



Intensive Care and Nursing Development Unit

Annual Report 2006-2007

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Introduction

It is time once again to conclude another year in the life of the Intensive Care Nursing Development Unit. Collating this annual report gives us time to stop and reflect and celebrate past successes and plan for the future. We realise that it is only by becoming more aware of our strengths and weaknesses that we are able to influence our development as individuals and as a team.

This report contains the regular sections on Unit updates, inter-team projects, development opportunities, research activity and user feedback.

In addition, we have introduced a new section as a result of feedback received on our last annual report. This section is entitled 'Performance' and outlines how the Unit has performed over the year in relation to activity, human resource management, finances and infection control. It is extremely important as a Unit that we reduce cross-infection, manage our resources effectively while at the same time support and develop our staff.

This year we would like to give a special mention and thank you to staff behind the

scenes who keep the Unit functioning. They are Jason Tatlock, Information and Audit Officer, who deals with all the jobs nobody else knows how to do! Mark Costello, Chief Technician who has the thankless job of retrieving and recovering all of the equipment that has been lost or left on the wards.

Magdalena Rigi and Mavis Kyeremeteng, the House Keepers who ensure that we get high marks and comments on the Unit cleaning audit and Blanche Takwi our support worker who is such an asset to the team with her happy, smiling nature. Finally, we would like to thank our two long standing volunteers Claudia Thompson and Caroline Heslop; the Unit would not function effectively without them. This annual report is dedicated to you all.



Jane-Marie Hamill
Clinical Nurse Lead

Helen Bass
Acting Clinical Nurse Specialist

Foreword

I have been involved as a Medical Microbiologist in intensive care for the best part of 30 years. During this time I have witnessed technological advances in the field of therapeutics and monitoring devices which have improved clinical outcome but which have also been associated with an increase in infections.



The breadth of infection control has become more complex especially with the increase in multiple resistant bacterial strains such as *Acinetobacter* sp and other Gram negative organisms and Gram positive organisms such as MRSA. The continuous implementation of sound infection control practices in our Intensive Care Unit is of paramount importance in caring for critically ill patients.

Early and appropriate use of anti-infective agents has a significant positive effect on outcome. The prudent use of antimicrobials in our Unit aims to minimize antibiotic resistance by targeting the microbe as soon as laboratory results are available.

The introduction of Infection Control Link Professionals (ICLP) in all parts of the hospital including the Intensive Care Unit has had a positive impact in terms of educating staff in infection prevention and control measures, implementing policies, conducting audits and generally making the point that infection control is everybody's business.

As a member of both the Infection Control and Intensive Care teams, I find my job very rewarding and enjoyable and hope that our combined efforts will help our endeavour to reduce the burden of healthcare associated infections.

Dr Berge Azadian

Director of Infection
Prevention and Control

Philosophy of care

Chelsea and Westminster Intensive Care and High Dependency Unit

Many different members of staff attend to 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 individual care.

We respect the rights of our patients, and understand that our care must be non-judgemental, 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 patients 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.



User feedback

On the Unit we receive feedback on our service in a number of ways. These are focus groups, relative satisfaction surveys, thank you cards and Patient Advice & Liaison Service (PALS) reports and complaints. In receiving this feedback it is important to do three things:

- Share it
- Learn from it
- Compare and review it

Using this method, we can reinforce the things we do well while improving or changing the things we don't do as well.

Focus groups

In 2006/7 we facilitated three focus groups in May and November 2006 and March 2007. The main themes and actions taken to address any issues are highlighted below.

STRESS

Some patients described the fear they felt when they heard they needed to go to ICU. The relatives felt anxious especially if they had to wait in the waiting room. Leaving ICU was a big factor psychologically as it was *"a signal that I was getting better, on the road to recovery"*.

ACTION

Ensure we greet all patients on their admission and encourage all elective (planned) admissions to visit the Unit, prior to their surgery. We also recognised the importance of letting relatives see their loved ones as soon as possible.

STAFF

The majority of staff were viewed as excellent - going the extra mile. One patient commented that the nurse gave their swollen feet a massage which felt amazing as they knew it wasn't part of the job.

Nursing staff were observed asking other groups of staff to put gloves on.

Patients felt they had a lot of time to observe. They could identify those who gave excellent care and those that gave average care.

Noise was distressing at times and it was important that staff were aware not to talk too loudly at nighttime.

ACTION

This was fed back to staff at the Unit meeting and during teaching sessions. We also had a noise awareness week.



CHOICE

One patient admitted they did not like male nurses carrying out personal care on them.

ACTION

We felt that in order to address this issue it was important to highlight in our information booklet that it is a mixed Unit and due to the fact that it is an intensive care Unit we have no choice but to nurse men and women next to each other. However if a patient has a preference in regards to their personal care they can discuss this with the nurse at the bed space who will endeavour to meet their privacy and dignity needs.

HALLUCINATIONS and FLASHBACKS

Some hallucinations were pleasant and some were frightening. In a couple of cases, patients thought they were in a prison camp and thought the photo board of staff were photos of prisoners.

ACTION

We have moved the photo board of staff into the corridor away from patients vision. We have also developed a post ICU booklet which highlights that patients may experience flashbacks and hallucinations and they can attend a focus group to talk about their experiences.

PREPARATION FOR DISCHARGE

Some patients highlighted they were unprepared for the physical changes to their body such as weight-loss and bloatedness. Some felt that they were unprepared for discharge to the ward. For example, it was difficult at first to find a toilet and allow enough time to get to it.

ACTION

The quality group have purchased some mirrors so that patients and their nurses can discuss the changes which have occurred to them.

Patients have found the focus groups very useful as it allows them to ask questions about their experience. They were all unanimous in their agreement that some sort of follow-up counselling would be beneficial.

Patient Advice and Liaison Service (PALS)

Between April 2006 and May 2007, there were 13 requests for information about the ICU. These are outlined in the following table.

The PALS is somewhere additional that visitors and patients can get support. It also acts as a liaison

between departments and identifies types of information we may need to provide for our visitors. For example, we have now put a notice in the shower room explaining that the water needs to run for five minutes before it gets hot.

Type of Information	No. of requests
Praise	1
Witnessing a will	1
Directions	2
Care team meeting	1
No hot water in relatives' shower room	1
Donation to the department	1
Follow up from the focus group	1
Meeting arranged to sort out arrangements for a baby whose mother was on the Unit	1 (successful meeting occurred between the two lead nurses of the departments and a positive outcome was agreed)
Counselling support	1
A request for an intensive care Unit patient's passport	1
A request for work experience	1
Query about wills	1



User feedback

Relatives' satisfaction survey

As stated in our Philosophy of Care the intensive care team is dedicated to providing exceptional care and service to patients their relatives and loved ones. To this end, the Relatives Satisfaction Survey is one of the ways we are able to receive feedback from relatives and friends. We are constantly trying to improve our services to help relatives through a difficult time and the reports which are generated by the survey provide an invaluable tool in identifying areas that can be improved.

The survey is now in its seventh year. Over the years there has been an increased awareness of what can be learnt from the surveys. There has therefore been a corresponding increase in the awareness of the importance of encouraging relatives and friends to complete the surveys. In 2002 we received 23 responses, in 2005 we received 49 and in 2006 the number was up to a record 54 responses. On the whole, the vast majority of replies have always been extremely positive. From time to time however, the survey throws up an area in which improvements can be made. We take such comments and suggestions very seriously and endeavour wherever possible to make appropriate changes.

"Everything was excellent and very professional"
MO (Oct 2006)

One area that we have tried to improve is the availability of medical information. Apart from improving communication between the Unit and the relatives, there is also now a folder in the waiting room containing such information.

"Very impressed with the care and support provided to the family, for us the most important thing was to be kept informed about his medical condition"
DM (Jan 2006)

The size and facilities of the waiting room continue to be a problem for some. Whilst we try to explain to relatives and friends that we are unable to enlarge the waiting room, we have improved the facilities by providing a new hot drinks machine and televisions in the overnight rooms. We will in future make enquiries about the feasibility of having a microwave.

"We as visitors were always treated courteously and all our questions were fully answered"
MB (Oct 2006)

"There needs to be more consideration for another waiting room as families tend to want privacy"
Anon (Aug 2006)

Finally the results and comments from the surveys provide encouragement and praise for the staff right across the Unit, from the porters and cleaners to the consultants.

"We found the ward spotlessly clean"
MB (Oct 2006)

"All nurses and doctors on HDU have been very caring - I'm most grateful"
AC (Dec 2006)

"There is no fridge or microwave for families to use, not everyone can afford the prices for food in this area of London"
Anon (Aug 2006)

"We wish you success in the future so other patients can enjoy your highly humane gifts in helping patients and their relatives"
CJ (Sep 2006)

Such positive comments provide us with confirmation

Formal complaints

that we are moving in the right direction and the satisfaction of knowing that we are doing our best to meet the standards set out in our Philosophy of Care.

Caroline Heslop

Quality Group Member and
Intensive Care Volunteer.

"Please don't change your very efficient Unit. I can't praise it enough and thank God it exists. Thank you all"
EH (Nov 2006)

Thank you cards

In 2006 we received approximately 125 thank you cards and letters. These cards express the sentiments of visitors and patients to the staff who looked after them. They make us reflect on the work we do, the way we do it and the individuals we meet and treat.

Thoughts that are expressed can make us feel we are implementing our philosophy especially in relation to primary nursing and privacy and dignity. They make us realise that sometimes the most important thing is to care about that 'father', 'mother', 'son', 'daughter', 'friend' in an understanding, compassionate and professional way.

Unfortunately in 2006 we received one formal complaint. Although we were disappointed that our practice caused someone to complain, it was an opportunity for us to identify what had gone wrong and put in place mechanisms to prevent it from happening again. In fact this incident was already being investigated as a clinical incident.

The nature of the incident was serious. A patient on night shift was given potassium chloride too quickly by a temporary (agency) staff nurse. They did not give the infusion through a pump and as a result the patient sustained a cardiac arrest. The patient was resuscitated successfully and was eventually discharged home. The complaint raised questions about why this had happened.

There was a formal review of this incident where we addressed the questions. We also identified the lessons to be learnt at an individual, Unit and Trust level. As a result of this incident, a number of changes have occurred:

- Although all temporary staff should have received an orientation document, some did not. Now this document has been updated and all temporary staff must say in writing that they have

received it and are aware they must not give intravenous drugs. This form is then sent back to the Clinical Nurse Lead who keeps an ongoing record of the nurses who have completed this orientation.

- Changes to the drug chart now highlight that certain drugs like potassium must be given via a pump.
- Changes to the shift co-ordinator training package highlight the responsibilities of the shift co-ordinator when dealing with temporary staff.
- The individual is having additional training in drug administration via their agency.

We have spoken about this incident at Trust level so that other areas can learn from it. The family received a full account of what happened and what we will do to try and prevent this incident from occurring again.

Jane-Marie Hamill
Clinical Nurse Lead

Inter-team projects

Quality assurance group

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

It has been another productive year's work as the group has:

- **Updated the admission information booklet.** This includes new information on the Patient Advice and Liaison Service (PALS); a list of some helpful support groups and guidance on how to give a donation to the Trust/Unit.
- **Production of a discharge booklet.** This is for all patients and was developed from focus group feedback.
- **Update of the information folders in the overnight and waiting rooms.** This is monitored by the quality group and ideas

for information have been based on feedback from the relatives satisfaction surveys.

- **Information folder on conditions/illnesses.** This folder provides information on a number of illnesses or conditions that patients may have. These include heart attack, heart failure, chronic obstructive pulmonary disease (COPD), pneumonia, asthma, sepsis and acute renal failure.
- **Focus groups.** These are held every four months. We have developed a folder on how we run these sessions, who attended and the themes that we try to cover. We present the outcomes and possible solutions to staff as a PowerPoint presentation. The actions and themes covered with an evaluation form are also

sent to the patients who attend sessions.

- **Refurbishment of relatives waiting area.** This includes the purchase of a new coffee machine and new flooring.
- **Relative and staff satisfaction surveys** are carried out in order to improve facilities for patients, relatives and staff.
- **The Unit has been awarded the Charter Mark three times** as recognition of excellence in service provision. Reapplication is due this year with assessment from an outside body in December 2007. A great deal of work needs to be gathered and collated as evidence to back-up our application.



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

Helen Bass
Acting Clinical Nurse Specialist
on behalf of
Rebecca Hill
Sister
Team D

Teaching group

The main purposes of the teaching group are: to co-ordinate staff development programmes, training, teaching and clinical supervision on the Unit. The attendance of the group is very good and all group members are active participants and are keen to take various projects forward.

The introduction of a new Band 6 study day which focuses on clinical and professional issues has proved very successful. This has provided members of the teaching group with the opportunity to gain experience in organising a study day. The agenda of the day is built around the development needs of the attendees. The days so far have been well evaluated. We hope to build on this success by linking the course content closely with the Band 6 Knowledge Skills Framework (KSF) post outline.

The Unit's teaching rota remains a key focus of the teaching group. The rota is organised on a monthly basis by a member of the group. We endeavour to meet the needs of all staff and encourage teaching by the multidisciplinary team. Additionally we invite outside speakers to meet current developmental needs on the Unit.



In response to an increased number of student nurses on the Unit we have developed specific teaching sessions for them whilst on placement. This has provided staff on the Unit with an opportunity to consolidate their teaching skills. The sessions have been well received. Students are asked to evaluate their time on intensive care so that we can build on this feedback and try to ensure they have a good learning experience.

We have recently used meetings to look at guidelines produced on the Unit, which means that the authors are given feedback on their work in a timely fashion.

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 work in the future.

Helen Bass

Acting Clinical Nurse Specialist

Inter-team projects

Off-duty planning team

The off-duty planning team (ODPT) provides guidance and supports staff to facilitate computerised staff rostering. A new computerised staff rostering system was introduced throughout the hospital at the end of 2006 and it was implemented in ICU in January 2007. The system enables the Unit to utilise the staff effectively. The programme has been set up to accept the required skill-mix of nurses per shift and recognises full and part-time staff and their contracted shift requirements. One of the advantages of the new system is that data can be accessed to monitor sickness, team cover, skill-mix, annual leave and study days.

The new computerised staff rostering system hopes to reduce the workload of the ODPT and at the same time enable the staff to manage their rotas, balancing their work, social and home life. A trial is ongoing in two hospital wards which will eventually be rolled out in ICU, where staff will individually request onto the computer directly, thereby saving roster creators even more time.

Negotiation is the key for this system to work effectively. The system accurately predicts the number of staff nurses needed in each band per shift. It is

very accurate and will identify for the ODPT where certain staff members will be needed. This allows for staff to have ample time to change their rota in accordance with their and the Unit's needs.

The ODPT deals with these issues and facilitates the negotiations between staff members, ensuring fairness throughout the Unit and ensuring that the rota is done ahead of time and that the Unit is well staffed on all shifts.

Maria Santiago
Senior Staff Nurse
Team H

Geraldine Fitzgerald-O'Connor
Acting Sister
Team C

Marketing group

The purpose of the marketing group is to market the Intensive Care Unit, both internally in the hospital and externally in the wider healthcare arena.

The marketing group funds two nurses (per conference) to attend the main nursing conferences, throughout the year. It also encourages nurses to present at these conferences. This year, Jane-Marie Hamill, Clinical Nurse Lead and Chris Chung, ICU Pharmacist spoke at the BACCN (British Association of Critical Care Nurses) Conference in September 2006 on 'Reducing medication errors in ICU'. Emma Long, Band 7 Nurse and Shona Perkins, Infection Control Sister spoke on collaborative work between ICU and Infection Control. Two nurses, Ann Sorrie, Band 7 and Hwee Leng Lim, Band 6 attended the RCN Conference. Gordon Turpie, Band 7 Nurse and Rodney Fernandez, Band 6 Nurse, attended the Anaesthetic Conference in Belle Plagne, France.

The marketing group have designed an evaluation sheet so that nurses can express how much they have learnt at these conferences and what they can bring back to the Unit.

One of the aims of the marketing group is to involve the Unit with the local community through as many projects as possible. In the past year we have been able to work with local and UK wide charities in gathering funds and support for their causes. We have been able to help by raising funds through our Christmas hamper raffle for Shelter and the Servite Primary School in Chelsea.

On July 6 2006, a team from the Unit took part in the JP Morgan Chase Corporate Challenge, a 5.6 KM run through Battersea Park. A great night was had by all,

and we were able to raise £695 through sponsorship for our chosen causes, in this case, the Multiple Sclerosis Society and the Chelsea and Westminster NHS Trust Intensive Care Unit. On the night, we also won the best t-shirt prize and a further £500 was gained for the Multiple Sclerosis Society, making our donation £845.

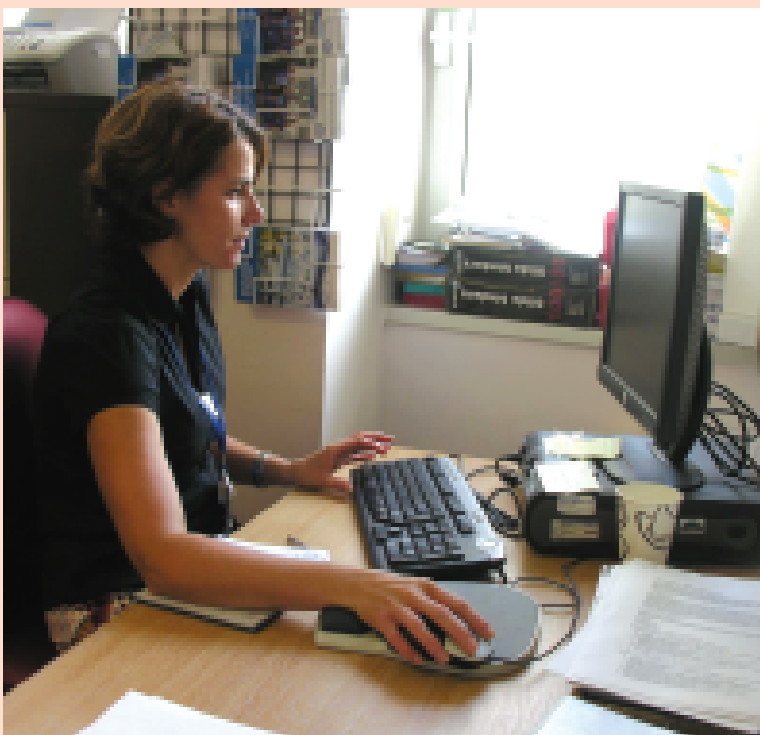
Our aims in the marketing group and on the Unit are to continue raising funds for charities and local community groups and to raise awareness of issues that affect the patients we care for. Two of our nurses, Helen Bass and

Diana Niland have been to a local school, Brandlehow School, during their Science Week to do some teaching on basic resuscitation. Ann Sorrie has taken a class, from this school, to 'The Florence Nightingale' Museum. This will link into the 'Supporting the Local Community' section of 'The Charter Mark' requirements. We are reapplying for the Charter Mark award for excellence of service in the public sector, again this year. We have received it thrice before.

The group also runs a stand for ICU, on the Hospital Open Day, which took place this year in May. We had many visitors to the stand, which consisted of a dummy in a bed linked up to a ventilator and dialysis machine. We were very pleased to win joint runners up for best stand competition.

We have also been very busy with the compilation of this Annual Report and will continue our work next year.

Danielle Pinnock
Staff Development Sister



Inter-team projects

Finance and supplies group

The finance and supplies group was set up to allow other members of staff within the Unit to take an active role in the overall budget and finances of the Intensive Care Unit. This is to improve the quality of care and services in the department as a whole.

The group is made up of the Unit staff representing the different primary nursing teams. It has an administrator, technician, healthcare assistant and clinical nurse leader. The purpose of the group is to provide financial reports, monitor expenditures and agree the allocation of funds.

The finance and supplies group aim to maximise efficiency in the use of resources, identify cost-saving ideas for the Unit, raise the awareness of the cost of items, problem solve any supplies or delivery problems, trial new products in a systematic and cost-effective way, and involve staff in the decision making related to finance and supplies in ICU.

For 2006-2007, the finance and supplies group:

- Completed a detailed list of all non-stock and stock items ordered and stored in the Finance and Supplies folder.
- Reorganized the main stock room and the clean room (IV fluids and miscellaneous items) with proper shelving and systemised storage for more space, making the room more user friendly.
- Highlighted the cost of each item and colour and bar coded lists of where each item is kept to decrease wastage and increase cost awareness.
- Introduced new equipment to the Unit after a thorough evaluation of the new suction liners, bowel management system and new ventilator circuit.
- Reviewed stock needs for tracheostomy and IV cannula in regards to doctor's preference, which reduces wastage.
- Bedside mirrors for patients, a need highlighted in the satisfaction surveys provided by the quality group.

Allberto AJ Albotra
Senior Staff Nurse
Team A

Research group

The last year has been a productive year for the research group. Guidelines at a glance have proved to be very successful. They are condensed versions of the original guidelines, the advantage being that they are easily available at the bedsides, laminated and user friendly for staff. They have therefore been well received.

Many of our guidelines are now ready for ratification. The Good Practice Committee previously disbanded us with the problem of not being able

to get our guidelines out into the clinical practice setting. We contacted our colleagues in Clinical Governance for a solution to the problem. They suggested that we peer review the guidelines within the group and relevant Unit staff before submitting them to the governance department to be ratified. This method ensures that guidelines are readily available and used on the Unit to consistently meet the needs of the critically ill patient.

Many new guidelines are taking shape such as active

Nursing diagnosis and Electronic Patient Records (EPR) group

The purpose of this group is to support staff in all aspects of care-planning and documentation. Its overall function is to achieve the highest possible quality in these areas.

Over the past year, meetings have occurred sporadically due to clinical demands within the Unit. Recently however the group has been able to meet and continue its work.

The group has focused on issues and concerns with regard to the use of nursing diagnosis and EPR. Some aspects considered have been of a technical nature, for example how to edit outcomes on EPR which are either achieved or

repetitious. Other discussions have revealed confusion in relation to the expected standards, such as how often baseline assessments should be reassessed, because this is not indicated on the EPR.

Access to EPR remains a difficulty, with nurses queuing at the nurses station for access to one of only three available terminals. Members of the group have been working hard to facilitate meetings with Draeger and the hospital IT team to interface the bedside Draeger computers with the hospital EPR. We are hopeful this will take place soon to resolve this problem.

Data collection for critical care minimum data sets (CCMDS) is also included within the remit of the project group. This is regarded as a priority because the information will be used as a basis for future funding of the ICU/HDU. Over the last few months the data has been collected via a paper document filled in by staff at the bedside. It is expected that the data will be put onto the EPR system in the near future and the group will support staff further in using this process.

Members of the group have recently completed a documentation audit, which confirmed that standards of care-planning and documentation remain good overall, although there are some areas for improvement which have been incorporated within the group's objectives.

The following objectives have been devised to address issues raised by the audit and discussion within the project group:

Objectives for 2007-2008:

- 1 To improve the quality of care-planning.
- 2 Improve the standard of both handwritten and EPR information.
- 3 Improve staff access to EPR system.
- 4 Improve compliance and accuracy filling in CCMDS.

patient cooling, intra-abdominal measurements and LiDCO. These help to keep the Unit at the cutting edge of current developments in critical care practice and challenge staff to look at ways of delivering critical care services in the Unit. Ann Sorrie, Band 7 Nurse, has completed work on the introduction of the Liverpool Pathway in the ICU. In the pathway's current format, it cannot be used specifically for patients in ICU. More work therefore is needed to make it suitable for our patient group. Work for a

specific ICU pathway is being trialled at the moment in Liverpool. Edel Costello, Liverpool Care Pathway Facilitator, contacted all Unit Band 7 nurses for their opinion on taking this forward.

Work within the group continues with meetings on a bi-monthly basis. There is much to achieve in the coming year.

Gordon Turpie
Charge Nurse
Team F

Inter-team projects

Objective 1 – To improve the quality of care-plans

Ensuring that staff reassess baseline assessments every 7-10 days or more frequently if patient's condition changes.

Improve documentation of family needs and record communications.

Update care-plans as the patient's condition improves or changes for example, patient is weaned from ventilation or no longer requires inotropic support.

Decrease repetition in outcomes.

Objective 2 – To improve the standard of both handwritten and EPR information

Add information regarding documentation standards to staff orientation pack.

Ensure that each team has a copy of the documentation guidelines in their team folder.

Provide sessions on unit teaching programme to discuss the standards.

Re-audit documentation standards in 3-4 months.

Objective 3 – Improve access to EPR system for staff

Continue to liaise with Draeger and hospital IT team in order to upgrade software on the Draeger Explorer system to enable EPR access by each ICU and HDU bed.

Objective 4 – Facilitate improved compliance filling in CCMDs

Ensure that staff are aware of the purpose of CCMDs and how to complete it.

Audit compliance and accuracy of completing CCMDs data

Support staff when process is reintroduced on the EPR system.

The challenges faced by the group over the coming year are substantial, as staff leave and new staff join the nursing team. Much of this work will be ongoing. However, we hope to continue supporting our colleagues in regards to these aspects of their work.

Caroline Younger
Sister
Team B



Research

The ICU has continued to be involved in clinical research this year. This has been both local and multi-centre. Some of the projects from the preceding year have now been completed and are either in press or have been published. Other data that has been gathered has been presented at clinical meetings.

The project investigating the potential benefits of the drug Furosemide in acute renal failure and following haemodialysis is nearly complete.

Investigation into methods of oxygen delivery has resulted in a paper published in the journal *Anaesthesia* on the performance of a variety of oxygen masks at varying respiratory patterns. There is also a project assessing the mode of action of continuous positive airway pressure ventilation. Some of the early data has proved extremely interesting and has been presented at several meetings including the Anaesthetic Research Society, where it was deemed worthy of a prize. The project continues and it is hoped it will be submitted for publication in the very near future.

As an adjunct to the research into the performance of oxygen delivery systems, a project looking at handheld spirometry in patients with respiratory distress has started and is also producing some interesting results.

One trial that has been very frustrating has been analysis of the levels of triggering receptor as expressed on myeloid cells (TREM-1). The immunology department have had great difficulty in producing reliable results with the novel assay. However, they have now succeeded and the ethics application has just been submitted.

New technologies have also featured in the ICU and have been undergoing assessment. A new cardiac output monitor the Vigileo (Edwards Lifesciences) is being compared to our standard the LiDCO. A more 'user-friendly' monitor, the Vigileo may replace the LiDCO if it can be demonstrated to perform as well. We are also looking at the LiMON monitor, which can assess dynamic liver function in a non-invasive manner. We have a project running where we are comparing the LiMON values to renal function in those patients with severe sepsis to see if there is evidence of hepatic failure associated with renal failure in this group of patients.

A paper is just about to be submitted describing our experience with a novel method of inserting a central venous catheter. We found that it had a similar complication rate as the standard method, but was associated with a 50% reduction in colonisation rate. An adaptation to the design has recently arrived and we are gaining further experience and hope to present the technique we have developed to the wider intensive care community.

Finally, we also joined a national trial this year. The ISOC trial was a multi-centred project auditing the use of blood and blood products in the intensive care environment. A ten week audit was performed recording which products were being used, how much and for what indication. We audited 62 patients and the trial data is now being analysed prior to presentation.

Dr Adrian Wagstaff
Research Fellow

Performance

The following section will review our performance in the last year with comparisons made to the previous year.

This section will cover activity and information, finance, human resource management, and Infection Control.

Activity and information

Chelsea and Westminster Intensive Care /Nursing Development Unit consists of ten beds which are flexible to provide level 3 (intensive) or level 2 (high dependency) care, depending on the needs of patients. In addition there are two burns intensive care beds.

2006/7 saw a slight decrease in the number of level 3 patients compared to previous years but an increase in level 2 and level 1 patients. This may be due to changes in surgery, as well as decisions about the outcome of patients being decided much earlier on the ward. The increase in level 1 patients may be due to the effects of the closure of this service on the ward. However, there are plans to reintroduce a level 1 service in 2007/8, so these figures may decrease next year. Length of stay of the ICU (level 3) patients has decreased but the level 2 patients have increased which may be reflective of the delayed discharges.

Table 1 Activity General ICU/HCU

Finished Consultant Episodes(FCE)	04-05	05-06	06-07
LEVEL 3	221	196	169
LEVEL 2	195	200	296
LEVEL 1			(103)
Length of Stay (LOS) (Days)	04-05	05-06	06-07
LEVEL 3	-	6	4.5
LEVEL 2	-	2.5	3.5
Occupancy	04-05	05-06	06-07
LEVEL 3	90%	96%	72%
LEVEL 2	154%	108%	178%
Admission	04-05	05-06	06-07
Elective	71	59	85
Emergency	345	337	380

The majority of patients who are admitted to ICU/HDU are emergency cases. It is recommended that when patients are ready for discharge, this process should be completed within six hours. In 2006-07, 67% of our patients were transferred after six hours and 12% after 24 hours. In 82% of the cases, the reason given was that there were no beds and in 9% of cases there were no siderooms. It is an objective this year to try to improve discharge from ICU.

Table 2 Burns ICU

Finished Consultant Episodes (FCE)	05-06	06-07
LEVEL 3	28	20
Occupied Bed Days (OBD)		
	339	278

In 2006/7 there were 20 patients treated and combined occupancy was 41%. At present, there are plans to expand the burns service.

Finance

The performance targets this year were to keep within budget, make cost savings and improve efficiency. These goals were achieved as the year-end position was a credit of £85,000. This was achieved by recruitment and by flexible management of staff by the senior Unit staff when co-ordinating as illustrated below.

The Unit also has a Trust Fund. At the end of 2006/2007, we had a surplus of £3000. Most of the income comes from donations. This year we have spent money on the following services or items for our relatives, patients and staff:

- A coffee machine for the relatives room
- Painting the kitchen and relatives room

- Development of a post ICU booklet and information cards
- Funding the Unit's Annual Report
- Purchase of locks.

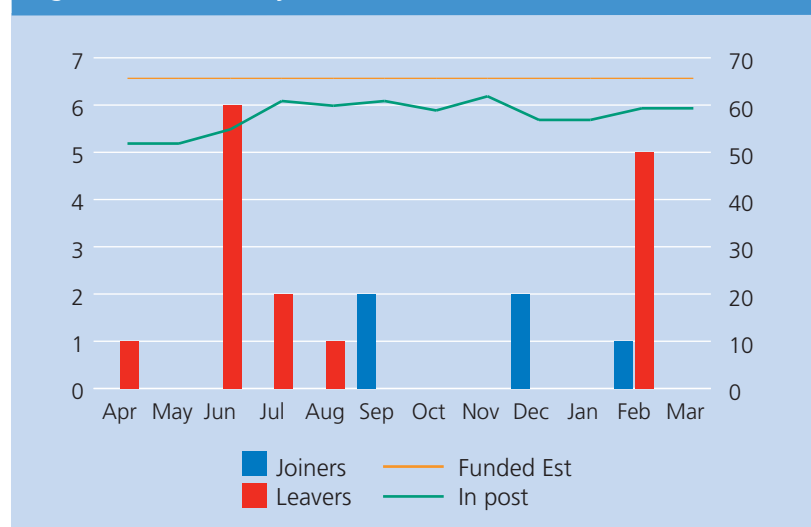
Staff suggest ways in which this money is spent and who it will benefit and this is channelled through the finance and supplies group.

Human resource management

The Intensive Care/High Dependency Unit is funded for 65.8 whole time equivalent (wte) posts. In 2005 the Unit funded establishment increased slightly in order to provide staffing to fund the two Burns Intensive Care beds.

In 2006, we had 15 new staff join and four staff leave the Unit. This is illustrated in Figure 1.1 and as a result of this recruitment, we only have seven vacant posts on the ICU/HDU.

Fig 1.1 Leavers and joiners in 2006/07



Performance

A comparison of leavers and joiners over the last six years is illustrated in Figure 1.2.

Over the last three years the main reasons given for leaving are:

- Moving out of London 26%
- Travelling or returning to their home country 33%
- Career change leaving ICU 26%
- Retirement 4%
- Leaving nursing 4%

The Unit also supports flexible working so 23% (14/60) of our staff work either part-time hours or job-share. The main reasons that staff work flexible hours are either childcare or study leave requirements.

Fig 1.2 Leavers and joiners from 2000 to 2006

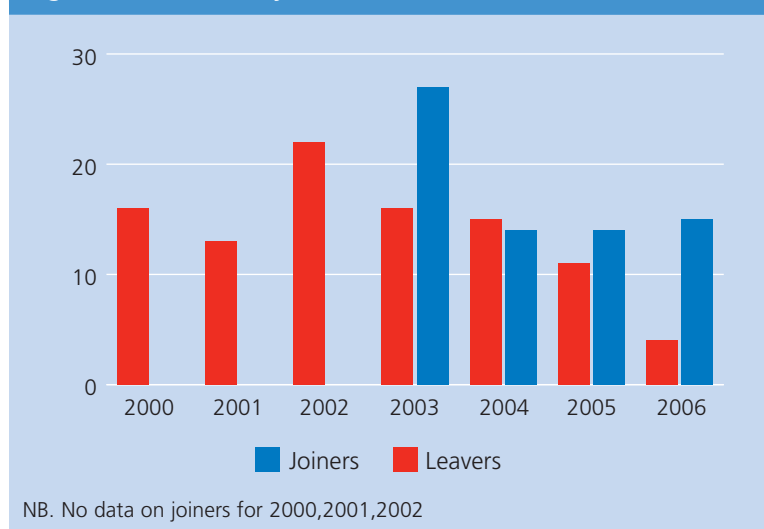


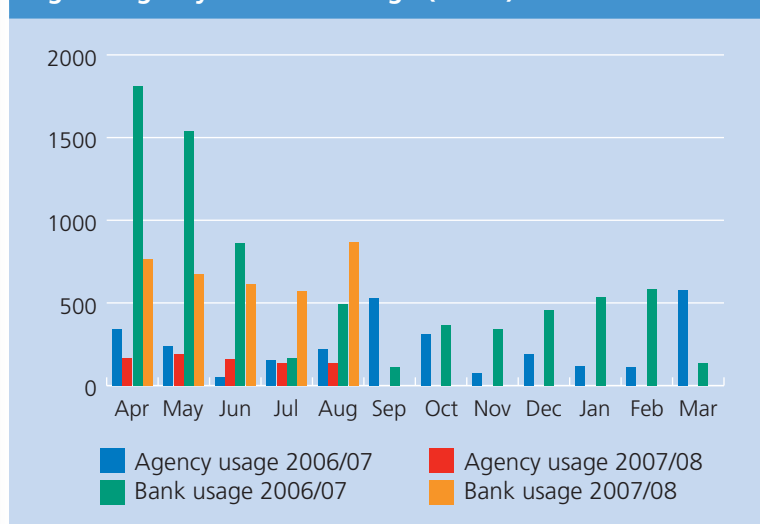
Figure 1.3 illustrates the amount of hours used by agency and Staff Bank in 2006/7. This has reduced significantly which is reflected in the successful recruitment of staff. In addition, the staff on the Unit are excellent at reviewing staffing levels on a shift by shift basis. They are able to balance the need to be

a responsive emergency service with the need to be cost-effective while meeting the needs of the patients on the Unit.

Jane-Marie Hamill
Clinical Nurse Lead

Jason Tatlock
Information Officer

Fig 1.3 Agency and bank usage (hours) in 2006/07



Infection prevention and control 2006

Over the last year the Intensive Care Unit has seen major changes in Infection Prevention and Control. Chelsea and Westminster NHS Foundation Trust at the beginning of 2005 rated second highest for MRSA bacteraemia rates in London. Since the publication of these rates and Winning Ways (DOH 2002), the Infection Control Link Professionals (ICLP) system was introduced Trust-wide. Two senior nurses from the ICU attended the four day intensive course in July 2005. The Trust set the ICLPs the task of improving intravascular line care and hand hygiene rates through regular auditing.

Since the introduction of the hand hygiene audit the Unit has seen a rise from 6% to >50% compliance. During the time of intravascular line audits there has been a reduction in MRSA bacteraemias. An environmental audit was also undertaken by the ICLPs and Infection Control then formed a template for action on the Unit that continues to be developed.

Hazel Boyle, Band 7 Nurse and Emma Long, Band 7 Nurse ICU, are developing the profile and the importance of Infection Prevention and Control within the intensive care environment. In May of

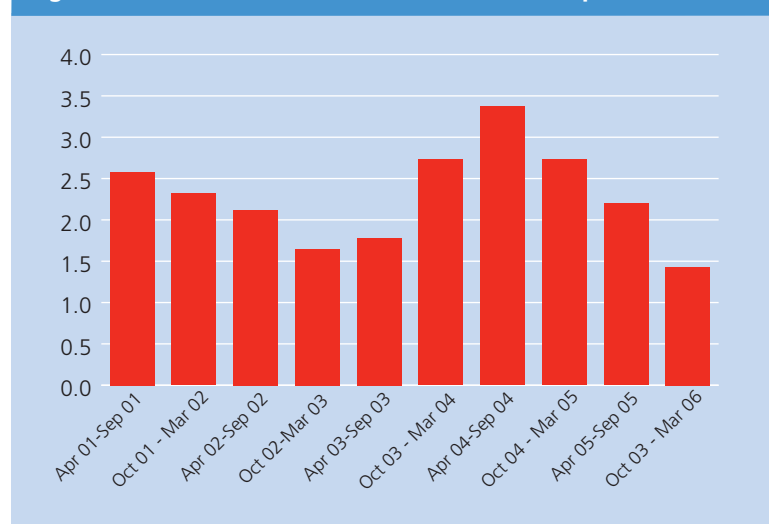


2006 Emma and Shona Perkins (Infection Control Sister) spoke at the British Association of Critical Care Nurses regional conference in Brighton. The presentation was on collaborative work between ICU and the Infection Control team and the changes

made within the Unit and hospital in reducing infection rates. In July 2006, Hazel collected data for the second national prevalence study on Hospital Acquired Infections. (Data not yet published).

Emma Long
Sister
Team H

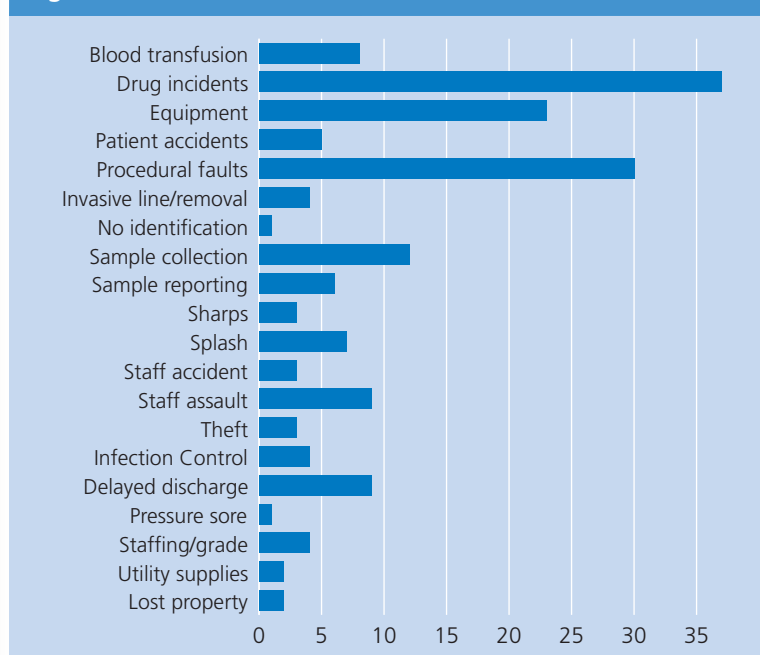
Fig 1.4 Trust MRSA Bacteraemia Surveillance Apr 01-March 06



Performance

Clinical incidents on the Intensive Care/High Dependency Unit 2006

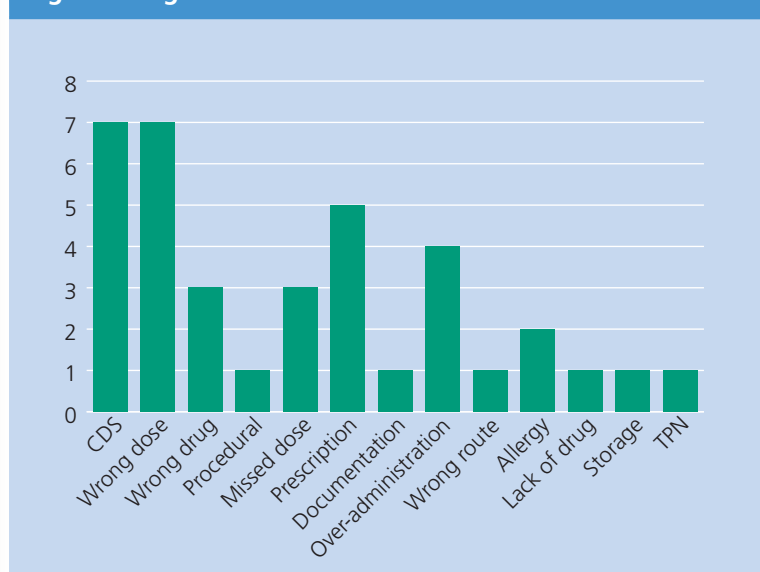
Fig 1.5 Clinical incidents in ICU/HDU in 2006/07



In 2006 there were 178 reported clinical incidents. These are identified in different categories (see left). Some of the actions we have taken as a result of the incidents are:

- Identification of all emergency sockets especially the uninterrupted power supply in the High Dependency Unit.
- Purchasing of locks for all staff lockers in order to reduce the incidents of thefts.
- Combining handover with safety checks in order to ensure that they are done
- Clarifying the details on how to order an interpreter.
- We did have a serious incident but the actions have been highlighted under the section in this report on Complaints.

Fig 1.6 Drug incidents in ICU/HDU in 2006/07

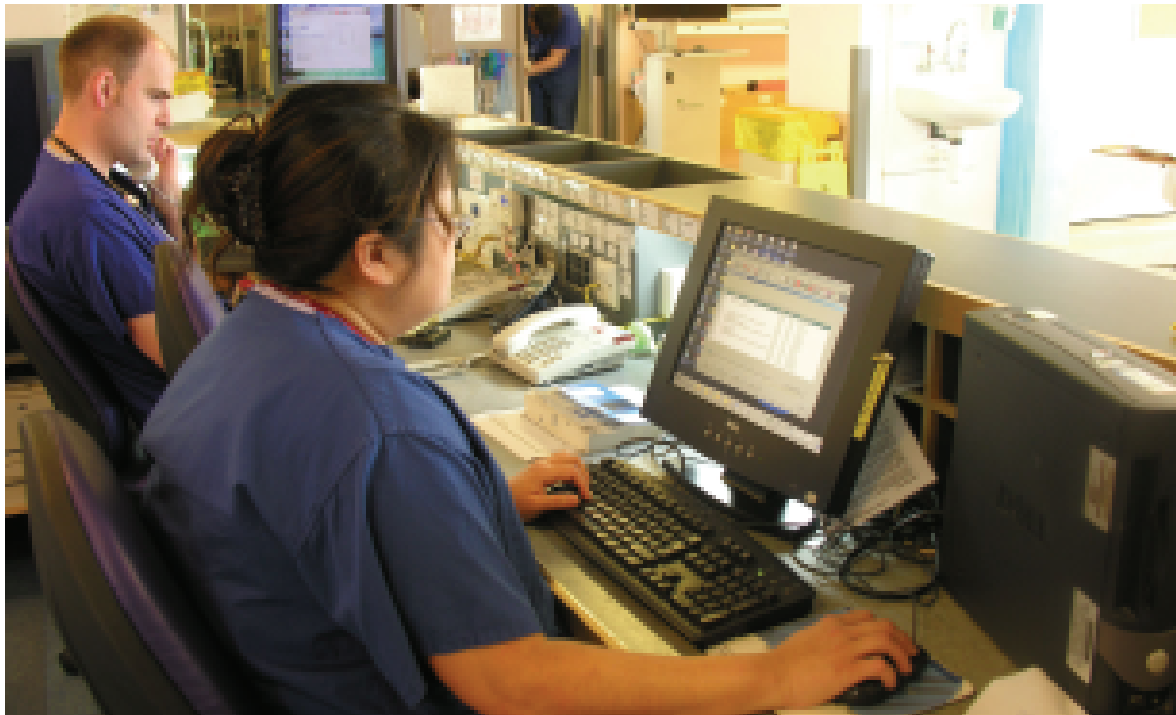


There were 37 drug incidents in 2006; the categories have been highlighted above. This is 20% of our total number of incidents. All these incidents have been fed into our six monthly drug quiz, pharmacy folder and monthly Unit meeting.

Jane-Marie Hamill
Clinical Nurse Lead

Development opportunities

Staff development role



The staff development role is a rotational one between the Band 7 nurses on the Unit. So far, three Band 7 nurses have undertaken this role. In June 06, we took over, working together in a job-share capacity. We co-ordinate the Foundation of Critical Care course, which is a six month course for qualified nurses who are new to ICU. The role is divided between clinical time (50%) working with the nurses at the bedside and management time when we organise the monthly study days, mark workbooks and

support the students and their preceptors. It is an excellent opportunity to combine informal teaching at the bedside and formal teaching on the six study days.

We are enjoying this role as it gives us a chance to be involved in the development of nurses new to the intensive care environment by guiding and supporting them to achieve their objectives, whilst updating ourselves and improving our teaching skills. It is a pleasure to see the students succeed, pass their

essays and gain their certificates and then move onto the Critical Care Certificate in Professional and Personal Development in ICU (CPPD) course.

We have learnt a great deal about the structure and organisation of a course linked with a university, especially as this course changed from a Level 5 (Diploma) to a Level 6 (Degree) course in July 06 last year. We are now running the second intake at Level 6 over the next six months and then we will handover to another Band 7 nurse in ICU.

Danielle Pinnock
and **Ann Sorrie**

Staff Development Sisters, ICU

Development opportunities

Foundation of Critical Care Course (FOCC)

Our Foundation of Critical Care course for nurses new to intensive care has had another successful year with 10 staff completing the course and going on to undertake the Certificate of Professional and Personal Development (CPPD) in Intensive Care at Thames Valley University (TVU). This year the Foundation of Critical Care course was reaccredited by TVU. The course, formerly accredited at academic Level 5 (Diploma) is now accredited at academic Level 6 (Degree). The change in academic level prepares participants to study at a higher level and will help make the transition to the CPPD easier. The first cohort of students successfully completed the new Level 6 course in December.



Charge Nurse Gordon Turpie was instrumental in securing the reaccreditation of the course. Gordon prepared and presented the lengthy documentation required by the University's accreditation

panel. Ann Sorrie and Danielle Pinnock have now assumed responsibility for the course and have successfully run the first cohort.

Audrey Blenkarn
TVU Link Lecturer

Student perceptions of the Foundation of Critical Care course

The FOCC course has taught me a great deal in terms of gaining a deeper insight. It has helped me to understand the physiological aspect of the patient. The knowledge and skills I gained from this course will enable me to practice my profession with confidence and deliver care competently. Deeper understanding of the disease processes have enabled me to deliver my care safely

and effectively. I therefore conclude that the FOCC is an important fundamental tool to prepare new staff members during the transition phase and make us confident and competent to care for patients in the critical care setting.

Gina Paluga
Staff Nurse
Team A

FOCC

I and four others started the FOCC course - run in-house by Chelsea and Westminster ICU - in July 2006. We were guided by the organised and ever patient co-ordinators, Ann Sorrie and Danielle Pinnock. During the six month course we had six study days, run by Ann or Dany, plus an ECG and ILS Trust-wide study day. In that time we also had a competency booklet to complete, workbooks before each study day, as well as

presentations, clinical supervision, a final exam and a 3,000 word essay. The study days covered respiratory, cardiovascular, neurological, renal and psychosocial aspects of assessment and care. The range of speakers included senior nurses from our ICU, as well as staff from all relevant fields in the hospital, including the research SpR, Infection Control, Chaplaincy, Dietetics and the Critical Care Outreach team. Every speaker was well-informed and well prepared, giving relevant information to guide our practice on the Unit. We were very lucky to have their time and experience. I am very glad to have had the

opportunity to do the programme - although I admit during it, I had my doubts and at times it felt like a baptism of fire. As well as getting used to a new workplace, conquering my fear of the ventilator, getting to know colleagues and grappling with the computer system, I had the added joy of having to come home and study to meet competencies and deadlines. My flatmates and boyfriend also suffered, having to put up with a maelstrom of books, piles of paper and unwashed cups, as well as six months of grumpiness! But here I am at the other side of it. I survived, as did my friendships and

relationships (just!) and the flat has its dining table back. I feel that my practice has benefited greatly and that I am becoming a useful member of the team. The programme certainly met its aims of providing a structure for learning and a focus for continuing my development in nursing. I am no longer one of the newest members of the team, which is slightly unsettling, but my hope is that as I continue to develop my skills, I will be supportive to new members.

Zoë McClure
Staff Nurse
Team J

Certificate in Professional and Personal Development (CPPD) in Intensive Care

Since becoming a member of staff in the Intensive Care Unit, I have been fortunate to have developmental opportunities. Initially, with the Foundation of Critical Care course, run within the Chelsea and Westminster Intensive Care Unit and then progressing to the Certificate in Professional and Personal Development (CPPD) in Intensive Care. This course is run over six months by Thames Valley University.

I commenced this course in April 2006, excited and apprehensive as I was taking the next step on the ladder to becoming an autonomous intensive care nurse.

The course was divided into two modules; the first being Nursing Interventions in Critical Illness. This builds upon the knowledge and skills gained during the Foundation of Critical Care course. It explores the pathophysiological and psychological effects of critical illness concentrating on management and care of the patient with single organ failure.

Module two which is Therapeutic and Nursing Interventions in Critical Illness: Caring for the Patient with Multiple Organ Dysfunctions focuses on multi-organ failure, sepsis and the systemic

inflammatory response syndrome and the management of these patients and their families.

Although at times it was tough juggling our work with studying and learning needs and also personal lives there was a great sense of support and guidance from colleagues and friends. On completion of this course a sense of relief and achievement was attained. This experience has been challenging, exciting and rewarding, helping me to develop my confidence and skills.

Michelle Bulfin
Staff Nurse
Team A

Development opportunities

Studying again

In January 2005 I started an MSc Degree in Advancing Healthcare, a distance learning programme based at the Royal College of Nursing Institute (RCNI).

The programme is a multidisciplinary course, open to nurses, midwives and other healthcare professionals. The programme comprises of six modules, followed by a one year dissertation.

I have found the course content so far both stimulating and challenging in equal amounts. I have learnt a great deal about the complexities of working within healthcare and more specifically the NHS. Additionally I have been introduced to new ideas and concepts.

I chose to study via distance learning as I felt that it would fit in with both my professional and social life. At times the distance learning experience can be a somewhat 'solitary' experience; however I have overcome this by attending the six weekly tutorials. This allows me to network with fellow students who are often from different professional areas and have different perspectives on issues. Alternatively it's a time to have a good old moan

about that assignment that you have to hand in!

Working full-time and studying part-time means that I have had to become extremely organised and disciplined. On occasions, it has meant studying when I would rather be doing something else, for example shopping!

All said and done it is one of the best opportunities presented to me as it has given me the opportunity to stretch myself academically and given me new confidence. I hope that I have been able to put into practice some of what I have learnt while also helping other Unit members who are studying whilst working.

A big thank you to all of my colleagues who have offered support, advice and have listened patiently to me 'blabbering' on about the latest thing I have read.

Helen Bass

Acting Clinical Nurse Specialist

End of Life Pathway

The Liverpool Care Pathway for the dying patient (LCP) has been developed to transfer the hospice model of care into other care settings. It is a multi-professional document which provides an evidence-based framework for the end of life care. The pathway has been adapted for use in the intensive care setting and provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions. Additionally, psychological and spiritual care and family support are included. This document can facilitate a peaceful, comfortable and dignified death for a patient in a busy and technical environment, allow doctors and nurses to deliver optimum care of the dying and promote multi-professional communication within Intensive Care.

Ann Sorrie

Staff Development Sister, ICU

Withdrawal of treatment audit

The justification of the rigors of Intensive Care is the prospect of a successful outcome and in the absence of this then it is questionable whether aggressive treatment should be continued. A critically ill patient is usually unable to express whether he or she would like treatment withheld or withdrawn. Thus, decisions made on the patient's behalf have to be taken by others, such as the critical care team and the family and must be

justified whether by a best interests test or by way of a substituted judgement. If aggressive ongoing treatment is not in the patient's best interest and is proving futile then a decision not to escalate treatment or in some circumstances to withdraw some aspects of the treatment may be required and the manner of withdrawal should be appropriate to the particular patient context.

An audit tool has been created to ascertain how decisions to withdraw treatment are made and the processes involved. The aim is to generate information surrounding this complex issue to help consider the way forward to manage the withdrawal of treatment from critically ill patients in a sensitive and consistent manner.

Ann Sorrie

Staff Development Sister, ICU

Presentation at the BACCN Conference: Multidisciplinary Risk Management of Medicines on the ICU

Last year, the Clinical Nurse Lead, Jane-Marie Hamill and I presented at the BACCN conference. We described the work we carried out on ICU with respect to risk management of medicines and how we adopted a joint multidisciplinary approach to address the problems that arose.

Although it was not my first time presenting at a national conference, it was the first time I presented at a national conference for a discipline other than pharmacy. I found it to be a worthwhile and invaluable experience. There were many similarities to pharmacy conferences in terms of organisation, topics chosen and delivery of material. It was also an opportunity to support

colleagues who were presenting other pieces of work, share ideas and network with people from other Trusts.

Our presentation described what measures we had in place to reduce the number of medication errors:

- Designing an ICU drug chart with input from all disciplines
- Holding quarterly multidisciplinary incident review and Clinical Governance meetings
- Holding a quarterly risk management drug quiz based on past incidents
- Audits: pre and post drug chart prescribing error audit, missed dose and storage of medicines audit
- Updating the intravenous competency test

- Enforcing use of intravenous drip counters in addition to using intravenous rate controlled infusion pumps to detect errors when the pump is incorrectly set or malfunctions
- Three monthly drug stock list reviews.

We were pleased that our presentation stimulated a lot of interest and discussion. A number of delegates asked for a sample of our ICU drug chart.

I thank Jane-Marie Hamill for inviting me to join her to present our work at a national nursing conference. I found it to be an invaluable experience.

Chris Chung

Head Pharmacist, ICU

Developmental opportunities

Nursing outside of the hospital setting

It all started in October 2004, I was working in a London Emergency Department. As I finished triaging a patient brought in by paramedics, I was approached by one of them and asked if I was interested in working as a nurse at a large 10K charity run - there were to be over 30,000 runners and the company I was to be working for required over 30 staff, a mixture of first aiders, paramedics, nurses and doctors.

I had never thought of earning extra money as a nurse outside the hospital, I was intrigued and not sure what to expect so as I was free and in need of some extra cash, I accepted the job offer.

Since then, I have never looked back. During my free time, I regularly work for the same professional medical company. Events I have worked at include; rock/pop concerts, sporting events, raves, religious gatherings, even filming productions at the BBC. Sometimes, you can be working on your own or in larger groups, depending on what is required.

Initially I found the work quite daunting as I was not used to nursing outside the safety net

of a hospital. It was an environment I was not used to, but with a well-stocked kit bag, you quickly learn how to adapt.

Planning must include an appreciation of the skills and equipment that can realistically be provided at the venue. Some events have medical rooms and at others we assemble large army tents, the company also has a mobile medical unit. These are always very well-equipped with all the emergency equipment required, from defibrillators, sphygmometers, emergency medication and all forms of dressings.

We have been told that the skills provided in events we have covered, have prevented the need for some hospital attendances. In large events the company always liaises with the London Paramedics and the Police. The potential for a major incident always exists and such an incident must be anticipated.

The casualties we see depends very much on the event we are covering. It is true that alcohol does increase the casualty rate, especially at pop and rock concerts. We also see strains, sprains and fractures due to crowd surfing and

crushing against crowd barriers. Occasionally there are assaults.

However, one of the most frequent medical complaints is a headache, which may affect both staff and crowd members; this is especially prominent at loud concerts and raves. Other common complaints are hyperventilation, asthma, epilepsy and hypoglycaemia. Specific problems may be anticipated at certain events, such as substance abuse at raves.

It is always worth remembering that in a large crowd there will always be someone with a chronic condition: the lack of common sense and preparation that such a person shows when determined to attend an event should not be underestimated, a good example of this are the amount of asthmatics who participate in running events without their inhalers! I always enjoy working at these events, sometimes I feel I am getting paid for doing something I love, like attending a concert.

Leila Hail
Staff Nurse
Team D

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Staff – April 2007

Dr Neil Soni

Consultant Anaesthetist
Consultant Intensivist
Director of ICU

Dr Rick Keays

Consultant Anaesthetist
Consultant Intensivist
Clinical Director for Burns

Dr Berge Azadian

Consultant Microbiologist

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Hwee Leng Lim
Alberto Albortra
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Rebecca Hill
Amanda Dixon
Rodney Fernandez
Saowanit Kampinij
Christopher Bray
Leila Hail

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Emma Long
Corazon Basbas
Marites Velasco
Aldrin Litang
Noku Kashiri
Maria Briones
Juliana Kachikoti

Elaine Manderson

Clinical Nurse Specialist

Mark Costello

Technician

Caroline Heslop

Volunteer

Emer Delany

Dietician

Ann Sorrie/

Danielle Pinnock
Staff Development Sisters

Dr Nicolas Fauvel

Consultant Anaesthetist
Consultant Intensivist

Dr Suveer Singh

Consultant Intensivist
Respiratory Physician

Dr Adrian Wagstaff

Research Fellow

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Gerry Fitzgerald-O'Connor
Amanda Joyce
Imelda San Miguel
Basanio Reyes
Ramon Flojemon
Julianne Poulin
Enrico Esguerra

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Jane-Marie Hamill/
Nerissa Verdejo
Josephine Bien
Jane Mbaluku
Eleni Ioannou
Jane Davies

Team I

Charlene Brown
Sarah Hector
Sharon Wyatt
Laura Giron
Shona Keogh
Hilary Taylor
Joel Villarosa

Jane-Marie Hamill

Clinical Nurse Lead

Magdalena Johnstone

Housekeeper

Claudia Thompson

Volunteer

Lorna Soares-Smith

Physiotherapist

Anna Bischler

Pharmacist

Dr Michelle Hayes

Consultant Anaesthetist
Consultant Intensivist

Dr Jonathan Handy

Consultant Anaesthetist
Consultant Intensivist

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Rachel Cowey
Francis Douds
Laura Edmonds
Marion Blennerhasset
Fernando Fegarido
Helen Weaver

Team F

Ann Hinds/Gordon Turpie
Ferial Mahiout
Rose Le Cordeur
Alexis Pelina
Amy Wood
Annalyn Gutierrez
Ciara McKenna
Saskia Peerdeman

Team J

Maria Stockmayr
Diana Niland
Rubina Vard
Maria Martin-Chicharro
Zoe McClure
Lennie Buslay

Jason Tatlock

Admin/Information Officer

Mavis Kyeremeteng

Housekeeper

Blanche Takwi

Healthcare Assistant

Chris Chung

Head Pharmacist

Jessica Murray-Wicks

Dietician

Contributions to working parties

Internal

Supplies/ Finance Group

Jane Marie Hamill CNL

PEAT group

Jane-Marie Hamill, CNL

Recruitment and Retention Group

Jane-Marie Hamill, CNL

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

Jane-Marie Hamill, Clinical Nurse Lead and Chris Chung, ICU Pharmacist 'Reducing Medication Errors in ICU' British Association of Critical Care Nurses (BACCN) Conference, Newcastle, September 2006

Emma Long, Band 7 Nurse and Shona Perkins, Infection Control Sister 'Changes made within the ICU and Hospital to reduce infection rates' BACCN Regional Conference, Brighton, May 2006



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