



Intensive Care and Nursing Development Unit

Annual Report 2010-2011

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Introduction

A Glass Half Full

In 2011 two specific events made me proud of Chelsea and Westminster's Intensive Care Unit (ICU).

The first was the when we achieved the Customer Service Excellent Standard Award. This replaced the Charter Mark Award which the unit held since 1999.

This standard is about improving the customer (patient) experience with particular focus on service delivery, timeliness, information, professionalism and staff attitude. It helps us to continually focus on what is important to the patient.

Inside the annual report there is an article explaining what the standard is and what we did to achieve it.

This year's annual report is divided in three distinct sections on patient experience, safety and clinical effectiveness. The report contains the regular sections about updates on the inter-team projects, development opportunities, research activity and user feedback.

Completing this annual report every year makes us take stock

of what our priorities are, what changes have occurred during the year and how we have responded to them.

For example, in the report about performance we outline the activity in the unit over the last couple of years, which helps to project and inform activity plans.

Similarly, we have reviewed our skill mix in order to produce cost savings. This is balanced with opportunities for staff development so that the unit staff become the initiators of change whether for a financial, quality or research gain.

Producing this annual report helps us to focus on events which occurred in the last year – 'a glass half full' – and allows us to relish and celebrate our success and achievements of the previous year before moving onto areas to concentrate on in the coming year. In all of our busy lives it is nice to allow ourselves to be reflective and think 'didn't do a bad job...'.

I started this introduction by outlining two events which made me proud. The second was when I received a letter in May from the son of a patient who had died on the unit.

He stated:

"You are the most wonderful ... team I have ever come across – the job that you do is quite extraordinary and I hope that you understand how much you touch the lives of your patients and families when they are at their most vulnerable.

You have taught me so much about patient care – if I can take even a little of that onwards in my career as a doctor, I shall be hugely proud of myself. And I shall never forget where I learnt it."

RB, May 2011

Jane-Marie Hamill
Head Nurse Critical Care

Foreword



The view from the unit

It has been a complex year for the Intensive Care Unit. We have not been immune to the wider anxieties sweeping the globe – financial worries, insecurity and concern for the future have loomed large recently.

Undoubtedly we must examine our practice and seek to eliminate any unjustified waste – the tax-payer deserves this at least – but such a commitment can sometimes feel at odds with delivering a high quality service. This quality has to date been exemplary and was recognised by an award from the Care Quality Commission – a rightly proud moment for the Unit. Will it continue?

All of us working in ICU understand how to respond when high pressure emergencies demand. A sudden surge in critically ill patients causes us to react – to the best of our abilities with the resources available. You can try and plan for events such as flu epidemics but it is not easy

to adequately plan for multiple burns (a possibility during the riots) or terrorist attacks.

Under those circumstances we would do our best in these worst of times, aware that it might not match the best treatment one would hope to give in the best of times. This is what cataclysmic events can do.

However, the credit-crunch-generated squeeze on government finances trickles all the way down to us. Budgets will experience unusual hardships – all the easy savings have been made, only difficult choices remain.

Is this going to lead to slippage in standards, corners being cut or the numbers and/or the skill of the staff being reduced? I really hope not – and I don't believe anyone at Chelsea and Westminster Hospital is interested in that, but it is difficult to see how one can square the circle of ever-scarcer resources whilst maintaining

the highest quality of care.

I must particularly praise Jane-Marie Hamill who has worked heroically during this new era of intense scrutiny. Our focus is quality and will remain so.

We have welcomed several new members of staff this year including Dr Marcela Vizcaychipi as a substantive ICU Consultant. New staff can dynamise the Unit and bring fresh ideas. I can already feel that happening – which is exciting.

Ultimately, successful intensive care is delivered by a team. The characters making up the team and their cohesion is the single most important factor in achieving the best for patients and the happiness of us, the workers.

The best one could wish for is a good professional team – and I hope we are.

Dr Rick Keays
Consultant Intensivist

Philosophy of Care

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 provide 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 others' grief.

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

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.

Patient experience

Patient diaries

We introduced patient diaries onto the ICU two years ago as a pilot project.

Initially we only offered diaries to patients in two of our primary nursing teams. However, the plan was to expand this to all appropriate patients, so we have gradually increased the number of primary nursing teams involved.

The aims of the diaries include filling in the potential gaps in the patients' memories of their ICU stay by giving them information in a chronological sequence. Many patients are frightened by the lack of control and understanding they have of their ICU time and we hope that reading their diaries can help them understand the experience better.

After discussion with the Clinical Governance team, we have introduced a feedback form. So far, patients' feedback has been positive and they say they really appreciate the care and regard that nurses have demonstrated when writing in the diaries. They also value the opportunity to return to ICU and meet with a senior nurse who can often answer questions about their ICU stay.

However, we have had some difficulties tracing patients or bereaved relatives following discharge or death and we have introduced a book to trace progress and location of the diaries. This includes contact details of the patient, their next of kin and GP. This has made the process clearer.

Over the next year, we are aiming to offer diaries to all patients who stay in ICU for more than three days.

Rosalie Le Cordeur

Sister
Team F

Quality Group

The Quality Group continues to monitor and improve the quality of service delivered by this Intensive Care Unit. This year we have been working on reviewing and revising the information we provide for our patients and their relatives.

Admission to intensive care is a traumatic and stressful episode for patients and their relatives. This can have a huge impact on their lives that can last for many years and we are all conscious that we must continue to work to make their time with us more bearable.

The most effective method of understanding the patient and relatives experience is the gathering of information and we have been doing this for many years in a number of ways.

We ask relatives to complete a Relatives Satisfaction Survey. Over the last year there has been a reduction in returns of these and on reflection, we concluded that it had become too long and that relatives may be put off completing them. Our volunteer Caroline Heslop has completely revised the format, making it shorter without losing the information gathered and we will be launching this soon. We would like to thank Caroline for the work she has done and her commitment to this project. We continue to run our focus groups where we invite former



A photo board located in the main corridor helps patients and visitors identify members of the ICU team

patients to come back and talk about their experiences. This a powerful meeting and we have

learnt a great deal about what we do well and what we need to improve on. This was presented at the Trust's Seasonal Conference this year and was well received.

Feedback is used to improve the information given to patients and their relatives and we are in the process of revising our materials.

Our admission booklet provides information for relatives about the unit and the hospital. Our discharge booklet provides information to our patients on what to expect after discharge from intensive care.

There are a number of information boards giving a broad range of information that

is helpful to all visitors. We have also developed a folder on common medical conditions and treatments that relatives may hear about, which is presented in way that is easier for non-medical people to understand.

I would like to thank all the members of the Quality Group for their hard work and continuing commitment. I believe it really does make a difference.

Rebecca Hill

Sister
Team D

Volunteering in the Intensive Care Unit

Why I became Involved with the ICU

My first encounter with the Intensive Care Unit of the Chelsea and Westminster Hospital was the afternoon of Friday 21 December 2001. I can't remember how I got there, but that was not because I was a patient – it was because my 18-year-old daughter Rachel had been admitted to the unit with meningococcal septicaemia.

For the next three weeks I virtually lived in the unit. We slowly progressed from the dreaded isolation of the side room to the main ward in the

ICU. I learnt to cope with central lines, dialysis machines, heart monitors and all the other paraphernalia which until then, as far as I was concerned, had only happened on Emergency Ward 10. I know this shows my age, but my age is of some relevance because it was on my 50th birthday that the big breakthrough finally came. She was taken off the ventilator and her first words were "Happy Birthday".

So how could I ever say thank you? Whilst in the unit I had been vaguely aware that there was a volunteer who appeared

from time to time to do I knew not what, so once Rachel was better I decided to approach Jane-Marie to see if there was a further opening for voluntary work. She was very receptive to the idea and once I had gone through all the right channels I was welcomed to the unit with my new identity – now a volunteer rather than a relative.

What I do in ICU

I normally work at the hospital every Wednesday morning for about three hours. The first job I do every week is filing the blood results and generally trying to keep patient records in some

Patient experience

kind of order. Next, I look after the plants in the corridor outside the unit and then there is always the telephone to be answered! Over time however, I feel my most important role has become that of a relatives' representative on the Quality Group, which in turn has led me to becoming responsible for the Relatives Satisfaction Survey.

Relatives Satisfaction Survey

There are two aspects to the survey. Firstly, we are trying to audit our nursing practices and secondly, we are trying to find out from relatives what improvements and changes they'd like to see.

We ask about the cleanliness of the unit and I always find it very reassuring to see that the vast majority feel, as I do, that the unit is kept immaculate. It is very useful to be able to pass this information onto the cleaning staff, especially when there is so often bad press about hospital cleanliness.

We constantly review the questionnaire in response to something that has changed in practice. For example, we developed an information folder on medical conditions due to relatives asking for it. To date, most people are still not aware of the folder so the survey is showing us that we must do more to promote it.

The waiting room has always been a problem; it is small and dark and not somewhere that

anyone wants to be. At one point however, it was suggested that it should be moved to outside the unit beyond the double doors, but as a relative I felt very strongly that this was an extremely bad idea because it would have meant that there were locked doors between the relative and the patient. So we have left it where it is and do everything we can to help relatives understand that it is the best option.

Other jobs

There are of course other jobs that I do as a volunteer:

- Every three years we have applied for the Charter Mark (now the Customer Service Awards) and I have joined in on the interviews and discussions with the assessor who is always most interested in the interaction between the unit and its users (in this case the relatives)
- I contribute to the Annual Report
- I have helped Jane-Marie reorganise various areas of the unit and there's always filing and photocopying to be done
- Occasionally I will become involved with other relatives, especially if meningitis is involved
- As a non-member of staff it is much easier for me to ask relatives for donations and have produced a leaflet which can be used if relatives wish to make such a donation
- And finally I am, of course, always happy to make the tea



The ICU has rooms available for relatives who wish to stay overnight and folders containing information about the unit

How a volunteer can help

Apart from the actual jobs I do on the unit, as an ex-relative I feel my main aim is in fact to try and be a constant reminder of the value of the unit's work.

There are days in hospital life where one thinks: "What am I doing, why am I doing this?", and I am well aware that some days can be incredibly depressing. I just hope that I can act as a reminder to all staff that what you do is priceless.

Caroline Heslop

Volunteer, Intensive Care Unit

Relatives Satisfaction Survey 2010–2011

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 has been based on 35 questions broken down into three sections relating to communication, 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 twelfth year and as in previous years the vast majority of responses from relatives have been very favourable. However, the number of those responding is markedly down on previous years. In 2010, 18 questionnaires were completed and in 2011 only 11 were completed, compared with 40 in 2008.

As a result of this decrease, the Quality Group has redesigned the questionnaire and reduced the number of questions so that the survey can fit onto a single sheet of paper.

As in previous years the results from the survey show that on the whole relatives are very satisfied with the service provided by the ICU, but that there are always areas that can be improved. By enabling 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.

We always knew who was "in charge" of our relative and who to approach and ask questions - a great system. SF Sept 10

We have, unfortunately, much experience of intensive care units. This one really stands out for us because of the friendly helpful staff. ST June 10

I thought everyone was so kind, thoughtful, professional and it was a great team. Thank you. LW Mar 10

More detail needed in the Medical Conditions Folder. Those relatives who are interested will usually want more information not less. Remove the coffee machine in the waiting room - it does not work! Replace it with a bookshelf and literature for relatives. Overall we think you guys do an outstanding job! SF Sept 10

I lost the light of my life in your hospital. Your facilities here are very good, but I have only one word for your staff - STELLAR! Thanks to you all for making such a horrible experience as bearable as possible. RC Oct 10

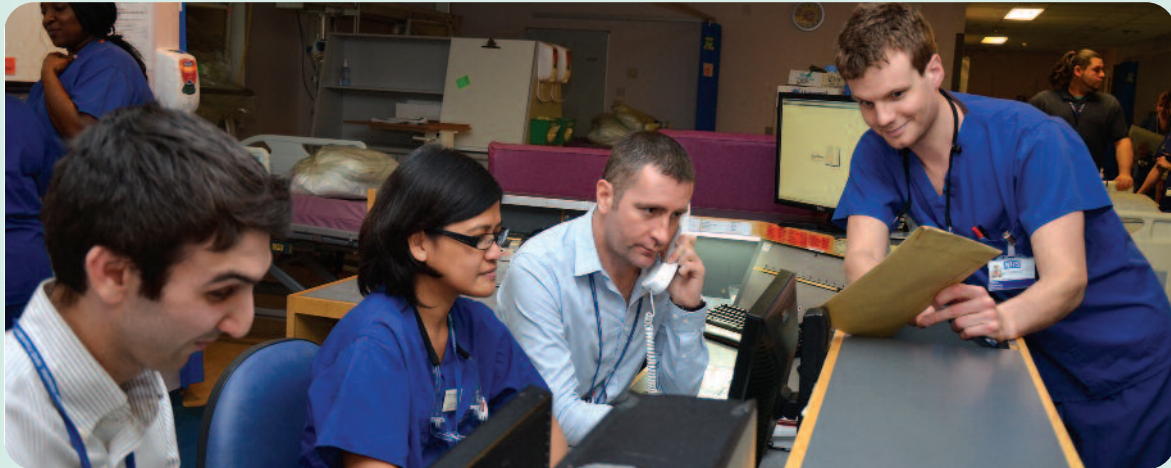
All the staff were excellent and I must mention Abdul the cleaner who keeps the ward spotless. WE March 11

Very happy with care given and friendliness of staff. Treated Mum with dignity and respect and put her at ease. MC July 11

I have nothing more to ask. Very satisfied with the services we received. NL Oct 11

Patient experience

Customer Service Excellence Award



The unit has been praised for its holistic and multidisciplinary approach to patient care

Since 1998 the Intensive Care Unit has applied for, achieved and retained the Charter Mark, which was a Government recognised award for customer service.

Last year the Charter Mark was reviewed and changed to the Customer Service Excellence standard which assesses the performance of public services in making changes and improvements driven by customers, patients or service users in areas that are important to them. It is designed to operate on three distinct levels:

1 As a driver of continuous improvement

In relation to customer-focused service delivery, identifying areas and methods for improvement.

2 As a skills development tool

By allowing individuals and

teams within the organisation to explore and acquire new skills in the area of customer focus and in relation to customer-focused service delivery, identifying areas and methods for improvement.

3 As an independent validation of achievement

By allowing organisations to seek formal accreditation to the Customer Service Excellence standard, demonstrate their competence, identify key areas for improvement and celebrate their success.

The five criteria against which the Intensive Care Unit was tested during a two-day visit by an assessor in March 2011 included customer insight, culture of the organisation, information and access, delivery and timeliness, and quality of service.

We produced a portfolio of evidence measured against each of the five criteria and then the assessor took time during his visit in March to interview patients, relatives and staff to check that what was written on paper in the portfolio was reflected in practice.

The assessor identified strengths of the Intensive Care Unit including:

- A holistic approach to patient care by considering all the factors which could improve care
- A multidisciplinary approach to making suggestions and taking decisions rather than a 'top down fait accompli' approach
- The determination, professionalism and loyalty to the unit of staff who are proud of their work and clearly put patients and their relatives first

- Focus groups that enable former patients and relatives to talk about their experiences on the unit—these groups help identify many improvements

Areas for development identified by the assessor included:

- Developing a more user-friendly philosophy of care by agreeing five or six key statements and displaying these at the entrance to the unit
- While adhering to the Trust-wide approach to handling complaints, staff should try where possible to take greater ownership so that aspects of timeliness, promises and protocols are adhered to
- Celebrating and promoting success and performance through the unit's newly revamped section of the Trust website

This award recognises the compassion, dedication and hard work that all staff show every day to ensure that patients and their relatives are getting the best care.

Elaine Manderson
Clinical Nurse Specialist

Jane-Marie Hamill
Head Nurse Critical Care

Customer journey mapping

As part of the Customer Service Excellence assessment, the ICU undertook customer journey mapping to better understand what it is like to be a patient or relative using the intensive care service.

Customer journey mapping can help to identify how the ICU 'treats' its customers during each contact that takes place. It is viewed from the standpoint of how the customer feels towards the Intensive Care Unit during the time they use the service.

In terms of customer understanding, journey mapping helps the unit to:

- See things from the customer's point of view
- Deliver information, messages and services at the most appropriate time
- Deliver a seamless, streamlined experience
- Get it right when it really matters eg when emotions are highest or the need is greatest
- Look at the current situation and the 'ideal' side-by-side, giving a chance to genuinely redraw the customer journey

We looked at four 'journeys':

- Emergency admission to ICU – patient
- Emergency admission to ICU – relative
- Elective admission to ICU – patient
- Elective admission to ICU – relative

See page 11 for an example.

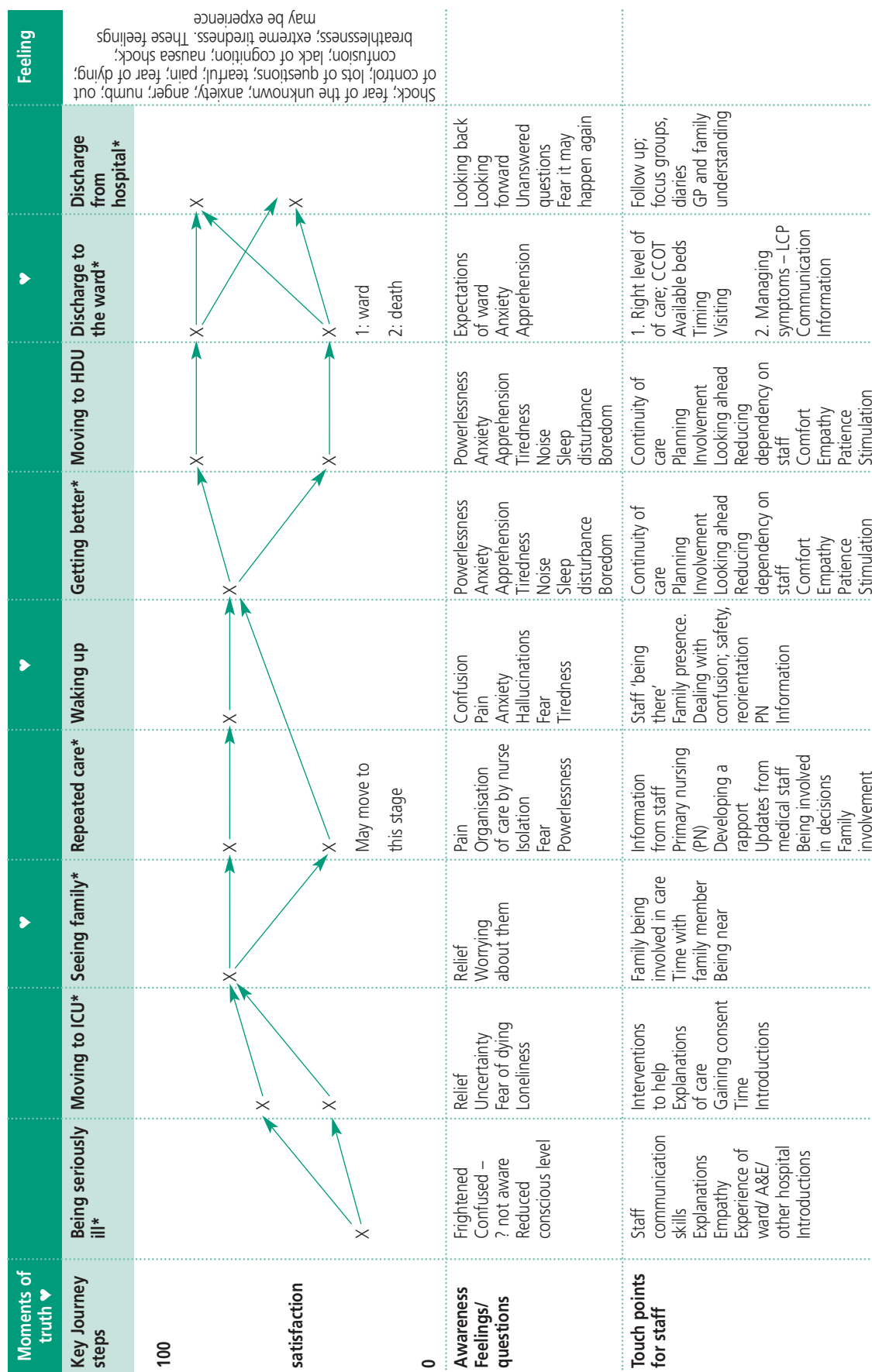
From undertaking this process we have gained a greater understanding of what it is like for our patients and relatives using our service.

We have fed back the maps to staff on the unit and all new starters receive a copy of the map, therefore enabling them to gain an understanding of what it is like to use ICU services.

We have also highlighted areas for future work including further work on delirium in ICU, communication skills training, rehabilitation and discharge from ICU.

Elaine Manderson
Clinical Nurse Specialist

Patient experience



Patient profiles

We have recently introduced a 'patient profile' to augment the care we provide to our patients when they are unable to communicate with us. The profiles are small summaries of the patient, what they like/dislike, what they do with their time, and are completed by relatives or friends of the patient who know them well.

They are designed to help the staff gain a picture of the patient outside of ICU. An example of the profile is below:

Staff have found these useful to build up a picture of the patient and helps them to make sure the patient receives care focused upon their needs and likes while they are unable to communicate with others.

Elaine Manderson
Clinical Nurse Specialist

Name (That they like to be called)

Family and Friends (People who are likely to be visiting and/or phoning. People important to your loved one)

Personality (What sort of person are they? ie happy, anxious etc)

Language spoken (If English is not their first language, will they understand staff speaking to them?)

Background (What do they do? how do they occupy their day?)

Leisure (Describe their hobbies, favourite music, what they like to read, sport interests, club memberships etc)

We regularly reposition patients to prevent pressure ulcers developing – are there any positions that your loved one likes or dislikes, or finds especially uncomfortable due to underlying conditions or old injuries?

Sometimes massage and touch can help to ease aches and pains and assist people in sleeping. Is there any type of touch or massage that your loved one likes or dislikes (e.g. ticklish feet)

Your loved one may have unique needs that you may know about that would be useful for us to know. (Do they sleep in a particular way? Do they have a favourite toy/ pillow, Do they have any phobias? ie needles etc)

Completed by (Name and relationship to the patient)

Patient experience

End of life care – an update

The Liverpool Care Pathway (LCP) is a multi-professional document for the care of the dying patient (*Ellershaw 2003*). Originally developed for the benefit of cancer patients, the LCP has since been adapted for use in other locations, such as the Intensive Care Unit setting.

However, the ICU is viewed as a place for saving lives and active treatment and patients are admitted with the hope of recovery from their illness, yet mortality rates remain high (approximately 16%). Thus, while striving for a curative outcome for a critically ill patient, it can be difficult to realise that the patient may not survive and is instead dying.

Having completed the Palliative Care in Cancer Practice Course at the Royal Marsden Hospital I reviewed the current literature relating to end of life care in the ICU to establish the difficulties that exist when making the decision to move from curative to palliative care for critically ill patients.

Three recurrent themes were identified:

- A lack of certainty of a patient's prognosis, illness progression and of death
- The elusive knowledge of patient preference and ethical dilemmas
- Poor communication

I looked at current practice to identify new strategies to improve future practice. These included:

- Improved communication in a dignified manner with the patient, family and staff
- Assistance and support for professionals so they be more at ease with death and able to accept that death is a normal process and not a failure
- Ongoing education and training for all staff involved in end of life decision making

Hopefully these strategies will encourage the appropriate use of the pathway in ICU for our patients who are dying, and ensure the multi-professional team delivers high quality care for dying patients and their families.

Ann Sorrie
Sister
Team E

Reference

Ellershaw J (2003) 'Introduction' (pxi – pxiii). In Ellershaw J and Wilkinson S (2003) 'Care of the Dying. A pathway to excellence' Oxford University Press

Safety and clinical effectiveness

Infection Control

It has been another productive year for the Infection Control Team as we continue to establish ourselves as one of the newer inter-team projects.

Patients we care for in ICU are more susceptible to infections due to the interventions deemed necessary for us to give our patients the best possible care.

With this in mind, the ICU set up the Infection Control Team which meets once a month. Our main aim is to ensure the

standard of infection control remains high within the unit.

We attempt to achieve this by continually evaluating current infection control practices and identifying improvements that can be made. Teaching sessions are then held to establish a consistency in infection control practices across all staff working in the ICU. A member of the Trust's Infection Control Team regularly joins our meetings to provide an update on events elsewhere in the Trust.

Of course these meetings would be fruitless if all the stakeholders in the ICU did not adhere to the infection control regulations. While it is imperative that all the doctors, nurses and support staff within the ICU work to protect the patient, it is also important that we educate all healthcare professionals and relatives who visit our patients on how they can prevent the spread of infections.

We have a new infection control notice board which is located in a prominent place within the unit. This is used to communicate updates on infection control to all staff in the ICU.

A big change to the team this year has been how we audit infection control.

The Trust has recently launched an online auditing tool called Synbiotix. The types of things we audit on a monthly basis include hand hygiene and central line care. Every month the necessary data is put into Synbiotix and it becomes a useful tool to benchmark our progress from month to month. The results of the audits are posted on the infection control board so staff can clearly see if and where improvements need to be made.

Over the next year the team will continue to strive to provide the most up to date practice with regards to infection control in order to protect our patients as best we can.

Katherine Thomas

Staff Nurse
Team H



A member of the ICU's housekeeping staff

Safety and clinical effectiveness

Tissue Viability Group

The Tissue Viability Group was set up last year to support the nursing team in reducing the incidence of pressure ulcers, and consider other aspects of tissue viability.

Over the last year, the group felt there was a need to improve the information available for staff. As a result we are currently developing a folder covering a variety of topics such as what wound care products are stocked in the unit, how they work and which type of wounds they are suitable for.

Another section provides comprehensive guidance (from KCI) relating to vac dressings. Other sections include a copy of the updated tissue viability pressure ulcer prevention guideline and information on the role of the European Pressure Ulcer Advisory Panel (EPUAP) and the organisation's online research and learning tools.

Additional information will be added to the folder over the next 12 months following feedback from the ICU team and in consultation with the Trust's Tissue Viability Nurse.

The group also found a need for improved understanding in identifying the earliest level of pressure damage and how to grade the severity of pressure ulcers when they occur. This is important because it affects

prevention and management strategies. Project members have enhanced their understanding of the EPUAP grading tool and are encouraged to share their knowledge with their team members. A teaching session on pressure ulcer prevention is included in the foundations of critical care course.

In addition to pressure ulcers, ICU patients are particularly susceptible to development of moisture lesions, for example due to discharge from wounds or faecal soiling. It is important to prevent this where possible and be aware of different strategies in avoiding or managing excoriation. One member of the group is developing a guideline summarising the differences between moisture lesions and pressure ulcers as defined by EPUAP and how they can be treated.

The group is also actively seeking to reduce the cost in wound care products and has identified a cheaper but effective product to reduce pressure over the patient's heels. The group will continue to review other wound care products to minimise waste and improve cost effectiveness.

Finally, the group will run a 'Pressure Ulcer Prevention Awareness' week to highlight all the information available on the unit. We hope that during the

remainder of this year our work will have a positive impact in improving patient's skin and wound care within the unit.

Caroline Younger
Sister
Team B

Organ Donation Committee

As part of the NHS Blood and Transplant (NHSBT) national agenda for increasing organ donation rates in the UK, it was recommended that each Trust should have a Clinical Lead for Organ Donation (CLOD) and an embedded Specialist Nurse for Organ Donation (SNOD).

It was also suggested that a donation committee be set up with the purpose of widening the message and ensuring that patients should be given every opportunity to donate organs in the event of their death if they had expressed that wish in life.

This committee was inaugurated in May 2011 and is chaired by Caroline Heslop. I am the clinical lead for organ donation.

This final act of altruism and generosity on the part of one

Morbidity and mortality meetings

Multidisciplinary Meetings

This section reviews the progress of our established Morbidity and Mortality and our newly formed Rehabilitation Group.

Morbidity and Mortality Meetings

The established Morbidity and Mortality Meetings are multidisciplinary and last for an hour and a half. They are chaired by the consultants on a rotational basis and the format

consists of reviewing the deaths of the patients who have died in the Intensive Care Unit during that quarter.

Each patient on admission to the unit is given an Acute Physiology and Chronic Health Evaluation (Apache) score (severity score). Any patient who scores less than 20 but dies, the consultant will review the reasons and identify patient cases which are presented at the meeting. A discussion occurs and any learning is identified.

For example, it was identified that it would be useful to have a regular report from the Coroner's office on patients who had died on the unit. We have also developed a log book on recording abnormal blood results which are rung through from the laboratory. This details who took the call and what action has taken place.

The second part of the meeting encourages discussion about future treatments, practices, and ensures different staffing groups are updated with what is happening on the unit and are able to give their opinions and suggestions in a constructive way.

For example, in past meetings we have discussed visiting times, consultant's rounds and ideas for donations. It is also an opportunity to network with colleagues. Staff are also given

individual can result in the transformation of several lives and for this reason must be managed with the utmost respect, care and sensitivity. The specialist nurses have been invaluable in this regard.

Organ donation by patients from our ICU is less common than on other units and this reflects the nature of our patients. Brain injuries, for example, are unusual at Chelsea and Westminster. Nevertheless, communication from the families of the few patients who have wished to donate has been very positive despite the deep sadness that inevitably accompanies this final act of giving.

Dr Rick Keays

Consultant Intensivist
Clinical Lead for Organ Donation



Staff prepare to take a chest X-ray

an update on the Liverpool Care Pathway and organ donation.

It is extremely well attended by more than 15 staff, but one learns that if a meeting includes lunch it is usually well attended.

Rehabilitation Group

This group was established in 2011 to provide a consistent, co-ordinated approach to rehabilitation and discharge planning of critical ill patients by the MDT (multidisciplinary team).

We have developed a proforma for arranging MDTs on the unit and this has been used and documented for a number of patients. It has helped to involve and include specialties such as speech therapy and occupational therapy in planning short term and long term goals for the patients. Other goals include setting up exercise plans for our patients and updating our discharge booklet.

Jane-Marie Hamill

Head Nurse Critical Care

Safety and clinical effectiveness

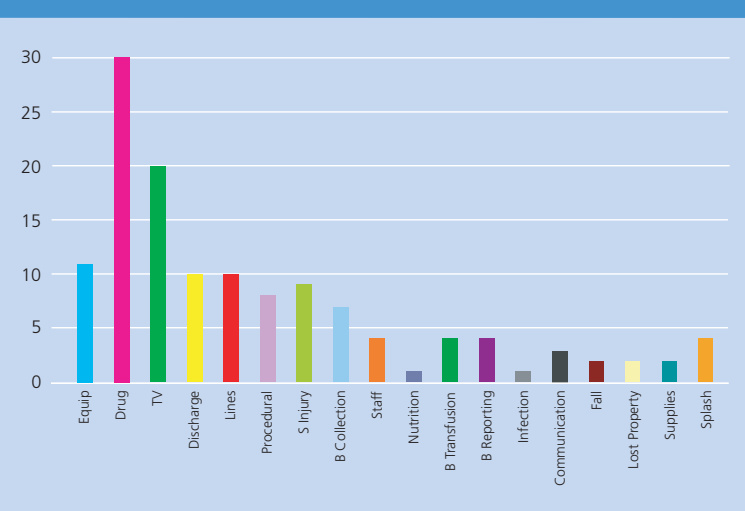
Clinical incidents

In 2010, 132 clinical incidents were recorded by staff in the Intensive Care Unit. Table 1 divides these incidents into specific categories.

Process

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

Table 1 ICU Clinical Incidents 2010



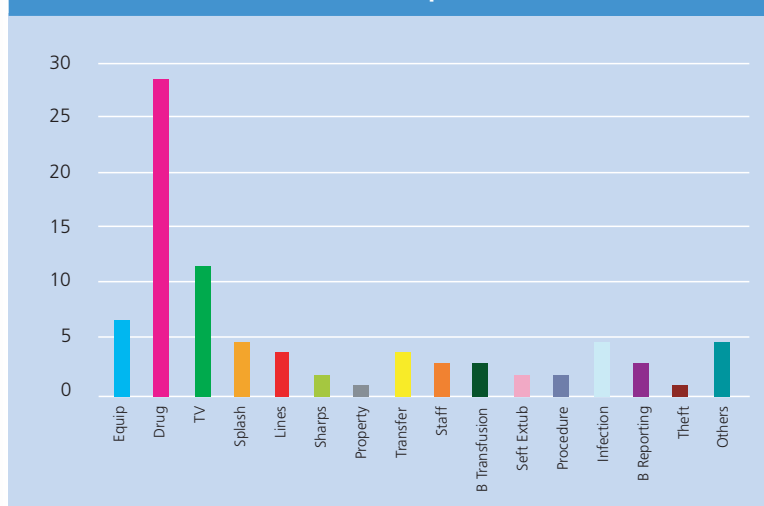
Each quarter a summary of incidents is presented to staff on the unit to reinforce good practice, or act on ideas or suggestions to prevent incidents from reoccurring. An annual review also takes place which is presented in the annual report.

Learning in 2010

Clinical incidents are a great way to review practice and think about where there are gaps in information, knowledge or process. The following examples demonstrate what the Intensive Care Unit has done to improve practice:

- The wrong feed was given to a patient – A list of documented feeds and what they are used for was placed in the kitchen to give staff updated information on why certain feeds are prescribed
- Patients self-extubation (removing Endotracheal Tube) – We looked at how staff were securing them and trialled different ET holders
- Documenting pressure ulcers – Having heel protectors to prevent pressure and discussion of them at the

Table 2 Clinical Incidents Jan-Sep 2011



- Tissue Viability Group
- Updated Drugs Quiz

Table 2 highlights the clinical incidents that have occurred in the ICU from January – September 2011. There have been 88 incidents documented by staff during this period.

Drug Incidents

There were 29 drug incidents during this period, so further analysis was undertaken to identify themes. These are listed in Table 3.

In some of these incidents, staff have had to re-do their Trust booklet to remind them of safe, correct practices in drug administration. We have

also introduced new bright green drug labels to be used on the pumps when we are giving inotropes so that staff will think before they alter a pump with an inotrope in it, and we have purchased a measuring funnel to correctly measure suspensions in our CD cupboard.

Blood transfusion is another area in which practice has changed due to a clinical incident.

When a patient has multiple transfusions they have an increased risk of developing antibodies. In order to reduce this risk, the time that the sample is valid for is cut down

to 24 hours which is highlighted on the blood comp ability form. There have been a few incidents in the Intensive Care Unit where patients have had blood after that 24 hour period. The form was changed and there is now a red stamp on the form that states DO NOT TRANSFUSE AFTER (.....). This is a visible way of getting staff to check what they are doing.

Clinical incident monitoring ensures safe practice is a transparent process where we can all learn and change practice as a result of what happened and not just where the incident occurred.

Jane-Marie Hamill
Head Nurse Critical Care

Table 3 Drug incidents

Type	Number	Details
Drug calculations	3	Mgs to mcgs
Admission	3	Drugs given when omitted
Omission	2	Drugs omitted when they should have been given
Drug administration process not followed	2	
Wrong Dose	4	
Wrong Drug	1	
Wrong mechanism	1	Drug given without filter
Allergy not checked	1	
Wrong fluid for transducer	1	
Dispensing	1	
Labelling incorrect	2	
Incorrect Volume	2	Suspension fluid
Cds broke	2	
Cd made up and not removed	1	
Pumps – wrong pump started	2	

Safety and clinical effectiveness

Health and safety

I took over as health and safety representative in September 2010.

One of the first things I did with my predecessor was a Health and Safety Assessment which incorporated patient care areas, hazard identification, working environment including control of substances hazardous to health, fire detection, equipment and training. It also covered moving and handling of patients on the ICU which often involves the use of hoists and sliding sheets. Nurses have training on this in their update days every other year, but the equipment has to be fit for purpose and available.

Electrical systems were also assessed and the UPS (uninterrupted power supply) on the Burns ICU satellite unit was found to be faulty. Electricians contracted to the hospital promptly fixed the problem.

Violence and aggression can be encountered from patients, relatives and visitors and staff are trained on how to deal with this. We successfully assessed and trialled the panic buttons located in various areas of the ICU. We also have a coded security lock on the entrance to the ICU to ensure patient and staff safety and we have areas for relatives to stay to try and decrease their levels of stress.



The unit has a secure entrance to ensure patient and staff safety

Stress for staff can be an issue due to the complexity of patients' and relatives' needs. We try to ensure that staff take adequate breaks and talk about any issues at handover and unit meetings. Clinical supervision is also on offer.

An area for improvement I identified was staff training in fire evacuation. While this is now incorporated into mandatory training it had historically been on a separate day and staff attendance had been poor. I organised for the Fire Officer to come to the unit to teach fire evacuation during the allocated teaching time held each weekday from 2—3pm

(between staff handover period). We have since had evacuation sheets put on all mattresses, which would have proved invaluable when we almost had to evacuate the unit recently during the installation of new generators for the hospital.

Nurses on the unit are encouraged to fill out risk assessment forms if they feel anything has occurred either potentially or actually. These are used as a learning tool and are sent to our manager who feeds into the Clinical Risk Team.

Danielle Pinnock

Sister
Team H

Care bundles

Ventilation Care Bundle

A care bundle is a way of ensuring the evidence-based clinical care that patients should receive is actually delivered. It is a quick and systematic method of auditing our therapeutic interventions.

The process starts by asking the question: "What elements of care should be delivered to a specified group of patients 100% of the time?". By doing this we are reducing the unrecognised omission of therapy and enhancing equity of care for patients. This can lead to reduced morbidity and a reduction in length of stay.

We have been auditing our ventilator care bundle for the past few years. The care bundle is made up of four elements, each of which has been found to improve care and outcomes for patients on ventilators:

- Head of bed elevation to 30° – to help prevent aspiration into the lungs
- Upper GI tract ulcer prophylaxis – to prevent stress ulcers
- Thrombo-embolism prophylaxis – to prevent Deep Vein Thrombosis
- Daily sedation holds – to reduce time spent on a ventilator

We have consistently achieved more than 90% compliance and frequently achieved much higher results as seen in the results table from 2010-2011.

Elaine Manderson
Clinical Nurse Specialist

Table 4 Preventative Ventilator Associated Pneumonia



Financial and environmental sustainability

Activity and performance

Performance 2010-11

When used effectively, measurements of performance can give us insight into the service we are trying to deliver – from the number of patients admitted, to the time patients are discharged, to the number of staff working on the unit. This gives a balanced picture into the service and identifies areas where we need to improve in order to be more efficient.

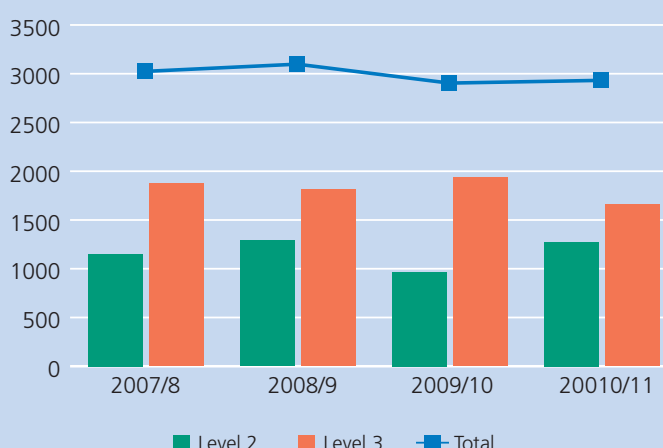
However, services do not sit in isolation within the Trust and sometimes what affects the flow maybe outside the control of the unit. We are responsible for knowing what those pressures are and highlighting them in a constructive way.

Activity

Chelsea and Westminster Hospital's Intensive Care Unit consists of eleven beds which are flexible to provide Level 3 (intensive) or Level 2 (high dependency) care depending on the needs of patients. In addition there are two burns intensive care beds.

Income for critical care activity is dependent on critical care bed days. Table 5 outlines the number of bed days per year from 2007 to this year. Fluctuations in activity can and do occur. This may be due to a particularly bad winter when flu means there are a lot of patients requiring specialised respiratory management.

Table 5 Intensive Care Occupied Bed Days



Fluctuations in 2010-11 have occurred in April-July with low levels of intensive care (Level 3) activity. This subsequently picked up towards the end of the year. A key challenge is to respond to these fluctuations while at the same time using resources effectively.

Quality Measurements 2010-11

We collect a lot of data on the Intensive Care Unit and Table 6 outlines quality measures we use to indicate the effectiveness of our service. Some of these measures are within our control and others depend on the flow within the hospital

Table 6 Quality Measurements 2010-11

Description	Number	Notes
Number of patients discharged between 22:00–08:00	21	It is seen as a clinical incident when patients are discharged between these times as there may not be the proper follow up. This would have occurred due to the late availability of a bed.
Number of delayed discharges greater than 24 hours	48	48 patients waited longer than 24 hours to be discharged from ICU
Number of patients cancelled due to no critical care bed	4	Only a small number of patients cancelled within the year due to no beds
Number of patients readmitted within 5 days	5	Numbers of readmissions has been low as well
Number of patients transferred to another hospital due to no critical care beds	2	Only low numbers of patients transferred out due to lack of critical care capacity

In response to the delayed discharges we are reviewing the discharge process with the involvement of the Clinical Site Managers, critical care outreach and ward staff.

Finance

Activity was high in 2011 which resulted in a lot of devolved income for the unit. Although bank and agency spend was high, this was related to activity. The financial analyst for clinical support helped to introduce a weekly sitrep form which enabled us to fill in the staff used, against the number of patients on the unit. This demonstrated the amount of income received for over activity and how this could be balanced by the cost of agency or bank. We fill in these forms every week and therefore can explain more precisely the reasons for under/over spend in the budget.

Intensive Care Trust Fund

The Intensive Care Unit has a Trust Fund and at the end of 2010/11 we have a surplus of

Staffing on the Intensive Care Unit

There is no doubt that the single biggest cost is staffing the unit and the biggest challenge is recruiting and retaining appropriately trained staff to provide safe and effective care to critically ill patients and their families.

The ICU staff provide expert nursing care to look after patients on the general and burns Intensive Care Unit.

Currently the unit consists of seven Level 3 (intensive care) beds and four Level 2 (high dependency) beds, as well as two Level 3 adult burns intensive care beds. These can be used flexibly depending on the needs of the patient.

We also have a policy of not refusing any admissions unless the staffing levels are such that patient safety is compromised.

£5,000. Most of the money comes from donations and in 2011 we had a particularly large donation which was raised by the wife and friends of a patient who died on the unit.

Ideas for spending the funds are raised with staff through the finance and supplies group. In 2011 we funded:

- An Echo probe for our ultrasound machine

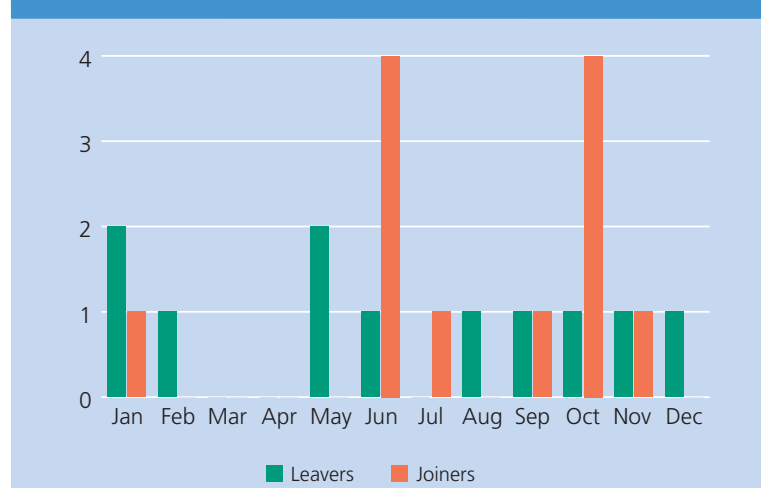
- An ice machine
- A portable DVD player for patients
- Sound Ears that highlight when the noise reaches a certain level
- Staff to go to conferences
- The staff Christmas night out

The fund is also used to provide lunch for our quarterly multidisciplinary meetings and our information booklets on the unit. We are extremely grateful for all the donations we receive and we always let the families know what we have purchased with their donation.

Recruitment

In 2010-11, one of the challenges of staffing the unit was the high number of staff off on maternity leave. At one stage this resulted in the equivalent of eight whole time equivalent (WTE) staff off at one period. A cost pressure was highlighted due to paying for permanent staff on maternity leave and at the same time paying for

Table 7 Intensive Care Unit Leavers and Joiners 2011



Financial and environmental sustainability

temporary staff to cover their posts. As these posts were at senior level, fixed term contracts were not an option.

This year 2011-12 the number of staff on maternity leave has returned to the usual numbers.

It is extremely important therefore to keep on top of recruitment and be aware that the process can take a minimum of six weeks and maximum four months. On the unit we capture the number of leavers and joiners that occur in the year (as outlined in Table 7), which helps us to identify if there are any trends.

In 2011 the number of leavers was spread out over the year. Time spent on the unit is shown in the table below.

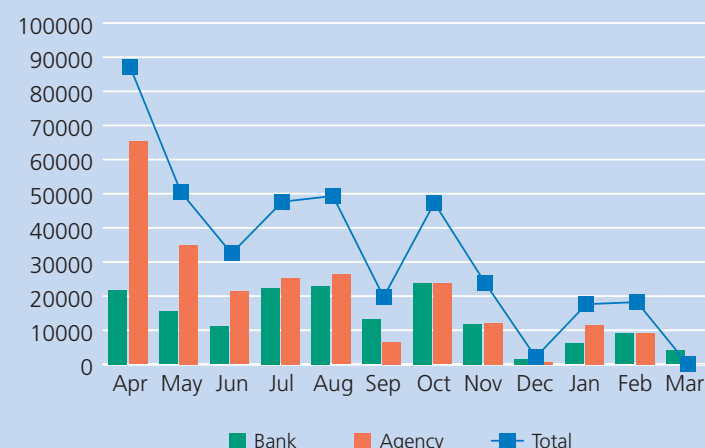
Time spent on the unit

Less than 2 years	4
2-5 years	6
More than 5 years	1

The reasons staff gave for leaving were to relocate to another country, change of job, to go travelling and to gain experience in another specialised Intensive Care Unit. One staff member felt that intensive care nursing was not the job they wanted and subsequently changed to health visiting.

If activity is high on the unit we have to supplement our staff with temporary staffing. Therefore, although our usage from April-August 2011 was

Table 8 Agency/Bank in ICU in 2011-12



high this was related to high levels of activity. Table 8 shows the agency and bank usage on the unit in 2011-12

One change that has been introduced is a weekly sitrep report devised by the clinical support financial analyst. Each week the number of patients on the unit and total number of staff including sickness, maternity leave and cost of temporary staff is updated on the spreadsheet.

This information highlights whether activity is down and therefore there should be no temporary staffing used, or whether activity is high and explains the use of temporary staff.

In 2011 we have also identified some savings by changing our skill mix. Table 9 shows that we have reduced Band 7 and 6 posts and increased our Band 5 posts.

Changes to Staffing 2011

As a result of these changes we changed our Band 6 job description to include a completed and passed mentorship course. We now hope only to externally recruit for Band 5 posts and internally recruit for Band 6 posts.

Retention

When talking about staffing, equally important are plans for retaining staff and ensuring they receive the training and skills to do the job.

Each new recruit to the ICU is placed on a pathway relevant to their band. For example, a new Band 5 nurse will commence the Band 5 pathway which involves completing the foundations programme that will lead to the intensive care course. After a period of consolidation they may undertake the mentorship course. These pathways provide the structure for staff to develop their knowledge and skills

Table 9 Changes to Staffing 2011

Post	Budgeted Establishment	Changes	Difference
Band 3	1	1	
Band 5 (admin)	1	1	
Band 5 (nurse)	25	30	+5
Band 6	30	25.5	-4.5
Band 7	8	7.5	-0.5
Band 8a	1	1	
Band 8b	1	1	
Totals	67	67	0

through formalised courses, project work and mentoring, and helping others.

The aim of these structured pathways is to produce competent, confident, expert nurses with excellent observational skills. This is important because the effective use of critical care nurses can greatly improve patient care and reduce the incidence of complications for patients. For example, their observational skills can reduce the impact of sudden patient decline and their holistic approach to care can

change the experience of care for both patients and their families.

On our Intensive Care Unit we want the critical care nurses to develop skills in stepping up and stepping down care, interventions and treatments, so that we intervene when the patient requires more support but equally speed up the process of discharge.

In addition, the structured pathways encourage and retain staff so that they are exposed to different situations and develop

different skills. For example, at Band 6 level, staff on the unit are expected to actively participate in inter-team projects. One project is the off-duty. Exposing staff to learning how to create a rota and balancing the needs of the unit with individual requests gives insight into the complexity of this task and indirectly helps the individual gain skills in conflict management.

In relation to critical care units, it is imperative that local strategies are adopted to counter the pressure that exists and provide a supportive working environment to enable the delivery of an efficient and effective critical care service. We are therefore thinking and implementing further plans for 2012.

Jane-Marie Hamill

Head Nurse Critical Care

Jason Tatlock

Administrator and
Information Officer

Off-duty Planning team

The purpose of the Off-duty Planning Team (ODPT) is to adequately staff the Intensive Care Unit with an appropriate skill mix of nursing staff. There is well known recognition of the stress of working rotating shifts and attempting a good work/life balance. The ODPT aims to promote this to each nurse

through self-rostering which allows for equality and flexibility.

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 to provide every staff member access to the Manpower Software System (MAPS) system to enter their own rota and the ODPT will provide training to all ICU staff prior to this being piloted.

Financial and environmental sustainability

MAPS is the computerised programme currently used within the Trust to create and manage the off-duty. This system has effectively eased the workload of the team when creating rotas for the unit. A useful example of this is that MAPS highlights the skill mix including the number of co-ordinators on a particular shift and gives quick access to monitoring sickness, annual leave and study leave allocations. The system automatically calculates staff working hours, so shortfalls can be readily addressed on the current rota being created.

From January 2011 the ODPT developed a new system of booking annual leave and updated the annual leave policy. A dedicated file contains the 'read only' template for annual leave on a specified computer within the unit. This displays the

availability of annual leave to take. Every member of staff has access to this template. If they see a space and wish to book, they are required to email the ODPT who will enter the name of the member of staff on the date requested. Requests are on a first come, first served basis depending on time and date of email. The request will most certainly be successful as long as the unit has adequate skill mix, team cover and co-ordinators.

The ODPT will then update each member of staff's computerised annual leave card which will display the remaining days left to take. Each staff member also has 'read only' access to the annual leave cards so they can manage their own leave and ensure they take their allocated leave in a timely manner.

All members of the ODPT are trained as rota creators and each

person rotates every three months to become key rota creator. Each member also rotates through other key responsibilities of the ODPT, for example hour keeper, annual leave bookings and the co-ordinators rota. The rota updater is now included as one of the competencies in the co-ordinators pack for Band 6 nurses in the unit, which allows them to update the rota on a daily basis, for example bank bookings and/or cancellations, updating sickness absence and ensuring skill mix on each shift.

Neil Anderson
Senior Staff Nurse
Team I

Thank you to all Off-duty Planning Team members for their continued hard work.

Amanda Dixon
Sister
Team J

Finance and Supplies group

This group was set up to allow staff other than the Clinical Nurse Lead (CNL) to take an active role in the overall budget and finances of the unit. The group includes a member of staff from each team, the CNL, unit administrator, technician and healthcare assistant.

The purpose of the group is to monitor expenditure and agree allocation of funds from the Intensive Care Trust Fund, and

improve awareness of costs, for example bank and agency staff, disposable items and equipment. We aim to save money where possible without sacrificing quality, and negotiate better deals with healthcare companies. We organise the trialling and evaluation of new products and address any problems with stock levels.

This financial year the unit has had to find a saving of

£322,000. We have saved £25,000 on the drugs budget by using some cheaper drugs, for example prescribing Ranitidine instead of Pantoprazole (unless the patient is high risk), reducing the types of dialysate fluids from three to two, and reassessing the types and sizes of naso-gastric feeds.

Staffing levels remain the same, but Band 5 staff need to complete the mentorship course

The Three Peaks Challenge

before they can apply for Band 6 posts and therefore remain Band 5 for longer.

We have reviewed the types of dressings we use, trialled some new ones and replaced those for our usual stock. We have trialled other new products including ventilator tubing, filters and endo-tracheal tapes, some of which we have changed to.

We have agreed funding from the Trust Fund for a new rehabilitation chair, carbon dioxide monitors, an ultrasound probe for central line insertion and echocardiograms, an ice machine and noise detection monitors. We have also revamped our information booklets.

Service contracts for equipment are being updated so we know who is responsible for each piece of equipment.

Our main store rooms have been revamped and labelled – including prices – to make it easier for people to find things and make everyone more aware of costs.

We have increased recycling with a new green bin, to tie in with the Trust's recycling target.

And last but not least we have organised the Christmas and summer nights out with some funding for food and drinks for staff.

Danielle Pinnock
Sister
Team H

"The challenge is courage. Courage is resistance to fear, mastery of fear, not absence of fear." Mark Twain

Outdoor activities are well promoted by our society and they are an excellent way to build up and prove team spirit when adversities come to light.

Outdoor activities also are challenging from the physical and psychological point of view. The challenge bursts the adrenaline and makes one's heart pump fast, which also wakes up one's fear of failure.

So one day, I found myself involved in charity events which were a great challenge as I had to not only train myself physically but expose myself to a completely new world.

The idea of approaching people and asking them to fund me, terrified me. A colleague of mine once said: "Marcela, you will not make a difference, do not waste your energy". I think this comment made me realise and reinforce my belief in manpower.

From then on I started taking part in events to support good causes and make people aware that they can make a difference if they believe in themselves.

The most extraordinary event I took part in so far was the Three Peaks Challenge in June 2010 which involved climbing the three highest peaks on mainland UK within 24 hours. There were eight of us and we were required to walk 24 miles,

climb 10,000ft and travel over 700 miles.

Apart from the physical aspect, the preparation consisted of hosting a BBQ for more than 50 people, contacting the local Tesco about displays and tin rattling and of course twisting the arms of friends, colleagues and acquaintances.

The minibus was also a challenge in itself, as the governor limited the speed to a maximum of 62mph! Fortunately the roads were clear and Saxon was a good driver so we advanced uneventfully between Ben Nevis and Scarfell Pike. Unfortunately we hit a traffic jam along the North Wales Coast so we were left with less than five hours to complete Snowdon. But we did it and completed the Three Peaks Challenge within the stipulated time. It was formidable – the experience, the team, the great financial support...the challenge.

One thing this experience taught me is that we must follow our dreams and that by sharing them with others makes them real. When one applies this concept to daily activities one can make a difference and achieve unimaginable things.

Anything is possible; we just need to believe in ourselves.

Marcela Viscaychipi
Intensive Care Consultant

Teaching and research

Teaching Group

The Teaching Group meets monthly and co-ordinates the teaching activities on the ICU. The group is made up of representatives of each of the primary nursing teams.

Each month the group receives updates on progress of courses, ensures that the teaching sessions for the 2–3pm teaching slots have been filled and reviews any ongoing developmental work.

The two main projects the group has been working upon are:

1 Developing a workbook for student nurses

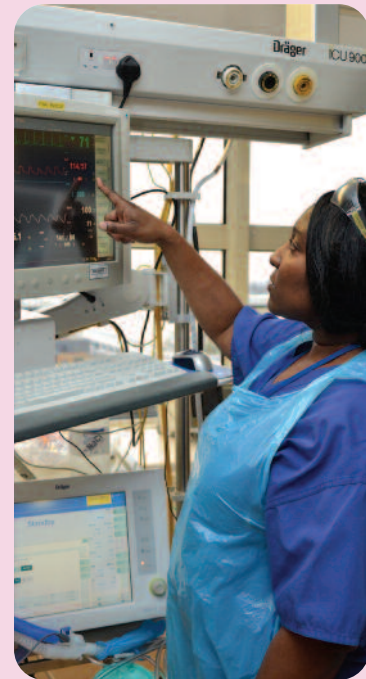
This is a self-directed workbook that helps student nurses navigate themselves through ICU. It is designed to

work alongside the learning they gain at university and also from working with their mentor.

2 Reviewing the ICU Band 6 programme

The programme has been reviewed and shortened slightly to reflect the needs of the nurse who has recently been promoted to a Band 6 role. The topics covered are advanced patient management skills, advanced communication skills and coaching and co-ordination of the ICU. The group hopes to start running the study days for the programme in early 2012.

Elaine Manderson
Clinical Nurse Specialist



A member of the ICU team

The staff development role 2010-11

I have been the Foundation of Critical Care (FOCC) course co-ordinator from September 2010 to September 2011.

During that time we have had two cohorts with four students starting each course. There have also been some students from previous cohorts who have been given an extension and we have had some Band 5 nurses and physiotherapists attend individual study days. The cohort sizes were optimal – big enough to enable discussion and small

enough to encourage the students to get to know and support each other well.

The summative assessments are a critical analysis essay and competencies. Throughout the six months, the students also need to complete workbooks (which prepare them for the study days) and pass a final test. They present a patient assessment and participate in clinical supervision. As the Staff Development Sister, I also regularly worked clinically with

the students, which gave them the opportunity to care for more complex patients. All the students passed their FOCC; indeed, some of them are already continuing their ICU studies at Kings College London!

From a personal point of view, this was a great learning experience. Not only did I improve my clinical skills, but I was also asked some challenging questions which encouraged me to think differently about situations. Running the FOCC

has given me more insight into the new ICU nurse's experience and hopefully I can use this knowledge to support and challenge these nurses more effectively, especially when I co-ordinate the unit. I enjoyed working so closely with the students in a supernumerary capacity and it was a pleasure to see the dedication of the students' preceptors.

The most rewarding aspect of this role is observing junior ICU nurses developing professionally. I have really enjoyed seeing their confidence grow, particularly when they cared for more

complex ICU patients such as patients receiving renal replacement therapy or Burns ICU patients.

The FOCC is accredited with the University of West London until March 2012, after which we are going to trial running it as an in-house course. This will give us more freedom to make changes to the course content or assessment strategies. We are hoping to make the workbooks and perhaps even the study days more patient-scenario based. This is based on feedback from students which is collected every study day, as well as mid-point

and at the end of the course.

In the past year, we have revised the competency book adding "transfers" to the existing ones. Having the physiotherapists attend and teach on one of our study days was good and we hope to have more multi-disciplinary team involvement.

I am now returning to my clinical role and have handed over to Charlie Brown. The next cohort starts November 2011.

Rosalie Le Cordeur
Staff Development Sister

Experience of the Mentorship course

I have been working in the Intensive Care Unit for the last two years. I decided to undertake a Mentorship course in May 2011, which ran at the Kings College University of London. During the module I developed my teaching skills and confidence.

I learnt how to create and establish an effective working environment for the students and acknowledged the fact that some students need to be approached with different teaching styles to facilitate their learning. I identified the importance of being structured and specific when delivering teaching and the demand to expand my own knowledge in order to be well prepared for teaching. I learnt the

importance of creating a learning contract with students to set up smart, realistic and achievable learning goals.

During this course I became a support for the students and frequently reviewed their performance by giving regular feedback and opportunities to discuss any issues. I also needed to be approachable and to articulate comprehensively to the students when they asked me questions.

The key responsibilities as a mentor are to support learning and assessment in practice, and make judgements relating to students' registration and fitness.

As a mentor, I have accepted my professional accountability within

the Nursing and Midwifery Council code of professional conduct and to facilitate students of nursing, midwifery and others to develop their competences.

I really enjoyed the Mentorship course. We had very proactive teaching sessions with great lectures. There were many group activities such as team exercises, video projection, preparing a mini teaching session for a small group of colleagues and discussions.

This course was very interesting and I gained a lot of knowledge which helped me to develop my expertise.

Lucie Stepova
Senior Staff Nurse
Team F

Teaching and research

Experience of the Foundations course

Foundation of Critical Care: Views from the outside

My experience of the Foundation of Critical Care (FOCC) course was by far not that of your average candidate.

The course is primarily designed for the junior intensive care nurse in order to consolidate what has been learnt prior to arrival in the ICU and establish where their skills will be taking them and how to better oneself to benefit the team and ultimately the patient.

As a Resuscitation Officer with minimal (at best) ICU experience and more specifically a paediatric nurse entering the world of adult medicine, it was suggested to me by my manager and colleagues that it would benefit me to attend the theory aspect of the course to refresh and develop my understanding of critical nursing and gain a greater understanding of adult medicine.

This was an opportunity I jumped at and have to say that overall I really enjoyed the experience. I approached the course with trepidation, realising I would be working alongside members of staff I have already taught, or will eventually teach either in nursing updates or Immediate Life Support courses. This bothered me somewhat as I am always aware of my lack of

adult experience and therefore fear for my credibility.

I was happy to realise that my prior training and "brainwashing" (for want of a better word) of standardised ABCDE assessment carried me through quite a bit.

The content and delivery of each module was always done very well and having to do the pre-course material was a great help. I do feel that I am now much more aware of how the body's systems interact with one another. It has made me question practice I have just "done" for years and made me aware of why I'm doing what I'm doing. With this in mind, it has made my understanding and need for more information relating to medicine and nursing much more enjoyable.

It has benefited my teaching and I can see how what I have learnt can be easily passed onto others.

The formal assessment of the course was a double-edged blade. I was concerned that I would fail my exam, however I surprised myself by getting a high score, much better than I thought.

The assignment was difficult for me. Not being in the ICU, and therefore not having exposure to Level 1 patients on a daily basis, resulted in my patient choice

being severely limited.

Unfortunately, my exposure to adult patients is only when a patient is either in peri-arrest or cardiac arrest. I'm often only with the patient for 30–60 minutes and then I have no further contact. Therefore I believed I was at a severe disadvantage when it came to my assignment. My colleagues on the course had days' worth of exposure to their chosen patient, enabling full and easy access to their notes and treatment and (from my point of view) easier critique of the care being delivered to their patient.

However, I was given lots of support from the FOCC tutors and I was able to scrape a pass enabling me to walk away from the course with 60 credits at Level 3, which I am hoping will help me towards my current MSc application.

I'd like to take this opportunity to thank the FOCC tutors for their unwavering support during the course and I hope I can return the favour soon and come and teach on some of the FOCC study days.

Andy Winter
Resuscitation Officer

Immediate Life Support teaching

I recently became an Intermediate Life Support (ILS) Instructor. This is a new challenge, but it will allow me to develop within my role as a Senior Staff Nurse on the ICU.

It all started while I was doing my ILS course and the Resuscitation Officer said that I performed well on the day with my knowledge and how I interacted with the other members of the team doing the course. They felt that I would be a good instructor and should undertake the Intermediate Life

Support Instructor Course, which I completed.

It has been an extra challenge to my role, which helps me to assess others and improve my teaching skills. You work closely with the resuscitation team who continually assess you on teaching, demonstration, your knowledge and how you assess others. It has been a great opportunity as it is something that is of great interest to me.

I have also recently completed my Advanced Life Support

course (ALS) and have been asked to do my instructor course for this – another new challenge which I hope to fulfil soon. I'm looking forward to learning in my new role and it has been great doing something different in my career.

My line manager gives me study leave each year and they have been very supportive of me with my love for ICU and resuscitation.

Karen Sisk
Senior Staff Nurse
Team E

Research Group

The Research Group has had a very productive year and it would appear from reviewing the past year's work it can be divided into four areas.

1 The generation of guidelines ready for ratification by the ICU clinical governance group

The process for ratification for our guidelines was described in last year's annual report. The guidelines ready for ratification over the past year have included the Handover and Bladder Irrigation guideline and the LiDCO and Flotrac (Edwards Vigileo) guidelines.

2 The presentation of guidelines in the process of development to the Research Group for feedback

The presentation of guidelines entailed reviewing the Passy Muir Speaking Valve and Intra-abdominal Pressure Measurement guidelines and the Total Parental Nutrition guideline. All were in various stages of development and each raised questions about our current practice, promoting a healthy discussion within the group in the quest for best practice.

Debate still surrounds the Delirium guideline as the Bloomsbury Sedation Scoring System was replaced by the Richmond Agitation Scoring System, and there was discussion around how to identify if a critically ill patient is delirious before introducing pharmacological treatments. Also, the Capnography guideline is awaiting consensus regarding when it should be used, for example all the time or just for transfers and intubation.

Teaching and research

3 The review and ratification every two years of existing guidelines

The two-yearly review of guidelines ensures that all existing guidelines are revisited to ensure they are up to date. For example, we are reviewing the Mechanical Ventilation guideline and have found that our practice had changed considerably over a two-year period with the use of new ventilator tubing and humidification sets.

The Research Group needs to review the oral care, prone positioning, inotropes, neurological assessment, suctioning and sedation guidelines during the forthcoming year.

4 The generation of new ideas for guideline formulation

As existing staff attend conferences and new members of staff come from other trusts, current clinical practices can be challenged and questioned, creating the opportunity for us to



A member of the ICU team

examine our clinical procedures. Two areas that have required new exploration are the time intervals for changing the inner cannulas for tracheostomy tubes if patients are on significant support from a ventilator.

The Enteral Feed guideline is also under review so we can ensure our patients receive their target calorie intake. Thus, how long we stop feed prior to surgery or

other procedures is under review and this is especially pertinent for our patients in the Burns ICU.

Finally, I would like to thank all the members of the Research Group for their hard work and commitment.

Ann Sorrie
Sister
Team E

Research within ICU

Research in Intensive Care at Chelsea and Westminster Hospital: My journey so far...

It all started at medical school in Corrientes, Argentina. Dr Brallard-Poccard and Dr Popescu inspired me and made me realise

that there is a greater purpose when one joins medical school. I remember meeting them out of hours to read in the library and write down our ideas on a piece of paper and then we tried to connect the ideas like tree branches connecting to their

leaves. It was a fascinating mental exercise and an amazing experience.

I will never forget how thrilled I was when I was invited to take part in a clinical study. My first clinical project was on diabetic

patients looking at the effect of Glucose-Insulin-Potassium solutions on postoperative outcomes. In fact, my job was to go to hospital at 5:30am to insert intravenous lines, take blood samples and start the treating solution or placebo.

One may think: "Why was that so exciting?" ...but for me it was a different world. It was great interacting with patients and physicians; it was an amazing experience. Patients' trust in science and belief that we could potentially improve their care and the course of their disease made me approach medicine in a completely different way.

I prepared myself through the years to be where I am today. This is the beginning of a long journey that has been started by my colleagues Dr Neil Soni in the Intensive Care Unit at Chelsea and Westminster Hospital and Professor Masao Takata, Sir Ivan Magill Chair in Anaesthetics at Imperial College London.

We at Chelsea and Westminster Hospital are privileged to have a fantastic team, eager to develop and push boundaries between science and clinical care. We are developing bridges between the two worlds.

Currently, I am closely involved in basic science research trying to understand the effect of anaesthesia and surgery on memory. With Dr Daqing Ma and our collaborators Dr Mike Johnson at Charing Cross

Hospital and Dr Magdalena Sastre at Hammersmith campus, we are trying to elucidate the mechanisms by which memory is impaired and how these changes are expressed genetically and are linked to dementia. We are also targeting specific proteins to prevent this phenomenon.

From the clinical point of view we started translating some of our results into clinical practice. In collaboration with Dr Valerie Page at Watford, Professor Jose Santos-Gracia from Cuba and Professor Lars Eriksson from Stockholm, we have developed proof of concept studies and are now trying to identify the role of statins and magnesium on memory.

In parallel to basic science research and in view of the fact we are a tertiary centre for high risk HIV and burns patients, in conjunction with Dr Michelle Hayes and Dr Suveer Singh, and in collaboration with King's College Hospital and our burns surgeons at Chelsea and Westminster Hospital, we launched a new line of investigation to get a better understanding of these groups of patients.

We have a data manager, clinical fellows and trainees working on these projects to elucidate our performance over the years and also identify areas needing further development to improve the delivery of care to these patients. This research will also help us generate data for future

prospective studies, which hopefully will lead us to a better understanding of these diseases.

The Trust's objectives are to improve patient safety and clinical effectiveness, to improve the patient experience, to deliver excellence in teaching and research and to ensure financial and environmental sustainability.

I personally think if we deliver excellence in teaching and research by default, we will improve patients' care and experience and secure financial sustainability. These will result in a happy and safe environment for patients and staff.

We must enjoy the process, as the result is the consequence of our actions.

Look me up in 10 years time and I am sure there will be plenty to update you on, new members of this fabulous team to introduce and future avenues to explore.

Marcela Vizcaychipi

Consultant in Intensive Care

Teaching and research

Critical Care Physiotherapy

Patients who survive critical illness frequently develop significant muscle wasting which can lead to long term disability. One of the roles of the critical care physiotherapy team is to try to minimise this muscle loss and promote early activity, which has been shown to improve long-term outcomes for patients. This issue was highlighted in the National Institute for Health and Clinical Excellence (NICE) guidelines for rehabilitation after critical illness in March 2009.

Since the publication of this document, the multidisciplinary team in critical care has formed a Rehabilitation Steering Group, whose objective is to ensure efficient and effective management of long-term patients. To facilitate this, the physiotherapy team has successfully raised funds through the Friends of Chelsea and Westminster Hospital to purchase two bikes for the unit, which enable patients to exercise even when bed bound. They are also in the process of purchasing a Neuromuscular Electrical Stimulation machine which helps to maintain and improve muscle bulk, even when the patient is so weak that they cannot trigger a muscle contraction themselves.

From a research perspective, the physiotherapy team has also been working on developing and implementing a scoring system which enables clinicians to grade physical recovery from

critical illness. This tool is called the Chelsea Critical Care Physical Assessment tool (CPAx) and is innovative and unique in its ability to plot patients' physical recovery from critical illness. This helps us to identify problem areas and helps patients to recognise the small improvements they have made in their physical recovery.

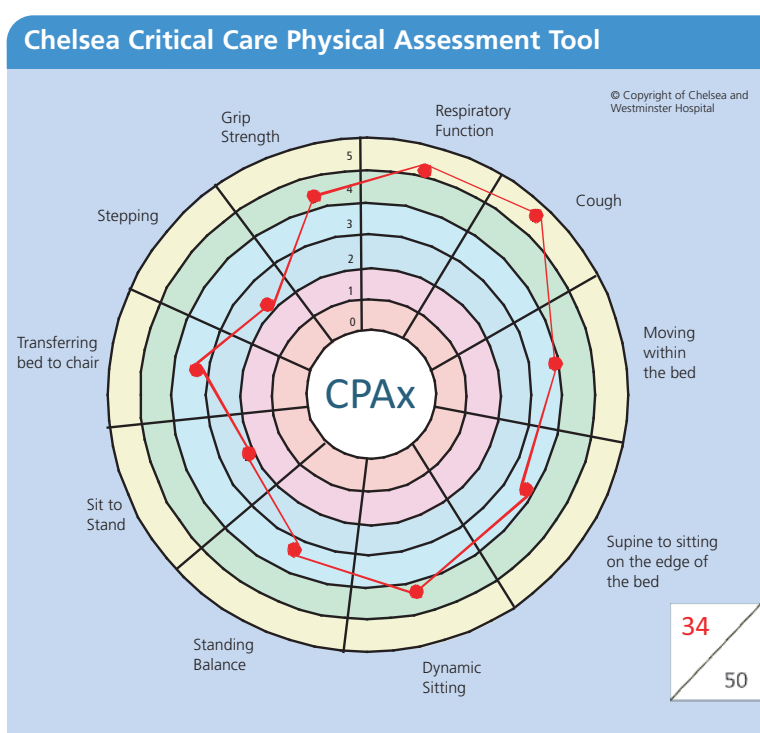
Current research is aimed at using the CPAx tool to see if it is able to predict a patient's long-term outcome and discharge location, which may help patients to plan their lives after discharge and reduce hospital length of stay. This work has been presented at both national

and international conferences and has been awarded with three peer-reviewed prizes including the Chelsea and Westminster Hospital Therapy Clinical Excellence Award 2010, which generated £1,000 for the team to invest in new equipment.

The CPAx tool is now being adopted by acute trusts across the UK, Ireland and Australia and it is hoped that it will become a standardised assessment tool used throughout critical care units.

Eve Corner

Senior Critical Care
Physiotherapist
and CLAHRC fellow



AcuBase

The ICU has traditionally used AcuBase for local activity and performance review. The database is critical care specific and is able to run reports relating to occupancy, morbidity and mortality, and severity scoring to name a few.

The benefits include local data management and comparison between other units who also use AcuBase. We currently have an interface between AcuBase and the hospital's Electronic Patient Record (EPR) system for demographics, which includes patient hospital number, next of kin, GP and NHS number.

Accomplishments in the last year include using the database for:

- Admission and discharge summaries and multidisciplinary team (MDT) daily notes (printed after each entry and placed in the patient notes)
- Severity scoring (Apache II)
- Past medical and medication history including antibiotic usage
- Occupancy and the summarisation of operational structure
- Accurate standard mortality ratio (SMR)
- Research

Looking to the year ahead, we intend to:

- Have AcuBase available at all bed sides via our Draeger monitors
- Introduce training for nursing staff to review notes at the bed side
- Interface microbiology results and the critical care minimum dataset via EPR
- Continue to use the database for pre and post critical care activity to provide a full assessment of the patient journey

Jason Tatlock
Unit Administrator

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Members of the ICU team discuss business planning ideas

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Editor



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