

BACCN

British Association
of Critical Care Nurses

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Front story Transferring your patient

Link Nurse Study day	1
Discussing Delirium	2
Suggestions and Opinions	2
Enjoyable Conference	2

Hi Everyone. This issue of the newsletter covers a lot of information from the BACCN conference. Vanessa and I were very fortunate to have been able to go to conference this year and really enjoyed ourselves.

If there are any issues you would like to bring to the newsletter, or have any topics you would like to discuss or write about Please let Vanessa and Marian know.

- The BACCN Conference was a great success.
- Belfast was a wonderful city.
- The people were very friendly and kind.
- There was a lot to keep everyone interested and entertained and many new ideas to bring back to our own units.

TRANSFERRING YOUR PATIENT ?

Your Critical Care Patient needs specialist care in another hospital. What happens? A few chaotic moments getting the patient prepared, Heated conversations about who goes and a premature 999 call? Sound familiar? Patient transfers on the road or in the air are probably the most dangerous situations, not only for the patient but also for the nurse and doctor escorting and looking after the patient. The working environment in the ambulance is very limited and unsteady, you are belted up on your seat. So many things can go wrong and when they go wrong, they do in style.... In Colchester we have started educating nurses, doctors and ODP's for safe transfers. We have commenced an all day study day. This is at present run twice a year, and so far feedback has been very positive. On the study day, we highlight



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safety issues and go through practicalities, preparation and equipment competencies. At the end of the study day, If successful, the candidates will have their transfer competencies signed off. Education on transfers is only part of making inter-hospital transfers safer. Colchester has invested in equipment such as their own transfer trolley that is still in the process of being purchased, warm

high visibility jackets and standardized transfer bags. Patient transfers are always specialized and should only be dealt with by experienced members of staff who have the appropriate competencies for inter-hospital transfers.

if you have any enquires, or want to share experiences, [please e-mail me.](#)

**AKU JOUHKI
Clinical Lead
CHUFT**

LINK NURSE MEETING IN THETFORD 22ND SEPTEMBER

The meeting was held at the Keystone Innovation Centre. Introduction to the day was chaired by Marian, one of the Link Nurse Co-ordinators. The BACCN administrator Vicky Quinn, from Southampton, gave a presentation on membership and recruitment. The BACCN was established in 1985. It now has 2,800 members within 15 regions in the U.K. There are also European and world-wide members. Every region has

its own committee members, who organize regional events There are Link Nurse Co-ordinators who communicate with link nurses within the critical care units around the regions and Hospital links with Matrons. The BACCN has a very good website with access to regional events, conference papers, journals and general news. Vanessa, also, link nurse co-ordinator, gave a presentation on the role of the link nurse. Link Nurse folders,

members registration, and ideas for future study days and events. A lovely lunch was served. Afternoon sessions included ICU issues in general and feed back from the Belfast conference. Over all the meeting was a great success. Evaluations of the day were very positive. Link Nurses were happy with one Link nurse meeting day per year, with the opportunity to meet up at the study day venues throughout the year.

Marian and Vanessa

DISCUSSING DELIRIUM

The pain, anxiety and ICU Delirium sessions attended at the 24th Sept BACCN Conference have inspired me to look further into the assessment tools used within our Critical Care Unit.

Lyndsey Kirwin, Calderdale & Huddersfield NHS Foundation Trust, presented work on the development of a pain assessment tool for use within the Critical Care unit. This tool uses physiological indicators of pain, due to the difficulty in communication with the unconscious patient.

Many Critical Care nurses will be aware of times when a lightly sedated patient increases their heart rate and blood pressure during suctioning or rolling for care. This may indicate inadequate pain relief, increasing sedation will possibly not reduce the amount of

pain experienced. Lyndsey went on to voice that a patient likened tracheal suctioning as having 'a red hot poker down the throat'. She highlighted the importance of recognizing and preventing moderate to severe pain as this can reduce mortality. Lyndsey recommends 4hrly pain assessment and review of analgesia before increasing sedation. She advocates using the 'KISS' style of assessment tool (Keep it simple stupid) More information on this assessment tool contact ; Nangfreeland@urme. Rochester.edu.

Nurses are only too aware that pain causes distress and anxiety, which may lead to delirium. Jennifer Watson, Royal Marsden presented the 'Distress Thermometer' to

assess distress levels 0–10 10 being the extreme distress

This tool enabled nurses to assess and guide further management to decrease or eliminate distress. Jennifer highlighted that evidence from follow-up clinics, showed patients who experienced distress or delirium in ICU were more likely to experience work or psychological problems post ICU for some time. Gary Beer and Sarah Askwith from Sheffield also supported the importance of assessing delirium and developed a screening checklist for their ICU. Donna Watson from USA discussed the need to treat the cause of delirium. Then highlighted that nurses are good at recognizing hyper-delirium but not at recognizing hypo-delirium. Donna stated

that subtle changes in patients condition can be missed with nurses working over 12 hour shifts.

These presentations and discussions have increased my awareness of the need to recognize and treat the causes of pain, anxiety and delirium early within Critical Care to improve long-term outcomes for patients.

Sister Julie Allen
Queen Elizabeth Hospital
Kings Lynn



SUGGESTIONS AND OPINIONS

There was a mention at conference concerning single sexed wards and its implementation in hospitals around the U.K. This has been brought about by essence of care guidelines of patients privacy and dignity. Could this work for ICU?

My feelings are that this could be a very expensive and complex organizational disruption for most estab-

lished ICUs. Beds within ITU are already sometimes hard to facilitate, to have to try and put males or females at certain sides of our units would be a nightmare.

An ICU manager discussed how they had just had a purpose built ICU, this unit has been completely made up of individual rooms. This is an ideal situation to help fight hospital acquired infection.

However, this has an enormous effect on staffing levels and would mean employing more staff to ensure there are runners available for emergencies and general fetching and carrying.

For some nurses it can be claustrophobic being in a room for 12.5hrs on a shift
What is your opinion?.

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Where's me nurse!



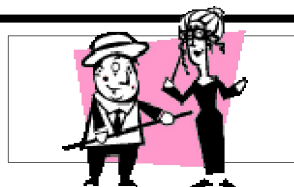
ENJOYABLE CONFERENCE

Being a member of the BACCN and link nurse coordinator, I was very pleased to be going to the 2009 Conference in Belfast 14th–16th September

I looked forward to both the lectures and the social events that had been prepared. Sunday we were invited to the Queens university where we were welcomed by the Mayor of Belfast. There were drinks and nibbles and music with Irish

dancing from the Belfast ITU Nurses. International and home speakers were very interesting and informative, covering various topics.

It was interesting to hear about a bowel protocol, which I personally have been involved in, ours being a little further ahead than the hospital in question. Other subjects were on: Transfer training, organ donation. There was an international perspective on neonatal care, this I found of



interest, as we have pediatrics in our unit prior to being retrieved to a specialist unit via the CATS team. Professor Linda Johnson gave an overview on the development of care for babies over the years and how certain drugs actually were more harmful than good and how through evidence based practice babies safety has improved. The professor however said third world babies are still dying in vast numbers.

Interestingly, there was a combined outreach and resuscitation team speaking. They stated they work 12hrly shifts and as a team of three, (including a physiotherapist) They all have transferable skills and work effectively as a team in a supportive educational role, trainer and practitioner running the resuscitation courses, alert, and attending cardiac arrests

The Gala Dinner/Dance was Held at The Europa Hotel but Frighteningly we were told it was the most bombed hotel in Belfast! Although it didnt stop us having a fantastic night

Vanessa Howlett Colchester
ITU

AN EXPERIENCED NURSE'S VIEW ON THE BACCN CONFERENCE

The BACCN International conference was the first time I had attended this sort of event and had the opportunity to meet and discuss critical care from a multitude of settings from trauma units to tertiary hospital staff like myself. I was made aware that all critical care nurses are recognizing the changes in our roles,



Patient Safety First

Patient safety first has at its heart a vision of an NHS with no avoidable death and no avoidable harm.

It's a campaign to make the safety of patients, everyone's highest priority.

The focus is on the implementation of five interventions:

***Leadership for safety.**

***Reducing harm from deterioration**

***Reducing harm in critical care**

***Reducing harm in peri-operative care**

***Reducing harm from high-risk medicines.**

Looking at aspects of care and safety within our unit

Has prompted us to review our Naso-gastric tubes and their insertion.

After tube insertion it was felt that testing the Ph on critical care patients may not be accurate due to the Proton pump inhibitors (PPI's) that most critically ill patients received, whilst on the ventilator care bundles. It was felt that an xray would be a better guide to assess the N/G tube's position.

This led us to look at the N/G tube itself. Companies that manufacture N/G tubes were contacted. A tube was required with an opaque line the length of the tube. This would enable the tube to be seen on an xray. Tubes we have found are by Medicina, which we are about to trial.

We have, from the same company, Purple coloured syringes marked oral/enteral to use with the N/G. The safety issues with these coloured syringes is that they are not IV compatible and can not be used on an IV port.

Sister Baker

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