Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Intensive Care and Nursing Development Unit

Annual Report 2007-2008

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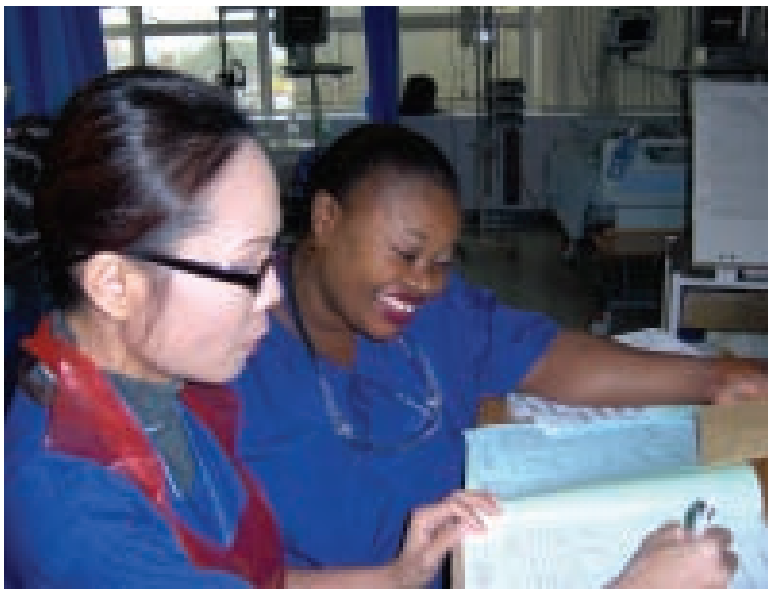
Introduction

Another year has passed on the Intensive Care and Nursing Development Unit, and it is time to reflect on our achievements and make plans for the future.

This report contains a broad range of topics, from the work of the inter-team projects, user feedback, performance and contributions from other members of the multi-disciplinary team.

All our staff participate in maintaining a service that continues to evolve and develop to reflect the needs of the critically ill patient. This is often reflected in the verbal and written feedback we receive from not only patients themselves, but also their relatives and friends. Our service has been further recognised by being awarded the Charter Mark for the fourth time, a fantastic accomplishment: thanks to all the staff who have worked so hard for us to achieve and maintain the standards required to merit this award.

The Intensive Care Unit has strong links with many other departments within the Trust, and we would like to pay special thanks to the physiotherapists, pharmacists, dieticians, occupational therapists and speech



therapists. Their expertise and knowledge is immense, and all our patients benefit from their involvement; thank you.

Thanks also extend to Jason Tatlock, Information and Audit Officer, whose work allows us to monitor and review our performance so effectively; Mark Costello, our Chief Technician who maintains and manages all of our equipment; Magdalena Rigi and Mavis Kyeremeteng, the Housekeepers who keep the Unit sparkling; and Blanche Takwi our Support Worker whose helping hands are invaluable to the nursing staff. We have two wonderful volunteers, Claudia Thompson and Caroline Heslop who also contribute a huge amount to the Unit.

Intensive care is a speciality that rarely stays static and looking towards 2009 we see the potential for our service to develop, particularly within a new speciality of bariatric surgery and the continuing development of our burns service. We also hope to extend the work we do with our ex-patients with the introduction of patient diaries to help chart their time in the Intensive Care Unit.

Rebecca Hill
Acting Clinical Nurse Lead

Elaine Manderson
Clinical Nurse Specialist

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 through continuity of care. 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 in an environment that is welcoming, safe and clean.

We respect the rights of our patients, and 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 making decisions 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, comfortable 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 the grief of relatives or friends.

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.

We, 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 competent, questioning and motivated staff.

User feedback

In this section we detail feedback that we have received from our patients and other users of the ICU. From this feedback we can continue to develop the service we provide to ensure that it is efficient, high quality and patient focused.

Relatives' Satisfaction Survey

The Relatives' Satisfaction Survey continues to be a valuable tool in assessing how the Intensive Care Unit is perceived by members of the public and is used to highlight areas in which we may improve our services.

The survey is based on a questionnaire of 34 questions broken down into three sections relating to communications, care and facilities. Respondents are also asked to add their own comments and suggestions. The results are tabulated twice a year and presented to the quality assurance group for discussion and action.

The survey is now in its eighth year. The number of those responding has increased over the years and is now fairly constant with 52 completed questionnaires received in 2007.

Below is a brief summary of the results collated for 2007:

- **Communications**
  There are 10 questions relating to communications.

  An area of concern continues to be communication between relatives and the consultants/doctors. The idea of having a fixed time for meetings between consultants and relatives was considered but it was agreed that this was impractical.

- **Care**
  There are 11 questions relating to care and primary nursing.

  As before, the vast majority of comments were very favourable.

  There was an increase in the number of those who would have liked to have had the opportunity to help more with the care of their relative. Nursing staff were informed of this.

  Virtually all respondents were in favour of Primary Nursing and 100% felt they were made to feel welcome on the Unit.

- **Facilities**
  There are 13 questions relating to facilities.

  At the beginning of the year the main area of concern was the quality of the food given to patients. This problem was solved with the introduction of a new specialised kitchen which came into use in April.

  During the first half of the year there was a decrease in the number of respondents who felt the cleanliness of the ward was excellent. This was probably due to temporary staff being used and in the second half of the year figures improved.

As in previous years the results from the survey show that the vast majority of relatives are very satisfied with the services provided by ICU.

There are, however, always areas that can be improved. The less positive responses received from relatives are invaluable in preventing the Unit from becoming complacent, and in assisting it to establish where further improvements can be made.

User feedback

"Although Teresa was gravely ill, I found the care she received was first rate. The ICU is truly an astonishing facility. Knowing she was in good hands was a great comfort."
CC October 07

"They had great respect and care for me, knowing that I had travelled from Surbiton in taxis and buses and back home again."
MR April 07

"Too rapid changes/ turnover of nurses does not allow a relationship of confidence to be maintained between patients/staff/relatives."
Anon Oct 07

"We really want to thank all staff in HDU and ICU for their support throughout our four day trauma watching our loved one pass away. We cannot thank you all enough from the bottom of our hearts for everything you've done."
LW May 07

"Because they (the Primary Nursing Team) understood the patient and they knew the relatives so it became like an extension of a large family."
DW July 07

"Primary nursing gives the personal touch and we felt we not only had a nurse but a good friend too."
CH March 07

"The whole experience was surprisingly positive despite being an anxious and frightening time for us relatives. We felt very confident in the care that Mum was receiving."
LR October 07

"As relatives living outside London issues such as parking/congestion charge have been puzzling."
MB April 07

"(They) explained carefully what was happening - excellent care, thoughtful, courteous and very conscientious throughout the time spent here."
JB September 07

"A neighbour of my mother was allowed in at the door and I was upset at the time that she was allowed in."
IF October 07

"One doctor tells you one thing and another tells you a completely different thing and you don't know what's going on."
WA July 07

Formal complaints

There have been no formal complaints this year.

Patient Advice and Liaison Service (PALS)

PALS is a hospital service that is available for patients and their families to use for support and information. It also liaises with departments to help provide information or help resolve issues. For the period of April 2007 to March 2008, PALS received four queries in regards to the Intensive Care Unit. They are as follows:

Type of Query	Number of Queries	Description	Outcome
Concern	1	Missing glasses during move from one ward to another	Glasses located by ward sister and returned to patient
Praise	2	Email from patient's daughter praising staff on the ward Comment card praising care: 'The nursing is of the highest quality'.	Letters of praise sent
General	1	Patient's next of kin requests information on power of attorney	Spoke to manager. Forms and information leaflet produced and given to the enquirer.

Rebecca Hill
Acting Clinical Nurse Lead

Elaine Manderson
Clinical Nurse Specialist

Inter-team projects

This section outlines the work of all the project groups in intensive care. These project groups provide staff with the opportunity to make suggestions and changes to the work of the ICU to improve the service and the care delivered to patients and their families. Each member of staff working on the Unit is a member of one of the inter-team project groups.

Quality assurance group

The group works towards improving the service we provide to the patients, their relatives and friends. We evaluate how we are performing through feedback gained from patient focus groups and relative satisfaction surveys. The team meets bi-monthly, and discusses ongoing topics and any future projects, both short-term and long-term, we could carry out to try and make the patients and their relatives' stay with us more bearable.

This year we have refurbished the relatives' overnight room and installed a new shower for them to use. The waiting area has also had new flooring put in. The staff coffee room has also been re-painted and now looks much fresher.

We continue to run patient focus groups and invite ex-patients back to participate. These meetings provide a forum for us to gain insight into the experiences patients have during, and after, their stay with us. We then present the main themes to the other staff in the Unit and develop strategies to try and alleviate the issues discussed and then feed these back to the participants.

Satisfaction surveys from relatives remain positive, and a huge thanks to our volunteer Caroline Heslop who collates the results and presents the findings. She continues to be a huge asset to the group.

This year we have developed our website, providing a broad overview of the Unit with information we thought would be useful to a wide range of people. This can be accessed through a link on the Chelsea and Westminster Hospital NHS Foundation Trust website: www.chelwest.nhs.uk/services/anaesthetics/intens_nurs_dev.htm

The biggest achievement this year is the successful re-application for the Charter Mark, a brilliant acknowledgment to all who work in and contribute to this Unit. It took a lot of time and work to ensure we had collected and could demonstrate the evidence needed to the outside assessor Trevor James for him to present this award.

Rebecca Hill
Acting Clinical Nurse Lead
Team D

Teaching group

After being off on a year's maternity leave I was delighted to come back into the role of teaching group leader to see how much work the team had achieved. The group's main objectives are to organise and coordinate teaching and training on the Unit, as well as plan and implement staff development programmes for all levels of staff and they have certainly achieved that and more this year.

The group has always consisted of enthusiastic members committed to ensuring teaching holds a high priority on the Unit. We provide orientation and teaching for all levels of staff who work on the Unit. We are constantly reviewing our practice through feedback from staff meetings.

A key action point on our plan is providing support and development to students nurses on their stay on ICU. Last year the group developed specific teaching sessions for their needs which were very well received. Following student feedback we developed further sessions they identified, which has meant students feel they are welcomed and supported in an environment conductive to their learning needs. Work on developing learning contracts has also been completed to help students with specific learning outcomes.

This year's main focus has been to build on the introduction of the Band 6 study day which focuses on clinical and professional issues. The day's aim is to meet the needs of senior staff nurses on the Unit whilst also allowing teaching group members to gain experience organising a study day. We aim over the next year to formalise a structured Band 6, two-year rolling programme with specific objectives linking in with Knowledge and Skills Framework (KSF) post outline.

The teaching group prides itself on meeting the needs of all staff through stretching the boundaries of capability.

Hazel Boyle
Sister
Team A

Inter-team projects

Off-Duty Planning Team

The Off-Duty Planning Team (ODPT) endeavours to adequately staff the Intensive Care Unit with the appropriate skill mix. As the team recognises that there has to be a balance between home/social life and work life, we believe we can achieve this through self-rostering. Self-rostering allows for equality and flexibility.

Since January 2007, the Unit has adapted the Manpower Software System (MAPS) - a computerised staff rostering system. This has eased the workload of the ODPT in creating and managing rotas for the Unit. It proved to be a very useful tool as it highlights the skill mix including the number of coordinators on a particular shift. It also gives quick access to monitoring sickness, annual leave and study leave allocations. The system also automatically calculates staff working hours so any shortfalls can be readily addressed on the current rota being created.

Currently all members of the ODPT are trained as rota creators.

The MAPS programme has recently been rolled out to include requests for temporary staff. The Unit's need to cover sickness or the Unit's clinical demand can be flagged up in the system and noted by the team that book the Unit's temporary staff. Short staffing in a certain shift can be promptly detected and covered accordingly by extra staff. In connection to this, the system can be a good auditing tool to use in monitoring the Unit's use of temporary staff. All coordinators have now been trained as rota updaters giving them access to make these necessary changes in advance, thus maintaining the safe number of staff per shift.

The rota updater training is being proposed to be included as one of the competencies in the coordinator's pack for Band 6 nurses in the Unit.

The ODPT is also updating the Annual Leave Policy. We aim to make the annual leave allocations between staff as fair as possible. After consolidating all staff comments and suggestions, we are hoping to trial this new policy towards the last quarter of 2008.

The roster is created a month in advance. An off-duty template is displayed for staff to put in their requests ahead of time. This is to allow staff some flexibility on their rota. Staff are reminded of their inter-team involvements (meetings) and the team and skill mix covers while drafting their requests. Negotiations between staff help us achieve flexibility in their working hours. The ODPT helps to make these negotiations between staff as fair as possible.

Rodney Fernandez
Senior Staff Nurse
Team D

Marketing group

This group aims to market the Intensive Care Unit both internally and externally. One way they have done this is to send nurses to conferences, both the British Association for Critical Care Nurses which two of our nurses attended and the Anaesthetic Conference in Val d'Isere, which nurses from Outreach attended. This helps to educate the staff and allows time for networking.

The Hospital has an open day once a year, for which the Unit has a stand which is run by staff. This year the Hospital was celebrating the 60th anniversary of the NHS. The stand had a mock-up of an ICU patient in a bed attached to a ventilator and a dialysis machine. Members of the team put together a quiz and we had 'Stick the Organ on the Body' for the children.

The group tries to raise money each year for a charity. This year some nurses took part in a 5km run in Battersea Park and raised £165 for 'Macmillan Cancer Support'. We also raised £150 for St Mungo's homeless shelter from our Christmas raffle.

The group also gets involved with the planning for the Charter Mark Award. A lot of organisation takes place to enter for this award as an outside assessor comes to the Unit to see how it is run.

Linking in with our Community Strategy to assist with our local neighbourhood, myself and another mother have both been helping on trips out, from our children's schools. These have been to diverse places such as 'The Wetland Centre', 'Bocketts Farm' and 'The Florence Nightingale Museum'. I also went and spoke to the Reception children (4-5 year olds) about my job as a nurse, in their Science Week.

Danielle Pinnock
Sister
Team H

Inter-team projects

Finance and supplies group

Like all of the inter-team projects, finance and supplies membership consists of a representative of each of the primary nursing teams and we are also joined by our healthcare assistant, our technician and the Unit administrator.

The finance and supplies group has a number of objectives which include:

- Identifying cost saving ideas for the Unit
- Raising awareness of the cost of items on the Unit
- Problem solving any supplies or delivery problems
- Trialling new products in a systematic way
- Involving staff of all grades in decision making related to finance and supplies in the Intensive Care Unit

Since our Trust has gained Foundation Trust status there has been an impetus for all staff to be more aware of financial matters and the Trust is looking at ways of producing cost savings without having a negative impact on patient care. Therefore much of the efforts of the finance and supplies group have been directed at trying to find cheaper alternatives to many of the routine supplies we use, whilst ensuring that all staff feel that the products are of comparable quality.

We have been looking at high usage items and trialling alternative products, so far we have changed the inline suction device we use which has resulted in a 50% cost saving on this item.

We are also in the process of arranging a trial of ECG electrodes (which are used to record electrical activity of the heart). We will trial this on the Unit and, if approved, this will reduce our spend on this item by between 40-60% depending on the product selected.

We are also looking at refuse disposal as members of the team have expressed concern that, frequently, sharps (items that can cut or puncture the skin such as needles) bins are used for the disposal of non-sharp items. This has an impact not only on finances, as sharps bins are costly to dispose of, it also has a negative impact on the environment.

We haven't only been focused on the cost of items this year; there have been times when we have run low on supplies. To help prevent this from happening again and to help us find out why we sometimes run low on supplies we have instigated a stock watch folder. All staff are asked to document what supplies we run low on or run out of and when this occurs. This means we can investigate the reason for supply deficits and amend stock levels if necessary.

Charlene Brown
Sister
Team I

Research group

As our Charter Mark was due for renewal this year the research group decided to use this as an opportunity to review the purpose, and role of the Chair of the research group along with the roles and responsibilities of individual members. The research group generated the following during a focus group.

The purpose of the research group was deemed as:

- A vehicle to highlight changes at a local and national level including National Institute of Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA)
- To use up to date evidence based literature to support best practice in the clinical area
- To discuss areas of practice that are pertinent at the time, for example infection control
- Introduction and maintenance of the 'Guidelines at a Glance' folders for use by the Unit and at each bed space.

The role of the Chair was defined as:

- Organising meetings, reviewing the action plans and providing feedback to the group
- Overseeing work that is being undertaken and evaluate it
- Linking with the clinical governance group who ratify the guidelines.

The role and responsibilities of individual members was visualised as:

- Attending meetings monthly and, if unable to attend, to send a representative
- Undertaking work allocated to them within a set time frame
- Providing feedback to the teams
- Actively contribute to meetings and give suggestions.

The research group meet monthly reviewing the action plan at one meeting and at the next meeting appraising guidelines that are ready to be sent to three critical readers for review before being sent to the clinical governance group for ratification.

The past year has produced many new nursing care guidelines, such as Sleep, Care of Central Venous Catheters, and Inotropic Drug Administration and more are awaiting review and ratification, such as LIDCO, Renal Replacement Therapy, Enteral Feeding, Sedation and Vapotherm. This reflects the work consistently generated by the research group. The research group also monitors guidelines that are due to be reviewed sending these to two critical readers prior to going to the ICU Clinical Governance group.

Finally, formal research continues from both the medical and nursing staff which all feeds back into the research group. Over the past year the research group has been able to step back and assess what it is trying to achieve and define the purpose of the group. This has allowed the group to refresh itself and enhance the cohesiveness and productivity of the group.

Ann Sorrie
Sister
Team H

Inter-team projects

Nursing Diagnosis and Electronic Patient Record (EPR) Group

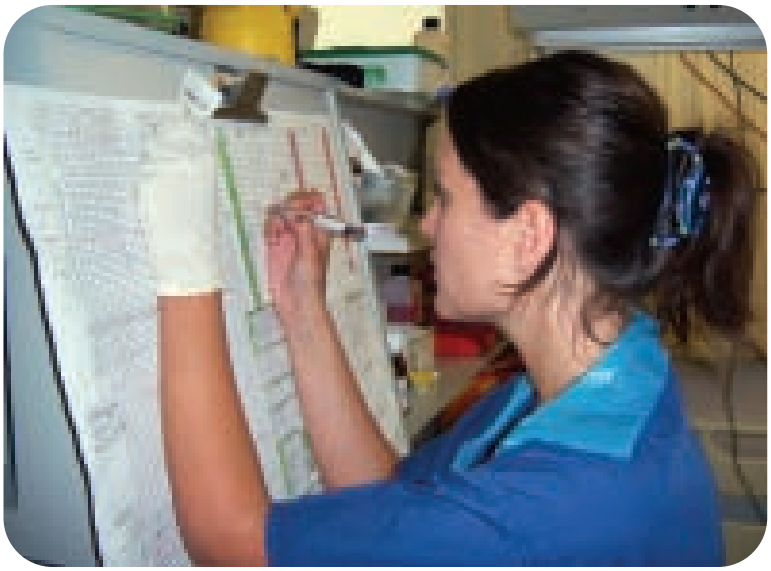
The overall purpose of the group is to maintain and improve all aspects of care planning and nursing documentation, including hand written documents and those recorded on the Electronic Patient Record (EPR).

The results of this year's annual documentation audit show improvements in a number of areas, particularly in completion and updating of initial patient assessments.

However, it was observed that few care plans included a specific nursing diagnosis to identify the needs of the patient's family. This seemed at odds with the Unit's philosophy which states that the care of the patient's family/friends is of particular importance. The audit showed that there were references to interactions (and information given) to the patient's family, but this was most frequently included in communication notes rather than the care plan itself.

As a result of these findings, one of our project group members, Senior Staff Nurse Angelo Batoon, agreed to lead a project to improve documentation of family care/needs.

He began by holding a meeting with a large group of nursing staff. He explained the problem and the importance of this issue. During the discussions which followed, staff indicated a number of barriers which they found affected them including:



- Lack of time for documentation during busy periods, as staff feel direct patient care takes priority over documentation
- Inadequate numbers of computer terminals to access EPR
- Difficulty in identifying appropriate nursing diagnosis

The group felt that the last of these barriers was the most relevant at present. It was agreed that they needed to improve their knowledge of a variety of nursing diagnoses and interventions which could be applicable to the psycho-social needs of patients' families.

As a result, Angelo has begun to provide some teaching sessions to increase understanding of different nursing diagnoses which will enable family care to be incorporated within the main body of our care plans.

During the next 12 months, the group intend to review the most recent Trust guidelines for record keeping and to further improve access to EPR via the bedside monitoring system.

Caroline Younger
Sister
Team B

Performance

In this section we outline the performance of the ICU; it covers activity and information, finance, human resource management, infection control, clinical incidents, critical care transfers and the Charter Mark application.

Activity and performance

Chelsea and Westminster Intensive Care and Nursing Development Unit has a capacity of 10 critical care beds and accommodates a combination of level 2 (high dependency) and level 3 (intensive) admissions. The Unit also manages two level 3 beds on the Burns Unit.

Level 3 and level 2 activity have continued to decrease in comparison to previous years (see table 1). This decrease is not exclusive to Chelsea and Westminster. The North West London Critical Care Network has identified a similar decrease in other units. Factors affecting this decrease may include major surgical procedures being performed at other hospitals, such as the transfer of vascular surgery to St Mary's and the intervention of the Critical Care Outreach Team working with other members of the MDT to identify and treat deteriorating patients.

Level 1 activity has seen the most dramatic decrease. Level 1 admissions are down 19% from the previous year. This is reflective of the hospital's slight increase in level 1 capacity and the introduction of the Acute Medical Unit.

Table 1 General ICU/HCU

	05-06	06-07	07-08
Finished Consultant Episodes (FCE)			
Level 3	196	169	157
Level 2	200	296	266
Level 1	–	(103)	(39)
Occupancy			
Level 3	96%	72%	73%
Level 2	108%	178%	158%
Admission			
Elective	59	85	95
Emergency	337	380	328

The objective of decreasing delayed discharges from ICU has remained a key issue throughout 2007-08. Recommendations have changed from six to four hours from the time of decision to discharge to actual discharge. 53% of discharges fell within this timeframe. Delayed discharges falling in the category of > 24 hours has increased by 5%. This was predominately due to no spare beds on the wards. We have put strategies in place, such as relaying discharge information to the bed managers every morning, to help improve the patient's hospital journey.

Emergency cases accounted for 78% of our total admissions, down from 82% the previous year. Our elective admissions have increased by 5%. This is due to the increase of bariatric surgery and it is expected to increase again next year as the Trust was selected as the regional bariatric centre in April 2008.

Performance

The burns ICU service (Table 2) had a combined occupancy of 33% for 2007-08. This is down from 41% for 2006-07. Refused admissions remain high due mainly to referrals being made when beds are occupied.

The Unit will continue to develop strategies in line with the Trust's objectives for the following year. Our objectives for next year include the ongoing project of decreasing delayed discharges and improving patient experience, improving discharge reporting for coding to reflect income and feedback performance to Clinical Governance for review.

Jason Tatlock
Information Officer
and
Clinical Auditor

Table 2 Burns ICU

	05-06	06-07	07-08
Finished Consultant Episodes (FCE) Level 3	28	20	26
Combined Occupancy Level 3	50%	41%	33%
Refused Admissions Level 3	20	15	20

Finance

The Unit has a trust fund, and at the end of 2007/2008 we had a surplus of £2,225. Almost all the income is from donations and we are extremely grateful for everyone's generosity.

We spend the money based on suggestions from staff, patients and relatives. This year we have:

- Redecorated the staff coffee room
- Funded the Unit's annual report
- Funded the successful re-application for Charter Mark.

Rebecca Hill
Acting Clinical Nurse Lead
Team D

Human resources

In 2007 the Unit had funding for 65.8 whole time equivalent posts. We had 10 staff left the Unit and 11 new staff joined the Unit from January 2006 to January 2007.

The main reasons given for leaving this year are:

- Husband relocated abroad.....20%
- Moving out of London 10%
- Moving abroad 50%
- Reduce travelling time.....20%

The Unit supports flexible working and 25.8% (17/65.8) work part-time or job share. The main reasons are child care or study leave. One member of staff has taken five months unpaid leave to complete her studies abroad, and another three months unpaid leave to fulfil a personal challenge of mountain climbing in the Alps.

Rebecca Hill
Acting Clinical Nurse Lead
Team D

Fig 1.1 Leavers and joiners in 2007/08

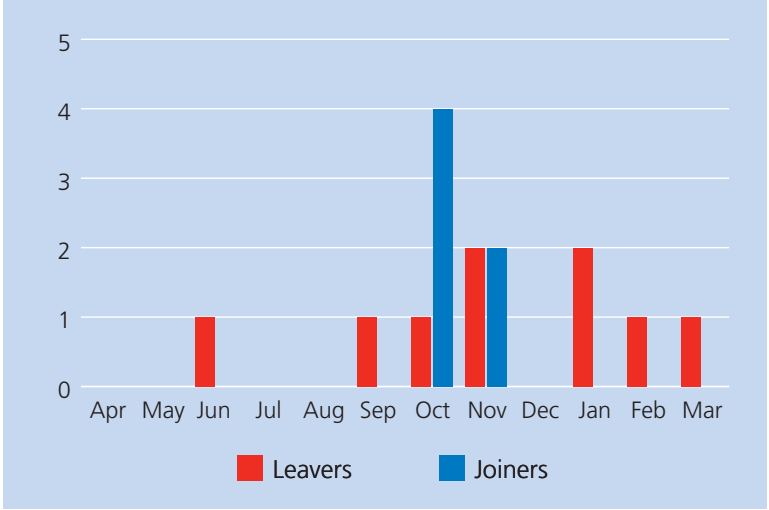
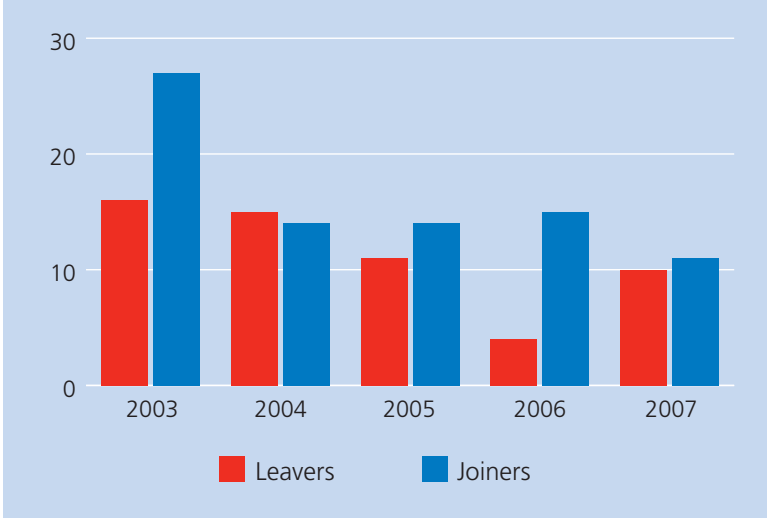


Fig 1.2 Leavers and joiners from 2003



Performance

Infection prevention and control

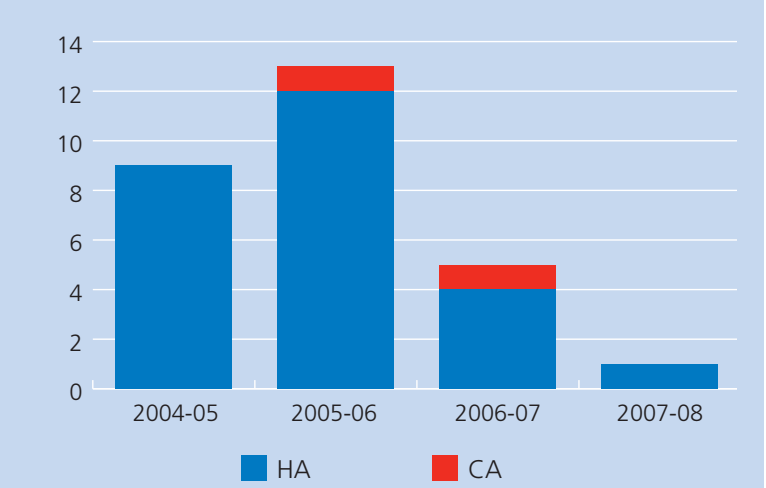
The Intensive Care Unit continues to see major changes with regards to infection prevention and control. There are now three members of staff who have completed the Infection Control Link Professional (ICLP) course. The Trust has implemented 'Saving Lives', with one of the ICLPs having a six-month secondment as the project nurse for implementing the policy.

The ICLPs continue to be responsible for monitoring hand hygiene and line care. Overall there is an improvement in compliance in both areas. A particular area of focus for the last year has been on-line care, with the ICU writing and publishing a guideline within the Trust for Trustwide use on the 'on going care of central venous catheters'. The Unit has seen a 75% reduction in hospital acquired MRSA bacteremias during the past three years.

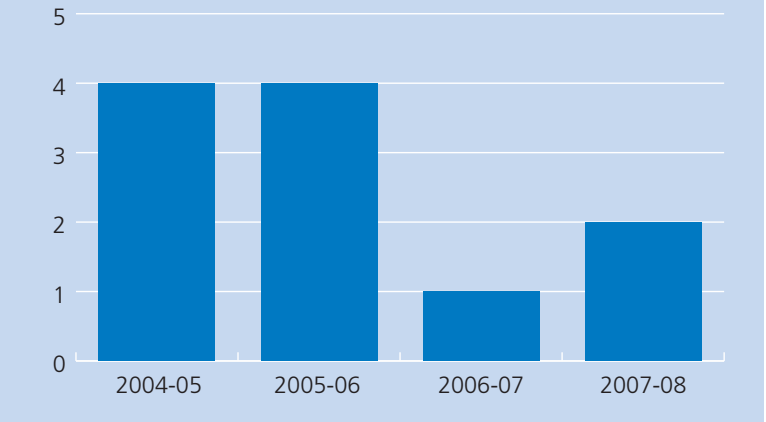
Clostridium difficile also continues to see low rates within the ICU environment. There was a rise from 2006-2007 to 2007-2008 but in patient terms this was relatively low.

Emma Long
Staff Development Sister

MRSA Bacteraemia ICU 2004-2008



Hospital Acquired Clostridium difficile in the over 65s on ICU/HDU 2004-2008

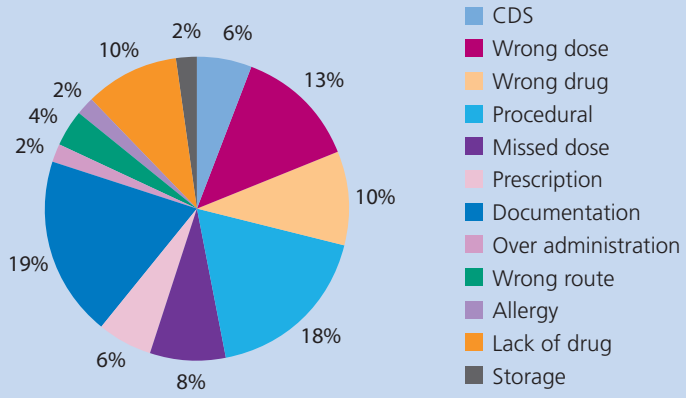


Clinical incidents

Clinical incident reporting is an important method of identifying areas of risk on the Unit. There were a total of 136 clinical incidents in 2007, compared to 173 in 2006. All incidents are investigated by the Clinical Nurse Lead and reported to the Trust Risk Management team.

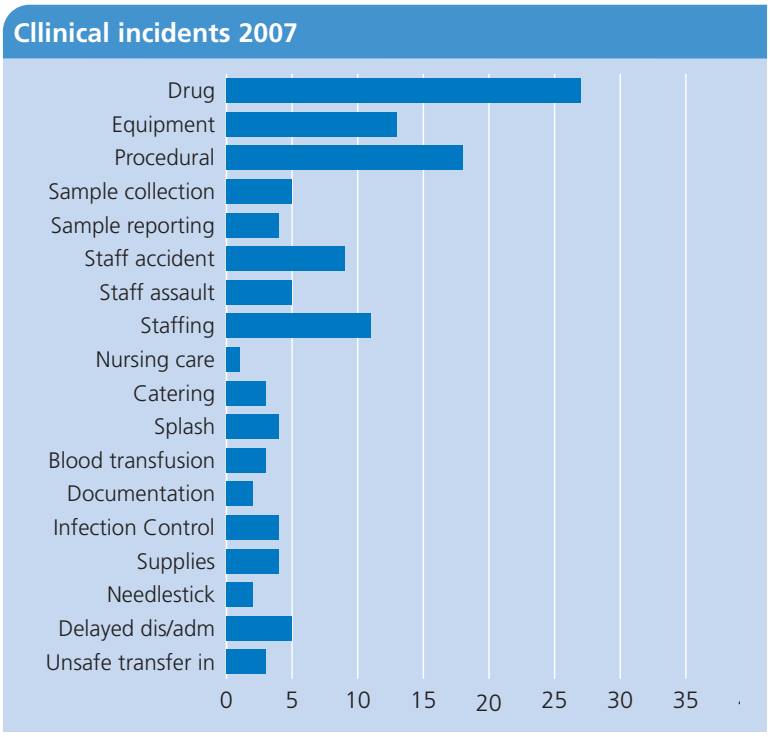
The Unit also runs quarterly Incident Review meetings, which staff are encouraged to attend. From these meetings, action plans are developed to try and prevent these incidents from happening in the future. Staff members say they find these meeting helpful and informative.

Drug incidents 2007



Clinical incidents fall into a number of categories. This method of recording makes common themes easier to identify and thus monitor improvements or otherwise, and address issues in a timely manner.

Cllinical incidents 2007



Drug incidents have been mainly the result of the incorrect rate of infusion, a discrepancy of what is recorded versus what is actually running and failure to double sign drugs given on the drug chart. We have addressed this by strategies we have put in place:

- A quarterly drug quiz where questions reflect the themes emerging from drug incidents
- Implementing and reinforcing infusion checks - they are part of the shift by shift bedside safety checks with the changeover shift nurse
- All incidents are reported and discussed with the Unit Pharmacist, Clinical Nurse Lead and the individual(s) concerned
- An updated drug chart has been developed to provide a clearer space to record the

transfusion of blood products

- Incorrect storage of drugs has been addressed by moving some intravenous drugs to locked cupboards, ordering a new lockable fridge, and reinforcing the need for the drug keys to be carried by a member of staff at all times

Blood specimen collection has improved slightly. We have achieved this by liaising with the specimen porters and developing procedures within the Unit to reduce the need to bleep the porters, and still ensure prompt delivery of samples to the lab. For example, checking with the medical staff that specimens could wait for routine collection, and encouraging staff to coordinate sample taking with each other.

Blood transfusion incidents are reported as mainly a result of poor documentation. The system for tracing blood products changed in the Trust, and to help with the smooth transition the Transfusion Practitioner has spent time on the Unit to help familiarise all staff with the new documentation and procedures and provided regular 'refresher' teaching sessions.

Procedural incidents referred mainly to bed spaces being incorrectly set up to receive a patient, or safety alarms not being set correctly. There are specific guidelines to address this and we have developed a 'guidelines at a glance' folder placed between each bed space on the Unit.

Rebecca Hill
Acting Clinical Nurse Lead
Team D

Critical Care Transfers

On rare occasions patients requiring intensive care need to be transferred to different hospitals. This can be the result of the unavailability of beds in their local hospital or for them to receive specialist clinical treatment. The movement of critically ill patients is something that is avoided whenever possible and the staff at Chelsea and Westminster Hospital endeavour to only move patients if it is for a clinical reason.

In order to make these moves safer the North West London Critical Care Network (NWLCCN) devised a critical care transfer form and its purpose is threefold:

- Provide legal documentation of a patient's condition during transfer
- Capture numbers of clinical and non-clinical transfers originating within North West London
- Enable extraction of clinical governance data eg clinical incidents, level of training of staff, transfer delays

In 2007/8 there were 14 patients transferred from Chelsea and Westminster Hospital to other local hospitals. Of these 14 patients, only one was transferred due to a lack of Intensive Care beds, the others were transferred for clinical treatment reasons. During these transfers no clinical incidents were highlighted.

Elaine Manderson
Clinical Nurse Specialist

Charter Mark number four

In 1998 the Intensive Care Unit was awarded a Charter Mark - a national award for excellence given by the government to public sector or voluntary organisations - and it has now been renewed three times in 2001, 2004 and 2007. It is a standard of excellent customer service.

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

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

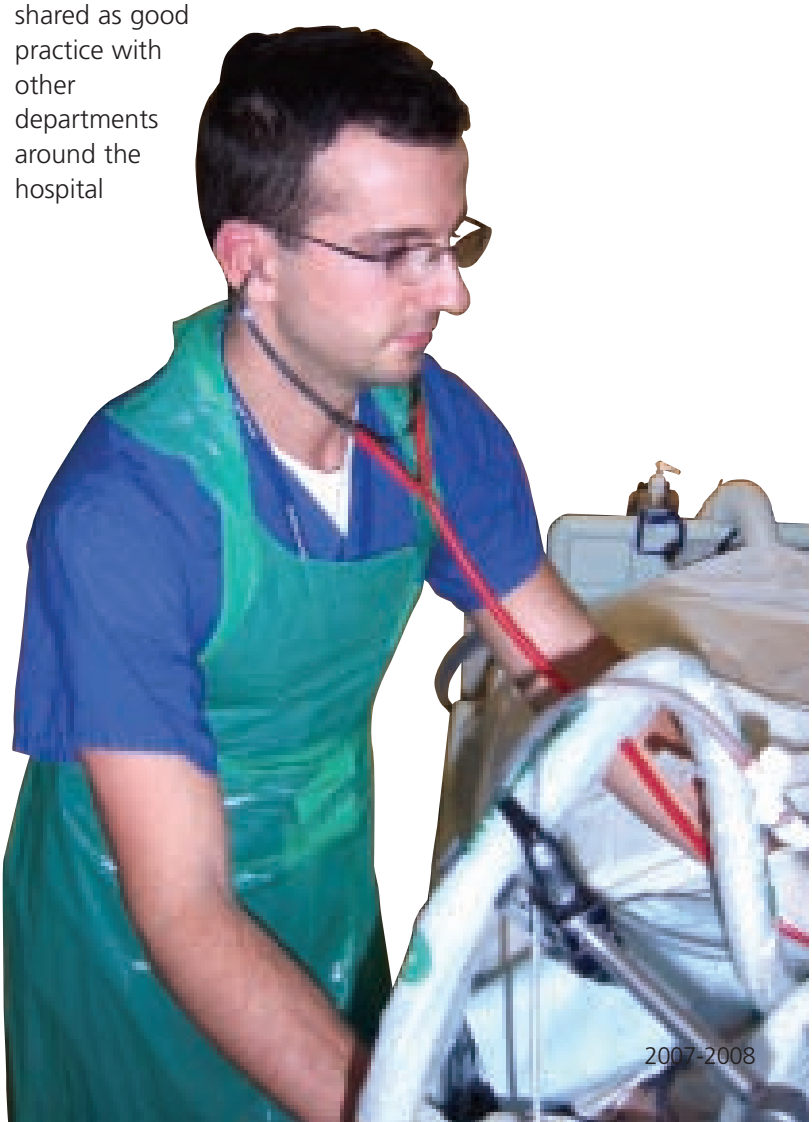
The emphasis of the Charter Mark is very much evidence of continuous service improvement, focused around the needs of patients and their families. We are proud to have had Charter Mark status since 1998 which means that our staff members have demonstrated that we have continually improved the service that we provide to our patients over that time.

The application for the renewal of the Charter Mark included a pre-assessment visit, the development of a wide ranging portfolio of evidence and the assessment visit itself in November 2007. The Charter Mark assessor was particularly impressed by the following areas:

- New ICU section of the Trust website www.chelwest.nhs.uk
- Orientation programme for new and temporary staff which has been shared as good practice with other departments around the hospital
- Use of volunteers on ICU including a volunteer who runs user satisfaction surveys

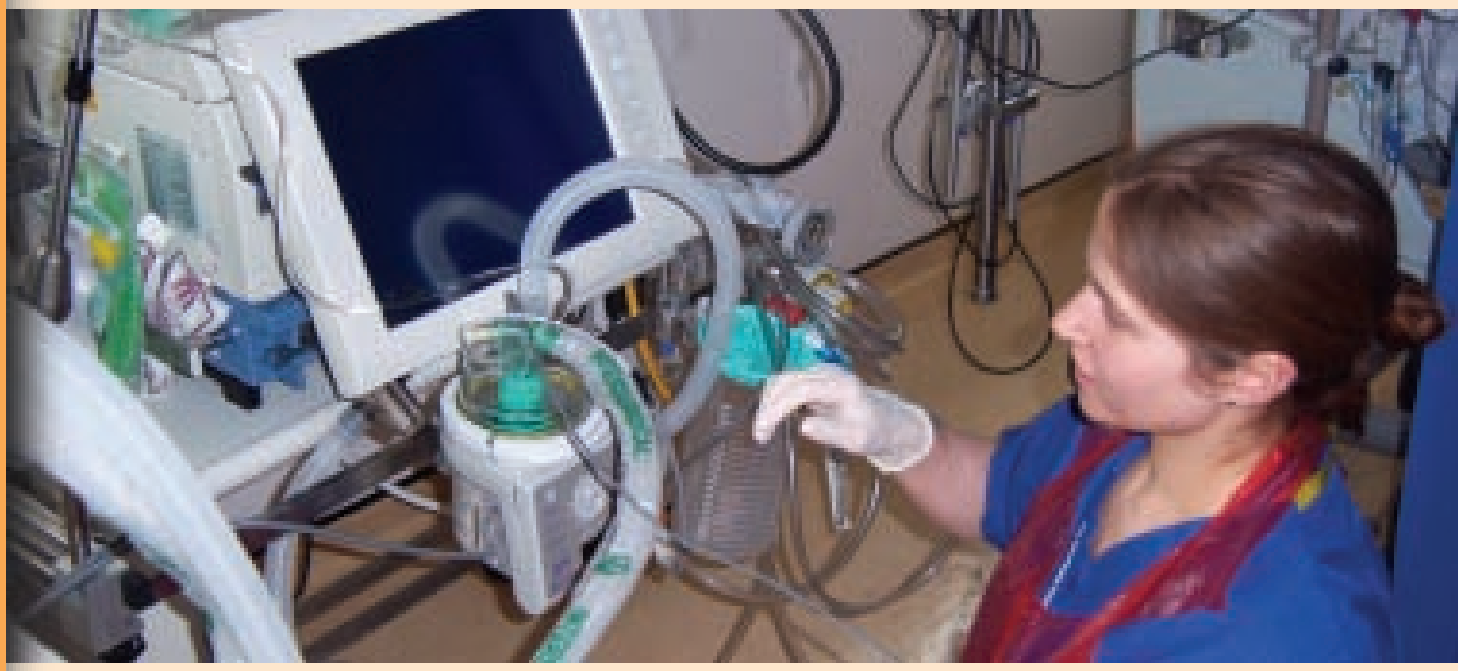
One of the advantages of undertaking the Charter Mark assessment is that we gain feedback regarding our present performance but it also gives us suggestions on how to improve our service, which is fed into our business plan on an annual basis.

Elaine Manderson
Clinical Nurse Specialist



Research

Transfer study



In October 2006 I recommenced my MSc studies in advanced nursing practice, having completed my intensive care course as a post graduate diploma. I am currently awaiting ethical approval for my research project.

My research project will be a prospective case note review on intra-hospital transfers. The title of the project is: 'Identifying critical incidents during intra-hospital transfers of the critically ill patient'. The transfer of critically ill patients within hospitals is common. This is due to advances in technology with diagnostic and therapeutic interventions.

There is a paucity of specific training for clinicians in transferring critically ill patients. Knowledge and skills are taken for granted on the assumption that these must be present for the clinician to perform their day-to-day duties, however increasing data shows that these assumptions are incorrect. While many clinicians assisting with transfers will possess the necessary skills that are required, they may never have been required to apply these skills outside of their familiar and controlled environment. Their knowledge of physiology, equipment and logistical aspects (eg oxygen required or route taken) is frequently inadequate.

Common themes that emerge from the literature are stabilisation of patients before transfer, ensuring adequate equipment is present and education to minimise these adverse incidents during intra-hospital transfers. My project involves collecting data from transfer forms and patient observations charts, analysing the data and then developing an education programme based on data to aid nurses in transferring these patients.

So far I have found the project challenging, I have learnt a great deal about ethical approval of research studies and a new respect for those who publish their work.

Emma Long
Staff Development Sister

Teamwork in Intensive Care Units

Intensive Care Units (ICUs) have been reported as complex areas with high levels of instability. In that context, teamwork is considered as a major component of safe, holistic and effective care.

Research has revealed that teamwork can potentially offer beneficial outcomes for patients in the form of reduced complications, re-admissions, length of stay and mortality rates; for staff by improving job satisfaction and wellbeing; and for healthcare organisations in the form of reduced costs and improved recruitment and retention of staff.

However, within ICUs research has mostly focused on doctor-nurse interaction rather than on the inter-disciplinary team, with less research conducted in the UK's healthcare context. Moreover, knowledge regarding the functioning of teams in ICUs remains minimal.

This research study will endeavour to address these issues. The findings from this study are expected to advance our understanding of inter-disciplinary teamwork within the ICU's complex setting, inform the development of realistic suggestions for facilitating team practices, and extend teamwork theory.

I am interested in observing everyday interactions between different professional staff, of different seniority and ethnic backgrounds, men and women, full-time and part-time. My aim is to understand the social processes that constitute effective teamwork and appreciate the diversity of views regarding inter-disciplinary work.

The information provided will help improve our understanding of how teamwork is achieved in ICUs which may fuel recommendations to practice and policy level for enhancing team performance and ultimately improving the quality of patient services and professionals' working experience and wellbeing.

The findings from the study will be reported in the form of a thesis that forms part of the award of PhD Nursing, King's College London. Finally, findings from the study will be published in a health-related journal.

Andreas Xyrichis
PhD Nursing Student,
Kings College, London

Developments

This section details developments in the service provided by the Intensive Care team and also individual staff development all of which is aimed at improving our patients' experience and care.

The Staff Development Role

The staff development role continues to be a rotational one between the Band 7 nurses (sisters/charge nurses) on the Unit. In October 2007 I took over as the programme co-ordinator from Danielle Pinnock and Ann Sorrie.

The Foundation of Critical Care Course is accredited 20 credit points at level 6 from the Thames Valley University London. The course aims to provide structured learning experience for nurses who are in a transition period from the ward environment to an intensive care environment. It also provides a focus for continuing professional and personal development.

The role involves 40% clinical time working with the nurses on the course to develop and teach at the bedside, 40% management time which is used for marking and organising the six study days, and 20% clinical time.

At the time of writing this, the January 2008 cohort has completed the course and a second course was prepared for September 2008. I have found the course very enjoyable. The time has allowed me not only to be involved in the development of nurses in the intensive care environment, but also aided my own development in running a course and getting involved in the Trust at a wider level eg intravenous therapy and Band 5 development.

I am currently preparing for re-accreditation of the Foundation of Critical Care course, which I hope will give me greater insight into the structure and organisation of a course linked to a university.

Emma Long
Staff Development Sister

End of Life Pathway

The end of life (EOL) strategy launched by the Department of Health outlines how patients should be cared for to ensure they experience a 'good death' (DH 2008).

This strategy has reinforced the work done in the last year on the adapted Liverpool Care Pathway (LCP) used on our Intensive Care Unit. The LCP was first developed for use with cancer patients but has now been successfully modified for use for people with other conditions and has been adapted for use in the intensive care environment.

Identifying patients who are at the end of life can be difficult in the complex field of Intensive Care because patients often have multiple problems and are unconscious due to sedation or their illness. Thus many decisions are done on their behalf in consultation with family and healthcare staff based on the best interests of the patient. However, once a decision has been made that a patient will no longer survive it remains vital that the patient and loved ones experience a 'good death'.

Having attended a North West London network meeting last year on end of life, the original pathway we have been using was updated and expanded to incorporate ideas used on the Intensive Care Unit at the Royal Marsden Hospital. The LCP will become a booklet incorporating many of the themes highlighted in the EOL strategy such as:

- Once a person has been identified as approaching end of life a care plan in the form of the adapted LCP will be introduced, assessing the needs and preferences of patients and reviewing and documenting these regularly
- Delivering a high quality of care to our dying patients and managing their last hours or days in a sensitive, peaceful, comfortable and dignified manner
- Supporting the family and loved ones during the patient's illness and after their death

The strategy also advocates the need for healthcare staff at all levels to have the necessary knowledge, skills and attitudes related to care for the dying in order to promote the success of improving end of life care. For this to happen, end of life care will need to be embedded in training and education 'at all levels and for all staff groups' (DH 2008). This will be the challenge facing us for the forthcoming year in order to continue our work in relation to good end of life care.

Ann Sorrie
Sister
Team H

Developments

Working with the Cancer and Palliative Care Team

As previously reported, the Unit has been working towards implementing the Liverpool Care Pathway for patients who are dying. The pathway is now being used on a regular basis within ICU with an average of two deaths occurring on the pathway each month. This is a great achievement as nationally ICUs have struggled to imple-ment and use the pathway.

The Trust's death and dying with dignity group has included a member of the ICU nursing team who has contributed to the review of both policy and practice around death and end of life care.

The cancer and palliative care team continue to offer regular teaching sessions on topics from lymphoma in HIV to the ethics of withdrawal of treatment. Both teams continue to be accessible for advice and support on an individual patient basis.

Catherine Gillespie
Lead Nurse - Cancer and Palliative Care Team

Pre-operative visiting

Following surgery, some patients will be admitted to the Intensive Care Unit or High Dependency Unit, either due to the complex nature of the surgery or because the patient has other significant health problems that require close monitoring post-operatively. Given that patients have expressed multiple anxieties about their admission to hospital, particularly for major surgery, the quality assurance group felt that the re-introduction of pre-operative visiting for patients undergoing planned elective procedures would be a useful project to undertake.

Individual responses to stress are unique to the individual but common symptoms of anxiety are sleep disturbance, poor appetite and poor concentration. Patients have also expressed worry about post-operative pain and nausea.

The general consensus is that the purpose of pre-operative visiting is to assess and inform. The expected benefits are the patient feeling less anxious about the admission, having a more agreeable than expected experience and having a more rapid recovery and discharge.

The information given by the Intensive Care Nurse can be a valuable contribution. The quality of the information is crucial, avoiding jargon, and not be drawn into giving information outside the nursing responsibility, for example information on the proposed surgery. There is a rolling teaching programme that all staff that have to carry out visits have to attend.

The nurse giving the information should be experienced in the after care expected in the intensive care unit.

Patients may well have already received a great deal of information from other hospital staff, and because there is documented evidence suggesting that verbal information be supplemented with written information, we have produced a comprehensive handbook that focuses on all aspects of the admission, with reference to the machinery used, expected routine course of events, nursing and medical staff, and facilities for visitors.

We hope to start pre-operative visits in the near future and are looking forward to the positive contribution we hope to make for the patient and their family.

Rebecca Hill
Acting Clinical Nurse Lead
Team D

The Role of the Critical Care Technologist

Although I have worked as a Critical Care Technologist (CCT) for 21 years, firstly at the Westminster Hospital and since its inception Chelsea and Westminster Hospital, it is only in the last year that this term has been recognised with professional registration and the establishment of a representative body, the Society of Critical Care Technologists. Additionally, a new degree course is available in Clinical Physiology which will be the basis for our future training.

A CCT can be defined as an expert manager of medical systems in the acute setting such as physiological monitors, ventilators, renal and liver dialysers as well as analytical and diagnostic devices. Frequently the CCT is a lone practitioner and must demonstrate good organisational skills, acting autonomously, but sometimes working with technologists in subsidiary departments such as Clinical Engineering. CCTs are also involved with infection control, supplies and procurement and research and development.

Risk management is also an issue for a CCT and my belief is that attention to detail and maximizing one's professional competence are the means through which risk reduction can be evolved naturally. A challenge for this year has been the determination of the point-of-care testing policy across our Trust to employ superior instrumentation, to ensure innovation.

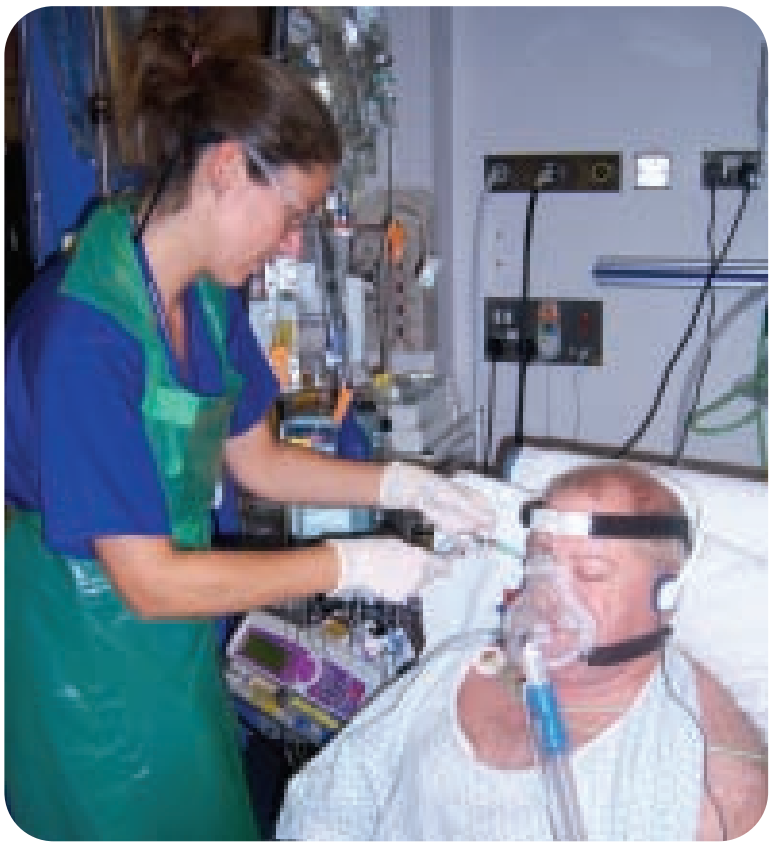
CCTs represent the leading edge deployment of medical technical personnel. I intend to use this pre-eminence to promote excellence in medical technology across our Trust in ways that are inventive and perhaps even radical.

Mark Costello
Chief Critical Care Technologist

Developments

Saving Lives - Project Nurse

I joined the Infection Control Team in February 2008 for a six-month secondment to implement "Saving Lives: reducing infection, delivering clean and safe care" (2007), the Department of Health strategy for reducing healthcare associated infections. I have always had a keen interest in infection control and enjoyed being an infection control link professional within the critical care setting. I had worked on the ICU for the past four years so this was a huge developmental opportunity for me both professionally and personally.



Initially I found it all rather daunting as I was not used to working at corporate level and I was certainly outside my comfort zone. Project management is a complex business but through being an integral part of implementing the Saving Lives initiative I have been able to see first hand how an acute hospital functions. It still amazes me how all the different departments, teams and specialist individuals all somehow work together to deliver a high standard of service.

Designing, implementing and embedding changes in practice on such a large scale has been challenging and at times overwhelming. The focus was on Central Venous Catheters and Peripheral Intravenous Cannulas to reduce the associated infections with these invasive devices. Being responsible for staff awareness and education, writing and implementing policies, conducting Trustwide audits, organising pilots and devising new forms kept me busy! I survived and have learned a great deal about the complexities of working at an organisational level not just at a departmental level. A bonus has been my computer skills have dramatically improved and I have made some new friends along the way (in departments I never knew existed)!

I hope that I will be able to put into practice some of what I have learnt on my return to ICU. Overall I found the secondment to be an invaluable experience.

Sharon Wyatt
Senior Staff Nurse
Team I

North West London Critical Care Network (NWLCCN)

The Intensive Care Unit is a member of the North West London Critical Care Network (NWLCCN). The NWLCCN was formed in 2001; the aim of the Network is to support the delivery of good practice and service innovation throughout North West London.

Work undertaken on the Unit in conjunction with the Network during the past year has included:

- **Transfer study days**

  These days are aimed at training experienced staff who undertake ICU patient transfers in hospital (eg to CT scan) or between hospitals. The aim is to minimise the risks for the patient.

- **Essence of care benchmarking**

  The nurses' group has provided the opportunity for units to contrast and share information and progress made with the national essence of care benchmarks. This work has led to the development of network guidelines to inform 'best practice' throughout hospitals in the NWLCCN.

- **Development of network-wide nursing practice guidelines**

  These guidelines were developed collaboratively between a number of organisations within the Network to ensure the delivery of consistent evidence based care throughout units in the Network. Guidelines developed this year include bowel management system and neurological management.

The nurses' group continues to meet regularly to update individuals with ongoing or completed work.

Elaine Manderson
Clinical Nurse Specialist

Tissue Viability Link Nurse in Intensive Care

As part of my role as a Senior Staff Nurse in intensive care I act as the Tissue Viability Link Nurse which means being a resource and adviser for the care and management of patients with wounds. I also act as a liaison between the nurses on the ICU and the Tissue Viability Specialist Nurse. My main goal is to ensure that we all provide standardised, up-to-date, evidence-based wound care.

I also aim to reduce the amount of waste we produce by using wound dressings properly.

I try to identify areas where more awareness or training is needed so I can organise relevant teaching and support, which could be done by product representatives who have valuable research information to share with us.

I had the opportunity to take a short tissue viability course at Thames Valley University last year where I learned more about complicated wound care from experts in the field. To develop my own knowledge I try to involve wound care in other courses I undertake.

Feriel Mahiout
Senior Staff Nurse
Team F

Developments

Staff Development and Education

Over the past year a number of Unit staff have continued with their professional development by undertaking further study. The Unit supports a number of courses that staff may undertake. These are outlined in Table 1 below:

Table 1

Courses	Details	Number of staff
Foundations of Critical Care	Six-month course which aims to provide a structured learning experience that enables nurses new to the intensive care environment to develop the knowledge and skills necessary to safely and competently care for critically ill patients	5
CPPD - intensive care	Six-month course run by Thames Valley University which builds upon the development of knowledge and skills from the Foundations of Critical Care	5
CPPD - mentorship	Three-month course that prepares staff members for the role of coaching and supporting staff in the clinical environment	6

As a result of the continued input into staff development a brief outline of the educational profile of staff members is outlined in Table 2. All staff who join the Unit undertake the Foundations of Critical Care Course and we ensure that all staff have access to specialist ICU training and can demonstrate, in practice, their competence through assessment.

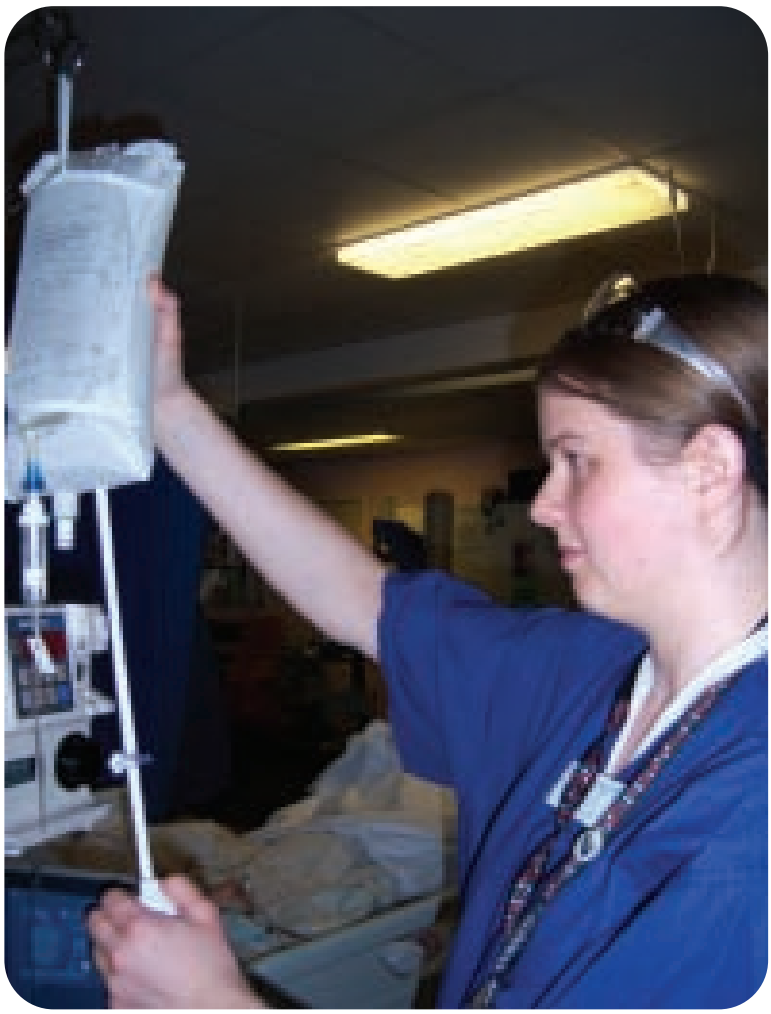
Table 2

	Number of staff	Percentage of staff
Staff with a diploma in nursing	19	30%
Staff with a degree in nursing	20	32%
Staff with a Masters degree or post-grad qualification in nursing	5	8%
Staff studying for a masters or post grade qualification in nursing	4	6%
Staff with a completed critical care course	55	87%
Staff studying for a critical care course (Foundations in Critical Care and CPPD - Intensive Care)	8	12%
Staff with a mentor course	42	66%

Pre-registration students from Thames Valley University continue to be welcomed to the Unit for placements. Over the past year we have seen 31 pre-registration nurses and midwives spend between one and eight weeks on placement here. Ward staff who are undertaking the 'Introduction to Critical Care' course at Thames Valley University also join the ICU team for short placements to give them an insight into work on the ICU.

The development of staff is of paramount importance to the Unit and is made explicit through the Unit's philosophy. It is hoped that through the continued development of our staff we will be able to deliver effective, patient-centred care.

Elaine Manderson
Clinical Nurse Specialist



Staff – April 2008

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Consultant Anaesthetist
Consultant Intensivist
Director of ICU

Dr Rick Keays
Consultant Anaesthetist
Consultant Intensivist
Clinical Director for Burns

Dr Berge Azadian
Consultant Microbiologist

Dr Nicolas Fauvel
Consultant Anaesthetist
Consultant Intensivist

Dr Suveer Singh
Consultant Intensivist
Respiratory Physician

Dr Michelle Hayes
Consultant Anaesthetist
Consultant Intensivist

Dr Jonathan Handy
Consultant Anaesthetist
Consultant Intensivist

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Martina Sauer
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Amanda Joyce
Imelda San Miguel
Basanio Reyes
Enrico Esguerra

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Fernando Fegardio
Frances Douds
Neil Anderson

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Sue Kampinij
Rodney Fernandez
Leila Hail
Christopher Bray
Daisy Maralit

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Clinical Nurse Specialist

Jane-Marie Hamill
Clinical Nurse Lead

Jason Tatlock
Admin/Information Officer

Mark Costello
Chief Technician

Emma Long
Staff Development Sister

Blanche Takwi
Healthcare Assistant

Caroline Heslop
Volunteer

Claudia Thompson
Volunteer

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Lead Pharmacist, Anaesthetist and Intensivist

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Cath Englebretsen
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Magdalena Johnstone
Housekeeper

Mavis Kyeremeteng
Housekeeper

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Director of Nursing and the Trust's **Nursing and Quality Directorate**

Kate Hall
General Manager, Surgery, Anaesthetics & Imaging

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