Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Intensive Care and Nursing Development Unit

Annual Report 2008-2009

Contents

Introduction

It always amazes me how quickly time flies by and yet another year has passed. The first annual report was produced in 1992 and now 17 years later we are still producing an annual report which reflects the work which is undertaken in the unit by the staff. The font and graphics of that first annual report may have changed to a more glossy and coloured version in 2009, but the principles, values and projects are still as apt now as they were then.

One of the many challenges for staff working in intensive care, where technology and complexity of cases is part of everyday life, is ensuring that the humanistic caring skills are as equally important as the technical skills. The focus as always needs to be on the patient and constantly improving the quality of care that is delivered to them.

In this year's annual report, we have outlined how we try to improve the quality of care we deliver to patients and their loved ones in a number of ways.

Through the quality group, we review what relatives think of the unit and act on their comments, we hold focus groups to learn from the patient experience and recently we have introduced patient diaries.

We also improve the quality of the care we deliver by ensuring that our staff are knowledgeable, questioning practitioners through a focus on education and training as outlined in this report. We respect the individual development needs of our staff by allowing them to have flexible working patterns in order to carry out a particular project, or experience different cultures or settings. Some of the staff stories are highlighted in the report.

In the performance section we have outlined our activity, financial targets and issues related to recruitment and retention of staff. These aspects of the service can be challenging and it is important that we work creatively together to address them.

We are a team on the unit and this year's annual report is a celebration of the collaboration of the ICU team including Magdalena Rigi and Mavis Kyeremeteng (housekeepers), Mark Costello (chief technician), Jason Tatlock (information officer), Blanche Takwi (support worker), Dr Berge Azadian and the infection control team, the critical care outreach team, Noël Geaney from purchasing, Chris Chung from Pharmacy, our two lovely volunteers Caroline and Claudia, Emer Delaney and the dieticians and the allied health professions, as well as the medical and nursing teams too numerous to mention.

Thank you.

Jane Marie Hamill
Clinical Nurse Lead ICU/NDU

Foreword

Intensive Care is known under various guises. In the States it is Critical Care, in Europe it has been described as Reanimation, but in the UK there has always been confusion between ITU (intensive therapy) and ICU (intensive care) and the only consistency is the word unit.

What is in a name? My personal view was not much. Certainly in 1985 when I started working in the unit I had little or no interest in what it was called, as long as it did what was needed. It was then a small room where the ventilators and volumetric pumps were kept. It predated most of the current monitoring, including at one end of the spectrum 'ITU friendly' dialysis machines and at the other end syringe drivers. Monitoring was basic, pulse oximetry was barely on the horizon and even arterial monitoring was brought in and set up by a special 'clinical measurement' service on an on-call basis. Nevertheless, it was where any 'intensive' therapy was carried out. Patients were sent to ITU; ITU did not go to the patient. It worked.

So what has changed? It is bigger, better equipped with state-of-the-art ventilators, monitoring and dialysis. It has all the basic equipment and a reasonable amount of sophisticated gadgetry. We do not, comprehensively, have all the very latest gear but we do have most of the latest gear that is likely to stand the test of time.

We now have more beds, more patients and even a satellite unit for burns. We have the capability to assist in the wards in the form of an outreach team and we regularly consult outside of the unit walls. We have far more multi-disciplinary activity with clear recognition of the expertise available from physiotherapy, dietetics, pharmacy, and speech therapy to name just a few.

The unit's position in the hospital structure has also changed. No longer an isolated room with mainly surgical patients that is somewhat peripheral to the workings of the hospital, the unit has a far more central role across most specialities and staff regularly go to the patient.

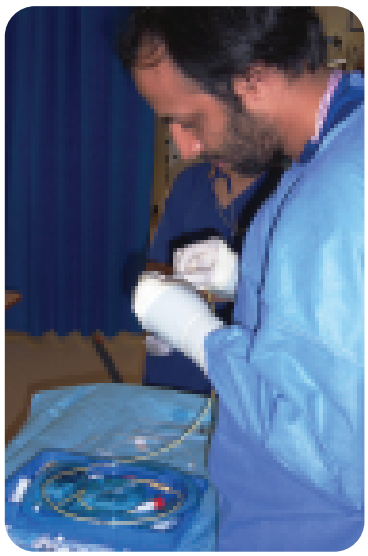
What has not changed is probably just as important if not more. We have committed staff working in an efficient, effective, cohesive and friendly unit. The ethos of 'can do' is associated with a clear view of what the unit should be able to do and a deep seated conviction that it delivers.

In 1985, for me it was a shock to realise how little equipment the unit had when compared to Australian equivalents. It was a bigger shock to discover that similar results were achieved without all the hardware. It was a hard lesson to learn that it is the people working in the unit - what they do and how they do it - that actually brings results and that is far more important than the technology. Technology brings some measurable results but far more impressive endpoints are often achieved in terms of patient care, which are more difficult or impossible to quantify.

What has not changed is the appreciation that when a patient is treated, it has an impact not just on them but on their families and friends as well. In delivering treatment and care to the patient, it is important and in their interest that the care extends to their family and friends.

That brings me back to the matter of a name. Care encompasses therapy but not vice versa. Care is focused on patient needs rather than on therapeutic objectives. Care is something that extends beyond immediate patient needs and of necessity. Care is a common goal that is easily understood. Common goals encourage cohesion and functionality.

That leaves the issue of the term 'unit' which may be a problem. Geographically, it suggests a degree of isolation and possibly, insularity. Alternatively, it also suggests a group, team or a recognisable entity to which one can belong, contribute and take pride in its achievements. It may invoke thoughts of elitism but that is no bad thing in areas delivering specialist care. These connotations therefore seem entirely appropriate.



One aspect of the evolution of this service over time is reflected in the name. In 1985 the focus was on the intensive therapy provided without due recognition of the subsidiary role of care. In 2009 the same care is delivered, but its importance in how the unit functions and in the results achieved, is clearly recognised.

So is the name important? My views have changed on the importance of the name. I am much happier working in an Intensive Care Unit than I would be in an Intensive Therapy Unit. At Chelsea and Westminster Hospital we have an Intensive Care Unit.

Dr Neil Soni
Consultant Anaesthetist

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

Relatives' Satisfaction Survey 2008-09

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 35 questions which are 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 ninth year and as in previous years, the vast majority of responses from relatives have been very favourable. The number of those responding was slightly less than in previous years, with 40 completed questionnaires received in 2008.

Below is a brief summary of the results collated for 2008:

Communications
While at the beginning of the year there was a further decrease in the number of those who felt they were able to speak to a consultant when they wanted to, there was a marked improvement in communications between relatives and consultants in the second half of the year.

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

There was a definite improvement in meeting relatives' spiritual needs and offering the support of social services during the second six months of the year.

There was however, a marked decrease in number who were aware of Primary Nursing during the second half of the year.

Facilities
During the first half of the year there was a decrease in the number of respondents who were given information about the facilities within the first 48 hours. There was also a decrease in the number of those who felt the cleanliness of the ward was excellent/good. The situation greatly improved during the second six months, with the majority of respondents stating that they were able to find the various facilities easily and18 out of 20 finding the cleanliness of the waiting room to be excellent.

The results from the survey show that on the whole, relatives are very satisfied with the service provided by ICU but that there are always areas that can be improved. By providing direct feedback from relatives, the Relatives' Satisfaction Survey will continue to be one of the unit's most useful tools in improving the services it offers to the public.

Caroline Heslop
Volunteer & RSS Auditor

"I felt the care and treatment of my husband was truly excellent. I couldn't praise this hospital high enough. Thank you from the bottom of my heart." Jan-Jul 08

"Our experience was one of openness, honesty and of caring." MS 11/08

"I was amazed at how much time the ward doctor spent with me, reassuring me and making sure I was also ok. This was so appreciated." Anon 12/08

"Lovely unit, excellent communication. We felt our mother could not have been in safer hands." VU 8/08

"The concept of Primary Nursing Teams seems unclear. There was no continuity of nursing. Every day had a different nurse." Anon 9/08

"It was great to have this continuity of care. Reassured us to leave him with familiar nurses whom we all felt we had gotten to know." Jan-Jul 08

"We knew who was looking after my Dad and the knowledge of his condition was well known and passed on in the primary team." Anon 12/08

"Nobody ever answered the door buzzer - I had to wait for someone to leave." Jan-Jul 08

User Feedback

Focus Groups

During the past year, we held three patient focus groups. The aims of these informal meetings were to gain the patient's perspective about the care they received in ICU and HDU. We already get feedback from relatives through the Relatives' Satisfaction Surveys but patient focus groups enable staff to increase their awareness of the patients' experiences. The information that we gain from the focus groups is fed back to the unit through discussion, with some recommendations to staff.

We try to invite between five and eight ex-patients to attend the groups and two senior nurses facilitate the discussions. Although the groups are informal and relatively unstructured, there are some questions to act as prompts. We aim to talk about patients' experiences of admission, transfer to the ward and finally, discharge back home. We also ask about issues such as privacy, dignity, pain management, noise, staff courtesy and help with meals. Our experience has shown us that getting the patients together in a group facilitates discussion better than obtaining feedback through surveys, as the patients are able to remind each other of their experiences and this brings abut new discussion topics.

We have re-emphasised the importance of communication with patients in our feedback sessions. Reassurance, reorientation and communication are vital to our patients and a very important part of the care we should be giving them.

The main issues that were noted, and have been brought to staff attention, were:

- Communication. The patients often can't ask questions and need frequent explanations. Even when they are sedated, they can sometimes hear our conversations and one patient was very anxious when he heard his family discussing 'all the tubes' and saying he 'didn't look good'.
- Noise can be a problem, especially at night.
- Conflict between staff is very distressing for vulnerable patients who want to trust nurses' competence and professionalism.
- ICU has a long-term impact on patients. Even when they are discharged home, many patients continue to suffer both psychologically and physically. Patients can feel weak, exhausted, anxious, frightened and lose their appetites, amongst other conditions or symptoms. They can find it difficult to come to terms with the trauma of their ICU stay and having 'lost' days within that time.
- Sometimes there may be too many visitors and patients can find it too tiring. We discussed reviewing our open visiting policy for HDU, but it is difficult to change because the physical environment of HDU can be used for ICU patients and it could result in inconsistency and confusion.
- Being woken too early in HDU, for no good reason. We try to provide patient-centred care which is not based around routine, but rather around the individual patient's needs and wishes.

In general, the patients who attended the focus groups were very pleased with the care they received in ICU and HDU. They were particularly impressed with our infection control measures, and for the most part, felt that our communication skills and respectful care was of an excellent standard.

Rose Le Cordeur
Senior Staff Nurse
Team F

Inter-team Projects

Marketing Group

The marketing group aims to market the Intensive Care Unit both internally within the Trust and externally to other Trusts and we do this in a number of different ways.

At the hospital Open Day in May, we had a stall with a mannequin and equipment from ICU so that we could explain and demonstrate to the public the kind of work we do. Our stand is always very popular with ex-patients and prospective staff.

We advertise at the main critical care conferences and fund two people from the unit to attend. Last year two nurses went to the British Association of Critical Care Nurses Conference in York and gave feedback to the unit.

Each year we try to raise money for charity and we do this with a Christmas raffle and charity run. Last year some members of our team ran for Prostate Cancer in the Adidas Women's Challenge in Hyde Park and raised £226.20. Some of our nurses took part in the London Duathlon in Richmond Park, which was sponsored by the Chelsea and Westminster Health Charity. We also raised £80 from the Christmas Hamper for the charity Shelter.

We also try to link with the community. I went to my son's school, Orleans Infants School in St. Margaret's and spoke to children aged 4-5 about being a nurse, for their school science week.

The group also organised the unit's Christmas Party with money donated from the ICU Trust Fund, which relatives had specifically requested be given to the nurses and doctors. This year it was held at The Pembroke pub.

The group also put together this Annual Report by asking different staff members to write articles. The report has a different theme each year.

Danielle Pinnock
Sister
Team H

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. The team recognises that there has to be a balance between home/social life and work life and we believe we can achieve this through self-rostering, which allows for equality and flexibility.

Since January 2007, the unit has adapted the Manpower Software System (MAPS) which is 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 useful tool as it highlights the skill mix including the number of co-ordinators 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 that shortfalls can be readily addressed on the current rota being created.

Recently we have entered all the training courses our staff have attended and the skills they have, so that these can be recognised and developmental needs highlighted.

The roster is created a month in advance. An off-duty template is displayed for staff to put in their requests ahead of time, 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. The Trust is planning on providing staff with access to the MAPS system to enter their rota and the ODPT will provide training to all staff prior to this being piloted by the end of the year.

Currently all members of the ODPT are trained as rota creators. The rota updater is now included as one of the competencies in the co-ordinators' pack for Band 6 nurses in the unit.

The ODPT has updated the Annual Leave Policy and we aim to make the annual leave allocations between staff as fair as possible. After consolidating all staff comments and suggestions we have rolled out the new guidelines.

Joanne Steen
Sister
Team C

Quality Group

The focus of the Quality Group is the quality of care we provide to the patients, their relatives and friends, as well as the staff working on the unit.

We run satisfaction surveys for the relatives and we get a good response from them. Based on the comments and suggestions made, we have been able to expand the facilities we provide for relatives and have made improvements to the quality of care they receive.

For example, we have provided televisions for the two overnight rooms, purchased new furniture for the relatives' waiting room and developed a folder with explanations of common illnesses laid out in a straightforward manner. We have also been able to provide free parking for those who have family or friends in the Intensive Care Unit and many relatives and friends have said this is the most effective and generous facility as they spend so much time at the hospital.

We provide a comprehensive information booklet which we give to the next of kin of all patients admitted to the unit. This is reviewed every other year, and updated as needed. We have now developed a discharge booklet that is given to all patients before they are discharged from the unit to the ward, outlining the possible

physical changes they may experience after spending time in the Intensive Care Unit, as well as providing information on the normal routine of the wards.

A really successful and popular event is the Patient Focus Group which we run four times a year. We invite up to eight ex-patients to the hospital to discuss their experiences and to tell us what we did well, but more significantly, where we can improve. We feed this back to all staff and act on information we gathered. This has been an extremely useful way of assessing our service and the patients say they have found it, at times, like a support group where they meet others who have gone through similar experiences. Some have found it difficult to come back to the hospital, but have done so as they have felt the need to express their thoughts and experiences to us. We are always grateful for their time.

We believe that the changes we have been able to make as a result of the patients' and relatives' feedback have contributed to the improved patient and relative experience, and we will continue to value their participation with thanks.

Rebecca Hill
Sister
Team D

Research Group

The last year has continued to be proactive and therefore positive for the Research Group.

The meetings continue to be held on a monthly basis and their purpose is to continue to review the action plans on odd months and to review guidelines and drafts on even months. By running the group in this way, we have continued to take guidelines forward and it gives the individual concerned valuable feedback on their guideline. They are then able to act on this and take their guideline forward to the next stage.

In the last year, the following guidelines have been taken forward and published on Datix:

- Care of the Central Venous Catheter
- Enteral Feeding
- Vapotherm
- CVVHD/DF Renal Guidelines

Guidelines at a glance have continued to be a useful teaching aide and give clear guidance to the staff at the bedside when looking after the needs of the critically ill patient.

Recent advances and changes in practice have also been discussed within the group and we have actively encouraged staff to present any new pieces of information or practice to the group for further discussion.

An idea of particular interest has been a PHD research study into team working on the ICU, whilst another colleague is commencing her MSc in patient transfers. These are both diverse but essential elements relating to the critical care environment and ways of improving it.

The meetings also keep the group updated about the research activities on the unit. One of the medical fellows on the unit has been invited to update staff about their studies on a six-monthly basis. In the past I have found this to be a valuable link between team working of medical and nursing staff.

Further to this, our Clinical Nurse Specialist will be examining the perceptions of Primary Nursing 10 years on. A values clarification exercise has already been sent out for staff to respond to and work will continue on this over the next year.

Lastly, I would like to thank all of the Research Team Members for their valuable hard work in the last year. It has proved to be a productive and cohesive group of individuals who adopt the team spirit wholeheartedly.

Gordon Turpie
Charge Nurse
Team F

Inter-team Projects

Teaching Group

The Teaching Group's main purpose is to co-ordinate and monitor all educational and staff developmental activities on the unit. We do this in many ways including organising and coordinating the unit's teaching rota, identifying staff teaching needs, developing and planning staff development programmes for all levels of nursing staff, primary nurse reviews and multidisciplinary education.

The main focus for the group has been to continue the work we started last year in formalising a structured Band 6, two-year rolling programme. This programme has been designed to help guide staff in Band 6 roles in ICU to help them meet their KSF outline, promote effective patient-centred care and to progress their career. It is designed for nurses who have completed their studies in intensive care and mentorship. The topics are diverse and cover the clinical application of care, through to developing others and leadership and management skills.

The ICU-specific days are designed to run as a rolling programme over two years. There are no set orders in which the study days are to be taken. In addition to the ICU-specific days, there are a number of days run by the Learning Resource Centre and days shadowing staff. In total there will be 20 days.

Other points we are discussing and deciding on at present include possible competencies relating to KSF outlines, portfolio development, reflection on and in practice, coaching and leadership, projects relating to inter-term project groups and guideline development.

Our aim for the future would be to possibly look towards attaining accreditation, as we have done with the Foundations of Critical Care Course, a programme we run for staff new to the ICU.

I would like to take this opportunity to thank all the members of the team for their hard work and commitment to developing the needs of the unit. They should be very proud of themselves. I certainly am.

Hazel Boyle
Sister
Team A

Supplies and Finance Group

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

Members of the Supplies and Finance Group are available to make suggestions and comments on the way ICU Trust Fund money could be used to benefit the unit and its users. This includes the trialling and evaluating of new products, as well as education on reducing wastage through our annual quiz which highlights the cost of both disposable and non-disposable items.

Membership includes one representative from each of the Primary Nursing Teams, the unit's Healthcare Assistant, Technician, Clinical Nurse Lead and Administrator.

The group's accomplishments this year include:

- The introduction of new IV-giving sets for pump and gravity administration, which were evaluated by the

Nursing Diagnosis and Electronic Patient Record (EPR) Group

The purpose of the Nursing Diagnosis and Electronic Patient Record (EPR) Group is to promote and develop the quality of nursing documentation within the ICU/HDU. This includes all aspects of care planning, the use of nursing diagnosis, the electronic patient records and manual systems of record-keeping.

The following three issues describe some of the work which the group has undertaken over the last few months:

Access to EPR via Bedside Computers
One of the group's long term objectives is to improve computer access to EPR. This will enable staff to update care plans, record events, treatment and the patient's progress, without moving away from the bedside. It also enables access to patients' blood results, which are frequently referred to by the multi-disciplinary team.

We are also investigating the possibility of adding access to the Trust's Guide for Intravenous Drug Administration. At present 8 out of 10 computers on the ICU are linked to the EPR system. We hope to overcome technical difficulties in liaison with the IT Department to enable access to be extended to those in the Burns ICU.

Annual Documentation Audit
Each year the Trust undertakes an audit of nursing documentation. The purpose is to ascertain the quality of nursing records, ensuring that assessments are carried out and care is recorded accurately and appropriately.

Staff are also assessed with regard to their understanding of data protection issues and ability to access the Trust's intranet guidelines. The results of the ICU audit continue to

nursing staff and are consequently saving the unit money.

- A major overhaul of our main stock room to reduce clutter, improve accessibility and clearer labelling. This will continue to be maintained throughout the coming year.
- Allocation of funds to purchase a new sofa for the relatives' waiting room.
- The creation of stock lists for trolleys and bed dividers to reduce wastage and prevent overstocking.
- When extra staffing is required, prioritising those agencies whose rates are lower to help prevent any overspend and feed this back to all staff on the unit and other departments throughout the hospital.
- Highlighting spending trends and assessing areas for potential savings.
- The introduction of cheaper alternative ECG monitoring dots without compromising quality or patient care.
- Introducing new stock storage bed dividers that have been designed to the unit's specifications and are more durable to prevent the need for regular repairs.

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

Jason Tatlock
Information Auditor

Inter-team Projects

show good compliance and ICU staff are meeting the standards required overall. However, there are a number of aspects within the software programme of the EPR system which could be improved to enable better record-keeping within the Trust as a whole.

For example, some of the Patient Assessments completed by nurses when patients are admitted are complex and could be simplified. This would encourage staff to complete and update these records more regularly. Also, the text box used on the EPR which nurses use to evaluate patients' progress is too small.

These and other issues may trigger a Trustwide review of the software system and present new opportunities for all clinical areas to raise standards further.

Abbreviations

Within nursing documentation, many frequently-used terms which describe patients' treatment, physiological parameters and observations are abbreviated. For example, a reference to a patient's arterial blood gases is often written as 'ABG'.

Abbreviations are used because of the length and complexity of the terms used. This is done in order to save time and because the text box available on the EPR allows only relatively brief comments. Furthermore, the Documentation Audit has identified a tendency of nursing staff to use some abbreviations.

In the past, this practice has not been fully approved by the UKCC, a view reflected in the Trust's Policy and Guidelines for Record Keeping for Nurses and Midwives. The policy states that "the use of abbreviations should be minimised and risks associated with them recognised".

An example of risk may be that misunderstandings could occur when different disciplines use abbreviations which look similar, but actually mean different things. Also, patients may wish to access their health records and it is important to enable them to understand what is written.

However, the Trust's policy also states that "some allied health professionals in the Trust maintain a list of approved abbreviations". Following consultation within the ICU, the group decided to use abbreviations that are commonly used within a critical care publication and proposed that a copy of these abbreviations be placed within the critical care section of the patient's notes. This would allow patients and other members of the multidisciplinary team to refer to the glossary and

understand their meaning. The next stage is to submit this proposal to the Trust's Record Keeping Group for their consideration.

Over the next 12 months the group will continue its work, looking at the quality of our documentation and working with the ICU team and the Trust's Record Keeping Group, to meet the challenges and opportunities which may lie ahead and taking into account government initiatives.

Caroline Younger
Sister
Team B

Performance

Activity and Performance

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

Level 3 and level 2 activity have decreased slightly compared to previous years (see table 1), although level 2 occupancy has increased from last year. This is reflected in our elective admissions, which have seen an increase of 12% from 2007/08.

Table 1 General ICU/HCU

	2006/07	2007/08	2008/09
Finished Consultant Episodes (FCE)			
Level 3	169	157	153
Level 2	296	266	257
Occupancy			
Level 3	72%	73%	71%
Level 2	178%	158%	176%
Admission			
Elective	85	95	106
Emergency	380	328	304

The majority of our elective admissions are bariatric surgery cases which have increased by 29% for the reporting period. This is an expected increase, as last year the Trust was selected as the regional bariatric centre. During 2008/09, a total of eight bariatric cases were refused due to no capacity. Of these, four had their surgery cancelled and re-scheduled for a later date. Refused admissions are expected to decrease next year due to the introduction of a level 2 bariatric recovery bed that can be used to monitor patients overnight.

Discharges from the unit should occur within four hours from the time of decision to discharge, to actual discharge. There was a slight increase of 5% in discharging patients within four hours. There has also been an increase in delays due to a lack of side rooms available in ward areas. The strategy of relaying discharge information to the bed managers every morning remains in place. The ICU team continues to work closely with the bed managers to ensure the patient's hospital journey remains a priority.

The unit managed a total of 16 transfers in from other hospitals during 2008/09, more than half compared to 2007/08. A total of three patients were transferred out (outliers) to other hospitals due to non-clinical reasons. This was primarily due to a lack of capacity.

The Burns ICU service (table 2) had a combined occupancy of 40% for 2008/09. This has increased from 33% the previous year. 50% of all refused admissions were due to no beds at the time of referral. December 2008 was the busiest month, with a combined occupancy of 85%.

The unit has worked hard to ensure that a high standard of reporting is maintained. This includes providing quality data for critical care commissioning and also completing timely discharge summaries to reflect the Trust's targets and objectives.

Performance

The unit will continue to work with the North West London Critical Care Network and internal/external departments, to develop strategies to improve the service we provide to all our users.

Jason Tatlock
Information Auditor

Table 2 Burns ICU

	2006/07	2007/08	2008/09
Finished Consultant Episodes (FCE) Level 3	20	26	20
Combined Occupancy Level 3	41%	33%	40%
Refused Admissions Level 3	15	20	16

Morbidity and Mortality Meetings

As part of the quality assurance and governance of the unit, we hold quarterly Mortality and Morbidity Meetings. The meetings are chaired by a consultant anaesthetist who is involved with the Intensive Care Unit and they are attended by nursing staff, an information auditor, physiotherapists, microbiologists, a pharmacist and others who are involved in the day-to-day care of patients. We also invite the Risk Management Team to attend.

The purpose of the meetings is to explore and discuss topics of concern or interest that have been triggered through our data collection, or as individual interests.

The meetings open with the last three months of activity, presented by our information auditor. Patient admissions for level 2 (high dependency) and level 3 (intensive care) patients are discussed and compared with the same period the year before. Other data presented is patients' length of stay and any delayed discharges with the reasons. This is also compared to the same period the year before. For the last year there have not been any significant changes in either category.

A significant component of the agenda includes any unexpected deaths on the unit for the last quarter and this is presented by an anaesthetist.

A discussion and debate examines all aspects of the patient's admission to identify if there are any areas of practice or care that need to be changed, or if there is anything we could have done differently that would have changed the outcome.

The intensive care team has found these so useful and informative that we have discussed how to engage a wider audience within the Trust. How this can be achieved is under debate, but one suggestion has been to invite a range of medical and nursing staff who work outside the Intensive Care Unit to attend.

Rebecca Hill
Sister
Team D

Pharmacy

The work undertaken by pharmacy during the past year focused on reducing the incidence of drug-related errors on the ICU.

Each quarter, the Lead Pharmacist for Imaging and Anaesthetics and the Clinical Nurse Lead for ICU meet to:

- Discuss in detail all drug incidents that occurred in the previous quarter
- Identify trends in the types of incidents
- Implement a plan to prevent future recurrence

Examples of preventative action include:

- Updating the design of the ICU drug chart with pre-printed prescriptions
- Developing a pharmacy risk management quiz to educate and raise awareness
- Segregating and clearly marking similar-looking stock items
- Re-accreditation and review of checking techniques

Total Parenteral Nutrition (TPN)

The use of parenteral nutrition on the ICU has fallen by approximately 15% compared to the previous year. The drive for early enteral nutrition is recommended due to better clinical outcomes and less complications that are usually associated with parenteral nutrition.

The top three indications for TPN were major gut surgery (or related complications), gastrointestinal bleeding and ileus.

TPN duration ranged from two to 100 days with a median of nine days.

Outcome data over a 12-month period showed that approximately 50% of patients re-established enteral feeding.

Approximately £20,000 was spent on parenteral nutrition last year in the ICU.

Cost Savings

Various cost saving initiatives were put in place to reduce the financial burden on the unit. These include review of drug stock holding, cross charging of antiretroviral medication to the HIV Directorate and review of parenteral nutrition in patients re-established on enteral feeding.

The highest cost saving month in the past year amounted to £5,000.

Chris Chung
Lead Pharmacist
ICU

Performance

Balanced Scorecard on the Intensive Care Unit

One of the key objectives of Chelsea and Westminster Hospital is the sustained improvement and monitoring of quality of care and the patient experience.

The Trustwide introduction of the Balanced Scorecard in October 2008 is just one way that enables all clinical areas to monitor their nursing quality of care, identify and build on good practice as well as targeting areas for improvement.

Below are the six indicators decided on by Ward Leaders and Matrons. They are set out in 'traffic light' colours, where green indicates good practice, yellow indicates areas that are at risk of standards slipping and red shows areas where there is a need for prompt action. There was a general consensus that the sixth indicator should be decided on by the individual areas, to allow for focus on practice which has special significance for that department.

The Intensive Care Unit regards the patient as central to its service and has measured the quality of service in a variety of ways for many years, including patient focus groups, relative satisfaction surveys and other benchmarking audits.

The introduction of the Balanced Scorecards was a new and welcome addition and each team leader has taken the lead on completing audits with their teams. As a group, we decided that our chosen sixth audit would be nutrition and our compliance with the unit's policy, as it is well recognised that good nutrition plays an important part in the recovery of the critically ill patient.

Table 3 Balanced Scorecard

Indicator	Current measure	%	%	%
Hand Hygiene	HH audit tool	0-50	51-80	81-100
Pain Management	Pain audit tool	0-70	71-85	86-100
Privacy and Dignity	Essence of care audit tool	0-70	71-85	86-100
Patient Communication	Essence of care audit tool	0-70	71-85	86-100
CEWS/PEWSS	CEWS/PEWS audit tool	0-50	51-80	81-100
Ward to Decide				

Following any audit, the teams review the results and decide any action that needs to be taken, and the urgency of any changes that need to be made. Clearly any impact made from changes to practice takes time, so where there are improvements needed, a re-audit takes place three months following implementation of the new practice.

As there are several nursing teams carrying out the audits, we have to be sure that the outcomes and action plans are shared within the unit, to make the scorecards meaningful and ensure all staff understand the reasons behind changes to practice.

We already display our hand hygiene results on an information board on the unit, but there are other methods of communicating outcomes and planned changes. We have for example, presented in teaching sessions, placed the audit and actions in our communication book and added them to the agenda at our governance and unit meetings. We will also provide this information to a central Trust report.

The Balanced Scorecard is still a fairly new monitoring tool and inevitably there will be changes made when evaluating audit activity. However, we all recognise that if the result is improved quality of care, then that can only be a positive thing.

Rebecca Hill
Sister
Team D

Infection Control

Table 4 MRSA Bacteraemia ICU 2005-2009

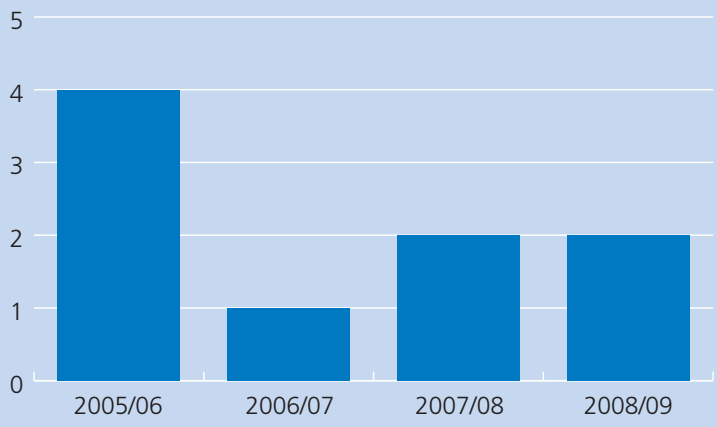
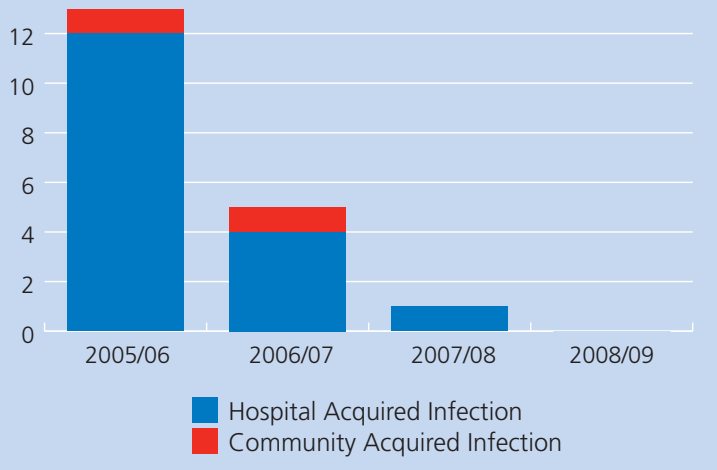


Table 5 Hospital Acquired Clostridium difficile in the over 65s on ICU/HDU 2005-2009



Development Opportunities

The Staff Development Role 2009

The staff development role has been a rollercoaster of learning for me over the last year.

The course was reaccredited by Thames Valley University London for 20 credit points at level 6. Once again, the course focused on a structured learning approach for the transition from ward environment to an intensive care environment.

The major change in the course was changing the summative assessment from a reflection essay using John 10th Model (1995) to a critical analysis. This gives the students a more flexible template for developing their reflective and critical analysis skills.

From a personal perspective, the process has allowed me to gain insight into the development of academic courses and the importance of ensuring quality assurance within the module.

The last year also saw another cohort, September 2008, complete their course in March 2009 and at the time of writing they were waiting for their results to be ratified.

In March 2009 I handed the course over to Joanne Steen who will take it forward and I will resume my clinical post. The last 18 months have been an invaluable learning experience which has changed the way I work clinically. My focus now tends to be on supporting new staff and developing their skills.

Emma Long
Staff Development Sister

Transfer Course

A number of staff on the ICU continue to support the running of a course designed to train medical and nursing staff working in ICU to safely transfer critically ill patients.

A multi-disciplinary approach and the need for team working are key features of the course. Staff on the course learn about:

- The importance of speed and pre-transfer stabilisation of patients
- The most likely problems that occur during transfers in London and how to respond before, during and after transfer
- The Critical Care Network transfer documentation and how it will help to systematically plan a transfer from start to finish

The course is delivered by critical care transfer experts and specialists from hospitals in West London. The highly interactive day includes:

- A comprehensive introduction to transfer standards and local transfer documentation in use within hospitals in North West London
- Detailed presentations from clinical experts
- Top "tips" for transfers
- Practical demonstrations

Staff also receive a free North West London transfer handbook and a handy pocket-sized aide-memoir at the end of the course to take away with them to use on future transfers.

Elaine Manderson
Clinical Nurse Specialist

Experience of a Student Nurse

When I was told I was going to the Intensive Care Unit at the Chelsea and Westminster Hospital for eight weeks, it immediately conjured up ideas of critically ill people connected to tubes and wires with lots of complicated and scary machines that beep every five seconds.

Within a few days of starting, my initial fears had vanished thanks to the excellent staff on the unit. They explained everything fully and made sure I was comfortable with what I was doing, allowing me to get hands-on experience wherever possible to help aid my learning.

The nature of the ICU means that there is one nurse to one patient, which I have found largely beneficial to my learning because of the time I get to achieve my learning outcomes and talk over aspects of the unit I am unfamiliar with.

The only downside to working on the ICU is that the patients are often critically ill and sedated, so it can be very upsetting to see and hard to deal with.

With patients who are sedated, it can be strange talking to them and getting no response, which I wasn't used to. However, the reward of seeing them recover, being weaned off the ventilator and then finally being transferred to the ward, has been the best part. This has kept me positive throughout my placement.

I have really enjoyed my placement on ICU. It has been a fantastic learning experience and I feel that in the eight weeks of being here I have come a long way. All the staff have been so supportive and willing to help at every opportunity - they are a credit to the hospital.

Katie Reynolds
Second Year Nursing Student
King's College London

Development Opportunities

Mercy Ships

From the months of February to May last year I spent time in Liberia, Africa, working for an organisation called Mercy Ships, a non-profit Christian organisation that seeks to provide quality healthcare and social projects to the poor and needy in various African countries. Everyone who works for Mercy Ships volunteers their specialist skills including surgeons, nurses, engineers and teachers.

Liberia is a country that has suffered from civil wars over the last 20 years and the last war only ended in 2005, leaving severe poverty and practically no healthcare system to speak of. Many people are suffering from diseases associated with poor sanitation and malnutrition.

As a nurse living onboard the ship, one of my first tasks was being involved in a day to screen thousands of locals, many of whom had walked for miles, to be assessed for suitability for surgery. Patients who were screened had a variety of problems from goitre to cataracts.

Mercy Ships offers a variety of surgeries including maxillofacial, general, ophthalmic, orthopaedic, plastic surgery and vaginal-vesico fistula repairs. Patients who were suitable for theatre were given a date to come to the ship for their surgery and any medications they needed to take before the operation.

A patient with a goitre waiting to be seen on screening day.

The ship is equipped with operating theatres, X-ray machines and 40 ward beds, including a basic Intensive Care Unit. I usually took care of between five and eight patients (adult and paediatric) pre and post operatively and had the opportunity to use my intensive care skills after one of the patients was transferred to the ICU after an epileptic fit post-surgery.

The main reason I went to Africa to work for Mercy Ships was to help people who I felt didn't have the privileges and opportunity to access the healthcare that in this country can be taken for granted. I ended the three months feeling that instead of giving, I had received so much from the beautiful patients I nursed and their inspirational attitudes of gratitude and joy in the face of extreme adversity.

My time in Africa was an incredible experience which I will always fondly remember. It has given me a whole new perspective on poverty and has emphasised to me what an incredible institution the NHS is.

I am proud to work for an organisation which delivers world class healthcare, free at the point of delivery. I know the people of Liberia would be amazed to have access to such an incredible blessing.

Frances Douds
Senior staff nurse
Team C

Research Opportunity

For my final and practical part of studying medical anthropology, I decided to be a participant observer in an intensive care unit in Germany that not only provided all the usual biomedical treatments, but also offered complementary medicine to its patients.

The complementary approach practised in this hospital is anthroposophical medicine (AM), which incorporates the emotional and spiritual aspects of human beings and their interwoven relationship with the physical body.

AM differs from all other forms of non-mainstream medicine, as its founders Rudolf Steiner (1861 - 1925) and Ita Wegman (1876 - 1943) made it very clear that all practitioners have to be state-trained biomedical doctors and nurses. In addition, AM can potentially be implemented in all aspects of healthcare.

The availability of AM today differs very much from country to country, ranging from general practitioners to acute hospitals. My experience of the unit and the hospital was very much coloured by the present political landscape of the German healthcare system, with its financial cutbacks, shortages of staff, and increase of not just patient numbers, but also with regard to more complex and challenging healthcare needs.

The focus of my work was to observe the relationship between biomedicine and AM, how this was implemented in clinical practice and how staff, patients and relatives experienced and felt about AM.

One aspect of the findings showed that although AM is a very holistic approach to treating patients, only physical treatments such as massage, compresses, medications (ranging from oral to intravenous drugs), creams and oils were used and only in a sporadic fashion, rather than in a structured or routine way. The same applied for the use of anthroposophical therapies such as music, painting and movement therapy. Many barriers were identified by staff such as lack of staff, lack of time and other factors such as the difficult relationship of intensive care versus complementary care.

I observed many patients receiving AM treatment and the response appeared to be neutral to positive, even though it was difficult to assess as a whole, as many patients experienced communication difficulties due to being ventilated or sedated.

What was interesting however, was that not all patients and relatives were aware that AM medicine was practised in this hospital, but it was regarded highly as they felt more recognised as an individual. Some patients would travel extensive distances to be treated in this hospital.

Being a participant observer in this intensive care unit for three months, I witnessed many beautiful, intimate, painful and difficult moments, all of which made me reflect on my own practice. I have grown tremendously through this whole experience, realising much more about what efforts are required to make medicine more human, and confirming my belief that this is achievable.

Although the implementation of AM in intensive care is only in the very early stages and many barriers have been identified for a more routine use, the prospects are promising and the general attitude of staff towards AM is a positive one.

Saskia Peerdeman
Staff Nurse
Team F

Development Opportunities

Liverpool Care Pathway

The End of Life (EOL) Strategy launched in July 2008 by the Department of Health clearly outlines how patients should be cared for, to ensure they experience a 'good death' (DH 2008).

With this strategy in mind, the adapted Liverpool Care Pathway (LCP) for use in our Intensive Care Unit continues to be modified to accommodate changes in practice and new directives from Government bodies. For example, the inclusion of a section to aid the identification of potential organ donators.

The LCP is now a comprehensive and multi-professional document which allows any critical care professional involved in the care of a patient, who is at the end of their life, to initiate and use the LCP.

Once the LCP had been established for use on the Intensive Care Unit, the next logical step was to audit its use for patients who had died on the ICU.

The ICU LCP cannot be audited using a National Audit Programme as it has been adapted too much from the original, therefore every three months an audit is done to establish how many patients who died during that period were placed on the LCP. The medical and nursing notes for patients who were not placed on the LCP are then examined and the details of their final days and hours are noted.

The information is then presented at the quarterly Mortality and Morbidity Meeting which is open to all critical care professionals. This allows for a discussion about the appropriate and timely use of the LCP and can aid members of the critical care team to think more about the purpose of the LCP and when it could be used effectively, to ensure critically ill patients and their loved ones experience a 'good death'.

One of the current challenges facing the use of the LCP in ICU is the early detection of the critically ill patients who are at the end of their life.

The Department of Health strategy also advocated the need for end of life care to be embedded in the training and education at all levels and for all staff groups (DH 2008). By attending courses such as the Pathway of Care of the Deceased Patient and the LCP in ICU Study Day (Royal Society of Medicine), the necessary knowledge, skills and attitudes relating to the care of the dying can be attained and disseminated to staff to promote the success of improving end of life care.

The forthcoming year will focus on the continuing education of staff, audit of the uptake of the LCP and proceed to the auditing of the LCP documentation.

Ann Sorrie
Sister
Team H

Medical Devices Training

During the past year, staff on the unit have been ensuring that they are competent to use all the high risk pieces of medical equipment that they utilise in their day-to-day work.

High risk equipment is identified by a red triangle placed on the equipment and staff know that this identifies the need to undertake training on it before using it with a patient. The aim of this is to reduce potential incidents with patients.

For staff new to working in ICU, this involves undertaking a work-based training day facilitated by the staff development sister and unit technician. This training day is then followed up by clinical competencies built into their Foundations in Critical Care Course.

For staff already working in the ICU, they have to complete assessment documents every three years to demonstrate their ongoing competence. This information is then entered into the staff roster database, so that it is easily available.

Elaine Manderson
Clinical Nurse Specialist

Staff – April 2009

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Consultant Anaesthetist & Intensivist

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Consultant Anaesthetist & Intensivist
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Dr Jonathan Handy
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Dr Nicholas Fauvel
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Dr Michelle Hayes
Consultant Anaesthetist & Intensivist

Dr Suveer Singh
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Magdalena Rigi
Housekeeper

Mavis Kyeremeteng
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