Chelsea and Westminster Healthcare NHS
NHS Trust

# Intensive Care and Nursing Development Unit Report 2004-2006

# Contents

# Philosophy of Care

## Chelsea and Westminster Intensive Care and High Dependency Unit

Many different members of staff care for patients within this department. Together we are dedicated to providing compassionate, exceptional care and service. We recognise the uniqueness of each individual and his or her right to dignity, and as such are dedicated to providing the best possible, individualised care.

We respect the rights of our patients, and that our care must be non-judgmental, based on sound ethical and moral principles. We recognise that the severity of illness experienced by our patients may render them incapable of participation in the decision making processes that affect their care. As direct care givers, we must serve as the patient's advocate, in consultation with family and significant others. We will provide care in such a way as to respect the dignity, privacy and confidentiality of patients and families.

We aim to assist our patients towards recovery and independence. When it is not possible, we try to prepare them for a peaceful and dignified death. We feel it is important not only to share in the joy of a patient's recovery, but also in the sorrow and pain of a patient's death, and to ease others' grief.

We believe that the caring environment we provide for our patients should be reflected in our attitudes towards each other and that each member of the team is a valuable asset. Staff have the right to be treated with respect and to go about their work without risk to themselves. Every member of staff should have the opportunity to develop their skills through the provision of professional development tailored to their own needs.

The intensive care team believe that our work makes a difference, benefiting patients and their loved ones. We feel that we are in a privileged position of trust and that this privilege should be repaid by the provision of the highest standards of care, delivered by questioning and motivated staff.

# Foreword

**As a relatively new consultant in the Intensive Care Unit, I have found the role offers various challenges but these have been made all the more surmountable due to the strength of the unit of which I am a part.**

The term 'unit' describes perfectly the ethos behind the ICU at Chelsea and Westminster. As a junior doctor here I never felt without support from nursing and medical colleagues and this certainly has not changed since commencing my position as a consultant. The unit has an excellent reputation both nationally and internationally. This is reflected in the receipt of the 'Charter Mark' awards and the presence of our staff in the faculties of meetings and conferences around the globe.

Such cohesiveness is extremely attractive to prospective employees but is also necessary given the rapidly changing environment of acute hospital medicine. Reduced junior doctors' hours, the European Working Time Directive, increasing public expectations and increased professional accountability are just a few of the major changes taking place at present. However, they never seem to detract from our objective to achieve the very best for our patients and their relatives.

What does the future hold? Education is an area of personal interest and establishing a comprehensive teaching programme for the junior doctors rotating through ICU is proving to be a challenging area. Research and audit has always been part of the ethos of the unit and I hope to continue along that path. In addition there are a number of exciting new ventures on the horizon including the patient 'follow-up' clinic and the development of the Burns ICU. Such excursions into unchartered territory are typical of a unit which is prepared to lead rather than follow and will hopefully continue to do so over the decades to come.

**Dr Jonathan Handy**
Consultant Intensivist

# Introduction

Last year due to a variety of reasons the ICU annual report was not published and so we have produced a bumper edition this year reflecting on activities on the unit in 2005 and 2006.

The report consists of the regular elements such as recounting our progress in the inter-team projects and feedback from the users of our service. In addition, in the last year the unit has gone through a major change in that it is now responsible for the care of the critically ill burns intensive care patient.

Effective change depends on individuals working as part of an informed and committed team who have a clear and explicit vision of what is trying to be achieved. Both the ICU and the Burns team have made significant progress in the last year, and this undoubtedly is due to professionalism and flexibility of staff. This annual report celebrates and recognises all this hard work.

**Jane-Marie Hamill**
Clinical Nurse Leader

# Unit projects

## Charter Mark – going the extra mile

The staff on the Intensive Care Unit at Chelsea and Westminster often 'go the extra mile' to ensure that patients and their families get the best. This could be by offering overnight stay rooms to relatives, sorting out places in the hospital school for patients' children or getting a much loved video for patients to watch.

It's for these reasons that we have been successfully awarded the Charter Mark for the third time. We have been previously awarded the status in 1998 and 2001.

The Charter Mark is a standard of excellent customer service awarded by the Government to public sector or voluntary organisations. This means that government agencies, police forces, prisons, museums, schools and healthcare settings can be awarded the Charter Mark.

Out of the 2,481 organisations that currently hold the Charter Mark, there are only six other Intensive Care Units.

Charter Mark holders have demonstrated that they have set high standards, offered choice to their customers, looked to continuously improve their service and empowered staff to make changes for the better. In short Charter Mark holders listen, act and deliver.

The first stage was to hold a number of focus groups, where staff members 'brainstormed' ideas of how we demonstrated the evidence the criteria were looking for.

The next stage was to meet for half a day with the assessor to go through the evidence that we had collected together and identify any areas that we were weaker in. We were then able to develop our full application and submit it for assessment.

The final stage was a full day visit to the ICU by our assessor, Trevor James, on November 5 2004. On this day Trevor met ICU staff, patients, relatives and other hospital staff to discuss the daily work of the ICU team.

The Charter Mark scheme is a voluntary process which involved the staff on the ICU preparing an application outlining our performance against six criteria. These are:

1 Set standards and perform well
2 Actively engage with your customer, partners and staff
3 Be fair and accessible to everyone and promote choice
4 Continuously develop and improve
5 Use resources effectively and imaginatively
6 Contribute to improving opportunities and quality of life in communities.

He was very impressed with the enthusiasm and commitment of staff in providing patient-focused care and he found that relatives and former patients were equally impressed with the care and services offered. He was also impressed with the way that the ICU staff work with other departments and teams in the hospital to provide a co-ordinated and streamlined service for patients.

Other areas that we were commended for included:

- Our customer care standards and the services we offer to patients and visitors
- The way that we monitor performance
- The visitor and staff satisfaction surveys and our patient focus groups, which we use to gain information on how we can improve our services.
- Our annual report
- The way in which staff can be identified by name badges and photo boards
- The way in which we encourage and respond to feedback from all our users
- The use of volunteers to help on the unit.

One of the advantages of undertaking the Charter Mark assessment is that we gain feedback regarding our present performance, but is also gives us suggestions on how to improve our service. These suggestions included:

- Developing a website to share information on the unit
- Holding the patient focus groups more frequently
- Developing a newsletter to circulate to patients and visitors
- Analysing the compliments and complaints that we receive in more depth to identify themes that my help with service improvement
- Consider ways to monitor our financial indicators to demonstrate that service improvement is cost effective
- Consider ways that we can become more involved in our local community.

The whole process from start to finish took roughly nine months and required approximately three working weeks to co-ordinate the application and gather the evidence together. Although this seems to be a large investment of our staff time and of unit resources, we believe that the process has been invaluable in helping us to plan for the future.

**Elaine Manderson**
Clinical Nurse Specialist

# Unit projects

## Developing a weaning flow-sheet for ventilated patients

An ongoing piece of work for the nursing and physiotherapy staff on the ICU has been the development of a weaning flow-sheet.

Being on a ventilator has been found to increase the risk of patients developing complications. This project aims to reduce the time a patient spends weaning from the ventilator by using a clear method of assessing a patient's progress and highlighting how reductions in ventilator support can be made.

The flow sheet has been introduced through a programme of education:

- Weaning charts were redeveloped
- Each staff member received a pack outlining the flow sheet and some research articles that were used in the development of the sheet
- A week of teaching sessions followed
- Each day patients identified as being suitable for weaning are commenced on the flow-sheet
- Support for staff is offered by the Clinical Nurse Specialist and Clinical Physiotherapist Specialist.

It is hoped to follow on from this, by comparing time spent on the ventilator before the introduction of the flow-sheet, with time spent after its introduction and by developing a flow-sheet for other modes of ventilation.

**Elaine Manderson**
Clinical Nurse Specialist

## Patient focus groups

We started to hold patient focus groups in September 2003 in association with the Day Surgery Unit. Following recommendations from our Charter Mark assessment we decided to make the arrangements for these groups more focused.

We decided that it would be beneficial to hold two or three per year. These groups would be for ex-patients or relatives who had been on the Intensive Care Unit. The purpose of the focus groups would be to elicit the experiences of the patient or carer while they were on the unit and since discharge. Any comments, thoughts or suggestions would be fed back to the quality group. In this way we could action any suggestions.

Each group lasts for an hour and is focused around the questions outlined in Table 1.

The first group consisted of five ex-patients and a carer. They were all eager to talk about their experience. They also had lots of unanswered questions.

All of the ex-patients had been on the unit for longer than two weeks. They were all ventilated and had been given some form of sedation. They acknowledged that their memories were very disorientated and confusing.

At times it was hard for them to distinguish between reality and fiction.

We did however try to capture some of their memories and experiences:

### Dreams

All of the ex-patients experienced some form of dreams. They were unsure if the dreams happened before or after consciousness. Some of the dreams were pleasant; others had dark dreams. Some of the ICU staff featured in the dreams.

In trying to explain this they felt that perhaps they surfaced into reality and registered a staff member's face so when they slipped into a dream-like state the staff member's image featured in the dream.

A patient whose bed was opposite the staff noticeboard felt that the faces were watching him and appeared to come alive. They mentioned that seeing photos of their family was very comforting.

### Information

Some of the patients were unsure if they were told what happened to them. Others found that it was very helpful for staff to explain what they were doing. The carer felt especially comforted by the staff talking to their relative.

**Table 1**

Questions used for the focus group

- How were you or your carer prepared for your admission to the ward/unit?
- What specific memories stick in your mind about your experience on the Intensive Care Unit?
- How were you prepared by staff for leaving unit/hospital?
- How have you coped with being at home following your time in hospital?
- If you had an opportunity to change anything about your experience what would it be?

Most of the ex-patients had questions:

'How did I become so ill?'

'How did I catch the bug?'

'What happened to me while I was in the ICU?'

'How can I be sure I won't get this sick again?'

Some felt a summary of events while they were on the unit might be helpful, others felt they needed to be stronger before they were given a full account of what happened.

# Unit projects

## Patient focus groups (continued)

### Environment

One patient felt the environment was very clinical and bright. They could all remember noises, especially bleeping sounds. They were conscious of people speaking but felt comforted as if it was a confirmation of life. When one patient was waking up, she felt very claustrophobic. They all stated the unit was calm and they felt loved and cared for while they were there.

### Discharge from the unit

When they spoke of the wards they commented that there were less people around and therefore they had less attention. Some remarked that they had a great recovery, but experienced up and down days. At times they were very emotional. They felt their concentration was disrupted, making it difficult to read. They spoke about physiotherapy and how they had to learn to walk again. One patient commented on being shocked and frightened at the amount of muscle loss they had experienced, and another of physical symptoms they experienced that impaired their recovery and rehabilitation. Another felt the ward rehabilitation was rushed and they were discharged home too early.

### Discharge home

They described feelings of distress and being unsure if they will ever get over the trauma. They felt scared, with a loss of personal confidence, but also afraid it will happen again. They were slow at doing things. The support from GPs was varied. However one patient stated it was hard to ask for help unless you admitted you needed it.

### What changes would you like see?

One suggestion was to have a support group concentrating on emotional and psychological support following critical illness. In addition it might be useful to have a diary, which would document factual events of what happened during their stay.

There are a number of things we can learn from holding these focus groups. Firstly, discharge from ICU/HDU is only the beginning of the recovery journey from critical illness. Secondly, we should never underestimate the power of touch and caring in ensuring that a patient is treated as a human being especially in such a technical environment. As one patient commented, she remembered being in a big black hole but because she could hear the nurses speaking to her and holding her hand she was not frightened. The focus group is also a way of letting patients know they are not alone, it is both therapeutic and enlightening.

As critical care professionals we have a lot to gain from listening to ex-patients and carers experience of their critical illness. We can learn about how the drugs, treatment, interventions and environment can affect outcomes. As a unit we can use this information to develop a business plan for a follow up clinic. The purpose of the follow up clinic would be to address the psychological, physical and supportive requirements that these patients need. This is the next step in helping patients come to terms with what has happened to them.

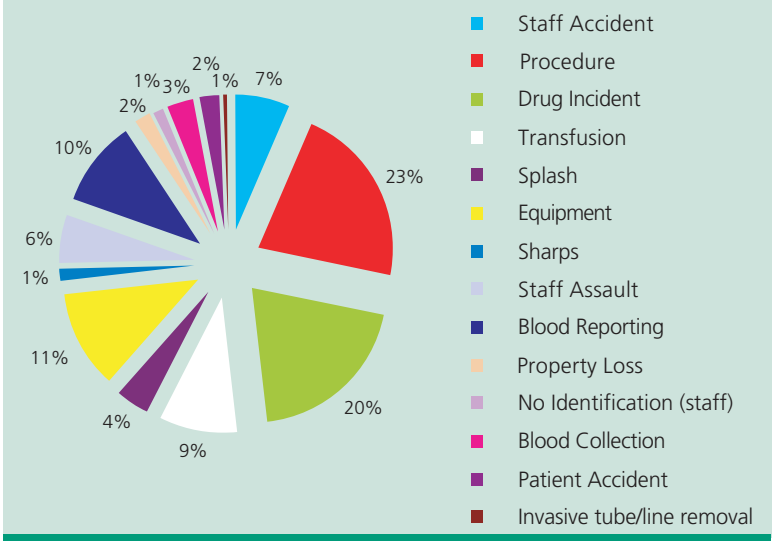
**Jane-Marie Hamill**
Clinical Nurse Leader

**Amanda Joyce**
Senior Staff Nurse - Team B

# Clinical incident reporting

Clinical incident reporting is necessary and beneficial in helping us to address risk issues on the Intensive Care Unit. A quarterly meeting ensures that all staff take responsibility for incidents that have occurred. In addition their suggestions on preventing the incident from occurring again means that any changes will hopefully be sustainable.

In 2004 there were 148 clinical incidents reported on the unit, in 2005 there were 181. See figures and table below for specific categories.




**Clinical incidents on the Intensive Care Unit 2004**

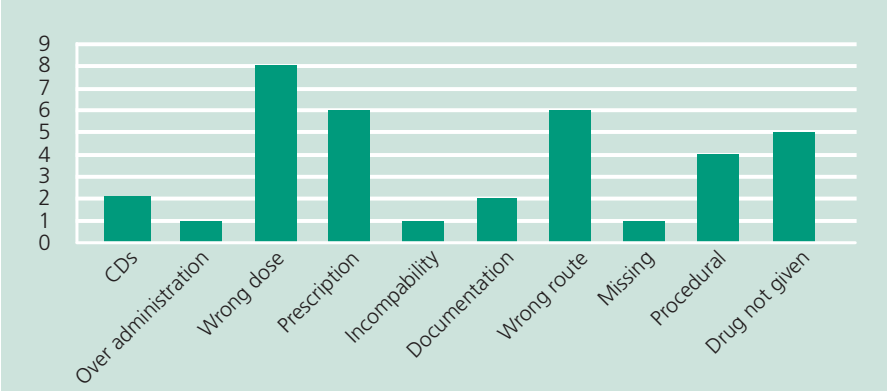



**Fig 1:1 Drug incidents ICU 2005**


**Fig 1:2 Drug incidents ICU/NDU 2004**

| CATEGORY | NUMBER |
|---|---|
| Blood transfusion | 7 |
| Drug incidents | 39 |
| Equipment | 17 |
| Invasive line removed | 1 |
| Needle stick | 3 |
| Poor observation | 1 |
| Procedural | 39 |
| Sample collection | 7 |
| Sample reporting | 13 |
| Sharps disposal | 2 |
| Staff accidents | 11 |
| Staff assaults | 10 |
| Staffing/grade mix | 8 |
| Utility supplies | 1 |
| Delay in discharge | 3 |
| Lost property | 1 |
| Security | 1 |
| Theft | 1 |
| Training | 5 |
| Hypoglycaemia | 1 |
| Patient accidents | 4 |
| No identification | 1 |
| Splash Injuries | 5 |

# Unit projects

## Clinical incident reporting (continued)

The following have been instigated during the incident reviews and the following actions devised:

*Drugs*

In this period the main causes of drug incidents were due to drugs being given via the wrong route or the wrong dose. A number of strategies have been put in place to reduce this:

- Quiz - held every three months by the unit pharmacist to update the knowledge base of staff regarding medications
- Audit - done to identify the number of drugs incidents linked to 'missed doses' - as a result, there have been some changes made to the present pre-printed drug chart
- Incidents discussed with Pharmacist, Clinical Nurse Lead, raised individually and at unit meeting
- All staff involved in drug incidents are spoken with individually and learning/training needs identified.

*Procedural*

- The unit has devised a draft procedure looking at dealing with aggressive and violent patients, with new restraint guidelines developed as part of the North West London Critical Care Network
- Linen which was stored outside Lift Bank A has now been removed
- Patients who are discharged from the unit with a tracheostomy in place, have specific paperwork on the care of the tube that needs to be filled in.

*Transfusion*

- Regular updates and teaching from the Blood Transfusion Nurse
- Information on blood transfusion in times of major haemorrhage
- Informing Haematology and using their guidelines and storage system when we are transferring patients to another hospital with a blood transfusion in progress.

*Splash injuries*

- More disposable goggles purchased and increased awareness among staff about how to use them

Everyone on the unit recognises the need to fill in clinical incidents forms as part of our risk management strategy on the unit. They also recognise that practice can and does change as a result.

**Jane-Marie Hamill**
Clinical Nurse Leader

# Pharmacy developments

The recent work undertaken by Pharmacy focused on reducing the incidence of drug related errors on the ICU:

### Risk Management Drug Quiz

An interactive risk management quiz based on common drug incidents that occurred over the last three years is now run on a quarterly basis. Less common incidents likely to cause serious harm to the patient are also addressed. A register of participants is kept to ensure all nurses, regardless of shift work, annual leave etc, have attended the sessions. All participants to date have rated the session very useful and given positive feedback on how it would change their practice.

It was necessary to focus on drug incidents involving nursing staff as they were associated with the highest proportion of errors and trends. However, there was a small proportion for which medical and pharmacy staff were responsible. This highlights the need for a multidisciplinary approach to risk management and regular review of the systems in place.

### Missed Dose Audit

A high proportion of drug incidents were due to missed doses, therefore, the missed dose audit last carried out in April 2002 was carried out again in July 2004 to identify problem areas.

### Pharmacy Intervention Week

'Pharmacy Intervention Week' is held on a quarterly basis. Pharmacists are requested to record all their interventions and classify them according to minor, moderate or severe risk. The majority of interventions tend to fall within the moderate band. Details and actions taken to prevent recurrence are fed back at the ICU Clinical Governance meetings.

### Pharmacy Initiated Cost Savings

Pharmacy initiated cost savings for the financial year beginning April 2004 have been in excess of £37,000. Strategies used have involved contract price negotiation, review of medicines and route, regular review of intravenous feeding regimens and duration, and free trial stock.

**Chris Chung**
Lead Pharmacist
Anaesthetics and Imaging

# Unit projects

## Analysis of feedback from relatives

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.

On the Intensive Care Unit we have a visible philosophy of care. The sentiments expressed in the thank you cards show we are practising what we believe...

***'We are dedicated to provide the best possible, individualised care'***

*"It was comforting to be dealing with one person who knew all the facts about my sister rather than speaking to someone who hadn't met her or didn't know of her condition"*
JT (Nov 2005)

*".....I was unaware of the astonishing care that I was given, though I have received much feedback from friends and relatives who visited during that time as to the attention and total dedication of staff"*
JS (May 2006)

*"Usually gratitude is expressed when the patient leaves a unit alive and well, but the family - grievous at their loss - could not have been more complimentary about the care and kindness given by all of your doctors and all of your nurses"*
TP (Dec 2005)

***'The intensive care team believe that our work makes a difference, benefiting patients and their loved ones'***

*".....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 (Jan 2005)

***'Respect the dignity, privacy and confidentiality of patients and families'***

*"All that you did for her and the way you preserved her dignity which was important to her"*
MG (August 2005)

*"You allowed us time to wait for a miracle and then gave us time to come to terms with reality"*
DH (Feb 2006)

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 reccurring. 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 stay in hospital.

**Jane-Marie Hamill**
**Clinical Nurse Leader**

## In-house preceptorship course

Over the recent past, the ICU has seen an increase in the number of learners coming to the unit to develop critical care skills. At this time we have not seen the same increase in numbers of preceptors to support them; the result is a shortage of registered nurses being able to support students.

The ICU decided to take a proactive approach to this problem by designing a programme to develop skills in nurses to be able to preceptor pre-registration student nurses. The programme was developed jointly between the ICU and the local education provider, Thames Valley University (TVU).

A number of different formats were considered before the final programme format was decided. This involved building on existing work based around one hour workshops and associated workbooks for staff mentoring students undertaking TVU critical care modules. The resultant programme is a 12-week programme consisting of three workshops, two workbooks and a period of supervised mentorship *(see Box 1 for a breakdown of the programme)*.

The programme focuses on the principles of adult learning and promotes work-based, self-directed study with a strong emphasis upon reflection mirroring the philosophy of both the pre-registration nursing curriculum and the ICU.

**Box 1 Course format**

| | |
|---|---|
| Week 1 | Start work on Workbook one - coaching and facilitation<br>Start supervised preceptorship |
| Week 4 | Workshop one - coaching and facilitation<br>Continue supervised mentorship |
| Week 8 | Workshop two - assessing competence<br>Workbook two handed out<br>Continue supervised mentorship |
| Week 12 | Workshop three - reflective review |

**Table 1 Topics covered and learning outcomes covered in workshop one and workbook one**

| | |
|---|---|
| What makes a preceptor? | To consider the skills and attitudes required to be a preceptor |
| Domains of learning | To consider the four areas that effect learning |
| When people learn best | To reflect on own learning experience |
| Learning opportunities in the ICU | To reflect own unit culture |
| Creating a learning culture | What elements are needed to create a culture |
| Key elements of a learning culture | What elements are needed to create a culture |
| Tools that help create a learning culture | To identify the process they can put in place to facilitate the development of a learning culture |
| Evaluating learning | To identify methods of evaluating learning both in students, by students and by self |
| Giving and receiving feedback | To identify the skills required to do this effectively |

# Unit projects

## In-house preceptorship course (continued)

The first aspect of the programme includes a workshop and workbook that are designed to introduce staff to the main roles and responsibilities of coaching and facilitation within the workplace, activities and group work are used to help elicit the staff members understanding of these.

A breakdown of the topics and learning outcomes covered is seen in table 1. These are put in place to enable the staff member to gain the knowledge and analytical skills to enable them to reflect and evaluate their own experiences of coaching and facilitating staff in the ICU.

The second part of the programme consists of a workshop and workbook introducing the principles and practice of assessing clinical competence. This is then put into practice with the staff member and their student nurse through a number of assessment tasks in the practice area. Topics covered in this aspect of the programme include:

- Competence - what it means
- Assessing competence
- Feedback
- Making assessment decisions

**Box 2 Reflective review questions**

What were my hopes for undertaking this course?

What factors have influenced your participation in this course?

What are the consequences of being involved in coaching and assessing, for your- self, your team, your patients and the service?

What have I learnt from being involved in coaching and assessing about yourself, your role, your role in the ICU service?

Enjoyable aspects?

Less enjoyable?

What are the areas I want to focus on in coaching and assessing in the future?

Throughout the 12-week programme the staff undertake a period of supervised mentorship. A pre-registration student nurse is allocated to them for a duration of eight weeks during their critical care module placement. The staff member is responsible for overseeing the student's learning experience and also assessing the student nurse's competence in relation to their learning outcomes for their module.

Staff are encouraged to make use of reflective diaries to record their progress in mentorship. During this period the staff member is supported by their own clinical mentor, the Clinical Nurse Specialist and also the university link lecturer.

In the final aspect of the module in week 12 the staff members present a reflective review of their experiences to each other. This has been found to be an excellent way of finishing the programme and acknowledging that this is just a starting point for continued development as mentors. Box 2 presents the reflective questions asked.

The course has resulted in an increase in the number of staff who can facilitate the development of student nurses, ensuring an even spread of work in this demanding role.

**Elaine Manderson**
Clinical Nurse Specialist

**Audrey Blenkharn**
Senior lecturer, TVU

# Burns Intensive Care

**Development**
One of the biggest changes to occur in 2005 was when the General Intensive Care Unit (GICU) became responsible for the operational management of a Burns Intensive Care Unit (BICU) with two beds. This meant that the critical care needs of these patients would be provided by the GICU staff, while the burns unit staff would provide expert care in the management of the burns wounds. The unit has admitted and looked after 30 patients this year.

While the staff viewed the merger on the whole as very positive with excellent learning opportunities a number of issues were raised. These were:

- Education and training
- Patient allocation
- Culture
- Junior nurses working on the unit
- Isolation
- Equipment
- Information
- Infection Control

In order to deal with these issues constructively a small working group was established with core members from GICU and BICU.

In the last year a number of small but significant changes have taken place. These are outlined in Table 1.

The plan over the next year is to continue to build on the good work which has been started.

Finally, it is extremely important to mention and thank all the staff on the burns and the Intensive Care Unit for their maturity, co-operation and hard work. It has been challenging at times but in the end, if the patient receives excellent care, then it has been worth it.

**Jane-Marie Hamill**
Clinical Nurse Leader

**Table 1 An outline of the changes which have occurred as a result of the BICU and GICU merger**

| | |
|---|---|
| Education | • Burns workshops run by CNS (attended by 60% of staff)<br>• Development of Work Books with a number of BICU competencies<br>• Burns Study Day (joint day done with Burns and ICU staff)<br>• Plans to include care of the Burns Intensive Care patient on the Intensive Care Course<br>• Staff have attended the Care of the Severely Burns Patient course |
| Equipment | • Standardisation of the ventilators and the monitors |
| Patient allocation Intensive | • The same philosophy and care delivery as the General Care Unit<br>• Development of an additional role of the BICU Co-ordinator<br>• Primary nursing team allocation, decided by staff through a process of consultant where staff had to vote for a number of options. |
| Drug | • Development of a CD protocol |
| Infection control | • Development of core standards for the Burns Unit and the General Intensive Care Unit |
| Staff relationships | • Improved working relationship between the two areas. |

# Research activity

The Intensive Care Unit has been involved in a number of areas of research over the past year. The following gives a short account of some of the projects we are currently involved in. All of these studies aim to improve the outcomes of critically ill patients.

### 1 Does Frusemide improve renal function in patients with renal impairment?

A randomised controlled trial looking at the effect of a Frusemide infusion on creatinine clearance in ICU patients with renal impairment. This consists of random allocation to Frusemide or no infusion, with daily measurements of serum and urinary creatinine, urinary volume and thus calculation of creatinine clearance

### 2 Does Frusemide improve renal function in patients stopping renal replacement therapy?

A randomised controlled trial looking at the effect of a Frusemide infusion on creatinine clearance in those ICU patients who are finishing renal replacement therapy. This consists of random allocation to Frusemide infusion or no infusion, with daily measurement of serum and urinary creatinine, urinary volume and thus calculation of creatinine clearance. Both this and the above trial are entering their second year of recruitment.

### 3 Caspafungin vs Micafungin in the treatment of systemic candidiasis or candida sepsis

The Intensive Care Unit is one of the hospitals involved in this European multi-centre trial comparing two antifungal agents in the treatment of systemic or invasive candidiasis. We hope to recruit two patients during the study period of two years.

### 4 Relationship between serum lactate, base excess, ScvO2 and pH during active resuscitation

New admissions to the Intensive

Care Unit who are acidotic and require resuscitation will have the above variables measured at intervals. The results gained should help to establish the relationships between the variables and their individual benefit in assessing the progress of the treatments being administered.

### 5 Auditing the use of a new generation of central venous catheter

A new design of central venous catheter requires a different method of insertion which we believe is the future of central venous access in intensive care patients. We are auditing its introduction to gather information about its use and further modifications to its design. Data is also being gathered about any complications and infection problems that, whilst unexpected, might arise.

### 6 Audit of microbiological data detected from the Intensive Care patients

All microbiological results obtained from the ICU patients are being recorded, paying particular attention to the appearance of multi-resistant strains. The clinical effects of this data are also being studied and an assessment of the likelihood of infection vs. colonisation is being made.

Outcomes of the patients are also being recorded to establish the relative virulence of the different flora seen on the ICU.

### 7 Audit of antibiotic use of the Intensive Care Unit

In tandem with the above study, the use of antibiotics in the Intensive Care Unit is being observed. Are these drugs being used empirically or based on appropriate microbiological data? The indications for their introduction and the length of their use are also being recorded.

### 8 Outreach studies

Several studies looking into the clinical effectiveness of outreach interventions, education and support are ongoing outside the ICU.

## Future Plans

The use of new catheters and monitors coupled with an interest in early goal directed therapy may lead to collaboration with the Outreach Team, A&E and the Burns Unit. This should permit the study of the effects and outcomes of aggressive treatment for critical illness, trauma and burns; leading to the development of better guidelines, protocols and practice for these groups of patients.

**Dr Adrian Wagstaff**
Clinical Research Fellow

# Inter-team projects

## Teaching

The teaching group is responsible for facilitating and developing both formal and informal teaching and staff development programmes, as well as organising multidisciplinary orientation. The attendance of the group is very good and all group members are active participants and are keen to take projects forward.

One of our main focuses has been to update the resource files on the unit which cover all topics related to intensive care nursing ranging from ventilation to disseminated intravascular coagulation to care of relatives. There are 15 files in all and each member of the team was responsible for certain files. We had a prize for the best file which ensured there was healthy competition between members. Our resource files are now full of up to date, relevant information within easy access to all staff. Other things we have been up to this year include:

- Acquired new books to maintain our unit library on microbiology and surgical nursing
- Introduction of a new band 6 grade study day on clinical and professional issues - this will hopefully provide the opportunity for participants to reflect on clinical practice and current issues outside of the immediate clinical environment. It is also an opportunity for members of the teaching group to gain experience of facilitating study days and all that this entails. Guidelines have been put together to offer guidance for study day co-ordinators.
- Multi-disciplinary teaching.

Our teaching rota has remained full to capacity throughout the year as we endeavour to meet the needs of all staff.

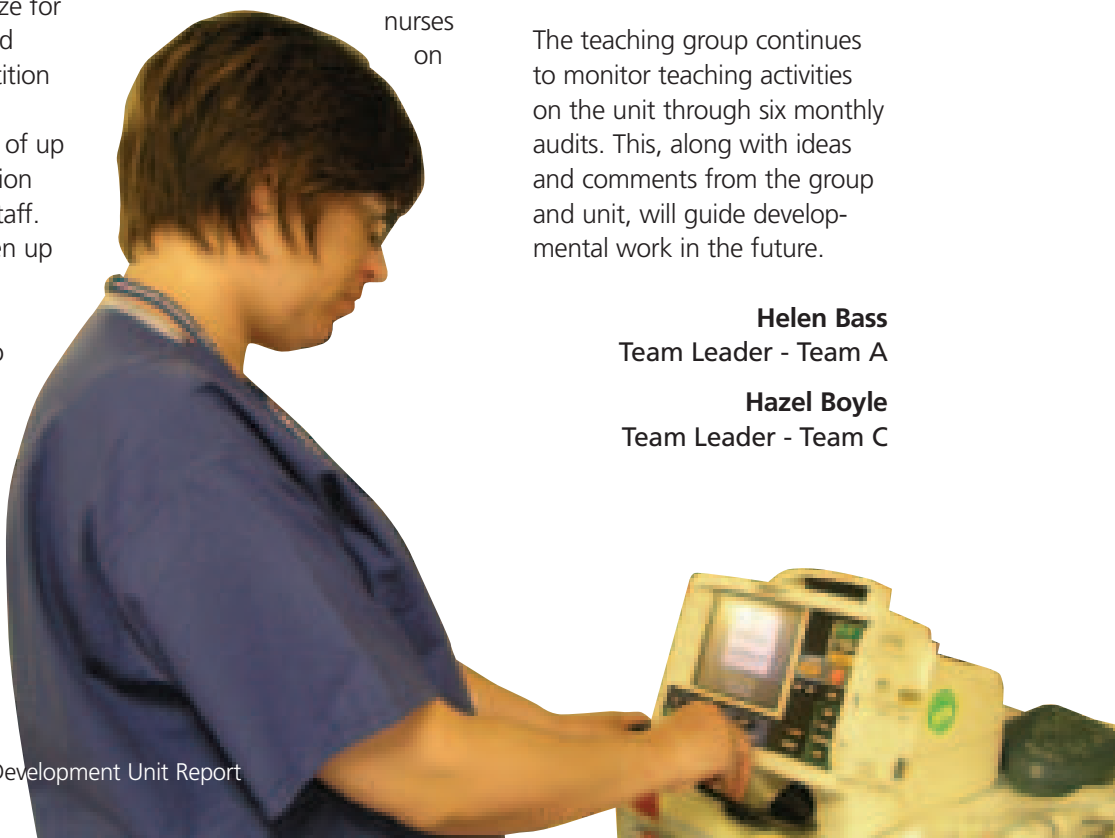
We now have a greater number of student nurses on more frequent placements. In response to this the group has put together a number of sessions that can be presented to the group. This helps them with their learning whilst on the unit and the sessions have been thus far well evaluated. We are sure this work will continue to evolve.

Teaching group members are encouraged to produce teaching sessions that they can present if a teaching opportunity arises. This is an effective way to share knowledge, skills and to gain teaching experience. Members have also found that it is a useful way of providing evidence for their educational portfolios.

The teaching group continues to monitor teaching activities on the unit through six monthly audits. This, along with ideas and comments from the group and unit, will guide developmental work in the future.

**Helen Bass**
Team Leader - Team A

**Hazel Boyle**
Team Leader - Team C



# Quality Assurance

The Quality group focuses on the quality of the service the Intensive Care Unit provides to relatives, patients and staff.

Our biggest achievement was to be awarded the Charter Mark for the third time. This award was given in recognition of the excellent service we offer, and that we are constantly striving to improve for all our users. The work involved the collection of a lot of evidence, which was needed by outside assessors as proof of our activities. This was a huge job and many members of the Unit where involved, so a big thank you to everyone.

We carry out both relative and staff satisfaction surveys and action any changes that have been flagged up from the results. The relative satisfaction surveys are given out on the admission of a patient. We monitor responses and devise action plans to address themes that have been raised. Over all, we receive very positive feed back, but try to respond to ideas and comments made by the relatives of our patients. Improvements as a direct result of our surveys include:

- New entrance doors with new intercom
- Information board between relatives' overnight rooms
- Improved information folders in waiting room and overnight rooms
- The provision of information leaflets on a variety of subjects that will be helpful to relatives.

This coming year we plan to refurbish the relatives' waiting area, and provide a new hot drinks dispenser in the room. For the patients, we are to refurbish the shower room to make it easier and safer for the patient to use.

We also hold bi-annual patient focus groups to help us improve the experiences that our patients have while in our care.

Providing information to relatives and patients is an important part of our philosophy of care, and this year we are updating our admission information booklet, and our relatives' information folders. A new project we are developing is an information pack for relatives on some conditions that may contribute to the admission to the Intensive Care Unit. We are asking them what they may find helpful, and topics so far put forward include diabetes, renal failure, pneumonia and septicaemia. We will gauge how helpful they find this in future surveys.

We are also producing a discharge booklet, designed for patients and their families. This has been done as a direct response to patient focus groups, where a common theme was the anxiety patients felt going from the ICU to a ward. It includes information on both physical and emotional responses that people who have spent time in intensive care experience, and information on useful resources that can be accessed to help. We received helpful advice from the outreach team, physiotherapists and medical teams when writing this booklet, so thank you all for that.

We will continue developing ideas and improvement projects for all who come in contact with the service, and thank everyone who has helped us do so.

**Rebecca Hill**
Team Leader - Team D

# Inter-team projects

## Off-duty planning team

The aim is to facilitate the nursing staff in self-rostering. Each primary nursing team has a representative on the group, and each rep will at some point complete three consecutive rotas. This is time-consuming and can be a little frustrating on occasions, so the rest of the group provide support as and when required. In the monthly meetings, issues that have been raised by staff are discussed and clarified or resolved. This may involve taking an issue to the monthly unit meeting to be further discussed or it could, for example, involve an audit.

Staff are able to work a combination of long days and short days, to suit their individual requirements, and flexible working is considered on an individual basis.

The group also keep a monthly record of people's working hours, and will remind them if they should make up hours.

The Off-Duty Planning Team provide guidance and support to staff, primarily to ensure that the unit skill mix is of the required level, and also that the primary nursing teams have reasonable cover through the month.

Finally, and most importantly, the team recognise that there has to be a balance between home/social life and work life, hence advanced rota planning and a flexible approach to most short notice social arrangements.

There have been many changes within the group over the last year.

More recently computerised staff rostering has been introduced. This is a totally new computerised off duty Manpower software system which has three levels of access.

Level 1 - Access to all staff to enable them to input their data requests
Level 2 - Access to the group to authorise shift changes
Level 3 - Access to managerial personnel to access personal information ie sickness, annual leave.

The team has been meeting with the computerised rostering representative regarding customising the programme to the unit's requirements. The programme will benefit the group in many ways.

Currently the ODPT has difficulty in obtaining an even skill mix on the unit. The programme will be set to only accept a maximum of for example 10 staff per shift, two co-ordinators, four band six and four band five nurses. Once these shifts are filled, it will not allow staff to add to the shifts, therefore staff have to add to shifts which are vacant. This will assist the unit to maximise the skill mix.

At present all staff hand write off duty requests on the monthly rosta. The new system requires staff to enter their off duty into the computer themselves, significantly reducing the work for the ODPT by not having to individually enter all staff members off duty requests.

The programme recognises full and part-time staff and their contracted shift requirements, ie full-time staff are required to work five nights, 28 weekend hours and a Friday late every month. If these individual requirements are not met it will

highlight the discrepancies. The computerised system will enable the unit to use staff effectively and decrease the work for the ODPT by having to rearrange the off duty numerous times before it is finalised. The programme will keep a 'tally' of cumulative hours worked. This will significantly reduce the work of the 'hour keeper'. The programme can be used as an audit tool, the data can be accessed to monitor sickness, team cover, skill mix, annual leave and study days.

The computerised staff rostering will enable the unit to keep using self rostering as it makes people feel valued and allows staff to have freedom to work shifts which where possible suit them.

This programme was on trial on a ward and ICU. It is now being rolled out across the hospital. In the future it may be adapted to enable bank staff to use it too.

**Ann Hinds**
Team Leader - Team F

**Feriel Mahouit**
Deputy Team Leader
- Team F

## Supplies and finance

The Supplies and Finance Group meets every two months to discuss ways to increase cost effectiveness and awareness and to decrease wastage through action planning.

Members of the supplies and finance group are available to raise suggestions and comments on the way trust fund money could be used to benefit the unit and its users. This includes the trialling and evaluating of new products, to education on reducing wastage through our annual quiz, which highlights the cost of both disposable and non-disposable items. These members include one representative from each of the Primary Nursing Teams, the unit's Healthcare Assistant, Technician, Clinical Nurse Lead and Administrator.

The group's recent accomplishments this year include:

- The introduction of new in line nebuliser pots and patient hygiene wipes, evaluated by the nursing staff and consequently saving the unit money on both these items per annum
- A transport table that attaches to each bed, designed to the unit's specifications, reducing the risk of equipment breakage
- Allocation of funds to purchase ICU textbooks, patient sundries such as a hair-dryer and a new sofa bed for one of the relatives' overnight stay rooms
- Reorganisation and cost labelling of our main stockroom
- Data projector which enables Powerpoint presentations for all educational sessions occurring on the unit
- Ongoing monitoring of items borrowed by other departments which highlight the need of those items for other departments.

The work done by this group is ongoing and will continue to focus on troubleshooting supplies and finance issues as well as maintaining and promoting positive relations with our supplies department and other departments within the hospital.

**Jason Tatlock**
Administrator/
Information Officer

# Inter-team projects

## Marketing

This group continues to fund nurses to help them attend conferences. Two nurses went to the British Association of Critical Care Nurses World Congress; with another two presenting their research two others attended the RCN conference in June. We also encourage nurses to submit articles for publication.

We provide application forms for the BACCN and keep a list of those members. The unit was represented at two jobs fairs, one at Earls Court and the Royal College of Nursing to recruit nurses, four nurses applied for jobs following this.

The group was involved in the Hospital Open Day in June 2004, where we had a stand with a mocked up ICU bed, as well as pictures of the unit explaining the day to day running of the ICU. Members of the public were able to ask questions, some of whom had been in ICU themselves and were shocked to realise how much technology is used. There was also a quiz with prizes being gratefully donated by local businesses. We won a merit award for our stand.

Some of the group formed a working group to gather information for the Charter Mark which was reapplied for and successfully gained in November 2004.

We raised money for the charity Shelter from our Christmas hamper raffle, and are looking at how we can contribute more to Charity as a unit this year. The marketing group organises staff to attend conferences - this year two nurses went to the RCN conference. One staff member went to the BACCN conference which focused on 'Back to Basics', which highlighted the issue of holistic nursing care. This is very much in line with the way we organise the nursing care in our unit, using the Primary Nursing model. From this we are raising the profile of Primary Nursing on our unit, by revisiting our Unit Philosophy (which we do every 3-4 years).

The Intensive Care Unit participated in many fund raising events throughout 2005/06. On July 7 2005, 33 staff members had entered the JP Morgan Chase Corporate Challenge, a 5.6 kilometre run through Battersea Park. This is an event conducted throughout many countries throughout the world aiming to bring together business groups to promote exercise; with a little competition thrown in. 20,000 people were to participate, but because of the horrific bombings earlier that day the event was cancelled. Yet later in the year half of the original group participated in the run themselves, raising £250 for the charities Asthma UK, and Age Concern.

Over the winter period we asked staff that were clearing out their cupboards to bring any unwanted clothing into the unit to be gathered for a charity to sell, with the proceeds going to Great Ormond Street Hospital.

Throughout 2006 the marketing group aims to promote the Intensive Care Unit again through participation in as many fundraising events as possible.

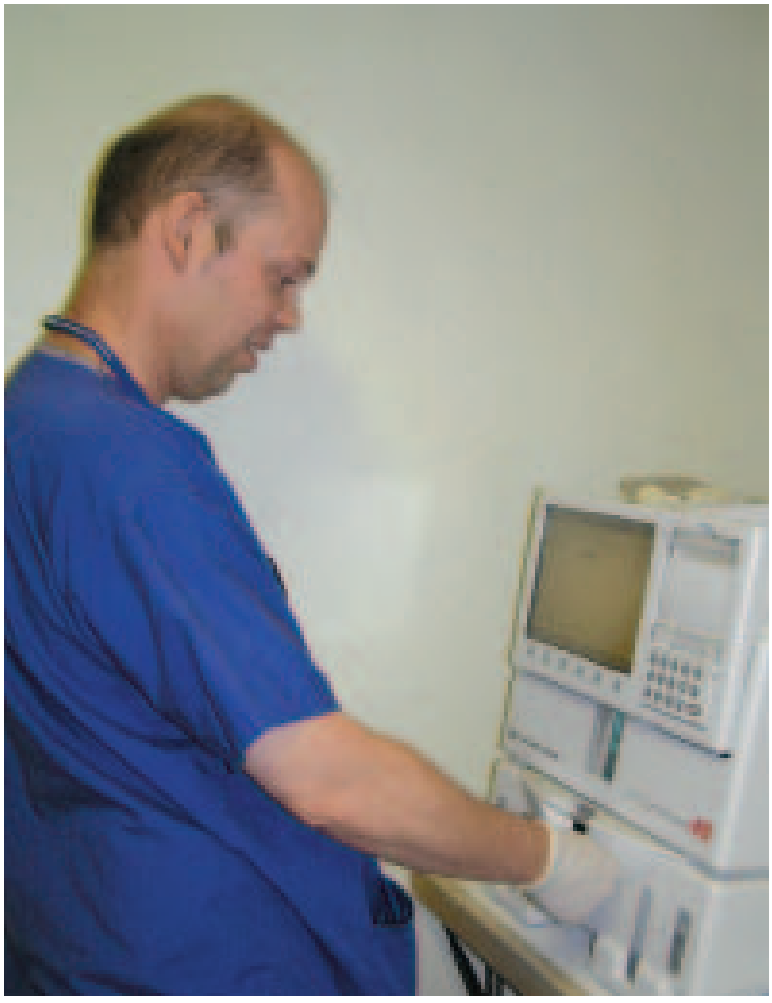
**Danielle Pinnock**
Team Leader - Team H

**John Gough**
Senior Staff Nurse - Team C

## Research group

The research group has had a very productive year. New evidence-based guidelines on topics, such as ventilation, discharge planning and intubation have been written and ratified. 'Guidelines at a glance' have evolved from these guidelines and are laminated by the bedside summarising the pertinent points of each guideline for everyone to read.

The group has embraced activities such as the tracheostomy care bundle and ventilation care bundles supported by the North West Critical Care Network. These bundles have not only reinforced present patient care delivered to critically ill patients but also introduced new practices. Infection control has been highlighted as an area to focus on actively with the intention of encouraging best practice to reduce and contain infection rates.



The research group continues to provide teaching sessions surrounding the need for research, the theoretical base of research and to explore and examine the methodologies by critiquing research studies. Some of these are medical and nursing studies currently ongoing or about to begin on the unit. This process will allow us to continue to challenge our own practices and beliefs on the ICU.

**Ann Sorrie**
Team Leader - Team H

**Gordon Turpie**
Staff Development Charge Nurse

# Inter-team projects

## Nursing diagnosis and Electronic Patient Record (EPR)

The purpose of this group is to support staff using nursing diagnosis in their care planning, and to further develop their knowledge of this approach to classifying patient problems, defining them and providing a range of potential interventions to achieve specific patient outcomes.

Nursing diagnosis has been widely adopted by nurses within the UK to provide a common language which enables a consistent method of written communication and actions that is understood and accepted by nurses. The ICU team here at Chelsea and Westminster was the first in the UK to adopt this into ICU practice.

The second aspect of this group concerns the involvement of the nursing team in the development of the hospitals EPR system.

The main achievements of the past two years include:

- Consulting staff to identify issues, concerns and suggestions in relation to using nursing diagnosis and the EPR system
- Assisting with the ongoing training of staff as the EPR is modified
- Providing feedback to staff regarding the national strategy for the development of an EPR system
- Attending trust meetings concerning nursing diagnosis and EPR to ensure the unit's perspective
- Getting all bank staff training to use the EPR
- Access to the EPR system via the Patientline system at the patient's bedsides
- Completing a documentation audit - the group has now focused on the following areas:
  - Completion of nursing assessments
  - Updating these as patient needs change
  - Consistently including nursing diagnoses relating to family needs
  - Ensuring that care plans are used during handover.

Future plans include getting the EPR system installed on our new monitoring system, the development of the ICU web page and further audits of documentation.

**Caroline Younger**
Team Leader - Team B

# Developmental opportunities

## British Association of Critical Care Nurses Conference - September 2004

Cambridge in the autumn was a beautiful and tranquil setting for the conference, in conjunction with the World Federation of Critical Care Nurses.

We were able to choose from an expansive repertoire of speakers and subjects over the first two days, and took advantage of the opportunity to hear about the experiences and research, pleasurable and painful, from nurses from all over the world.

Notable talks included a talk about trauma from American nurse specialists provided an interesting if somewhat grisly insight into treating burns victims in Philadelphia. This contrasted with the award winning talk from a nurse from New Zealand, who is part of an ICU team that arrange to take patients home to die, and also arrange day trips for patients who know they are going to die on the unit. It gives them the opportunity to experience one last personal comfort.

One of the important parts of the conference was seeing a number of colleagues giving talks to the assembled crowds. It was an eye-opener to see the range of topics covered and to watch people demonstrate how their research, however small, contributed in some way to their esteem and to the profession.

In addition to the talks there were workshops and poster presentations, which provided further information and evidence of the varied aspects of work carried out by the Intensive Care Units. Each country has its own way of running the Health Service and ICU, and what each found important was different but still interesting. It was a varied conference covering many aspects of ITU from many perspectives.

This was an interesting and informative conference to attend. It provided a lot of food for thought, and its aim was to encourage and appreciate the involvement of nurses within their profession. This was evident from speakers who were well known in spheres of nursing, such as Royal College of Nursing Secretary, Beverly Malone. Her talk focused around nurses becoming more politically active, on a local and national level. She argued well that if nurses wish to shape health policy they have to be more involved. Her theme was 'knowledge is power', and she acknowledged that not every nurse would want to be involved in politics, but that the profession needs motivated, enthusiastic members to become the influential body that it could be.

There were a large number of delegates and their common interest was the recognition of the 'professionalisation' of nursing and the contribution that nurses can make, from clinical practice and research to being an active and respected political figure.

**Ann Hinds**
Team Leader - Team F

# Developmental opportunities

## Presenting at an international conference

As part of my degree studies I undertook a research project on nurses' feelings and perceptions of the 'difficult to manage' patient on critical care.

Leading on from this I had the opportunity to present an oral presentation of the findings of my research at the 2nd International British Association of Critical Care Nurses Conference and 1st Congress of the World Federation of Critical Care Nurses. This enabled me to share my findings, not only with my colleagues, which had been done locally, but on a much larger scale. .

The findings fell into five broad categories: Stress and workload, control, 'doing the right thing', safety and 'knowing the patient'. What surprised me was the impact that this group of patients had on staff and what coping strategies the nurses had for dealing with the emotional and physical stress involved. The conclusions highlighted concerns about planning and assessment of care, not only in critical care, but throughout the hospital.

The actual presentation was in the afternoon and after a nervously long wait, my turn finally came. Despite my nervousness, this was not obvious to colleagues in the audience who reported a confident speaker who spoke with clarity and expression. This was a reflection of months of hard work which developed my research skills and knowledge within this subject.

At the end of it I felt a huge sense of relief, but also a great sense of achievement, as it had been a personal goal which I had finally achieved.

The research process enabled me to explore a difficult situation of nursing which features in the intensive care setting. This method of learning broadened my perspectives and afforded me a clearer view of the current issues and opinions. Through this I gained a new measure of understanding and am now able to offer higher levels of support making a more effective contribution to an area that requires greater understanding and guidance.

**Louise Saunders**
Team Leader - Team I

# A staff member's experience of climbing Kilimanjaro

Kilimanjaro is the highest free standing mountain and the highest point in Africa. When I decided to climb it on my summer holidays, little did I know that it would be one of the most psychologically challenging walks I have ever taken.

Our climb took five days to climb from the Marangu National Park gate to the summit. During this time many people felt the effects of altitude, suffering severe headaches, shortness of breath and vomiting that were alleviated by rest and lots of water.

The final climb started at midnight, we set off after breakfast. We proceeded slowly in the darkness on a switchback trail over loose volcanic rock.

After an hour the snow fell thick and fast as we continued our climb. My breathing became more difficult as my chest became tighter but with my companion we continued to quietly walk and encourage one another.

Finally, as dawn was starting to break six hours later, I reached Gillmans point. What was supposed to be a spectacular sunrise was actually a view of more snow and clouds. A hot cup of tea was welcomed, as our water had frozen a few hours earlier, before deciding to under take the three hour round trip to the summit.

The ascent to Uhuru peak was slow and exhausting. On seeing the summit sign, a burst of energy arose and reaching it a sense of relief. It was at this point we were only allowed a few minutes for photos, due to air quality (or lack there of) with cloud cover.

On my descent, it was apparent just how little oxygen had been taken up by my lungs, as I developed Sulphur dioxide poisoning as Kilimanjaro is a dormant volcano and still emits sulphur. I became drowsy, but yet within myself aware. On descending quickly to Kibo, I was amazed and overwhelmed at just how altitude affects you.

The next two days were spent descending down the Marangu route and a time to reflect on my last four days and wonder if I'm mad enough to walk the slopes again for a view that is breathtaking.

**Emma Long**
Deputy Team Leader
- Team A

# Developmental opportunities

## Flexible working

I have been employed on the ICU/NDU since June 2000. Initially this was as an E grade staff nurse, and currently I am a band 6 Deputy Team Leader. The unit has always offered the option of flexible working, and in this way I have managed to achieve some personal goals.

In September of 2004, an opportunity arose for a secondment with the Resuscitation Service. This was to be for a period of four months, to cover maternity leave. The plan was then to return to the Intensive Care Unit.

I enjoyed the new and varied aspects of my role. This involved training all levels of staff in Basic and Advanced Life support, helping to run national Resuscitation Council courses, attending Cardiac Arrest calls and assisting with auditing of in-house cardiac arrests.

At the end of the secondment, a two day position became available. I discussed this with the ICU/NDU unit Clinical Nurse Leader and my Team Leader, and am now in the enviable position of having a dual role. This means I retain my ICU skills (working part-time) and am a Resuscitation Officer two days a week. I enjoy the variety, and have expanded and enhanced my teaching skills, (which benefits both departments); and both sets of colleagues get the inside track on any new developments!

**Diana Niland**
Deputy Team Leader - Team J /
Resuscitation Officer

## Acting Clinical Nurse Lead

Due to the maternity leave of our clinical nurse lead, the opportunity arose for one of the G grades (band 7 nurses) on the Intensive Care Unit to 'act up'. The post was for eight months, with handovers at each end. This would enable the smooth running of the unit, and also minimal disruption. It also provided an opportunity to work a different pattern.

The post was advertised internally and there was much discussion amongst the current band 7 nurses about the possibility of taking on the role. With some trepidation I applied and was successful and in February 2005 became the Acting Clinical Nurse Lead' for ICU.

I received several weeks handover, which was an insight itself, learning many new things including how to ensure that the payroll was up to date, attending Trustwide meetings and attempting to organise my own meetings and time. I soon learned that I needed to work at a different level in order to achieve objectives. Prioritising became second nature. Flexibility and adaptability were other skills I had to develop.

During the eight months of this post the learning curve was not just steep, at times it was vertical. I was lucky enough to have some superb support networks in place and accessed some new ones too. I soon learned that the relationship with my colleagues needed to be different, that at times I would have to be the leader, sometimes a manager and also a friend. I believe my ability to people manage was enhanced a great deal, at times stretched, but overall it grew.

I have thought about what to say about the job, but writing a list of what it entailed, appears somewhat boring which the post was certainly not. During the eight months in the role, I began to understand about how the NHS works, project management, outsourcing, computer circuits, electronic devices, amongst other things, none of which was expected!

I became more aware of the need to respond to initiatives and directives from both the Trust and the Government. One of the changes that happened was the merger of the Burns Intensive Care Unit and the ICU. This was a massive change for all concerned and proved not only difficult for all and challenging but there was also a need for new ways of working, in order to resolve the day-to-day issues and maintain the service.

During this time my knowledge of people grew, not only my colleagues on ICU, but about people in general and how different we all are. I wanted to be able to make time for colleagues who needed me in this role.

In hindsight I enjoyed elements of the role; it has given me great deal of confidence, insight and developed my own self-awareness even more. I have new found respect for the person in this role. I also appreciate the fact that it has reinforced for me that I enjoy both my clinical role and the flexibility of the hours I work.

I would like to formally take this opportunity to thank all of my colleagues on Intensive Care for the support that they gave me during this post, it was most appreciated.

**Louise Saunders**
Ex-Acting Clinical Nurse Lead and Team Leader - Team I

# Developmental opportunities

## Staff development role

Since starting this post and running the Foundations of Critical Care Course in July 2005 I have been faced with many new challenges. The first six months saw me settle into and adjust to this new role. However I felt that after six months it would be beneficial for me to reinforce what I had learned by teaching a new cohort. This would also see me involved in the re-accreditation of the programme.

At present I am in the process of running my second course with another five students in the cohort. Feedback from the first cohort concluded that the course was well received. They enjoyed the study days.

The study days also gave experienced nurses on the unit a chance to develop their own teaching skills by participating in the teaching sessions. Students considered the standard of teaching to be good with a sound variety of speakers and hand outs. The pre-study day workbooks were considered to be beneficial for revision of anatomy and physiology and introduced them to the topics that would be discussed in greater depth on the study days.

Students managed to meet up with their preceptors on a monthly basis to review their learning contracts and competencies. They believed that the competencies were good because they helped fill the knowledge practice gap.

Overall the students found the course interesting. It helped them gain competence and confidence when caring for critically ill patients and their families. As one student commented "it helped make things click".

The course has now been running for three years and is due for re-accreditation. The work is completed and was due to be put forward to the Thames Valley University Accreditation of Prior Experiential Learning committee at the end of June 2006. The major changes will include the course now being offered at level 6 (degree level). The competencies have been streamlined to 15 and the workbooks are now offered as multiple choice questionnaires. The element for accreditation will be the summative assessment which is a 3,000 word reflective essay based upon a patient assessment. This compares to a 1,500 word essay on the present course. It is thought that the increased word count will enable students to develop their analysis and ideas further.

I will be leaving the post in August and wish to thank everyone that has supported me in this role in the last year. Finally I wish the new programme co-ordinators well.

**Gordon Turpie**
Staff Development
Charge Nurse

# Anaesthetic conference - Belle Plagne

In January I attended this annual conference in France, with three other nurses and seven doctors from Chelsea and Westminster Hospital.

There were many topical issues being presented including bird flu, how it will affect patients and how it will affect all of us in our daily lives. Issues such as the schools and transport systems being closed down, meaning that many people will have childcare problems or not be able to get to work easily. The message seemed to be not if the HV1 virus will mutate, but when.

The bombings of July 7 2005 and the kind of injuries that presented to A&E departments was another very good talk given by a registrar. There were a lot of blast injuries that were very horrific, with loss of limbs and burns. The communication system was discussed as this was poor with mobile phone lines being blocked and the ambulance service not being able to communicate to one another, due to loss of radio contact, so it was not known how many patients certain hospitals were admitting. The use of e-mail as a very good method of communication in these times was discussed.

Research was presented, for example 'The use of Facial CPAP & how it affects the patient's arterial blood gases'. Workshops were also being run concurrently - I attended the X-ray workshop which was very informative.

Alongside all of this was the skiing, which we managed to fit in between the lectures. The snow was great and the resort not too busy, so not too much waiting on the lifts. All in all, we all had a great time and updated ourselves along the way - I would highly recommend it.

**Dany Pinnock**
**Team leader - Team H**

# Staff development and education

The continued development of our staff working on the unit is of high importance. Over the past two years our staff members have continued to undertake a number of different educational courses:

- Foundations of critical care
- Certificate of professional development in critical care
- Supported Learning in the Clinical Environment

During this time, in conjunction with our link lecturer from Thames Valley University, we have developed an in-house Preceptorship course to assist staff in developing their role in the development of pre-registration student nurses. It is hoped that this course will match to the requirements for role of associate preceptor as discussed by the Nursing and Midwifery Council.

The unit also recognises that staff may have differing developmental needs and has devised a number of developmental pathways to guide staff through their professional development. Not only do these outline the academic opportunities available, but also other potentially valuable ways of enhancing the way in which nurses practice. Examples of elements in these pathways include:

- Clinical supervision and action learning
- Shadowing staff
- Inter-team project work
- Study days run by the unit and the trusts Learning Resource Centre
- Attending conferences
- Preceptorship
- Teaching on the Foundations in Critical Care Course
- Writing for publication

We have also supported two of our team leaders to attend a week long course exploring the use of practice development in their roles. This course, run by the Royal College of Nursing, helps to develop the facilitation skills required to promote patient-centred care.

Pre-registration students continue to be welcomed to the unit for placements. Students spend eight weeks working with a primary nursing team in the delivery of patient care in order to gain an insight and practical training in intensive care nursing. During this year their orientation pack and placement objectives have been revised and updated by the teaching coordinators group.

**Elaine Manderson**
Clinical Nurse Specialist

**Summary of activity**

| | 2003-2004 | | 2004-2005 | | 2005-2006 | |
|---|---|---|---|---|---|---|
| Discharged patients (FCE's) | Level 3 | 192 | Level 3 | 221 | Level 3 | 196 |
| | Level 2 | 187 | Level 2 | 195 | Level 2 | 200 |
| | **Total** | **379** | **Total** | **416** | **Total** | **396** |
| Occupied bed days | Level 3 | 2567 | Level 3 | 2292 | Level 3 | 2448 |
| | Level 2 | 783 | Level 2 | 1125 | Level 2 | 791 |
| | **Total** | **3350** | **Total** | **3417** | **Total** | **3239** |
| Refused admissions | **Total** | **16** | **Total** | **20** | **Total** | **9** |

# Publications and research


Manley, K (1990) the birth of a nursing development unit **Nursing Standard** 4 (26) 36-38

Warfield, C. & Manley, K. (1990). Developing a new philosophy in the NDU **Nursing Standard** 4 (41) 27-30

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Jenkins, D. (1991) Developing an NDU: the manager's role. **Nursing Standard** 6 (8) 36-9

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Manley, K. (1993) The clinical nurse specialist **Surgical Nurse** 6 (3) 21-25

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Mills, C. (1995) Transfer to the ward from ICU: families experiences, **Nursing in Critical Care** September 20-25

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Saunders, L (2004) Nurses feelings and perceptions about difficult to manage patients in ICU. BSc dissertation. Kingston University.

# Unit staff – April 2006

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Gordon Turpie
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# Contributions to working parties

## Internal

**Supplies/ Finance Group**
Jane Marie Hamill CNL

**PEAT group**
Jane-Marie Hamill, CNL

**Recruitment and Retention Group**
Jane-Marie Hamil, CNL

**Staff Site Group**
Louise Saunders, Sister

**Tissue Viability Group**
Caroline Younger, Sister

**Trust Documentation Group**
Elaine Manderson, CNS

## External

*Pan London Critical Care Practice Development Forum*
Elaine Manderson, CNS (secretary)

*North West London Critical Care Network – Nurses group*
Elaine Manderson, CNS

*London Standing Conference – Critical Care Group*
Jane-Marie Hamill, CNL

## Conference presentations

*Nurses' perceptions of difficult to manage patients (free paper)* – Louise Saunders, BACCN/WFCCN conference. Cambridge, UK.

*Nurses' experiences of weaning from mechanical ventilation (free paper)* – Elaine Manderson. BACCN/WFCCN conference. Cambridge, UK.

*Critical Care Needs Must! (poster presentation)* – Hazel Boyle/ Audrey Blenkharn. BACCN/WFCCN conference. Cambridge, UK.

*Beyond the 998: an innovative approach to filling the mentorship blackhole (free paper)* – Elaine Manderson/ Audrey Blenkharn. BACCN conference. Weston-super-Mare, UK

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General Managers and Acting General Manager - Anaesthetics, Imaging and Surgery

**Lyn Garbarino**
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