



Intensive Care and Nursing Development Unit

Annual Report 2009-2010

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Introduction

Time is free, but it's priceless. You can't own it, but you can use it. You can't keep it, but you can spend it. Once you've lost it you can never get it back.

Harvey Mackay, best-selling author and business motivational speaker

When it comes to writing the introduction for the annual report, I am always struck by how fast the year has gone. On a day-to-day basis we can worry about having enough time to finish projects, meet deadlines, revise for exams and complete our day's work. Eventually we come to a realisation that time is what we make or do with it. It is our responsibility and we should therefore cherish what we have accomplished in the past and look forward to what we can do and change in the future. It is for these reasons we have been producing an annual report for the last 18 years.

The annual report, written and produced by staff on the Intensive Care Unit (ICU) gives details of key projects that the unit is involved in. It is a way of standing back from our busy working lives and allowing the opportunity to reflect, celebrate, inform and promote this work.

2009 was the year in which we had to produce robust pandemic flu plans as there were fears that the UK would be hit by a massive pandemic from the H1N1 virus. The unit, in liaison with the rest of the Trust produced detailed plans on how it would deal with an

increase in critically ill adults and children. As is highlighted in the report, several ideas and teaching plans were developed. It turned out that H1N1 did not have the impact that was anticipated. However later in the year when we had an unfortunate outbreak of *Acinetobacter baumannii*, we had to put into practice the plans we had devised for the pandemic.

We moved from the Burns Unit to Recovery to the Coronary Care Unit. We cleared the ICU and over the Christmas period the whole unit was stripped and cleaned.

This period was very difficult for staff, but they met the challenges with flexibility, sensitivity and understanding. We would like to thank all staff working in the different areas who helped and supported us during this time.

There were a number of things we would have done differently, but there was also key learning which we have used to change current practice. For example, we established an infection control inter-team project group, we reviewed how we set up for an admission and we changed our ventilation tubing.

This annual report is organised in line with the Trust's three objectives of patient safety, clinical effectiveness and patient experience.

In the patient experience section we review patient diaries, the Relative Satisfaction Survey and results from the Patient Experience Tracker. In the clinical effectiveness and safety section we give feedback from all the inter-team project groups, clinical incident report and give accounts of staff experience abroad in Haiti.

The report also includes a section on finance and environmental sustainability looking at activity, staffing and unit performance.

We hope you will enjoy reading this report but please do give us feedback so that we can change either the content or format in the future.

We know that the coming years will be challenging due to financial constraints but we will not stop producing this report as we are proud of what we do and what we have achieved.

Jane-Marie Hamill
Clinical Nurse Lead ICU

Foreword

It has been a strange year; one where the challenges came almost all at once. I realised how fortunate I was to work on this unit when I witnessed the unquestioning dedication all staff showed during some very trying times.

First we had the threat of a swine flu pandemic overwhelming the resources of the NHS then we had the less apocalyptic reality. All this required planning – huge amounts of planning. It needed resources – taking inventories, stocking and stockpiling so that when the patients flooded in we would not be washed out. It demanded new approaches – working with a face-fitting respirator that looked more like a blitz-era gas mask was one of the more notable.

Thankfully, the flood never materialised and all of our flu-sufferers survived. One of the advantages of the flu planning process was preparing for providing intensive care outside of the Intensive Care Unit. This helped enormously with the second challenge to be thrown our way: multi-resistant infection.

Intensive Care Units around the world are fighting a constant battle against bacteria acquiring resistance to available antibiotics and intensive care patients are the most vulnerable in the hospital. When we developed the

problem with *Acinetobacter* we were faced with a scourge. It is easily transmitted and very difficult to eradicate from the environment - once it appears. Combating this was going to take a supreme effort.

We relocated some patients to Marie Celeste Ward, used theatre recovery, used the Burns Unit and even split the unit into two distinct entities. Often we were providing intensive care, with all its complexity and technology, at three or four separate sites around the hospital. Moving between these sites required a complete change of clothing and the most careful attention to infection control procedures.

It was during this time when the impressive dedication of the staff was most evident. The uncomplaining acceptance from the nurses and doctors-in-training that there was no alternative to this, however difficult it was to achieve, was inspiring. Meanwhile, the unit was cleaned and fumigated with ozone and peroxide. Nurses spent Christmas Day and Boxing Day deep cleaning the unit - as well as continuing to look after our other patients.

A lot of talk in the modern NHS is of 'efficiency' but 'dedication' is rarely discussed. We should wish for both but I know which one I admire the most.

Over the next few months the

problem was brought under control and normality was restored. Are we relieved? Definitely. Are we relaxed? Not a bit of it! This is a global problem which is going to require the utmost vigilance and we will be helped all the way by our microbiology colleagues, notably Dr Azadian.

Whilst we are on the subject of indispensable colleagues and as the new Director of ICU, I must mention Dr Neil Soni. He has been Director of ICU since 1985 and has led the unit with a drive and commitment that few could match. He has made the unit one of the foremost in the country, his clinical experience is unparalleled and his guidance is wise. A huge number of patients, nurses and doctors around the world have a lot to thank him for. I certainly have. Thankfully, though he may have relinquished the directorship, he still continues his clinical work

So what of the future? A new coalition government and a national debt that is frightening to even contemplate. Expenditure is going to be tight, costs will need to be justified - and justified again for good measure. Despite these pressures I have no doubt that the unit will continue to work to the highest possible standard. I have seen the dedication.

Dr Rick Keays

Consultant Anaesthetist
Director of ICU

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 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 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

Patient diaries were introduced to the Intensive Care Unit during 2009 as a pilot project. The purpose of the diaries is to help patients recover from their ICU stay by enabling them to understand more about what happened to them while they were critically ill.

It has been well documented that patients can suffer from a wide range of problems following their ICU stay. Physical problems include weakness, pain, stiffness, voice changes and lack of appetite. Psychological problems include difficulty concentrating and sleeping, nightmares, hallucinations, amnesia, anxiety and depression.

The diaries address these issues by providing a chronological record of their stay, from a non-medical perspective. The aim is for nurses to write in the diaries once during a shift. Topics include any progress the patient has made (such as sitting out of bed for the first time), and any news from home or references to things that interested the patient when he or she was well (for instance, relatives' visits or sporting events).

Another objective of the patient diaries is the improvement and promotion of nursing practice on our ICU.

In the ICU environment, care can become task focused, technological and medicalised; the diaries promote the caring aspects of nursing and encourage the ICU nurses to relate to the patient as a person.

Because this is a pilot project, we limited ourselves to introducing patient diaries to just two primary nursing teams - Team F and Team H. I sought advice from clinical governance, the legal department, the research and development representative and the Burns psychologist. I also spoke to nurses on other ICUs who had successfully introduced patient diaries. I reviewed relevant literature, and wrote guidance that included 'dos and don'ts'. A resource folder has journal articles and anonymous extracts from diaries. Teaching sessions have focussed on the process of writing diaries and discussing entries in order to learn from them. We kept the first two diaries as a learning tool, and I transcribed them so that we could discuss the entries.

Anecdotal feedback from the patients and bereaved relatives has been encouraging, although we have no formal means of obtaining it. They say they are amazed that nurses would take the time to

write the diaries and that the diaries have helped them understand what happened.

Three of the ICU sisters interviewed the nurses who wrote in the diaries from the two primary nursing teams, to learn from their experiences and find out how things could change. On the whole, they were positive about the diaries and agreed with their aims. However, they did have concerns about time constraints and the quality of some entries. They highlighted that writing in the diaries when a patient is dying can be difficult. The nurses felt that the diaries showed they care about their patients, and that they promoted a more holistic approach.

Eventually, we hope to involve all the other primary nursing teams in offering diaries to appropriate patients. Team C is the next team to join this project.

Rosalie Le Cordeur

Sister
Team F

Patient diaries - giving a diary to a patient

Team H was one of two teams to trial patient diaries on our ICU. We did one diary as a trial run and then the next time a patient was admitted to our team for more than three days, we commenced a diary on their stay. This patient ended up staying with us for a number of weeks and had a very supportive family, who was aware that we were writing a diary. They always seemed keen to have the chance to look at it at a later date.

The protocol is that once the patient has left hospital, we leave it six months before sending them a letter about the diary. We then phone to see if they are interested in receiving the diary and set up a meeting. We do not just send them the diary, as they may want to ask questions about their stay and experiences in ICU. We allocate an hour for this meeting, as it is felt that this is long enough and if there are ongoing issues then a councillor may need to be informed.

When we had the meeting both the patient and his wife came. Myself and my job-share partner were present. Initially it was just lovely to see our ex-patient looking so well



and telling us what he remembered about his stay with us.

At one point during his stay he thought we were witches casting spells around him and on another day he thought there was a pigeon on the unit flying around. He also thought he was in a boat and that his mother was there a lot of the time, when she wasn't. He was on morphine and was hallucinating, but it was interesting to discuss it and try to explain why some of these hallucinations arose.

Quite a lot of the time was taken up by him saying how he is managing now and what

plans he has for the future. We gave him the diary and told him to take it away to read, as there wasn't the time to read it all then and there. We asked him to contact us again, if there was anything in it that he needed more explanation on or wanted to discuss. He seemed very happy with this and we have not heard any more from him as yet.

Danielle Pinnock
Sister
Team H

Patient experience

Quality Group

The Quality Group's key purpose is monitoring and improving the quality of service we provide to patients admitted to the ICU and their relatives who visit.

For relatives, we run satisfaction surveys. We receive a good response from them and have been able to improve the facilities we provide for them. For example, we have recently redecorated the relatives' waiting area and expanded the folder on common illnesses where explanations are laid out in a straightforward manner. We have also updated our admissions booklet and now have it translated into 10 languages which we are aiming to increase this year. The unit staff and our translation service have generously contributed to this, with many thanks.

For our patients, we have updated our comprehensive discharge booklet that outlines possible physical changes they may experience after a stay in the ICU, as well as the routine of the unit.

A popular and productive project is the Patient Focus Groups. The meetings are run up to four times a year and past patients are invited back to the hospital to discuss their experiences from admission to the unit to discharge home.

These meetings are extremely useful and we have made a number of changes to our practice by gaining a deeper understanding of what the patients feel and experience while they are in our care. We are very grateful for all patients who attended, and those who provided written information when unable to come to the hospital.

A colleague and I presented our findings on Patient Focus Groups at this year's British Association of Critical Care Nurses (BACCN) conference in September 2010.

As the Lead for the Quality Group, I would like to extend my thanks to the staff for the contribution they make, the support we receive from other members of the unit and of course, to all the relatives and patients for their time and participation which has been so very helpful.

Rebecca Hill
Sister
Team D

Relative Satisfaction Survey 2009–

The Relative Satisfaction Survey continues to be a valuable tool in assessing how the Intensive Care Unit is perceived by members of the public and is used to highlight areas in which we may improve our services. The survey is based on a questionnaire of 35 questions broken down into three sections relating to communications, care and facilities. Respondents are also asked to add their own comments and suggestions. The results are tabulated twice a year and presented to the Quality Assurance Group for discussion and action.

The survey is now in its 10th year and as in previous years the vast majority of responses from relatives have been very favourable. The number of relatives responding is down on previous years, with 35 completed questionnaires received in 2009 compared to 40 in 2008. The reason for this is the disruption caused by the Acinetobacter outbreak which resulted in several patients being cared for in Recovery rather than in the ICU.

Below is a brief summary of the results collated for 2009:

- **Communications**

Whilst there was a decrease in the number of respondents who received the Telephone Card and the Information Booklet in a timely manner, there was an improvement in the amount of information they received, its consistency and also in the availability of doctors and consultants.

- **Care**

There was little change in responses regarding the care received. There was however, an improvement in the understanding of the role of Primary Nursing, although two respondents felt that it

did not offer continuity of care. There was an increase in the number who felt that the questions were "not applicable" which while not being a positive response, implies that there are no major problems in this area.

- **Facilities**

Similarly, there was an increase of "not applicable" responses regarding information relating to availability, quality and location of facilities. However, the majority of respondents felt the cleanliness of the ward was excellent.

The results of 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. There was an increase in the number of questions that relatives felt were irrelevant and the Quality Group will consider amending the survey to reflect this. By providing direct feedback from relatives, the Relative 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 and Relative Satisfaction Survey Auditor

"Never seen such a gentle and available staff...night and day." OD 6/09

"Being calm and giving consistent information and honest answers to questions." CF 4/09

"My husband was constantly commenting on the noise in the ward particularly at night, even the noise of the bins being closed." PM 4/09

"We found the care our daughter received was excellent. All staff were excellent and we were very impressed with how well we were kept informed." DB 5/09

"Waiting room was rather small. I heard some upsetting news regarding the condition of my friend." Anon 6/09

"The burden on staff, patients and carers of completing paperwork, often providing complicated data already supplied, is onerous, unnecessary and inefficient." TD 8/09

"Was made fully aware of everything that was happening." KH 12/09

"Being kept in the loop. Having the same nurses to avoid confusion." KH Dec 09

"Very pleased with care received, nothing was too much trouble for the staff." LD 10/09

"Overall as a foreign resident in the UK I had a negative perception of NHS facilities. This has been totally reversed." SB Dec 09

Patient experience

Pre-operative visiting

Following surgery, some patients will be admitted to our Intensive Care Unit - either due to the complex nature of the surgery, or because the patient has significant co-morbidities that require close monitoring post-operatively.

Given that patients have expressed multiple anxieties about their admission to hospital, particularly when major surgery is involved, the provision of information has become a key element of the patient-centred care we provide on the unit. Fear of the unknown is a common theme, with fear of post-operative pain, nausea and even death being reported.

Although a patient's anxiety is often relieved when procedures are discussed with their anaesthetist and surgeon, information about admission to the ICU has been sparse. Since numerous documents have been published debating the benefits of pre-operative visiting in reducing anxiety, the unit launched pre-operative visiting for all our planned elective surgical admissions earlier this year.

Pre-operative visits are held primarily to inform and assess the patient. Staff who carry out the visit are required to have a recognised critical care qualification as a minimum.

This is to ensure that they have adequate experience of the expected post-operative period in the unit and therefore confident in clarifying any points of concern. Any verbal information is supplemented by written information and we have developed a booklet to be given to the patient at the time of the visit.

The success of the visits depends on the planning and implementation of this new project. I have written a guideline and teaching sessions have been carried out on the unit where staff are familiarised with the guideline and booklet and points of concern or explanations are provided. Initially, two nursing teams were the first to carry out the visits and by the end of the summer, the rest of the unit staff will take part.

Rebecca Hill

Sister
Team D

Patient Experience Tracker (PET)

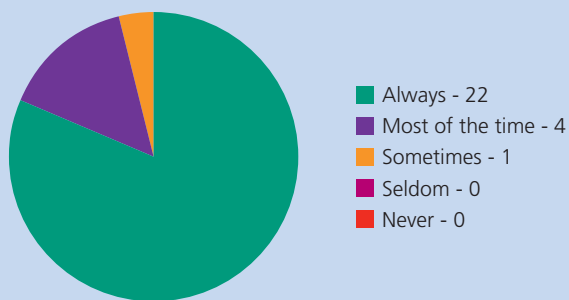
In 2009 the Trust introduced an electronic patient feedback system to help identify how satisfied patients were with their care. The system is an electronic keypad, placed in wards and departments, on which patients provide push-button responses about their hospital experience.

We started to use this Patient Experience Tracker (PET) in the Intensive Care Unit in May 2010.

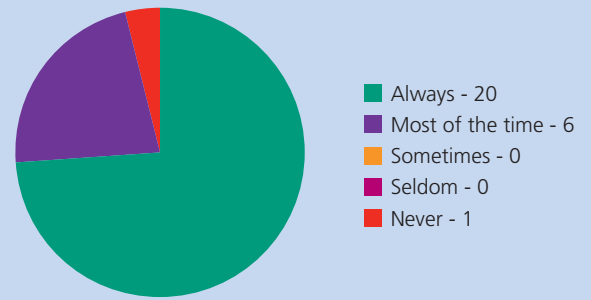
We decided as a unit the five key questions we wanted to ask our patients and that we would use the PET on patients who were discharged to the ward. We agreed that some patients would not be appropriate to survey, such as those who were unable to understand what we were asking them to do, for example patients who were confused or unconscious.

I was asked by the Clinical Nurse Lead to take responsibility for the PET. I see my role as ensuring that appropriate patients have the opportunity to use the PET, explaining how and why we are doing it and displaying our results in the communication book and at the Quality Group. I believe that it is a very useful way of gaining immediate feedback from our patients and in my experience

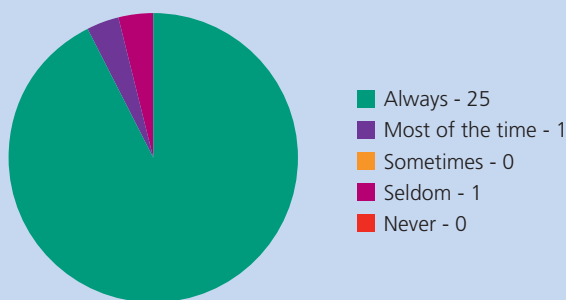
Were staff friendly and approachable? – 94%



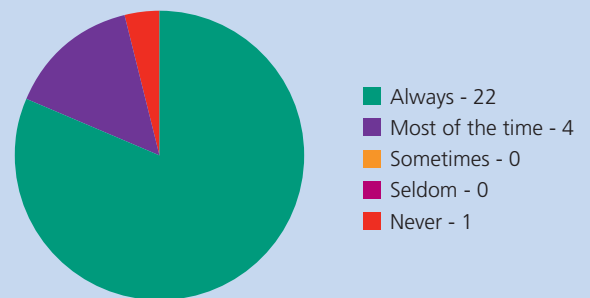
Was your pain controlled? – 90%



Did you feel your privacy was maintained? – 96%



Did staff answer your questions in a way that you could understand? – 93%

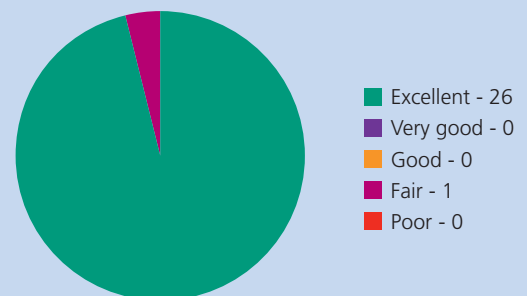


patients like to be asked their opinion. It also ensures that we act on the feedback.

Since we started in May 2010 we have used it on 27 patients – 97% responded that they had excellent care on the unit. We want to ensure that this is 100% all of the time.

Blanche Takwi
Healthcare Assistant
Team F

Overall, how would you rate your care on the unit? – 97%



Safety and clinical effectiveness

Infection control

Infection control has long been a challenge for intensive care units. The patient group we care for is very susceptible to infection and while much of the therapy we provide for patients can be life saving, it also has the disadvantage of placing patients at greater risk of acquiring infections. Many of these infections are also becoming increasingly harder to treat, as organisms become resistant to the antibiotics we have previously used, and this year we had the added challenge of dealing with the threat of pandemic influenza. This means the prevention and control of infection has become an important area of focus.

To help us with the challenges we faced this year, we set up an inter-team project group whose sole focus is infection control. Inter-team projects enable staff of all grades to get involved in infection prevention and control and we are lucky that the group is multidisciplinary, with participation from nursing, medical, therapy and domestic staff. We also have strong links with the hospital's infection control team.

The new infection control team is involved in a number of activities. We perform audits on hand hygiene,

peripheral and central line care and report our findings to the unit and at Trust level. If our results for these audits fall below an agreed standard then action plans are put into place to improve our care.

Infection prevention and control is a very dynamic area, with constant new developments. To ensure that staff are kept aware of these developments, we provide regular teaching sessions and ensure that orientation packs are kept up to date so that new staff to the unit will know what procedures to follow.

We are also undertaking a review of all our current guidelines and procedures to see if there is anything more we can do to reduce the risk of infection for our patients. Members of the team are currently working on guidelines for parenteral nutrition administration, the use of personal protective equipment and reviewing all aspects of respiratory care.

The next year is going to be a busy and challenging time and we hope to be rewarded by a reduction in hospital acquired infections.

Charlene Brown
Sister
Team I

Tissue Viability Group

The ICU has started two new inter-team project groups this year, one being Tissue Viability. This group has been formed in response to various factors, the most important of which is the increasing number of patients presenting with pressure ulcers.

In order to meet our objectives we have decided to meet on a monthly basis and have agreed on our terms of reference and the purpose of the group.

Although most of us are not tissue viability experts, we see ourselves as a resource for the unit and able to access relevant information as needed. Each team member's role is to promote awareness of tissue viability issues within their primary nursing team and to help staff provide better and safer practice for patients.

We agreed that our main aims are preventing pressure ulcers in the first instance, helping nurses care for any pressure ulcers appropriately and improving our documentation.

Recently, there have been more patients on ICU requiring vacuum-assisted dressings and we discuss how to help nurses care effectively for these patients. We review the dressings available on the unit and gain better control over

supplies and cost effectiveness of these, in conjunction with the Supplies and Finance Group.

The Tissue Viability Group also supports nurses in choosing the correct dressing for wounds, whether these are surgical, acute or chronic. We aim to promote awareness of any innovations in wound care.

The Tissue Viability Group has organised for clinical experts to come and teach on the teaching rota and we have formed links with the Tissue Viability Nurse for the Trust. We have reviewed the pressure ulcer guideline and we will liaise with the Research Group to write a guideline for vacuum-assisted dressings. We have also discussed improving team members' wound care

knowledge by presenting a journal article at every meeting.

We hope to be able to work with all our colleagues to reduce pressure ulcer incidence on the ICU and to improve our wound care in general.

Rosalie Le Cordeur
Sister
Team F

Experience of Tissue Viability Nurse secondment

In June 2009 I worked on a four-month secondment as a Tissue Viability Nurse in Chelsea and Westminster Hospital. I found the experience very rewarding and eye opening.

I had previously acted as a link nurse for my unit and in 2007 I took a three-month tissue viability course at Thames Valley University, so I was very happy to have the opportunity to apply my acquired knowledge.

I had great support from the specialist plastics sisters, Outpatient 1 sister, my then-manager, as well as my ICU manager.

The position involved working with key staff in our hospital

such as the nursing director assistants, stores, representatives from several relevant companies, matrons, ward managers and especially the nurses who greatly needed my support.

In the ICU, we deal mainly with pressure ulcers and complicated open abdominal wounds. The surgical wards had patients with similar wounds. My new challenge was to supervise the care for patients with chronic wounds such as venous and arterial leg ulcers and advanced grade pressure ulcers in the medical wards. The nurses needed continuous support and guidance as they were busy and could not accommodate seriously needed teaching sessions.

The seasonal conference was an opportunity for me to give updates in a workshop.

In these four months I have realised that we needed to work closely with the primary wound care team to improve continuity of care for the patients transferred between the two areas and a more effective use of the budgets.

I have now returned to ICU, where we have since started a new project group for tissue viability.

Feriel Mahiout
Senior Staff Nurse
Team D
Tissue Viability Link Nurse

Safety and clinical effectiveness

Role of the Specialist Nurse in organ donation

Several years ago whilst working a night shift, I cared for a young patient who had sustained a brain stem injury. Following a family interview where a poor prognosis was given, the patient's family wanted something positive to come out of their son's death. In this event he helped others by becoming an organ donor. The family's selflessness at this difficult time and the role that the Transplant Co-ordinator had to play really interested me and eventually led to a change in my career direction.

The UK has one of the poorest organ donation rates in the western world, with hundreds of people dying each year. Three people die each day in this country waiting for a transplant.

When I make a referral of a potential donor to our central office, they have a list of 'super urgent' patients on their white board. These patients will die unless they receive an organ and a match is found within days. When facilitating a donation, this focuses your attention to do the best you can for a positive outcome for these patients and their families.

The Organ Donation Taskforce was commissioned to identify obstacles to donation in the UK. The report outlines

solutions that will make organ donation a usual rather than an unusual event within a hospital setting. It is hoped that donation will be considered in all end of life care where appropriate. The Taskforce published its recommendations in 2008 which have now been accepted across NHS Trusts within the UK.

One of the recommendations highlights the need for a dedicated Specialist Nurse for Organ Donation (SNOD) to work within hospitals. Having previously worked at Chelsea and Westminster it is hoped that my introduction will result in a close collaboration between myself, clinical staff and the Clinical Lead for Organ Donation (CLOD), all of whom I will work closely with to look at ways of maximising donation within the Trust. A committee will be set up to formalise this process and the findings will be fed back to the Trust Board on a six-monthly basis. This position will be filled in the near future and I am working closely with Dr Keays on this at this moment.

Part of my role in the hospital is to form close relationships with key members of staff that will form a link with donation. For example, this involves meeting the Mortuary

Technicians who help facilitate tissue donation and raising my profile within the emergency department, an area where we will take referrals.

Finally, while almost all of us say we support organ donation and would wish to receive an organ if we needed one, only 27% of us have joined the Organ Donor Register.

Certainly one of the most rewarding parts of my job is following up donor families after donation has taken place. To know that a family wanted something positive to come out of their loved one's death at such a difficult time is very brave. Letting a family know that their loved one has made it possible to give a person a life-saving or life-changing transplant is an extraordinary event and provides comfort for the family. The result is the gift of life.

Gordon Turpie
Specialist Nurse for
Organ Donation

Morbidity and mortality meetings

Since 2005, the Intensive Care Unit has been running quarterly morbidity and mortality meetings. These are multidisciplinary and last for an hour and a half and are chaired by the consultants on a rotational basis. The format consists of reviewing the deaths of patients who have died in the Intensive Care Unit in that quarter.

On admission, each patient is given an Acute Physiological Assessment and Chronic Health Evaluation (APACHE) score (a widely-used method for assessing the severity of illness in acutely-ill patients in intensive care units). Any patient who

scores less than 20 and dies will be identified, reviewed and presented for discussion at the meeting. There are usually two case studies presented which are discussed and any learning is identified.

The second part of the meeting encourages discussion on future treatments and practices and ensures different staffing groups are updated with what is happening on the unit and enables them to give their opinions and suggestions in a constructive way. For example, in past meetings we have discussed the new ventilator care bundle, new feeding

regimes and changed practice as a result of our *Acinetobacter* outbreak. It is also an opportunity to network with colleagues. Staff are also given an update on the Liverpool Care Pathway and organ donation.

The meetings are minuted and these are sent to all staff. It is extremely well attended, with over 15 staff attending but this may be due not only to the content of the meeting but the lovely lunch provided by Tray Gourmet.

Jane Marie Hamil
Clinical Nurse Lead ICU

Clinical incidents

In 2009, 126, clinical incidents were recorded by staff on the Intensive Care Unit. The following table divides these incidents into specific categories.

Category	Number	Category	Number
Drug Incidents	36	Staff Assault.....	3
Blood Transfusion	2	Staff Accident	2
Equipment	21	Documentation	1
Procedural.....	10	Needle Stick Injury.....	1
Blood Sampling	2	Infection Control	1
Sample Collection	5	Patient Accident.....	2
Sample Reporting.....	5	Extubation.....	1
Patient Safety	2	Delayed Discharges	2
Patient Care	9	Housekeeping	1
Communication	4	Visitors Accident.....	1
Staffing Unit.....	8	Patient Fall	1
Splash Injury.....	5	Allergy	1

Safety and clinical effectiveness

A number of actions were instigated as a result of these incidents:

- New endoscope procedure which helped staff prepare the bronchoscope for procedures
- New ventilation tubing to assist with improving infection control practices
- Changing Transducer fluid from heparinised saline to normal saline
- Development of a Tissue Viability Group to lead in pressure sore prevention on the unit

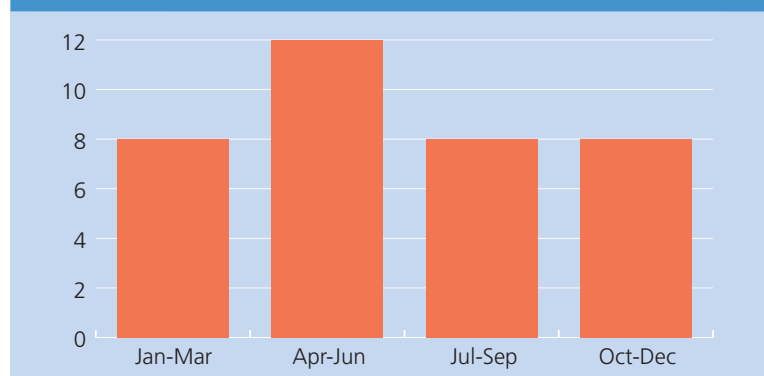
Drug Incidents in the Intensive Care Unit 2009

There have been 36 drug incidents in the Intensive Care Unit in 2009. The following table displays the numbers per quarter.

A number of trends were highlighted in relation to these incidents including:

- Drugs left in bed spaces not properly cleared after the patient is discharged
- Patients allergies not checked
- Temporary staff not following correct processes
- Mistakes made with unfamiliar drugs
- Lack of supplies of certain drugs
- Issues with patient-controlled analgesia
- Sodium bicarbonate given instead of phosphate
- Fentanyl prescriptions
- Ordering of drugs at the appropriate times

Table 1 Drug incidents in ICU 2009



In liaison with the ICU pharmacist, we devised a number ways to address these issues:

Training

- Updating staff on the use and dosage of fentanyl
- Encouraged ICU staff to speak with medical and pharmacy staff before giving an unfamiliar drug
- Update temporary staff orientation programme
- More training on patient-controlled analgesia

Supplies

- Separating sodium bicarbonate and phosphate as they look similar
- Re-looking at stock levels of some drugs
- Placing a red line around certain drugs in the cupboard-when it falls below a certain line this alerts staff to reorder the drug
- Re-looking at bed spaces and changing the way we restock bed areas following the discharge of a patient

In addition, we have number of key ways of reducing our drug incidents or addressing training needs:

Pharmacy Quiz

- This is held on the unit every six months and is adapted and updated according to the clinical incidents identified for that period

Communication

- Incidents are discussed with the pharmacist, Clinical Nurse Lead and are raised both individually and at the unit meeting
- We have a clinical incident review meeting every quarter to review clinical incidents that have occurred during that quarter and identify actions to reduce the risk of these occurring again in the future

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

Jane Marie Hamill
Clinical Nurse Lead

Flu training

H1N1 Influenza Preparations

As part of the preparations for the H1N1 influenza pandemic, staff on the ICU had to prepare for the potential impact that a large number of critically ill patients could have had on intensive care services. The focus was on three areas:

1. Robust plans for increasing the ICU service
2. Training for ICU staff on caring for paediatric patients
3. ICU training for non-ICU staff

The first area considered methods for increasing the number of intensive care beds

should they be needed. This involved looking at areas of the hospital that had the facilities for us to use, looking at staff working patterns and also increasing the equipment and stock that would be needed.

The second and third areas focused on education and training of staff, to enable them to look after patients who were different from normal. For the staff in ICU, that was the potential need to look after critically ill children and for staff in ward areas to look after sick adults. This training was delivered by staff in the Trust and the North West London

Critical Care Network by a series of study days. This training was supported by a handbook which was given to staff to help them in practice. Thankfully the H1N1 threat to health was not as serious as first imagined and the ICU saw a very small number of patients admitted to the unit. The planning and training that was put in place in a very short space of time was not wasted and it has demonstrated how we can deal with unexpected and unusual circumstances in an extremely constructive way.

Elaine Manderson
Clinical Nurse Specialist



Safety and clinical effectiveness

Acinetobacter

Acinetobacter baumannii **Outbreak**

In November 2009, a number of patients developed a multi-drug resistant bacterial infection called *Acinetobacter baumannii*.

Acinetobacter is a type of bacteria that can be found in many sources in the environment, including water and soil. Some strains can cause skin or wound infections and in patients who are ill, it can cause lung infection (pneumonia) or infection in the blood.

The outbreak and the prevention of further patients becoming infected resulted in ICU staff working in different ways to allow for the hospital to continue providing intensive care services. The main ICU was isolated until the patients with the infection were able to be discharged to side rooms on the wards. This meant setting up temporary intensive care units in other parts of the hospital in line with our emergency flu pandemic plans for ICU expansion.

Daily meetings of key staff in the Trust were also held to deal with any issues that developed during this time.

Other patients who required intensive care were cared for by ICU staff in either the Recovery Unit in theatres or on

the Coronary Care Unit. Staff working in the areas to which ICU had moved were fantastically supportive and the ICU staff demonstrated great flexibility and adaptability in difficult circumstances.

After the last patient with the infection returned to the ward just before Christmas, a deep clean of the ICU was undertaken. This involved scrubbing the equipment, floor and walls on the ICU and also using a hydrogen peroxide gas to clear the unit of the bacteria.

Staff and patients returned to the main ICU in January 2010.

Unfortunately, a small number of patients have continued to develop Acinetobacter. In addition to maintaining strict isolation of these patients, we have also reviewed a number of our practices including:

- Reminding staff of the importance of hand hygiene- we have seen an increase in hand hygiene compliance to above 80%
- Renewing the flooring in ICU to have clear lines indicating the patient area where gloves and aprons are worn
- Changing our ventilator circuits to reduce the risks of developing pneumonia
- Removing the patient notes from the bed area to a secure notes trolley to prevent this as a means of cross infection

- Caring for elective patients (planned surgery) in the Recovery Unit, rather than the main ICU – this will be reviewed later this year once we are confident that we are clear of the infection
- Setting up boxes of stock for new admissions rather than leaving the bed area set up, which makes daily cleaning easier

The outbreak was challenging for the team and we have learnt a great deal from it, which can be taken forward for other situations where we may need to work outside the 'normal' ICU setting. We know that we can set up additional intensive care services in less than a day and that our staff are fantastic at rising to a challenge.

It has also provided us with the opportunity to review our infection control practices, with the aim of preventing this from happening again.

Elaine Manderson
Clinical Nurse Specialist

Financial and environmental sustainability

Off-Duty Planning Team

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

It has proved to be a useful tool as it highlights the skill mix including the number of co-ordinators on a particular shift and also gives quick access

to monitoring sickness, annual leave and study leave allocations. The system also automatically calculates staff working hours, so shortfalls can be readily addressed on the current rota being created.

We have recently entered all the training courses and skills that our staff have achieved so their skills can be recognised and developmental needs highlighted.

The roster is created one month in advance and an off-duty template is displayed for staff to put in their requests ahead of time. This is done to allow staff some flexibility on their rota. Staff are reminded of their inter-team projects and team and skill mix cover while drafting. The Trust is planning on providing staff with access

to the MAPS system to enter their own rota and the ODPT will provide training to all staff prior to this being piloted.

All members of the ODPT are trained as rota creators and each person rotates every three months to become key rota creator. 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 the co-ordinators to update the rota on a daily basis, for example bank bookings and/or cancellations depending on the requirements of the unit, updating sickness absence and ensuring skill mix on each shift.

Amanda Dixon
Sister
Team J

Matching Michigan

Matching Michigan is a quality improvement project based on a model developed in the United States which aims to reduce central venous catheter (CVC) related infections.

The project took place in Intensive Care Units in Michigan and combined both technical and non-technical interventions (incorporating changes in clinical practice and

culture). This saw a significant reduction in infection rates in ICUs and also demonstrated improvements in the quality of patient care delivered to patients with CVCs following adaptive interventions.

In the UK, Matching Michigan is being led by the National Patient Safety Authority (NPSA) and 97% of acute trusts in England are currently

participating in the two-year project. Chelsea and Westminster has been involved since December 2009. Data is collected daily and used to determine rates of infection. The two types of data collected are:

- CVC days
- CVC blood stream infections

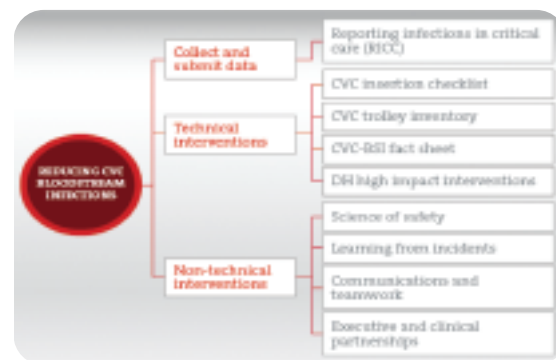
This data is submitted each

Financial and environmental sustainability

month via the online data collection and reporting tool. It is envisaged by the NPSA that by rolling out this project, quality will improve and replicate the results found in Michigan.

The diagram to the right shows the processes involved, incorporating technical and non-technical interventions, in reducing CVC bloodstream infections (patientsafetyfirst.nhs.uk)

Jason Tatlock
Information Administrator



Activity and performance

There have been some challenging and demanding pressures this year in regard to data collection and performance targets, including changes to our critical care bed establishment for reporting, the *Acinetobacter baumannii* outbreak which resulted in patients being nursed in four different clinical areas and changes to the hospital's ward areas.

Previously, data was based on an establishment of seven level 3 and two level 2 beds. This was changed as a result of the demands on our service to a funded establishment of six level 3 and four level 2 beds. These changes are reflected in the dramatic decrease of our level 2 occupancy for this year (53%) but give a better indication of patient flow in the unit.

The *Acinetobacter baumannii* outbreak saw patients being nursed in the Intensive Care Unit, Burns Unit, recovery and Marie Celeste Ward and as a

Table 1 General ICU

	2007/08	2008/09	2009/10
Finished Consultant Episodes (FCE)			
Level 3	157	153	167
Level 2	266	257	201
Occupancy			
Level 3	73%	71%	88%
Level 2	158%	176%	53%
Category of Admission			
Elective	95	106	102
Emergency	328	304	266

result, managing data collection and ensuring timely validation proved to be challenging at times.

It was important that during this unusual time, all patients had the correct specialty attached to their episode of care, that critical care daily data was complete and accurate and that discharge summaries were completed within 24 hours of discharge. I am pleased to say that all members of the team helped to ensure that all these different elements were

completed. We also achieved 100% compliance with discharge summaries during this period.

We also saw an increase in the amount of patients discharged directly home from intensive care-a total of six in 2009/10. This is the result of an increase in delayed discharges from the unit to the wards-only half within the target time of four hours.

This was due to a combination of reasons, including a lack of siderooms in ward areas,

delayed discharges on wards and an unavailability of beds within the hospital. It is expected that our delayed discharges will increase further next year as all patients whose length of stay is greater than 48 hours will require a sideroom on discharge.

The unit admitted 15 patients from other hospitals and transferred out 12 (up from three the previous year) due to non-clinical reasons. This was primarily due to the unit being closed during the *Acinetobacter* outbreak.

The Burns ICU service had 21 admissions this year (one more than the previous year). Overall occupancy for this year was 58% which was an increase of 18%. The Burns ICU service also had an

Table 2 Burns ICU

	2007/08	2008/09	2009/10
Finished Consultant Episodes (FCE)			
Level 3	26	20	21
Combined Occupancy			
Level 3	33%	40%	58%
Refused Admissions			
Level 3	20	16	24

increase of 54% in ventilated bed days which suggests that the service dealt with more acute cases.

An increase in demand for critical care burns beds has seen an increase in the amount of patients refused, mainly due to no beds being available as the increase in occupancy reflects.

The year ahead will provide us with more demanding targets

and service issues that will need clear and comprehensive strategies to achieve. By working together as a unit, with our users such as the North West London Critical Care Network and internal departments such as performance, finance and clinical governance, we look forward the challenges that await us.

Jason Tatlock
Information Auditor

Supplies and Finance Group

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

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

Members are available to all members of the multi-disciplinary team who wish to

raise suggestions and comments about areas of spending that could be used to benefit the unit and its users. This includes the trialling and evaluating of new products, to education on reducing wastage through our annual quiz, which highlights the cost of both disposable and non-disposable items.

Accomplishments of the group this year include:

- Colour labelling of our main stock room to enable clearer sections and adding stock

barcodes for more efficient ordering

- Identifying alternative clinical stock such as filters, circuits and bathing products at a cheaper price without compromising quality
- Negotiating with suppliers for a better deal on stock and lower prices
- Encouraging recycling and reducing the amount of waste leaving the ICU
- Identifying new ways of reducing costs service, such as limiting bank and agency use and by asking for ideas to be placed on a suggestion

Financial and environmental sustainability

- board in the staff room
- Implementing two bed space stock boxes on admission, which leaves all bed spaces free of stock and therefore prevents overstocking and wastage
 - Monitoring the borrowing of disposable stock by other wards and departments and highlighting these to enable

- them to order their own supply
- Displaying our financial position for all staff to review at the end of each month

The work of this group is ongoing and we will continue to work closely with staff working in the ICU and throughout the hospital to

promote cost awareness and effectiveness.

On behalf of the group, I would like to thank Charlie Brown for her work throughout the year and welcome Danielle Pinnock who is our new chair.

Jason Tatlock
Information Administrator

Charity work in Haiti

The Haiti Hospital Appeal is a UK-based Non-Governmental Organisation set up in 2006 for the sole purpose of empowering Haitian medics to provide free healthcare to the estimated 70% of the Haitian community to whom basic healthcare does not reach.

Based just outside Cap-Haitien, the country's second city in the north, the organisation had set up and was running a busy clinic and children's home. It was midway through building a ward intended for obstetric use when the country was devastated by the earthquake of 12 January 2010, which killed over 230,000 people and rendered millions homeless and injured. The hospital subsequently quickly established itself as a satellite spinal unit to the local hospital located 30 miles away.

Having just completed a Diploma in Tropical Nursing, I was asked to volunteer and

spent three weeks in April 2010 working at the hospital, along with a small team of nurses and physiotherapists from the UK. We joined a volunteer nurse and physiotherapist from the UK who had both been working tirelessly with the project since the earthquake and had done a fantastic job given their limited experience with spinal patients, lack of resources and medical support.

The hospital had inadvertently become Haiti's very first spinal unit and had been running somewhat blindly for the few months it had been in operation, with only limited input from western doctors.

We were caring for 24 patients, all of whom had spinal injuries of varying degrees. They had all lived and worked in the capital Port au Prince and most were rescued from collapsed buildings within one hour of the earthquake.



The patients remained in Port au Prince for around six weeks and some were operated on during that time. Most were paralysed and were being looked after by their families and friends within makeshift hospital tents, usually lying on dirty concrete floors with limited access to food, water and basic medical requirements.

It took a few weeks for them to be reviewed by medical teams, x-rayed and then appropriately treated. It took around six weeks for the patients to be transferred up to the hospital in Cap-Haitian. Most paraplegic patients had developed grade 4 pressure cavities and those who had been operated on had picked up infections in their wound sites due to the unsanitary conditions.

A general day would include dressing changes, reassessment of wounds and care plans, physical rehabilitation and transferring patients via helicopter to the local hospital for x-rays.

Much of my day would be spent teaching the Haitian nurses skills and procedures such as basic life support, wound care and assessment skills. The education system in Haiti leaves a lot to be desired but there is a definite eagerness to learn.

All of the hospital's equipment and supplies had been donated from the UK, but while most were either old or out of date, everything was used.

The simplest tasks we perform in the UK were so much harder in Haiti. We had only one sink with minimal tap water, but no hand soap or towels and only one bin for the entire ward. Gloves had to be used sparingly and there was no such thing as privacy curtains. Every patient had lost many



members of their family and some in their entirety.

Tidoune was a 34 year old lady who was just beginning to weight bear and walk again. She was taken to Cap-Haitian within days of the earthquake and didn't know the whereabouts of her son, husband or any of her family. With a lot of investigation we were able to track down and contact her sister in Port au Prince more than three months after the earthquake. Tidounes' family thought she had died and it was an emotional reunion with her son and sister a few days later.

The life expectancy of many of our patients was a sad reality. Many of the patients had never seen a wheelchair before, yet they were now to be confined to one for the rest of their lives and had to learn to adjust to them. There is no such thing as a pavement or un-potholed road in Haiti.

We were discharging patients back in to tents in Port au

Prince and it is likely they will remain living in those tents for the foreseeable future. Living in an inaccessible, sometimes unsanitary environment with no community healthcare or support networks may for many prove to become an impossible task to overcome in the coming years.

Haiti and its people have been through a heartbreaking time. Its citizens have lost many family members and friends, their homes, their precious few possessions and livelihoods. The country was in a desperate state before the earthquake and it is almost unimaginable that it will be able to rebuild itself without decades of support and funding from the first world.

However, in the face of their tragic circumstances, every single Haitian I met possessed such amazing spirit, hope and optimism for the future.

Helen Foley
Staff Nurse
Team B

Financial and environmental sustainability

Staffing on the Intensive Care Unit

Staff provide expert nursing care to critically ill patients on both the general and burns Intensive Care Units.

The unit currently consists of six 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.

Staffing both areas can be a challenge when they are both occupied. The main goal for 2009 was to increase the number of permanent staff, thereby reducing the amount of bank and agency staff required on a shift.

Table 1 demonstrates this decrease in spend over the last year.

The main reason for this decrease was due to the recruitment in permanent staff. One of the key lessons when recruiting staff is how long the process may take.

The time taken from advertising a post to the candidate starting can be as much as four months, therefore it is important to identify and plan the best time to recruit and to pick up cues when some staff are leaving. We keep records of when staff join and leave the unit so we can keep ahead of

Table 1 Total spend in 2009-10 on temporary staff in ICU



Table 2 Leavers and joiners in ICU 2003-2009



what is happening. This is illustrated in Table 2.

We also keep records on how long staff have worked on the unit and their reasons for leaving.

In 2009, fifteen staff left, nine of whom had worked on the unit for more than five years. Reasons for them leaving included moving into a different field of nursing, moving abroad or gaining a promotion.

Staffing units in London will always present challenges but by working with our human resource colleagues we can identify strategies to tackle these. This will ensure we keep a permanent workforce, thus reducing the amount of money spent on temporary staff.

Jane Marie Hamill
Clinical Nurse Lead ICU

Teaching and research

Teaching Group

It has been an exciting year for the Teaching Group following the launch of the Band 6 Study Day Project that according to the feedback and evaluation we gathered has been a success.

The Study Day is a two-year programme tailored to the Agenda for Change Band 6 developmental pathway, with the ultimate aim of accreditation as a formal in-house study similar to that of the Foundation of Critical Care Course. At present, the Teaching Group is collecting data, evaluations, and suggestions to improve the scheme.

The project has created six study days that the Band 6 Staff can attend depending on their available study leave, with the aim of completing all six days within two to three years. In

addition, there are a number of study days that will be run by that Learning Resource Centre.

The program has also instigated simulation sessions that will be led by the ICU Clinical Nurse Specialist. The sessions aim to enhance observation skills and to encourage reflection on a series of scenarios which will promote team work.

The Teaching Group's main aim is to co-ordinate, implement, and evaluate the educational development of students and staff across all bands within the Intensive Care Unit. This is achieved by formal and informal teaching.

Formal sessions include the Foundation of Critical Care Course and Band 6 Developmental Study Days. Informal teaching includes the

daily one-hour teaching sessions held by the multi-disciplinary team and key personnel from within and outside the Trust, primary nurse reviews and bedside instructions.

Under the guidance of our Clinical Nurse Specialist, all members of the Teaching Group have worked hard to bring these developments into action.

I would like to extend my thanks to everybody within the group for their co-operation, hard work and active participation, especially in bringing about the successful launch of the Band 6 Developmental Study Days.

Jiji Bien
Sister
Team E

The staff development role 2009-2010

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

The course focuses on a structured learning approach for the transition from a ward environment to an intensive care environment. Students complete a critical analysis of care they experienced for a level 3 patient in an ICU, which gives

them a more flexible template for developing their reflective and critical analysis skills.

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

The last year also saw another cohort – March 2009 – complete

their course in September 2009. The September 2009 cohort are awaiting ratification.

The 12 months have been a real learning experience for me. The course has been an invaluable learning experience and has changed the way I work clinically because of it. My focus now tends to be on supporting new staff and

Teaching and research

developing their skills, rather than the sickest patient who is cared for by an experienced nurse who has already developed these skills. It has also enabled me to have insight into individual learning styles

that have to be appreciated when developing staff at this level.

I have also enjoyed the teaching aspect very much and teaching in the classroom is a role I

would possibly undertake in the future. In March 2010 I handed the course over to Caroline Younger while I resumed my clinical post.

Joanne Steen

Staff Development Sister

Staff development opportunities

Staff Development and Education

We have an ongoing commitment to staff development and education. This year a number of ICU staff have continued to do this by undertaking further study and the unit supports a number of courses that staff may undertake. These are outlined in the table below.

Our pre-registration nursing provider universities (London South Bank University and Kings College London) continue to send student nurses to the unit for placements. The collaboration with the two universities has been very successful, with 12 students joining the unit for placements

during 2009/10. The placements have been very positively evaluated by students and staff alike. We have also welcomed six pre-registration midwives.

Our post-registration students have been accessing the intensive care nursing course through Kings College London for the first time this year. The aim of this course is to enable ICU staff to critically analyse and evaluate the practice of intensive care nursing, with emphasis on the wider context of care of critically ill patients. The staff have adapted well to the change and have been supported in practice by Kings College London link lecturer Tina Day and course leader Suzanne Bench.

Our mentorship programmes continue to run within the Trust and are accredited by Thames Valley University. The ICU team also welcomes ward staff who are undertaking the 'Introduction to Critical Care' course, to give them some insight into work on the Intensive Care Unit.

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

Elaine Manderson

Clinical Nurse Specialist

Courses	Details	Number of staff undertaking course
Foundations of Critical Care	Six-month course which aims to provide a structured learning experience that enables nurses new to the intensive care environment to develop the knowledge and skills necessary to safely and competently care for critically ill patients	12
Intensive Care Nursing	This is a twelve-week course run by Kings College London which builds upon the development of knowledge and skills from the Foundations of Critical Care	9
CPPD – Mentorship	Three-month course that prepares staff members for the role of coaching and supporting staff in the clinical environment	8

Experience of the ICU course

I was lucky enough to be one of the first people to attend the Intensive Care Course provided by Kings College at the Nightingale School of Nursing.

The course aims to not only provide a formal recognised intensive care qualification, but also facilitate a greater understanding of the discipline through critical analysis, examining contextual issues and evidence-based research. Ultimately, this enables the nurse to build confidence in their skills by applying theory to practice.

The three month course included formal study days and distance e-learning and was evaluated through an e-learning "blog", practice assessment booklet and a formal exam.

It runs in tandem with our unit's educational pathway and allows the individual the opportunity to enhance patient care through greater understanding of this specialist nursing post.

At the end of the course, I felt a huge sense of relief that my formal learning had finished

but I recognised that as in all areas of nursing, my learning had only just begun. One analogy is that it's only after you've passed your driving test that the real learning begins!

I was also left with a great sense of achievement. I had achieved a personal goal in attaining my qualification and in doing so I believe I can continue the work that this unit provides through our philosophy of care

William Dalglish
Staff Nurse
Team J

Band 6 development programme

This programme has been designed by staff in the Teaching Group to help guide ICU staff in band 6 roles meet their Knowledge and Skills Framework, promote effective patient-centred care and 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. Staff working within and

from outside the unit have acted as facilitators.

The days are designed to run as a rolling programme over two years. There is no set order in which the study days are to be taken, thus making it very flexible to meet the needs of staff. They can dip in and out as their skills require.

The Teaching Group members are each running a study day on the programme, again helping staff to develop new organisational skills and experience new challenges.



Elaine Manderson
Clinical Nurse Specialist

Teaching and research

Research Group

The Research Group continues to meet on a monthly basis and reviews the action plans on odd months and guidelines and drafts on even months. This has allowed for the continued generation and development of guidelines, with the aim of bridging the gap between research and practice.

We have found that discussing the draft guidelines in the Research Group aids the systematic development of the guideline. The group can give advice and assist with the formation of a strategy to ensure the process for guideline development is logical, rigorous and evidence-based.

Once a guideline has been disseminated to the Research Group, which includes

members of the multi-professional team, feedback is given and the guideline is reviewed and presented as a second draft to the Research Group.

The final draft is then sent to three critical readers along with the Appraisal of Guidelines Research and Evaluation (AGREE) tool. The purpose of the tool is to provide a framework for assessing the quality of the clinical guidelines, to ensure the potential biases of the guideline development have been addressed adequately and that the recommendations are both internally and externally valid for use. The assessment includes judgements about the methods used for developing the guidelines and the content of the final recommendations.

The final version of the guideline is signed off by the ICU clinical governance group to be reviewed in three years and it is posted on the Intranet to enable it to be accessed by all areas.

Members of the Research Group are informed of new advances or current research activities, by inviting staff to present their work at the monthly meetings. This continues to be a useful exercise.

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

Ann Sorrie
Sister
Team H

Staff Survey

Every year the NHS sends out a survey to all the staff working within it. This year's survey was broken down to cover nine key areas. Staff on the ICU participated in the survey, 43 of whom completed and returned it.

The survey provides the opportunity for staff to raise issues, concerns or praise anonymously and allows the unit to develop actions to resolve any problems in order to improve working lives and patient care delivery.

Things that were raised in this year's survey included:

- Staff did not feel that they were involved in decisions regarding their rosters. The off-duty planning team has reviewed the guidelines for staff in the use of self-rostering.
- Staff felt that they had excellent access to training.
- Staff identified that they did not know who their mentor was. A poster has been put up highlighting each staff member's mentor.

- Some of the staff did not feel that their work was valued by the Trust. We have invited senior managers along to meetings to highlight the work we do.
- Staff appraisals and feedback received were rated highly.

The survey was discussed with staff on the unit via a number of focus groups and the staff decided on how to deal with any issues raised.

Elaine Manderson
Clinical Nurse Specialist

Staff – April 2010

Dr Neil Soni

Consultant Anaesthetist & Intensivist

Dr Rick Keays

Consultant Anaesthetist & Intensivist
Director of Intensive Care

Dr Jonathon Handy

Consultant Anaesthetist & Intensivist

Dr Berge Azadian

Consultant Microbiologist

Team A

Hazel Boyle
Gerry Fitzgerald O'Connor
Emma Long
Hwee Leng Lim
Martina Sauer
Alberto Albotra
Toyin Ajay
Clara King

Team D

Rebecca Hill
Leila Hail
Ferial Mahiout
Daisy Maralit
David Thursfield
Edith Paligan
Nejat Mohammed

Team H

Ann Sorrie
Dany Pinnock
Maria Briones
Adrin Litang
Juliana Kachikoti
Kathryn Thomas
Ewa Sobolewska
Ricardo Montalbon

Elaine Manderson

Clinical Nurse Specialist

Mark Costello

Technican

Caroline Heslop

Volunteer

Cathy Hunt

Dietician

Abderrahmane Benkhdda

Housekeeper

Team B

Caroline Younger
Joanne Steen
Basanio Reyes
Imelda San Miguel
Nerissa Verdejo
Sally-Ann McNae
Helen Foley

Team E

Jiji Bien
Corazon Basbas
Maisie Robertson
Karen Sisk
Irene Dizon
Kevin Gallagher
Roshnee Nundall

Team I

Charlene Brown
Kiaw Lee
Laura Giron
Neil Anderson
Christie Magallon
Samsam Saeid

Jane-Marie Hamill

Clinical Nurse Leader

Joanne Steen

Staff Development Sister

Claudia Thompson

Volunteer

Emer Delany

Dietician

Mavis Kyeremeteng

Housekeeper

Dr Nicholas Fauvel

Consultant Anaesthetist & Intensivist

Dr Michelle Hayes

Consultant Anaesthetist & Intensivist

Dr Surveer Singh

Consultant Intensivist & Respiratory Physician

Team C

Jane-Marie Hamill
Elaine Manderson
Paula Lyons
Saowanit Kampinij
Frances Douds
Janice Basquerosa
Robert Donker

Team F

Rose le Cordeur
Marites Velasco
Rebecca Westlake
Zainab Marrah
Saskia Peerdeman
Lucie Stepova

Team J

Mandi Dixon
Rubina Vard
Lennie Buslay
Donna Goodfellow
Julanta Swift
Will Dalglish
Flores Cordeo

Jason Tatlock

Administrator

Blanche Takwi

Healthcare Assistant

Chris Chung

Pharmacist

Cath Englebretsen

Physiotherapist

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Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road, London, SW10 9NH

Cover: Jane-Marie Hamill (Clinical Nurse Lead), Rebecca Hill (Sister),
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