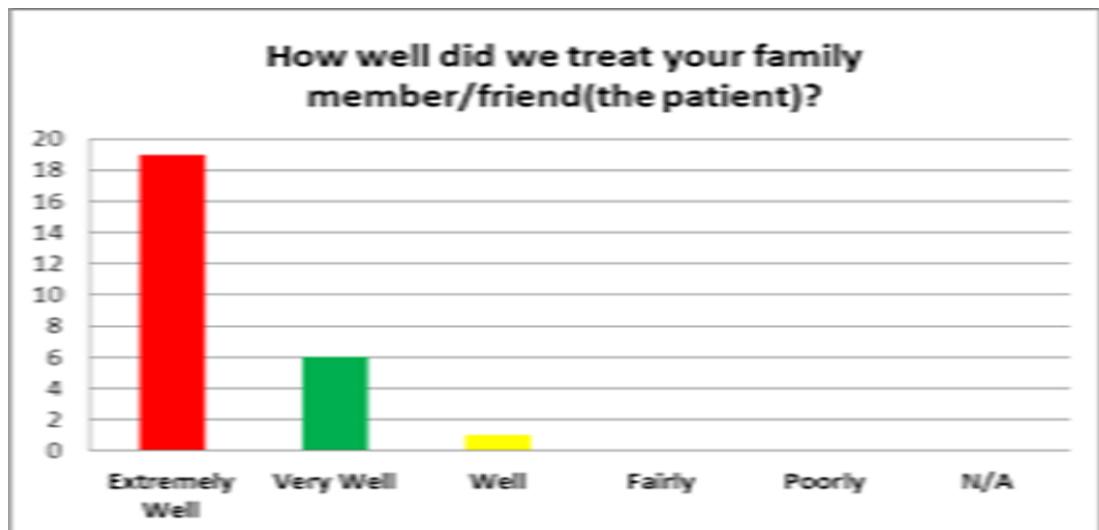
At the end of the Survey there is space for Free Text comments in which we ask for suggestions as to how the unit might be improved

Analysis January – Dec 2012

Responses to the new format have been very positive and the unit has received 43 /92(47%) completed surveys since its introduction. Since it is a new survey it has not been possible to compare the results to previous surveys. In future we will be showing a comparison in order to show improvements and /or deterioration.

What we did well





Areas we can improve on

Some relatives would like more access to the consultant. We have raised awareness with our staff to keep relatives updated on what is going on and to make planned appointments with the consultant.

Our relatives room was seen as poor as it was described as being dark and small. We were given a large donation from a relative's family so we have revamped the room so it is bigger, brighter and more homely.

Some relatives did not get specific information on Primary nursing so we have displayed posters in the waiting room and increased our teaching in this area.

We will also be displaying a YOU SAID WE DID Board so that visitors can see what we are doing in response to their suggestions.

In the questionnaire we have a place where suggestions or comments can be written, here is a selection.

Relatives Comments and Suggestions

Care of the Patient and Communication

JM – xx - Just one comment – we were sometimes given conflicting information depending on who we spoke to. Also, information regarding condition of treatment was shared with other visitors who were not close family. I think it should be restricted to close relatives only.

Anon – 7/6/12 ‘I have only to praise all the staff for their professionalism, help and advice.’

CD – 30/5/12 – ‘Thanks to all the ITU staff especially Simon’

Mrs H – 2/6/12 – ‘Care of our son was exemplary – every effort was made to keep him comfortable and manage his pain (not always successfully but not for want of trying)’.

Anon – 28/5/12 –‘It would have given me more confidence if all the nurses were staff members rather than the frequent use of agency nurses’

Anon – 27/5/12 – ‘Generally a supportive, welcoming atmosphere’.

How did we Treat You?

Anon – 30/5/12 – ‘My mother is 93 and had a longer than expected hip replacement operation. I was phoned at 4 am to say that she had gone to ICU. I was told there was nothing to worry about. The time of the call naturally caused alarm and might have been left for a couple of hours’.

Anon – 25/5/12 – ‘SPECTACULAR!! nursing whatever the outcome. “Rules” occasionally let them down. “You have to wear an apron”, “No she doesn’t”. Many weren’t given the same info which confused visitors, but that’s all’

Facilities

CM - 3/6/12 ‘- Constant monitoring of relatives’ waiting room as it was constantly full of 20+ members of some family so no room for others’.

Anon – 27/5/12 – ‘A ‘long term’ patient had a TV on loud which was quite intrusive. Overnight stay was very welcome. The waiting room is quite small’.

Mrs H – 2/6/12 – ‘Need a better waiting area (not nearly big enough)’.

Jane Marie Hamill
Head Nurse ICU

Caroline Heslop
Volunteer

FOCUS GROUP

On Chelsea and Westminster Intensive Care unit we run a focus group for ex patients and relatives at least twice per year. The focus group usually consists of four to six members.

The setting is comfortable and quiet so that the recipients feel relaxed and reassured that any information they disclose will be treated with respect and confidentiality. The purpose of the group is supportive as well as identifying areas that we the health care professions can learn from.

Theme	Descriptions	Notes and Actions
Admission	<p>It was interesting to note that all the patients admission to ICU was very different – from theatre , from the ward and from A/E</p> <p>The relative spoke about how even though he worked in the hospital , it was very surreal</p>	<p>Awareness of different patient pathways and how we can reduce anxiety of relatives and friends.</p> <p>Not to make assumptions that just because someone works in the hospital they understand what you are saying .</p>
Dreams Hallucinations Reality versus dream like state	<p>They remembered ‘Boat Race’ ‘Being Kept a Prisoner’ ‘Sucking my Arm’ (this patient had a vacuum dressing on) ‘Thinking about things in the past and translating them into the present’</p>	<p>Giving an understand of what causes these dreams and hallucinations and know that it gradually gets better</p> <p>Keeping patients orientated</p> <p>Patient diaries</p>

	<p>'You may see me sitting out of bed and you may think I am fully awake but I may be still in a delusional state'</p>	<p>Informing relatives what it may be like Development of discharge booklet to highlight what patients may experience This will be sent to the members of this group for comment. Development of leaflet for relatives to outline what they may be going through</p>
Loss of Memory No recollection of Visitors	One patient felt guilty both because they don't remember their relatives visiting and then because they didn't express large emotions when reading what the relatives had gone through.	Both the relative and the patient are going through this critical experience, both have different needs- both need to know that they shouldn't feel guilty.
Hope – for relatives / Friends	One relative stated that although he knew he had to be given honest information and that this involves painting a worst case scenario – having some hope is also good.	
Physical Changes Hands/Feet	<p>Skin on their hands and feet was very dry and came off. Development of ridges in their nail beds.</p> <p>The ex-patients expressed that it was difficult to understand the changes in their body and it would be useful to know that this may happen</p>	<p>Highlight this information at unit meetings encouraging staff to moisture these delicate areas.</p> <p>Highlight that this can happen post ICU in the information booklet</p>
Support	The group members thought it was very useful to talk	<p>Sending out specific web based support www.icusteps.org www.Heathtalkonline.org</p>
Sense of Time	Difficult to see the clocks	<p>Buying small clocks for HDU and get a big clock for ICU</p> <p>We talked about devising a memory board to help orientate patients</p>

Running the focus groups and listening to ex patients and relatives is such a humbling, informative experience that we have opened it up to other staff members.

Jane Marie Hamill
Head Nurse ICU

Rebecca Hill
Staff Development Sister ICU

THANK YOU CARDS

On the intensive care unit we collect and collate thank you cards and letters from visitors and patients. Thank you cards can give a valuable insight into the care that is being delivered and can be used to demonstrate what gives relatives and friends comfort when their loved one is critically ill. They can make staff feel

appreciated and be used to support them when difficult decisions are made.

Within the trust we have developed our values so we can use extracts from the cards to demonstrate how we are living them.

Safe	Respectfulness
'Despite being one of the scariest experiences of my life so far I don't think I could have been anywhere better or cared for so well. You made me feel really safe and reassured, especially when I needed it the most' (SS June2012)	'All that you did for her and the way you preserved her dignity which was important to her' MG(August 2012)
Kind 'The nursing care he received was phenomenal. As well as the kindness, consideration and helpfulness to myself and my daughter. There is a wonderful atmosphere. Nurses and doctors however busy willing to keep one informed and however tired always with a smile'(CL FEB)	Excellent '.....deep thanks for the love, care and attention.....to myself and also to other relatives –all of whom commented on the courtesy with which they were treated whenever visiting or calling the unit' '.....astonishing tenderness combined with technical efficiency.....all the kindness shown to my aunt ,my daughters and myself during that difficult time SM(march 2012)

When reviewing a service, we have a tendency to focus on what has gone wrong and seek methods to improve and prevent complaints or issues from reoccurring. While it is extremely important to do this equally we should focus on what has gone right and provide feedback to our staff on this. Thank you cards do this. In addition the themes of 'information, attention to detail, respect, care, compassion and kindness' expressed in thank you cards make us realise what is important and what makes the difference to our patients and their loved ones during their hospital stay.

Jane Marie Hamill
Head Nurse Critical Care



CLINICAL INCIDENTS IN THE INTENSIVE CARE UNIT 2012

In 2012, 155 Clinical incidents were recorded by staff on the intensive care unit (ICU). Table 1 divides these incidents into specific categories.

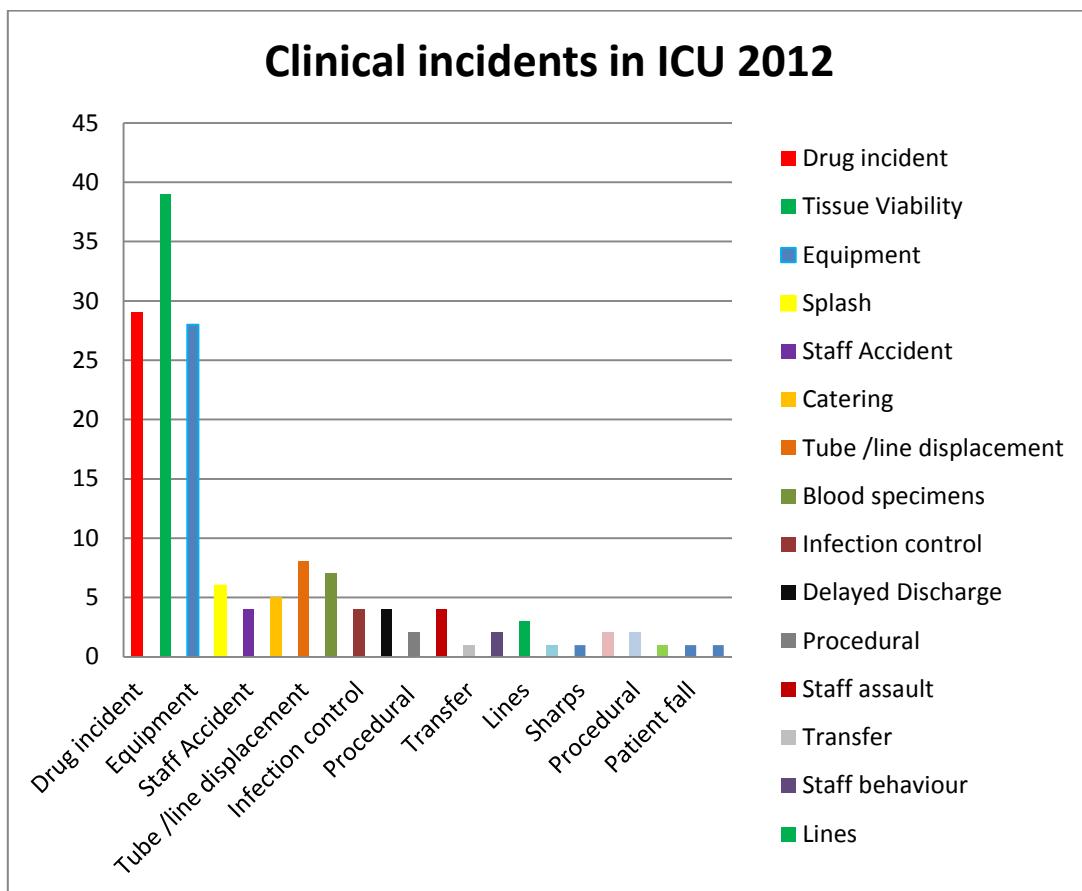


Table 1 Clinical Incidents on the Intensive Care Unit

Process

When a clinical Incident occurs on the intensive care unit, a form is filled out and the relevant staff are contacted depending on the incident. All forms are reviewed by the Head nurse for critical care who fills in the management section but also logs them on the ICU data base. All drug incidents are followed up with staff and the pharmacist is informed. Key triggers which lead to the incident occurring and key areas for development to prevent it happening again are identified. This is then documented in a letter to

the staff member. Each quarter a summary of incidents is presented to staff on the unit again reinforcing good practice or acting on ideas or suggestions to prevent incidents from reoccurring. An annual review also takes place which is presented in the annual report.

Learning in 2012

Clinical incidents are a great way to review practice and think about where there are gaps in information, knowledge or process

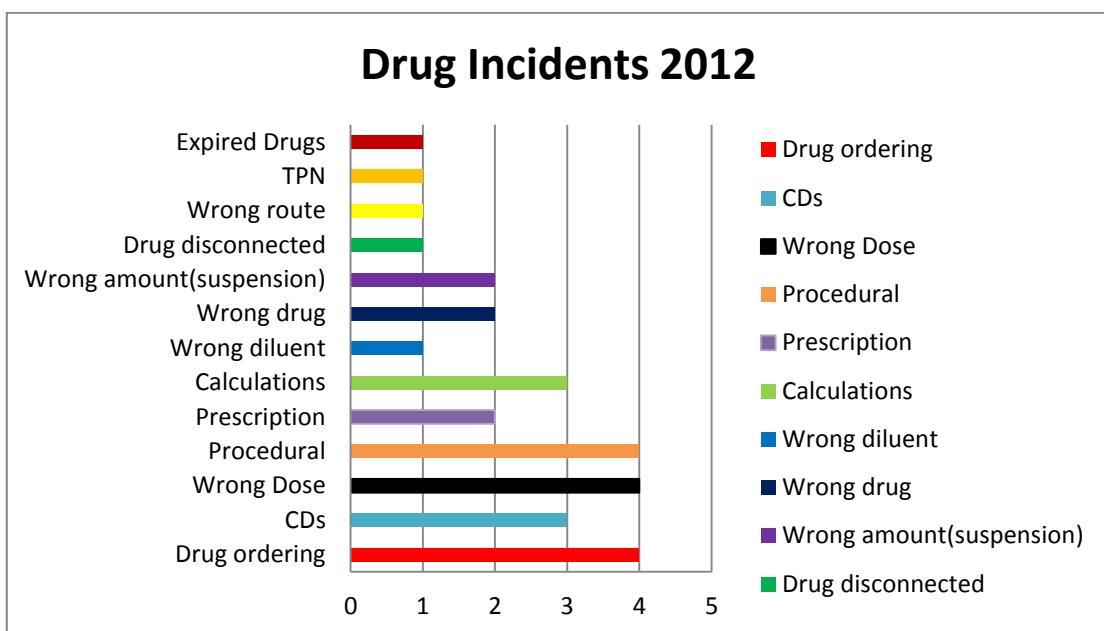


Table 2 Drug Incidents between January – December 2012

Drug Incidents

There were 29 reported drug incidents in 2012. Table 2 outlines the reasons for these. Any member of staff involved in a drug incident is met individually and asked their opinion on how the incident happened and how it can be prevented from occurring again. We incorporate these drug incidents into our drugs quiz so that all staff can learn from incidents which have occurred.

Tissue Viability

Last year we had 39 incidents related to tissue viability. On the unit we have set up a tissue viability group to review our pressure ulcer incidence and review products to prevent skin breakdown. We have also increased our teaching and training in relation to pressure ulcer management.

Equipment

In 2012 we had two significant incidents which caused us to change our practice. We had three incidents reported where the Vas Catheter used to deliver dialysis to our patients became detached from the hub of the catheter. We reported this to the MHRA, met with the company which resulted in the company

identifying a product flaw. This resulted in changing our suppliers of these catheters. The other incident was to do with NJ tubes and as a result of this investigation we changed our practice with this device as well.

Presenting themes from clinical incidents allows staff not only to know what happens to the incidents forms they fill out but gives them the opportunity to identify the solutions to the problems.

Clinical incident monitoring ensures safe practice, is a transparent process in which we can all learn and change practice as a result of what happened and not just where the incident occurred. It allows us to learn and develop practice as an individual, team and unit.

Jane Marie Hamill
Head Nurse Critical Care

PHARMACY

As a member of the C&W ICU multidisciplinary team, I feel fortunate to work alongside such pleasant and dedicated staff. I believe the secret

to the successful team spirit is having the optimal balance of experience, trust and transparency.

The role of the pharmacist is evolving. The pharmacist is an active member of the multidisciplinary ICU and parenteral nutrition team ward rounds; but last year also contributed towards the data collection of antibiotic prescribing for research purposes. We have been involved in the ICU rehabilitation rounds, patient diaries and within the last six months, the team has taken on providing a clinical service to level 1 Acute Assessment Unit patients.

Besides clinical interventions at ward level, minimising drug errors is facilitated by quarterly review of drug incidents together with the clinical nurse lead, Jane- Marie Hamil. The ICU team is particularly good at incident reporting and is proactive in making changes to reduce risk.

Parenteral nutrition (PN) usage is down compared to previous years. The ICU team is proactive in encouraging early enteral feeding where appropriate.

Last year a total of £34,000 was spent on PN. It remains the top expenditure drug for the financial year.

The top three indications for TPN were obstruction, ileus and malabsorption. Treatment duration was less than seven days for the majority of patients. An ongoing TPN data base with details of every patient is being kept by pharmacy. To date, two years' worth of data has been collected. The results have been presented back at ICU policy board and to the consultant surgeons.

The past year has seen the successful application for formulary status of dexmedetomidine and levosimendan. Whilst this is good news, both medicines carry a financial impact on our limited drug budget, therefore, use is being audited and the results will be fed back at quarterly multidisciplinary team meetings.

In summary, it has been a productive year, full of challenges both clinical and financial. However, at the same time, it has been rewarding and it will be interesting to see what 2014 brings our way.

Christine Chung
Lead Pharmacist

DIETETICS

The role of the ICU dietitian is to work in collaboration with the multi-disciplinary team (MDT) to promote optimal nutrition of the critically ill patient. In addition, they identify those at risk of malnutrition and plan patient specific nutritional interventions on this basis to maximise outcome and to follow up patients on a regular basis.

Important aspects of this role include:

- To improve feed delivery (both parenteral and enteral)
- To help minimise nutritional losses
- To evaluate nutrition related research and implement evidence based practice
- To provide education and training on ICU nutrition
- To undertake research and audit
- To assist nutrition guideline and protocol development
- To ensure adequate preoperative nutritional optimisation

We have worked hard as a unit to ensure NPSA compliancy in all aspect of enteral feeding. Through recent audits we have significantly improved the delivery of enteral feeds through innovative practice changes. This ensures safe, excellent and effective nutrition care for our patients which improves their rehabilitation process on discharge from ICU. We are also reviewing current practice regarding mode of feeding and using post pyloric feeding as first line.

Emer Delaney
Dietician

ACTIVITY AND PERFORMANCE

As NHS expectations increase so does the reliance on quality reliable data that can influence and determine strategy in an ever changing and demanding public health service. During the past year there have been many changes in what data is collected and what it is used for. This includes analysis at local and national level.

The Northwest London Critical Care Network continues to analyse data from all critical care units in our network. These quality measures include care bundle compliance, median length of stay, re-admissions, unplanned extubation rate, late night discharges, patient satisfaction and consultant sessional cover. To meet these measures we had to think creatively in terms of data capture. This included incorporating capture fields into our critical care specific database called Acubase which has also assisted in running local reports. Two areas for improvement in 2013 – 2014 are care bundles, particularly CVC, and late night discharges and we will have to work more closely with the wards to achieve this. We will continue to capture and monitor these measures and evaluate compliance in line with the network.

Table 1 on page 23 outlines activity in terms of admittance, occupancy and discharges for burns,

Activity	Admittance		Occupancy				Discharges			
	Admissions	Refused admissions	LOS	Occupancy	Target	Variance	Total Discharges	% Discharges< 24 hours	Target	Variance
ICU - BURNS	17	9	16	61%	75%	-14%	18	100%	100%	0%
BARIATRIC	17	0	2	n/a	n/a	n/a	17	94%	100%	-6%
HDU - Level 2	282	0	3	113%	75%	38%	299	92%	100%	-8%
ICU - Level 3	156	0	5	68%	75%	-7%	162			

Table 1

HDU Level 2

Level 2 patients usually require immediate care following major elective surgery or where there is a risk of postoperative complications. There was a 16% increase in the amount of level 2 admissions this year in comparison to the year previous. The majority of these admissions are admitted post

bariatric (elective obesity surgery), high dependency and intensive care patients.

Burns ICU

The burns ICU had a total of 17 admissions during the reporting year. This is the lowest number of admissions that the unit has seen since 2005. This is primarily due to the length of stay (LOS) being higher than most of the previous years and an occupancy rate of 60%, with only last year's occupancy rate being greater at 82%. This is also reflected by the unit only having a total of 14% of days with no patients. There were a total of 9 refused admissions and all of these were due to no beds available at the time of referral.

Bariatric

Bariatric admissions have decreased in comparison to previous years, 29 in 2010 and 20 last year. Most bariatric admissions to the high dependency unit are due to co-morbidities such as obstructive sleep apnoea or other underlying medical conditions.

operatively and are primarily for medical reasons such as cardiovascular and/or respiratory management.

ICU Level 3 There were 156 level 3 admissions to the unit in the year 2012 -2013. This amount of admissions has remained about the same

compared to previous years. Over half of these admissions were admitted from the medical directorate and of these, 75% came from the wards. No level 3 patients were refused admission during the reporting period. An occupancy rate of 68% was 7% lower than the target set at the beginning of the year; however, level 3 activity has remained static across many critical care units in our network so this is not unique to Chelsea and Westminster.

Jason Tatlock
Information Officer/Administrator



MORBIDITY AND MORTALITY

It has become increasingly important for trusts to evidence that they are systematically and continuously reviewing patient outcomes and especially mortality and morbidity.

Mortality & Morbidity Review meetings (M&M meetings) are held each quarter within the department. Attendees are from the multi-disciplinary team and other specialties are invited such as Microbiology, Specialist Nurse for Organ Donation and Surgical/Medical teams and discussions are linked to measurable actions and objectives. Methodologies are used for selecting which critical care cases are to be reviewed, primarily the use of the severity scoring system of APACHE II. Essentially, any patient with a score of less than 20 who died is discussed at the M&M meeting.

The Standard Mortality Ratio (SMR) is expressed as either a percentage or ratio quantifying the increase or decrease in mortality of a cohort of patients. The department had a SMR of 0.8 for the last year with a mortality rate of 13%.

Jason Tatlock
Information Officer/Administrator

BLOOD TRANSFUSION LINK NURSE

Blood transfusion involves a complex sequence of events, from pre-transfusion sampling of the patient to the delivery, collection and administration of the issued blood component. If an error occurs at any stage of this process there is a risk of harm to the patient which can include fatality.

The focus of the NPSA (National Patient Safety Agency) Safer Practice Notice 'RIGHT PATIENT, RIGHT BLOOD' is the prevention of major morbidity/mortality due to the transfusion of incompatible blood components.



The role of Blood Transfusion Link Nurse was recently introduced to the unit; it was a great

privilege for me to be assigned this role although a challenging and demanding one. It has allowed me to improve my prospective nursing capabilities and gain a wider variety of experiences to further my professional career. I underwent training sessions with the trusts transfusion practitioner (David Mold) to gain an overview and guidance for my role as transfusion link nurse.

As transfusion link nurse my responsibilities are to promote the implementation of good transfusion practice and perform blood transfusion practical competency assessments. This is a mandatory requirement and is an observational assessment which must be repeated every three years. I have carried out assessments of my colleagues on the unit, which for me is fulfilling and rewarding, and furthers their personal and professional development. It also ensures patient safety and best practise

Imelda San Miguel
Senior Staff Nurse – Team B

FINANCE AND SUPPLIES

As part of the finance and supplies inter-team project group, members have a responsibility to support the clinical nurse lead and take an active role in the budget and finances of the unit.

Finance and Supplies chief aim is to save money without sacrificing quality. We do this in a number of ways. As a group, finance and supplies monitor expenditure and aim to improve awareness of costs, such as the use of bank and agency staff. As a team, our goal is to reduce the unit's outgoing's and identify new ways to cut wastage. An example of this is the intensive care stock box. The box contains all the necessary items required for a new admission to the unit. This helps to reduce over-stocking of the bed space and the use of unnecessary items. A similar HDU box will be trialled soon. Furthermore, laminated stock lists in every bed space will also give staff an idea of how many stock items are required to equip an area sufficiently. Pricing labels have also been

attached to every draw in our stock room so that staff can identify the cost of each piece of equipment they use. We are hoping this will encourage people to stop and think about the use of the item and whether or not it is necessary. Two members of staff have also run a 'finance and supplies quiz' to help raise cost awareness - this proved to be really popular and has hopefully got us all to reflect!

To help improve cost effectiveness, finance and supplies also trial and evaluate new products, which in turn also helps to improve patient care. One major project undertaken this year has seen the introduction of a new catheter bag. Unfortunately, the previous stock of catheter bags were difficult to use and leaking from the chamber meant that staff encountered problems monitoring patient fluid balance accurately. Four new catheter bags have therefore been trialled over a monthly period and staff asked to complete a short survey on each. The results have now been collated and we are currently in discussion with the healthcare company to agree a favourable price on our new, more reliable, catheter bag. Further trials to be commenced include that of a new blood gas syringe and oxygen saturation probe.

As a group we also aim to address issues with unit stock, such as faulty equipment and supply levels. As a team, we also liaise closely with other departments such as pharmacy and dietetics to ensure a streamline supply of necessary items such as intravenous fluids and enteral feeds.

Over the past year, Finance and supplies have also endeavoured to raise money for the unit. With the success of international food day, Amanda Dixon, inter-team project lead, has set about developing an intensive care cookbook which comprises of recipes written by staff from around the world. The cookbook will then be made available to purchase, for a small fee, at events such as the hospital open day. The proceeds will then be made available to the unit

fund, to aid projects such as the transformation of our new visitor's waiting room!

Donations are always greatly appreciated by the unit and our patients to make their stay and their families stay with us just that little bit more bearable. We now have a new personal DVD player and a huge selection of DVD's available for people to borrow. We are also due to receive two brand new personal televisions for patient use. Further funding, has also enabled us to purchase a new rehabilitation chair, a supply of carbon dioxide monitors, an ice machine and noise detection monitors for the unit. A huge thank-you to everyone who donates, we are extremely grateful, you really do make a huge difference!

Sophie Holmes
Senior Staff Nurse – Team H

OFF DUTY PLANNING TEAM

The Off-Duty Planning teams (ODPT) aim is to adequately staff the Intensive Care Unit with the appropriate number of staff and skill mix. The ODPT provides staff with guidance and support to facilitate self rostering on the unit. Self-rostering is a system whereby nurses undertake responsibility for their working days and days off. The ODPT ensures that the self-roster system provides an adequate and safe level of appropriately qualified staff to ensure that quality nursing care is maintained at all times.

The ODPT recognises the importance of home/work life balance and believes this can be achieved through self rostering. Negotiation and flexibility is the key to self-roster success. To ensure fairness self rostering requires an agreement regarding how many nights and weekend shifts are worked in a four week period.

The roster is created one-month in advance and a template is displayed for staff to put their requests ahead of time. This ensures flexibility with the rota and allows the ODPT to see where shift changes need to be made.

The unit uses a computerised rostering system called MAPS. This has become a useful tool as it highlights the number of staff and co-ordinators on a shift at any one time plus provides quick access to skill mix of a shift. The system automatically calculates staff working hours ensuring that each member of staff are working the correct set hours and shortfalls can be easily addressed. The ODPT also record study leave, sickness and annual leave on MAPS.

Annual leave requests are also managed by The ODPT. A new system of requesting annual leave has been designed to ensure fairness and to provide a better view of how many staff are on annual leave at any one period. Staff email The ODPT and request their annual leave on a first come basis. The requests are then plotted on monthly planner which also provides quick access to other staff when planning their annual leave.

The ODPT comprises of a member of staff from each nursing team and meet on a monthly basis to discuss off-duty issues and roles. Each member of The ODPT is trained as rota creators and each person will rotate every three months to become responsible for creating the rota.

Leigh Paxton
Senior Staff Nurse – Team C



EXCELLENT

QUALITY GROUP

For a number of years there has been an increasing demand for Hospital Trusts to provide evidence that they deliver high quality care with improving outcomes, and that the patient's and relatives experience has been a positive one. The emphasis has been on gathering this evidence from the patients themselves as well as their relatives, not just the health professional who works for the organisation.

The work of the Intensive Care Unit has been committed to monitoring and improving the quality of care we provide to the patients and their relatives who come into contact with us. There are a number of approaches used, for example, clinical incident reporting that feeds back to the staff, clinical governance meetings, and Unit meetings where concerns and queries are discussed and action taken.

The role of the members of the Quality Inter Team Project Group has been to concentrate on the patient and relatives experience, and how we can improve the service we provide. The main approach is by gathering information through the relatives' satisfaction survey (RSS) and patient focus groups.

Often it will be a small change to procedure or practice that needs to be made, such as the provision of information in easily understood language. We have also re built the relatives room to increase the size and comfort of the area, and re developed a shower room as a direct result of comments made from the RSS. This building work was financed by a very generous donation made by the relatives of a past patient.

The Patient Focus groups are a powerful method of providing some insight to what the patient experiences, their dreams and hallucination's, fears and understanding of their time with us, on the ward and even after their discharge home.

We have written a number of booklets that all patients receive on their discharge to the ward and home explaining what physical changes they may experience and the potential emotional impact that their admission may have.

The information gathered has demonstrated that although we strive to provide the best care we can, we can never be complacent or make assumptions' on how we actually do.

Rebecca Hill
Staff Development Sister

TISSUE VIABILITY GROUP

ICU patients are extremely vulnerable to development of pressure ulcers (PU), as a result of their complex pathophysiology, and the use of therapies which compromise tissue oxygenation and circulation. The main purpose of the tissue viability group is to support the nursing team in reducing the incidence of pressure ulcers, through a multidisciplinary approach.

In addition we aim to improve our wound care management; developing our knowledge base relating to wound care dressings; management of vacuum assisted wound therapy; maintain supplies and maximise cost effectiveness.

Over the last 12 months the group has continued its activities providing information regarding pressure ulcer risk assessment, prevention strategies and staging of pressure ulcers.

We have analysed the frequency and location of pressure ulcers and have used this information to improve our practice, focusing on areas which appear particularly vulnerable to damage, within our client group. For example, it was noted that pressure ulcers on patients' heels could be prevented using heel lift boots, and by encouraging nurses to check this area more

frequently, and documenting care in a specially printed area of the ICU chart.

Similarly, we are encouraging staff to be more proactive in preventing pressure ulceration caused by equipment such as oxygen masks and intravenous lines which cause tissue damage.

In addition, we have developed:

- A quick reference guide to ensure that all staff are aware of the required interventions.
- A questionnaire to test knowledge of pressure ulcer prevention, grading and reporting
- A practice update session for staff undertaking the Foundation of Critical Care Course.
- Visits from specialist nurses to provide updates for staff in use of negative pressure wound therapy.

Another of our major aims is to improve our practice as tissue viability link professionals working with the Trust's Tissue Viability Nurse (TVN). This enables us to maintain good communication, to benefit from her expertise and share this knowledge with the ICU team. This involvement also ensures that the group members are up to date with innovations within the Trust. For example, we are currently implementing a new form of data collection via the Trust internet. This will provide us with a more accurate record of patients who are admitted with or develop pressure ulcers within the ICU and other wards. The information will help us to audit our care, documentation and determine how well prevention measures are being implemented.

In addition, we are currently looking at a skin care bundle devised by our TVN which we aim to adapt for ICU patients. This document will incorporate risk assessment, and prompt appropriate nursing interventions for pressure ulcer prevention. For patients who are admitted with or develop a Pressure Ulcer, a second care

pathway will be initiated to ensure staff follow the Trust guidelines in regard to reporting and management.

We recognise that much of this work is on-going and that constant review of our performance is necessary to achieve our aims in providing the highest quality care for our patients.

**Caroline Younger
Sister – Team B**

INFECTION CONTROL INTER-TEAM PROJECT GROUP

Infection control continues to challenge intensive care units within every hospital. Because of the nature of our patient group they are more susceptible to infection. Much of the therapy we provide for patients is lifesaving, however the very fact a patient is in hospital heightens the risk of hospital acquired infections.

Organisms are becoming increasingly resistant to antibiotics which have been previously used. Prevention and control of infection within intensive care is therefore paramount. The intensive care infection control team was established to educate members of staff and employ evidence based techniques to reduce infection. It plays an integral part in how the unit operates day to day. The team empowers multidisciplinary staff of all grades to be involved in working together to reduce infection within the unit. The team works closely with the hospitals own infection control team to do this.

The main roles of the intensive care infection control team is surveillance and investigation of infections, education of all staff throughout the unit, reviews of antibiotic use and antibiotic resistance patterns and reviewing up to date evidence based infection control procedures and policies.

Examples of the kind of work undertaken by the

team include continual audits into hand hygiene, urinary catheter care, peripheral access care and central venous catheter care. These results are collated and reported to the rest of the trust.

Strategic planning is then used to establish a plan on how to develop and improve our high standards.

Infection control continues to be a dynamic area, with an ever changing landscape. The Intensive Care Infection Control Team work hard to ensure all staff are up to date with any developments.

Regular teaching sessions, communications and updates are provided to educate multidisciplinary staff.

We hope this will continue to be done more effectively due to the increasing number of qualified infection control link practitioners who are now part of the team. We will continue to review and adapt where necessary, current guidelines in order to reduce the risk of infection to our patients.

As always the year ahead will continue to be a challenging time for the intensive care unit. However, we hope our hard work will be rewarded by reducing hospital acquired infections and improving the service we provide for our patients.

Matthew Harrison
Staff Nurse – Team J

INFECTION CONTROL LINK PROFESSIONAL

Infection control link professionals act as a link between their own clinical area and the infection control team.

Our role is to increase awareness of infection control issues in the unit and motivate staff to improve practice. It is essential that we receive training from the infection control team to ensure our competence.

Part of being an ICLP is to facilitate that our daily and monthly audits with regards to Infection Control are always up to date. It is also essential

that we meet our monthly threshold with all of our audits. These are hand hygiene, care of central venous catheters, care of peripheral lines and care of urinary catheters.

The Infection Control team regularly conducts meetings once a month and being an ICLP they give us feedback on infection control issues, both trust wide and nationwide.

Bass Reyes
Senior Staff Nurse- Team D

TEACHING GROUP

By their very nature, people are inquisitive. The goal of education should be to encourage answers, as it is in this way that we advance.

The Teaching Group seeks to facilitate this advancement of knowledge. We organise teaching sessions in the unit on a monthly basis considering the needs of all the staff, ensuring that the educational needs of ICU nurses from novice to expert are addressed.

Starting from Foundations of Critical Care, ICU course, mentorship courses and pathways for career advancement, such as Band 6 and Band 7 developmental courses in- house and trust wide. Because of the continuous advancement of the medical and nursing profession, as a team we inform all nurses and apply in the unit all new NMC Guidelines and National Government Plans in Critical Care Nursing e.g. Mentorship update and National Competencies framework.

Learning in nursing is a continuous process. Every day there are new research studies, guidelines, medications, protocols, equipment that we need to learn about; the teaching group establishes an inviting learning environment that promotes collaboration among the staff for the achievement of educational goals.

Maria Briones
Senior Staff Nurse – Team H



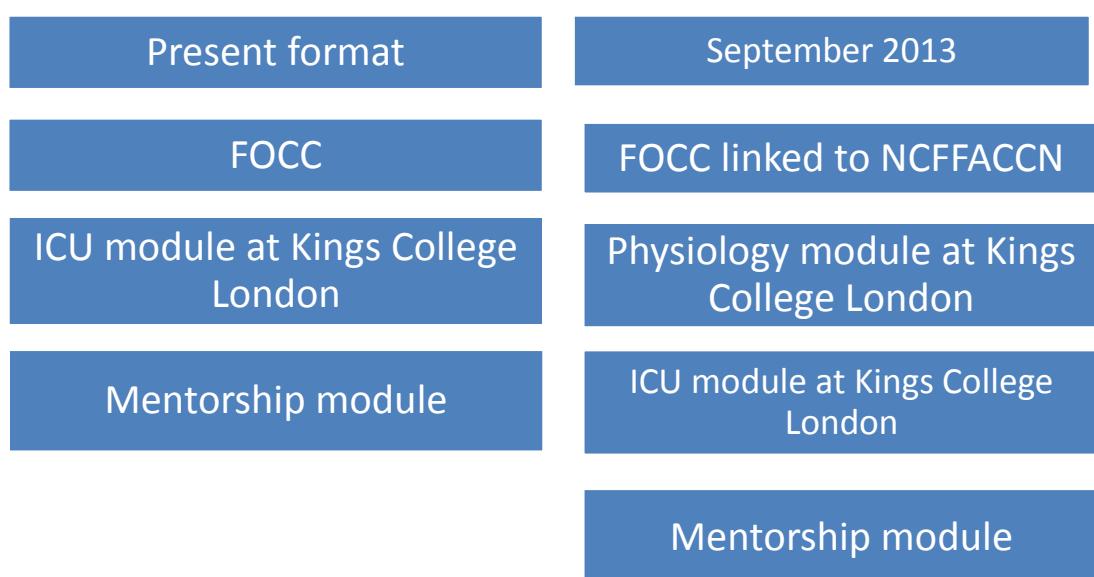
NATIONAL COMPETENCIES FRAMEWORK FOR ADULT CRITICAL CARE NURSES (NCFFACCN)

In late 2012 the Critical Care Network – National Nurse Leads (CC3N) launched some national competencies for adult critical care nurses. These consist of fundamental clinical competencies that are required by nurses in order to provide care for adult patients in ICU. They are designed to be used by registered nurses who

are starting out their careers in critical care nursing and will be able to link into educational courses used by universities who provide intensive care nursing courses. Until now each university and hospital has devised their own relevant clinical competencies and this has led to variations between different parts of the country, the introduction of these competencies will lead to a national consistent approach to training of intensive care nurses.

On the ICU at Chelsea and Westminster Hospital we have had our own competency based training programme for new nurses to ICU called the Foundations of Critical Care for many years, nurses then access the university based intensive care nursing course at Kings College London. The introduction of the NCFFACCN has prompted us to review our competencies and the pathway for staff training in ICU, Kings College has also reviewed their competencies for the Intensive Care Module. To match up to the NCFFACCN we have adjusted the clinical competencies and the education pathway for staff joining ICU this can be seen below:

Diagram: Pathway for staff nurse to ICU achieving competence



We will continue to review the competencies and ensure they are kept in line with national guidance.

Elaine Manderson
Clinical Nurse Specialist

APPRENTICE ROLE IN ITU

Working on intensive care as a nurse is very different from working on a ward, there is a lot more technology to deal with and the patients are much sicker. The transition from being an experienced ward nurse to an inexperienced intensive care nurse can be very challenging. So much so that staff often say they feel like a student again. To help ease this transition most units now run structured programmes for staff new to intensive care, where a student again. To help ease this transition most units now run structured programmes for staff new to intensive care, where formal training is given and staff are supported by a mentor. We have run a course like this on our unit since 2000. Despite this high level of support, some staff never make the adjustment to intensive care nursing. It's a challenging area and it's not suited to all.

In recognition of this we have established an apprentice role for staff new to ICU, staff join us on a one year contract and are placed onto our structured foundation course, during this they work regularly with our staff development sister and also have a designated mentor. They have competencies that they need to demonstrate and they have regular meetings to check on their progress and to identify if any additional support is needed. For staff that are not settling well into the unit these meetings enable us to facilitate career planning for them and the role offers staff the chance to experience ICU without having to make a long term commitment to it.

Charlene Brown
Sister – Team I

MY EXPERIENCE OF THE APPRENTICE ROLE

I started this apprenticeship back in May of last year. My interest in critical care, and the chance to develop my knowledge on this fascinating field, is what prompted me to apply for this post. I also remembered reading the staff national survey which showed that approximately 80% of staff would recommend their family member to work at Chelsea and Westminster hospital. I instantly felt that this trust could be my ideal work environment, fortunately enough, I was accepted onto the program.

During the past year, I've undertaken the foundation module in critical care and work competencies. It's been quite a challenge to work in a place where the staff working there are up to date and my queries seemed very basic. However, this foundation course in ICU has been very well set up and it enables me to link theory to practice. The course has taught me how to carry out an assessment of a critical ill patient, to analyse blood results, blood gases as well as review appropriate ventilator settings under supervision.

The experience as a whole has been very rewarding and you do feel more competent in caring for a critically ill patient. I like to take this opportunity to thank Charlie Brown, our module leader, who supported us through our journey of transitions from ward based nursing to ICU nursing

Jamilla Hussein
Staff Nurse – Team A

BAND 6 DEVELOPMENT PROGRAMME

As part of the on-going education and development for staff on the unit we have revamped the band 6 programme (Senior Staff

Nurse- SSN) for staff who are new to the SSN role.

Senior Staff Nurses in ICU are nurses who have completed their studies in intensive care nursing and are qualified mentors. The band 6 role has responsibilities for providing care to patients with little supervision, supporting junior staff and as they gain experience coordinating the burns ICU and general ICU. The new programme is designed to help them meet these requirements in a structured format.

The programme consists of three study days focusing upon different aspects of the band 6 role (see table below), in addition to these days the staff also produce a small teaching session of their choice , based on their learning during the course, to present to their peers. They also undertake a reflective review of their progress during the course.

	<ul style="list-style-type: none"> ▪ Delirium ▪ Organ donation <input type="checkbox"/> Case studies
Advanced Communication	<ul style="list-style-type: none"> <input type="checkbox"/> Managing Patient experience <input type="checkbox"/> Case studies

We have run two cohorts so far, and the feedback from participants has been positive with comments such as “excellent study days” “sessions are equally important to me as it has made me more aware of things at a band 6 level” “I enjoyed the variety of teaching method and group involvement”

Elaine Manderson
Clinical Nurse Specialist

EXPERIENCE OF BAND 6 DEVELOPMENT COURSE

The band 6 program is an educational development course which is available for all band 6s new to the senior staff nurse post within the ICU at Chelsea and Westminster. All participants will have completed their mentorship and intensive care courses and it is designed to build upon the knowledge of these courses, providing a focus for continuing professional and personal development, as well as giving a theoretical background in to the role of shift coordinator and further managerial issues. All these aspects enable us to effectively support our team leader in a deputy role.

The program consists of 3 study days each focusing on pathophysiology and clinical patient management issues commonly seen in an ICU, such as advanced airway management and ventilation, advanced cardiac management and burns. The clinical aspect of the day is followed by management development sessions which look at further developing our skills in subjects such as communication, shift leadership and effectively working with others. The program, which has been developed in house by the units

Topic covered	Key concepts of session
Advanced airway management and ventilation	<ul style="list-style-type: none"> <input type="checkbox"/> The patient with a difficult airway <input type="checkbox"/> Capnography <input type="checkbox"/> The patients ventilation flow mechanics <input type="checkbox"/> Case reviews
Working with others	<ul style="list-style-type: none"> <input type="checkbox"/> Coaching conversations <input type="checkbox"/> Dealing with conflict <input type="checkbox"/> Dealing with problem <input type="checkbox"/> Case studies
Advanced cardiac management	<ul style="list-style-type: none"> <input type="checkbox"/> The patient with arrhythmias <input type="checkbox"/> The patient who needs advanced haemodynamic monitoring <input type="checkbox"/> Case reviews
Coordination	<ul style="list-style-type: none"> <input type="checkbox"/> The role of the coordinator <input type="checkbox"/> Case studies
Tricky critters	<ul style="list-style-type: none"> <input type="checkbox"/> Managing the patient with tricky clinical presentations <ul style="list-style-type: none"> ▪ TENS / Burns ▪ Liver / GI bleeds

Clinical nurse supervisor, is delivered using a variety of different teaching methods, drawing on role play, workshops and presentations.

To complete the program we are required to complete a reflective account, highlighting our learning and development within the course, and finally, to prepare and present a teaching session on a clinical, leadership or educational topic of our choice to our colleagues. This session is then assessed and marked.

By participating and completing this program, I feel I have been allowed to develop and grow in confidence and skill to become an effective team member supporting my team leader. I have learnt managerial issues and have been able to effectively develop my communication and leadership skills which have enabled me to focus on areas in my practice that may need further development in the future.

Helen Foley
Senior Staff Nurse – Team B

BAND 7 DEVELOPMENT PROGRAMME

I was asked to participate in a new course for band 7 nurses at Chelsea and Westminster Hospital in January 2012. The leadership course consisted of 8 one day workshops running from January to September, each workshop focusing on areas of leadership development. Each of the workshops contained different learning activities, case studies and group discussion.

At the start of the course I identified 3 things that I hoped to achieve by the end, these being: To be able to share experiences of managing people and performance, develop networking skills and gain more experience in writing statements and business planning. The key challenges that I identified were being more outspoken in groups and gaining confidence in my own knowledge and experience. My main contribution to the

programme would be that I was very much into the patient experience and thrive to improve this for every patient that I care for.

At the end of the course you were required to do a poster presentation on a project that you undertook in your clinical areas. I was the lead for the patient diaries and decided to focus my project on developing and improving this for ICU, not only for the patients but for our ICU team.

Patient diaries were set up by Sister Rosalie Le Cordeur in 2010, after a pilot study the diaries were rolled out to all teams within the ICU. The patient diary aims to fill in the gaps of the patients stay whilst in ICU, they are written by the bedside nurse on a shift by shift basis. They are presented to the patient after discharge. They have been shown to reduce the psychological problems that many patients suffer after discharge.

I identified some issues with the diaries, these being mainly poor uptake from staff, lack of entries and a back log of diaries. My project was to audit, re-educate staff, and improve the number of entries asking other members of the MDT to get involved, clear the back log of diaries by improving the process for returning the diaries and obtain feedback from the patients, thus improving the content further.

My objectives set out at the start of the course were achieved and I received fantastic feedback from my poster presentation, with two other departments showing an interest in starting up their own patient diaries.

I handed back the patient diaries to Sister Rosalie Le Cordeur in October 2012 and was pleased with the developments I had achieved through undertaking this project as part of my band 7 development programme, all of this contributing to an improvement in the patients experience whilst on ICU and after discharge.

Joanne Learney
Sister – Team I

SECONDMENT TO KINGS COLLEGE LONDON

In December 2011, I started a year secondment at Kings College London, as a Lecturer/Practitioner for the 'Transition from Ward based to Critical Care Nursing' course. I had previously co-run a similar course at Chelsea and Westminster ICU, The Foundation Course in Critical Care. The biggest difference for me was that this class had 30 pupils in it compared to 6 or 8 I had previously been used to. This changes the dynamics of teaching from a small group to a classroom or even a lecture hall setting, which I found very daunting to begin with. To be a good teacher you not only need to know your topic very well, but you also need to be able to discuss it in an enthusiastic way, which will keep your students interest. Rather than just reading from power-point slides, the lecturer needs to be able to discuss their own experiences and put the learning into context for the students. It is also important to assess the student's knowledge during the session and I learnt that a quiz is a fun and effective way of doing this.

When I was not teaching, I had to organise any outside speakers, meet with students who were needing help, put the next study day's teaching on the website for students to access with relevant articles and liaise with the student's hospitals, sometimes visiting them personally to discuss the course.

Whilst doing this role I also did some clinical work, which I think is essential to keep up your skills. Personally, I think it adds to your role as a teacher, as you do not lose the reality of working clinically and the students can perhaps relate to you more. Half way through my year, I decided that I wanted to do a teaching course, so that I could be assessed and learn more about education. I decided to do the 'Teaching and Facilitation in Learning' Course, as a 'Practice Teacher' rather than a teacher, mainly due to the number of teaching hours that you have to accrue

and the fact that I work part-time. For a Teacher it is 60 days and for a practice teacher it is 24 days.

My secondment ended in December 2012, but I have returned to Kings College to do various teaching sessions and it has been very helpful to be assessed. I have taught on a variety of courses both pre-reg. and post-reg., to get as much experience as possible and taught an inter-professional group of nurses and physiotherapists. Inter-professional education is becoming more popular, as it is thought if different disciplines are educated together then we will understand each other's roles more and work better as a team. Now I am back working in ICU, I am still using my skills as a teacher both in the classroom on our 'Foundations Course' and also at the bedside. I am really pleased that I had the opportunity to work in a higher education environment, as it has developed my teaching skills and given me insight into this environment.

Danielle Pinnock

Sister – Team H

RESEARCH GROUP

The research group has had another busy year creating new guidelines and reviewing existing ones. The new guidelines have covered aspects of clinical practice that have been identified as requiring a more formal structure to reflect recent advances and changes in practice, taking into account any new advice from other bodies such as the National Institute for Health and Care Excellence.

Several of the new guidelines have required input and comments from different members of the MDT, for example the Passy Muir Speaking Valve (PMSV) guideline involved discussions with Physiotherapists, Doctors, Nurses and the Speech and Language Therapists, and this takes a great deal of co-ordination and time to achieve. However, the final outcome is the ratification of a new guideline. Guidelines ratified this past year have included Total Parenteral Nutrition,

Handover, Passy Muir Speaking Valve, Intra-abdominal Pressure Monitoring and Suction above the Cuff Endotracheal Tube. Several guidelines were due for review – Prone Positioning, Inotropic Drug Administration, and Intubation, Sedation which incorporated the Management of the difficult airway as recommended by the 4th National Audit Project of the RCA. Other new subjects that are being looked at are Oral Care, Peripheral Nerve Stimulator, Plasma exchange, Therapeutic Hypothermia after Cardiac Arrest and Capnography.

The Research Group has a Research Champion attached to the team who acts as a resource for research in the Intensive Care area and can provide support and guidance for staff, patients and the public. This entails staying up to date with relevant research regulations, policies and procedures and acting as a link between the Research and Development department and the Intensive Care Unit.

The Research Group also has links with the Research Nurses attached to research studies that are currently being undertaken in the Hospital and involve patients admitted to the Intensive Care Unit. The Research Nurses attend the research group meetings and give regular updates on the progress of the studies to allow staff to keep up to date.

I would like to thank all members of the Research Group for their contribution over the past year.

Ann Sorrie
Sister – Team H

RESEARCH UPDATE

My main project involves evaluating the inflammatory response seen after severe burn injuries. We are focussing on “microvesicles”, which are produced by cells in response to stress. At the moment, we are spending a lot of time refining our techniques for detecting these microvesicles, as they are much smaller than the

cells which our equipment is designed to study. Once we have robust methods, we will begin recruiting patients from the Burns Unit and ICU. The impact to patients is very small, as we will mainly use existing arterial and central lines to sample small amounts of blood. If they undergo bronchoscopy, we may also sample fluid from the lungs.

We have also been working on the VAP study over the past year, the first phase of which is now complete. The project is studying whether we can improve our diagnostic accuracy in patients with suspected ventilator-associated pneumonia (VAP) and therefore reduce unnecessary antibiotic use. This will be achieved by measuring a range of “biomarkers” in lung fluid, sampled by bronchoscopy. Provided the results of the initial phase are as expected, the next phase will commence this summer. As before, patients will undergo bronchoscopy but this time we will use the results of the lung fluid analysis to guide antibiotic treatment.

John Porter
Clinical Research Fellow

ProMISe

The ProMISe trial is a multicentre randomised controlled trial of the clinical and cost-effectiveness of early, goal-directed, protocolised resuscitation for emerging septic shock. Recruitment for this trial commenced in May 2011 at Chelsea and Westminster hospital and has now been extended for a further year, until April 2014. Meeting recruitment to time and target has been challenging.

Nationally, ProMISe has recruited two-thirds of their target number with 844 patients being recruited across 43 sites. At Chelsea and Westminster, we have recruited 13 patients (Diagram 1). Recruitment increased from 5 in 2011-2012 to 8 in 2012-2013 with the addition of

a second research nurse and the extension of screening and recruitment hours to 7 days per week. A further 134 patients were eligible for the trial but were excluded primarily due to: decisions to limit treatment (DNAR, advanced directive, aggressive treatment unsuitable) (n=61, 45.5%); out of screening hours (n=48, 35.8%); contraindication for CVC line (n=5, 3.9%); major cardiac arrhythmia (n=4, 3.1%); Acute Pulmonary Oedema (n=3, 2.3%); AIDs defining illness (n=2, 1.6%); immunosuppression (n=2, 1.6%); Primary diagnosis of ACS (n=2, 1.6%); seizure (n=2, 1.6%); GI haemorrhage (n=2, 1.6%); participating in another study (n=1, 0.7%); Transferred from another hospital (n=1); Requirement for immediate surgery (n=1, 0.7%). Many of the patients met more than one exclusion criteria.

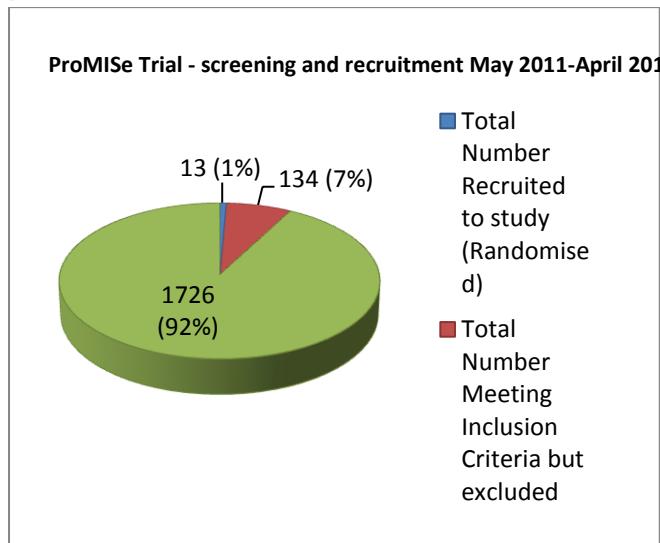


Diagram 1: May 2011-April 2013 Screening and recruitment

Two changes to the inclusion criteria have been made this year. Patients on immunosuppressive drugs are now eligible for the trial. Patients with DNAR orders can also be included as long as they have a ceiling of treatment that includes having a CVC line and inotropic drugs.

A poster, 'Recruitment of critically ill patients into a multi-centre Randomised Control Trial -a local perspective', focusing on factors that impact on recruiting to the trial was present at the RCN International Research Conference in Belfast in March 2013.

Teresa Weldring Research Associate – Nurse

The Intensive Care Unit of Chelsea and Westminster Hospital supports the development of Staff. It allows each member of the staff to find new roles and experience challenges within the roles they have chosen.

I was well supported by the unit when I was given the secondment post to do research (ProMISe). The move to Research and Development from Intensive care will provide a unique opportunity to learn the different structures and practices within research. The ProMISe trial deals with septic patients.

These patients will normally be admitted from the Accident and Emergency Department to the Intensive care. The process of admitting a patient on the trial, coordinating with the doctors and continuous detailed assessment are major challenges whenever a patient is recruited. It is an advantage that I have worked in the Intensive care unit, mainly because I know most of the people and the unit itself supports Research. The support that was given to me both by the A+E team and ICU team were excellent. The secondment demonstrates my professional and personal ability to adapt to change and shows flexibility as a nurse. It also opens up to new opportunities.

Jamie Carungcong Senior Staff Nurse – Research associate

PHYSIOTHERAPY

Critical illness and surgery can result in variable degrees of debilitation, depending on the severity of the insult suffered and the health and wellbeing of the patient prior to the events. The effects of major illness is a breakdown of muscle and vital energy stores to fuel the body's defence systems; and inherent immobility, which in itself can cause deterioration in strength and physical function.

The role of the physiotherapy team on the ICU is

to try to minimize this muscle breakdown, and rehabilitate patients back to health, when it inevitably occurs.

Over the past year the physiotherapy team have been working hard to improve the delivery of our service. We will be extending our working hours from a 4.30pm finish, to an 8pm finish in June 2013. The impact of this is a more comprehensive service, adapted to the complex needs of the patients, with better continuity of care.

We have also been working closely with our nursing colleagues to implement a *Rehabilitation Round* on ICU. This is a multi-disciplinary bedside ward round that we run once a week. It is specifically designed to address the psychological, physical and emotional needs of the patients. This helps us to develop patient orientated recovery goals, and support patients and relatives above and beyond their medical needs.

The physiotherapy team on ICU are dedicated to continuous professional development, innovation and research. This year, in conjunction with the Centre for Clinical Practice, we have developed and implemented one of the first high-fidelity simulation based training course for qualified ICU therapists. This allows us to simulate 'real-life' scenarios and develop both technical and non-technical skills in a safe and risk free environment.

We will also be engaging in a more comprehensive portfolio of research through a PhD fellowship secured by the Respiratory Physiotherapy Clinical Lead. This is to investigate how we can measure physical recovery from critical illness to improve understanding of the complexities of ICU acquired weakness.

Eve Corner
Clinical Lead Physiotherapist for Respiratory and Critical Care

REHABILITATION ROUNDS

Being in intensive care can have profound effects that can last long after discharge to the ward and home. People can suffer from muscle wasting, disability, stress, anxiety and depression. This has been recognised by the National Institute of Clinical Excellence (NICE), who issued some guidance for intensive care units in 2009 to help deal with these problems before they arise, through the development of robust rehabilitation programs. This has lead us as a team in ICU to introduce rehabilitation rounds.

The rounds occur every Monday afternoon and consist routinely of: the clinical nurse specialist; bedside nurse, senior physiotherapist; and junior doctor. The dietitian, pharmacist and senior medical staff also attend as required.

For the rehabilitation rounds, we compiled a checklist to address every aspect of the patients care needs. This includes: ventilation weaning; physical movement; nutrition; cognition; communication; and self-care. Each point on the checklist is reviewed during the round, and a patient agreed multi- disciplinary goal is set for all areas.

We have reviewed how effective the rounds are and have found that the introduction of the round has resulted in:

1. Increased completion of patient agreed goals;
2. A more holistic approach to ICU recovery;
3. Early introduction of help with communication for patients
4. Greater consideration of the need for pastoral care for patients and their families

A self-help manual called 'on the road to recovery' is also in development. This guides people through the transitions from ICU to home. It contains information on diet, appearance, exercise, mobility, pain control, sexual function,

sleep, mood, memory and speech. The self-help manual is currently undergoing stakeholder review and will be implemented shortly. Staff feedback has been positive.

Elaine Manderson
Clinical Nurse Specialist
Eve Corner
Clinical Lead Physiotherapist

NORTH WEST LONDON CRITICAL CARE NETWORK (NWLCCN)

The ICU continues to work with the NWLCCN in developing intensive care services throughout North West London.

Dr Jonathon Handy continues as service lead for transfers and coordinates the running of regular transfer training study days for staff working in ICU. He has also led on the development of training films of subject areas on the transfer course and other vital subjects related to ICU. These have been distributed to all the ICU's and A&E's in Northwest London so that staff who are unable to attend study days in person can still access the vital training in transferring critically ill patients. The video casts include:

- introduction to the network
- why worry about transfers
- principles of critical care transfers
- physiological effects of transfers
- principles of pre-transfer stabilisation
- medico -legal aspects of transfer
- know your transfer equipment
- ambulance familiarisation
- transfer documentation
- Sessions on specific patient problems such as aortic emergencies, neurosurgical transfer, major trauma and paediatrics.

- crisis resource management
- principles of evacuation and shelter for ICU

We are also working with NWLCCN in developing a website resource. This will cover all aspects relevant to critical care including clinical care and guidelines, policy development, organisation and education. The website will be designed to meet the need of staff working in ICU, but will also be a site that patients and their families can access to provide them with information that may be of help for them.

Elaine Manderson
Clinical Nurse Specialist

CUSTOMER SERVICE EXCELLENCE

The ICU has successfully held a customer service award (firstly the Charter Mark and latterly the Customer Service Excellence award) since 1998. Every year we have a compliance check to ensure that we are still meeting the levels required for the five criteria for the award, which are customer insight, culture of the organisation, information and access, delivery and timeliness, and quality of service.

Our latest assessment found that we were fully meeting all the criteria and the assessor stated that we as an ICU "*Have a passion and thirst for continuous improvement and this is typified by the many improvements and innovations reported. They have embraced all development points raised at their Continual Compliance Review in 2012 and have continued to be a beacon for promoting the benefits of Customer Journey Mapping.*"

They felt that our strengths were:

- The ICU continue to excel at Customer Journey Mapping and promote this concept as best practice
- Developing a comprehensive 'On the Road to Recovery' booklet using

invaluable patient and relative insight and extending the customer journey beyond leaving the ICU.

- Better response to Relative Satisfaction Survey providing more detailed data from which to improve levels of service.
- Responding to any disappointing scores in the Relative Satisfaction Survey, e.g. improving the waiting room.
- 4 new decisive core values with 'excellence' as one have provided a vehicle to more clearly demonstrate commitment to the patient and customer excellence
- No complaints in last 6 months.
- Rehabilitation Rounds being introduced to further improve levels of service with inputs from both staff and patients.

They went on to suggest a few areas for further development in the coming year:

- Incorporating our values into our rehabilitation/ discharge book that we are redeveloping
- Consider how we may monitor our values and how they are being implemented in practice
- Continue to develop our patient diaries and consider if we would like to offer photographs as part of them.

Each of these areas will be considered by our quality improvement Interteam project group in the coming months.

Elaine Manderson
Clinical Nurse Specialist

Jane-Marie Hamill
Head Nurse – Critical Care

CARE QUALITY COMMISSION ESSENTIAL STANDARDS AUDITS

The Care Quality Commission is the regulatory body for healthcare and regular inspects the hospital in relation to the Essential Standards of Quality and Safety. These standards are:

- respecting and involving service users
- consent to consent and treatment
- care and welfare of people who use the service
- meeting peoples nutritional needs
- cooperation with other providers
- safeguarding people from abuse
- cleanliness and infection control
- safe and appropriate management of medicines
- safety and suitability of premises
- safety, availability and suitability of equipment
- workers staffing and supporting staff
- assessing, monitoring and improving the quality of service provision
- complaints
- maintaining peoples personal care

As part of ensuring that we are meeting these vital standards on an on-going basis we audit and benchmark our performance against these standards on a weekly basis. The audits are carried out by staff from other areas of the hospital visiting the ICU and working with staff on the unit to assess performance. By doing this we ensure that staff are familiar with the standards and we are also able to identify areas that could be improved upon. Things we have changed from these audits include:

- Ensuring that all staff wear large name badges with their role on them
- Ensuring that relatives are able to speak with a doctor after the ward round
- Updating the pharmacy folder for staff
- Revamping the process for staff undertaking drug administration competencies

Feedback from the audits is given at the senior nurse, ICU monthly team and at our sisters meetings; we will continue to look at our practice and aim to continually improve.

Elaine Manderson
Clinical Nurse Specialist



Staff April 2013

Dr Neil Soni
Consultant Anaesthetist & Intensivist

Dr Alex Li
Consultant Anaesthetist & Intensivist

Dr Rick Keays
Consultant Anaesthetist & Intensivist
Director of Intensive Care

Dr Michelle Hayes
Consultant Anaesthetist & Intensivist

Dr Jonathon Handy
Consultant Anaesthetist & Intensivist

Dr Suveer Singh
Consultant Intensivist and Respiratory Medicine

Dr Marcella Vizcaychipi
Consultant Anaesthetist & Intensivist

Dr Berge Azadian
Consultant Microbiologist

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Tomasz Sitek
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ACKNOWLEDGEMENTS

Amanda Dixon

Sister, Intensive Care for editing this report

The staff of the ICU would like to acknowledge and thank the following people for their continued support

Dr Rick Keays

Director of Intensive Care

Karen Robertson

Divisional Operations Director -Clinical Support

Dr Mike Weston

Divisional Medical Director-Clinical Support

And a final special thanks and tribute to

Dr Neil Soni

Consultant Anaesthetist & Intensivist

Dr Neil Soni has run the Intensive Care Unit at the Old Westminster Hospital in Horseferry Road and the new Chelsea & Westminster Hospital in the Fulham Road, from 1985 until 2008. Over 23 years he has crafted and led one of the best Intensive Care teams in the country. He qualified in Medicine from Bristol University in 1976, did his postgraduate training and then moved to Australia, doing 3 years in medicine there before he commenced his anaesthetic training from 1980 to 1984. He then returned to England in 1985 and joined the old Westminster Hospital as Senior Lecturer in Anaesthetics/Director of Intensive Care to the Magill Dept of Anaesthetics.

It is fair to say that Dr Soni is an Intensive Care doctor of world-renown. He has published widely – including 63 original papers, 7 books as Editor in relation to anaesthesia & intensive care, multiple chapter contributions, over 50 abstracts, 18 Editorials in Peer reviewed journals & 32 review articles. He is an international speaker on both anaesthesia & intensive care. Dr Soni was recently a visiting Professor and gave his Inaugural Lecture in Australia. He has just been awarded an Honorary Membership of the Intensive Care Society. He set up the examination for the UK Diploma in Intensive Care Medicine and was instrumental in the establishment of the recently formed Faculty of Intensive Care Medicine.

He has performed some landmark research over the years and has guided many trainees to fulfil their academic potential. He has supervised many doctoral theses and has been editor of Current Anaesthesia & Critical Care, The Journal of the Intensive Care Society and has been on the editorial board and refereed for numerous other journals.

He is also on the Board of the Westminster Medical School Research Trust and is the main organiser for the charity which participates with the Parliamentary All Parties Ladies Committee. They fund raise all year round to purchase equipment for C & W and twice yearly hold a Champagne Reception to raise these funds. The receptions have been held at nearly every high profile venues including 10 Downing Street. Dr Soni works tirelessly for this charity and they have raised thousands of pounds over the years for the hospital.

He also organises for our doctors and nurses to attend the State Opening of Parliament every year and is highly thought of by Black Rod's Office at the House of Lords.

But the most important thing about Dr Soni is his commitment to his patients – for many years he was constantly on-call and available to the hospital. Countless patients and families have reason to be profoundly thankful for his medical care and unparalleled experience. He even has a dog named after him by a grateful patient. He is an excellent doctor, hugely respected by his colleagues for whom he has often been a big support. He never hesitates to tell you when you have been a moron, but also remembers to tell you when you have got something right!

He is retiring and we shall miss him. The hospital will lose someone of titanic accomplishment – but, after all the work he has put in over the years, he deserves a bit of a rest.

Dr Rick Keays
Consultant Anaesthetist & Intensivist
Director of Intensive Care

Dr Berge Azadian
Consultant Microbiologist

INTENSIVE CARE UNIT ANNUAL REPORT 2012 -2013

RESPECTFUL
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