Waikato Hospital Critical Care Department

Medical Orientation

CCD

Hartley 2016

CONTENTS

Critical Care Department Values & Fundamental Information

13th June 2016

Critical Care Department
Waikato Hospital
Intensive Care Unit and High Dependency Unit

Welcome

It is our pleasure to welcome you to the Critical Care Department at Waikato Hospital for the next 6 months. For some of you it will be familiar territory and for some a foreign land with lots of machines that go “bing” and nursing colleagues that are ever present.

During the next few days you will receive a non-clinical orientation, which will be followed by three or four weeks of supported practice. We plan to orientate you to the environment and to introduce you to key members of the department. It is important you understand we have clearly defined standards of behaviour and expect our staff to work with in them. We have a stable senior Medical team who are here to assist you in your clinical decision making and a senior Nurse team here to facilitate your practice in an environment that is new.

You will receive your Intensive Care Handbook which will guide you when faced with practice issues you may be unfamiliar with. It will cover your daily responsibilities expectations when reviewing, admitting and discharging patients, departmental research, hospital transports and will touch on some key medical conditions and a general approach to their management.

The other resource is the CCD medical Orientation booklet, which is a structured tool to ensure you have a comprehensive understanding of CCD and develop a basic knowledge and skill base that is essential for safe patient care team work and effective communication.

If, during your time in here, you have problems and are not able to deal with them through discussion with your peers, please feel free to approach Geoff, Colleen or Robert Martynoga who holds the portfolio for Registrar wellbeing.

Thanks, and welcome again

Geoff McCracken and Colleen Hartley
Clinical Director and Nurse Manager

Spheres of Influence

All Clinical staff in the Critical Care Department have three spheres of influence; Leadership, Professional Performance and Operational Management. These spheres all have equal importance to the overall integrity and credibility of our Department.

Leadership

Leadership is not reserved for those in appointed positions; it is working together with an agreed vision and setting an agreed direction. We should want to be engaged and feel valued for our contribution. We should be proud of what we know and how we practice to benefit those we advocate for. There should be a strong desire to mentor and positively role model our collective wisdom to those who follow us. We must value diversity and involvement of the team utilising the strengths each of us has to build our overall capability. We should count on effective leadership during times of change. This all starts with us.

Professional Performance

Professional Performance is the delivery of quality patient care as set by our professional and regulatory bodies. We should be prepared to audit the care we provide against the set standards to ensure we are delivering our best.

We have individual responsibility to guarantee our practice is delivered at the highest standard. We should seek feedback on our performance and be accountable for any recommendations received.

We must seek learning opportunities to advance our knowledge and actively share those skills and strategies for patient care with our colleagues.

We must collaborate and work with other health care providers to create an environment for the betterment of our patients.

Operational performance

This is matching demand with supply. It is directed by the Ministry of Health in the form of health targets and contract management. Patient flow is paramount, to achieving both these requirements. Understanding the constraints of the hospital and the impact this has is important to increased efficiency and effectiveness. Working collegially across departments, focusing on our patients to ensure good utilisation of resources is imperative. Integration of quality in practice, whilst mitigating risk, coupled with the demands of innovation, is challenging but necessary in this economic environment. Analysing the past to predict the future is prudent when being fiscally responsible.

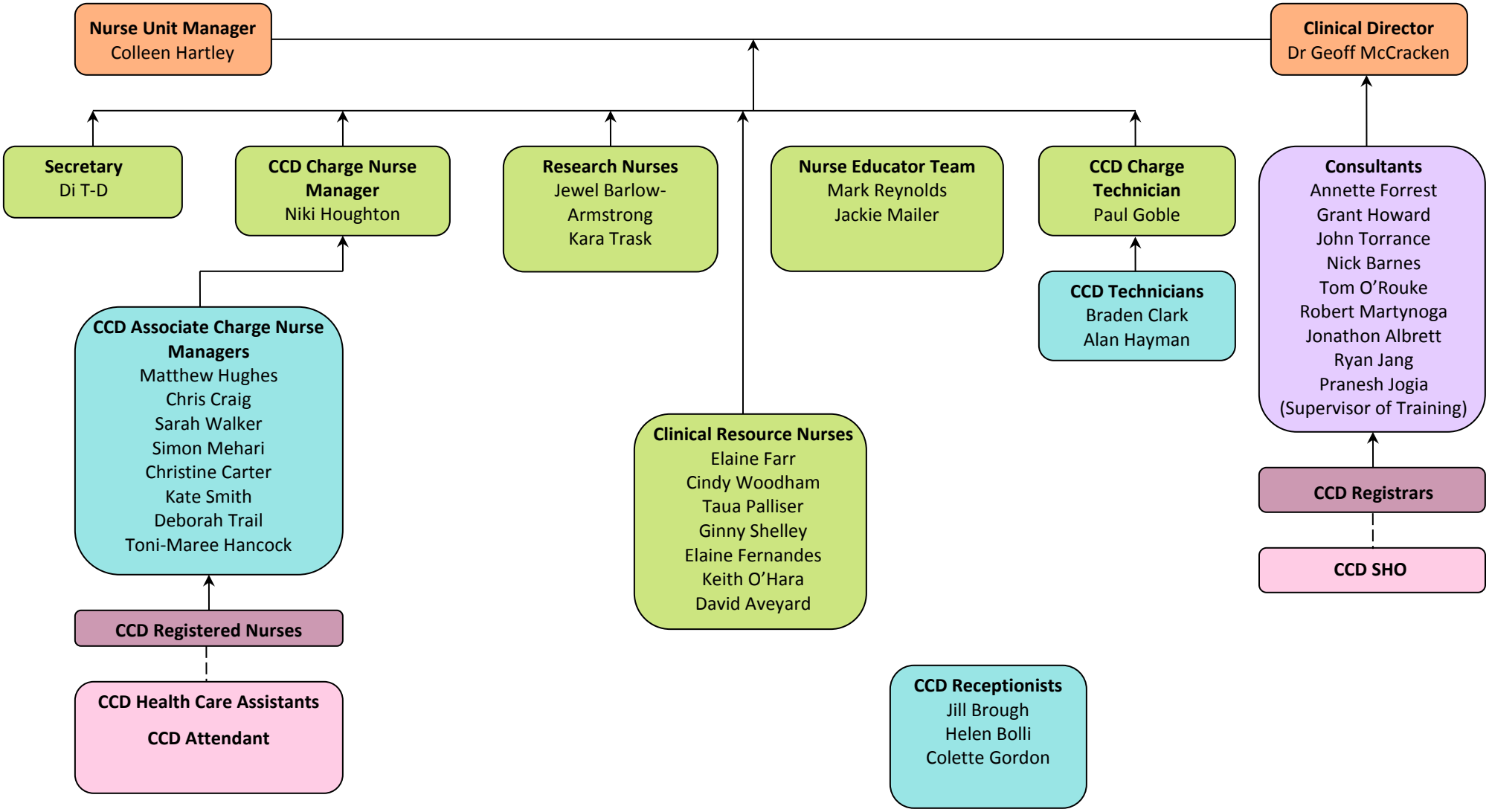
The difference between roles is where the influence is focused.

Spheres of Influence in Action

The following table illustrates how these Spheres of Influence impact within each medical role, with the overarching benefit to our patients.

Role	Leadership	Professional	Operational
Manager/Clinical Director	Self and Others	Governance of Care	Allocation of Resource
CNM/Deputy Director	Self and Others	Direction of Care	Management of Resource
ACNM/Consultant	Self and Others	Co-ordination of Care	Provision of Resource
RN/RMO	Self and Others	Delivery of Care	Use of Resources
Patients			

Who do I Report to in Critical Care?



Introduction to the ICU Environment

If you are working in ICU, you should have received three reference booklets:

1. The Waikato Hospital Intensive Care Unit Handbook
2. “Drug doses” by Frank Shann
3. “Paediatric Intensive Care Guidelines” also by Frank Shann

Other important folders you need to know are:

1. The Intensive Care Unit Drug Guidelines folder
2. The Protocols, Procedures, and Guidelines folder s for General, Cardiac, Neuro, Renal and Paediatric

These folders are located in both the General and the Cardiac pods of the Intensive Care Unit.

The ICU Drug guidelines have been written to outline the uses, preparation and administration of drugs commonly used in the Intensive Care. They can also be found at the ICU page on the intranet. If you cannot find a drug in these manuals, appropriate dosing can usually be found in the “Drug doses” handbook by Frank Shann.

The Protocols, Procedures, and Guidelines folder are useful references that outline common Intensive Care management practices.

They have been developed by the Consultant and Senior Nurse teams over many years and are designed to ensure patient and staff safety.

The HDU environment is guided by the procedures and guidelines for the wards. These can be found on the intranet under policy and guidelines. ICU Policy procedure and guidelines do not apply in the HDU environment.

Deviation from the protocol is not recommended unless the Consultant and Senior Nurse on shift are aware of your rationale.

The 24/7 team needs standardisation to protect our patients and ourselves from harm

Our mantra is

“Nothing changes until it changes”

Grant Howard 2012

Clinical Practice Committee (CPC) - Practice and Equipment

The Department has a process for change; this is called the Clinical Improvement Committee. This committee meets 6 weekly and is chaired by Paul Goble our Charge Technician. You are welcome

to submit any change suggestions to this group for consideration, and are welcome to attend the meetings when they are scheduled.

Communication and Technology in CCD

WICCD Intranet page under development

WICCD will be the department intranet site which is used to communicate with staff on a number of topics

Paging staff

Dial **9 3 2** (wait for continuous tone)
Enter the **pager number**
Enter the function digit **1**
Enter your **extension number**, followed by a #
Replace the phone receiver

Interpreters

Interpreters are available as per the WDHB Interpreters Policy. This policy can be accessed in the Administration and Clinical Policy Manual. We also have interpreter software loaded on to the department iPads. This may assist in the short term.

SBARR

SBARR is the Waikato DHB communication tool that provides a common and predictable structure to clinical communication.

Why have a communication tool?

The Health and Disability Commissioner (2007) stated “Health services need a culture of openness that allows junior staff to highlight concerns to senior staff and to enhance communication across disciplines. SBARR is the tool the Waikato DHB has adopted to support the communication identified by the commissioner

Health Waikato staff completed over 1000 incident forms identifying staff to staff communication issues last year

SBARR has been endorsed by the Health Waikato Clinical Board, Chief Executive Officer, Chief Medical Advisor and Nursing Directorate, because communication errors have caused a significant proportion of serious harm to patients

Declined Referrals to the Department

This is the format we would like you to use when you are referred a patient for admission and decline the admission. You will be given a pad of forms to have and to complete. The department are trying to quantify how many patients are referred and not accepted, or are referred not accepted and then present acutely. This information will be used to support future growth of the department which will ultimately impact on your colleagues. Please familiarise yourself with the format and provide depth to your responses. These will be viewed internally only and will not be used for any other purpose than gathering data.

Vocera

Vocera is a wireless communication device that allows the user to talk to individuals or groups within the Department or to an individual outside of the Department e.g. paging.

Alan Hayman is the Vocera Techspert and is happy to orientate those of you who are unfamiliar with this device. Please ensure you schedule a session with Alan.

Vocera Introduction

1. Collect your vocera badge
2. Fit it with a rechargeable battery
3. Log into vocera - follow the instructions, by saying your name
4. Log into a role - push button and say *"add me to……"* e.g. (ICU General Registrar).
5. To call a person - say *"call…. e.g. "Mark Reynolds"*, or *"call Critical care Nurse Educator"* you can call by a persons name or role
6. To locate a person, say *" locate…. e.g. Mark Reynolds"*
7. If someone calls you - the genie will ask if you can accept a call, you need to say *"yes" / "no" or press call button for "yes" or do not disturb button for "no".* If you accept the call say "*hello (Name) speaking*" so the other person knows you are online
8. Once your shift has finished you need to log out - push button and say *"log out"*. Then clean and pass your vocera unit onto the next person in that role or place back on the shelf in the Work Rooms

9. There are instructions on the wall by the units, also check your lanyard card. Speak clearly and it is vital to use the right commands *(add me to, call, locate, log in, log out)*

Vocera Department Listing

ICU Roles	HDU Roles
Nurse Roles	
ICU Nurse Roles: ICU Nurse in Charge (ICU Nurse Coordinator) ICU ACCESS Nurse ICU Transport Nurse ICU Admin	**HDU Nurse Roles***:* HDU Nurse in Charge (HDU Nurse Coordinator) HDU ACCESS Nurse HDU Admin
Critical Care Roles	
Critical Care Technician Critical Care Nurse Educator Critical Care Research Co-ordinator Critical Care Charge Nurse Critical Care Receptionist	
Doctor Roles	
ICU Doctors Roles: ICU General Consultant ICU Cardiac Consultant ICU Consultant HDU ICU Registrars (ICU Reg) ICU General Registrar ICU Cardiac Registrar ICU Senior Registrar ICU SHO	**HDU Doctors Roles:** ICU Consultant HDU HDU SHO

Electronic Whiteboard (eWB)

Located in the staff bases in both ICU and HDU, displaying information directly from the i.PM system such as:

- Patient name
- NHI number
- Bed number

The daily Medical handover report is updated daily and printed from the eWB by:

1 Clicking the Critical Care icon at the top of the hospital intranet page, this will take you to the department (ICU and HDU) eWB

2 Hover the mouse over the word “ward” and click on “ICU of HDU” respectively

3 If you are in ICU, hover the mouse over the word “reports” and click on “Doctor’s Handover”

4 If you are in HDU, hover the mouse over the word “reports” and click on “Nurse Handover”

5 Print off the report.

6 Please be mindful, these report have a lot of patient information and should not be left lying around.

Important Nursing Roles:

NM: Appointed position to lead and manage the critical care department. This role covers ICU, HDU, PAR, Research team, and the general business of the department. I have oversight for all RMO issues, and can be a first point of contact for you. Definitely a non-clinical role, however can and will assist as necessary. This role represents the department outside, in the wider organisation.

CNM: appointed position to lead and manage both HDU and ICU, nursing and clinical practice. Generally a non-clinical role, however can and will assist as necessary. Has oversight to all matters in the department and is the first point of contact for escalation of concerns.

Associate Charge Nurse Manager (ACNM): an appointed position of leadership and clinical management. Responsible for immediate patient care, HR issues, patient flow and bed management. Due to this role being 24/7 (ICU) we offer a training position to two senior nurses annually, much like the senior registrar position. When they are on they act in the same capacity as the ACNM and have the same authority.
The HDU team ACNM work 10 hours/day 5 days/ week, and also have a 2IC role for succession planning.

ACCESS Nurse: this role is designed to support ICU nursing care of patients with an appropriately experienced nurse and may be delegated certain responsibilities on a shift by shift basis.
HDU does not have an ACCESS role.

NET: an appointed position dedicated to the teaching of registered nurses across the department. Assists in the development of education resources for equipment and practice changes in the department, work closely with the Medical education team to enhance collaboration with in the CCD.

Communication with the ACNM

The “constant” team in the department is nursing are the ACNM’s and when we work together everything will be accomplished. It is imperative you do not assume all nurses are senior, despite their degree of confidence. You can be confident the ACNM or delegate is the appropriate person for you to discuss concerns or plans with, not necessarily the bedside nurse.

The ACNM is paramount for the smooth running of the shift. If you are leaving the floor for any reason, please inform them of where you are going, the “no surprises rule” works best here.

If you need to admit a patient then the role of the ACNM is to facilitate this. If beds are tight, the ACNM will make the decision as how to allocate staff to make it happen. Do not decide yourself if the there are no beds in ICU.

If you have been informed of the need to arrange a transport, again do not go directly to the flight nurse, go to the ACNM, they will arrange the necessary releasing of staff to get going.

The ACNM role is pivotal to the effective and efficient clinical running of the Department, which is why there is always one rostered on.

Emergency Management

During your position here we will be running a mock emergency simulation and you will be informed of your roles prior to this occurring. It is important to familiarise yourself with the CCD Emergency Management Plan which is located in both the ICU and HDU disaster station's. The Plan covers issues such as what to do in the event of an emergency for example:

- Fire
- Mass casualty

An outage such as:

- Power failure
- Computer failure
- Vocera failure

During an emergency the Nurse in Charge (ACNM or 2IC) will become the incident controller and delegate responsibilities as appropriate. This will happen in conjunction with the Consultant on Call, however, in the first instance you will be the nominated medical person.

Resources to help you – all located in folder or disaster station

Department plan Generic Emergency Management Information: Templates for recording staff and patient movement. Request forms for supplies. Staff registers for call back staff. General contingency plans i.e. what to do if power fails, loss of sewerage etc

Department Emergency Response Plan (DERP): written for our department: lists our essential equipment and supplies and how to replace or relocate them.

Emergency Flip Chart: basic emergency procedures.

Evacuation Procedure Meade Clinical Centre: detailed information about fire evacuation

An overview of the process is as follows below.

CCD

Emergency Management

ACNM / Nurse in Charge Responsibilities

- If you have been notified of a fire or smoke: Initiate the Alarm, Ring 99777 state location and describe the situation. Activate nearest alarm/manual call point.
- If EWIS (emergency warning and intercom system) has been activated i.e. alarms are broadcasting.

Prepare for Evacuation: ICU is to remain on standby until directed by the Duty manager/Fire Department.

1. Collect and wear the red hat from disaster station. Your role is Floor Warden until you are replaced.
2. Allocate staff member to man the WIP phone (red phone).
3. Allocate staff member to handout Emergency Management bags to staff.
4. Meet with staff at Emergency Management whiteboard and make plans for evacuation:

Patients in consultation with Medical staff:

- Who can be transferred to other areas?
- Who can be moved out of unit first?
- Which patients require portable monitors, transport ventilators and emergency equipment?

Staff

- Primary Nurses to complete stage one of Evacuation Checklist.
- Allocate duties to any additional staff available to you who are not directly Primary Nurses: Access Nurse, HCA, Technicians, and Admin Staff, orderlies or any staff sent to help from outside CCD.
- Consider need to call in additional Nursing staff, CCD Technicians, Heath Care assistants.

Visitors

- Allocate any able-bodied visitors to bed spaces; ensure any visitors not required leave the building.

Liaison

- Inform Duty manager of any resources or staff required.
- Regularly update primary nurses, escalate to Stage two of Evacuation checklist if needed.
- Registrars to liaise with on call consultant.
- Inform HDU NIC of event as may not be aware of alarms activating within your Cell.

Documents/Tracking

- The name of all patients, staff and relatives must be recorded. You must document if anyone leaves the area and where they have gone. Use your handover sheet or resource allocation plan in this folder.
- Complete Incident Status Report (Department plan Generic Emergency Management Information pg. 29)

Personal Paperwork

We are all employees of the Waikato District Health Board and have agreed to provide a service of which you will deliver in this department over your next 6 months.

As you will be aware the duties here are rostered 24/7, so you are likely to do more nights and afternoons than you have previously in your other clinical areas, however, there are positive's to a rostered position.
Our roster has been designed by a former registrar and has been agreed to by registrars that have gone before you. It is designed to ensure the department is covered safely and that you are not fatigued when you are at work. It has been developed to accommodate 14 people providing a 14 week rolling pattern, of which 2 of those weeks are in a relief role, covering annual leave, study leave, and sick or short notice leave. You are rostered on average of 32 hours per week over the 14 weeks, more some weeks and less other. This ensures it is fair and equitable to all staff. Please be aware of this when requesting leave, as it cannot be granted. We have a duty of care for the provision of service for our patient's.

1 Leave requests - Annual and Study

All leave requests need to be in to Di Takiari, the Departmental Secretary as soon as possible we prefer a minimum of six weeks to assist with planning. There should be no surprises if you are getting married or having children. No leave will be process until the form is received. Please feel free to talk to either Di or Colleen. Nick Barnes shares the portfolio for oversight of the registrar roster as he manages the Consultant for roster.

The Intensive Care has 2 relieving registrar at any time to cover leave. This means there can be no more than two registrars off on planned leave at any one time.
There will be time when requested leave has been approved and an unplanned absence has occurred, this will be communicated to all staff via electronic means or you will be phoned individually. You may be requested to pick up extra shifts to cover the roster. These are voluntary and you have the right to refuse, however as a team we need to work together.

If there are competing requests for leave the order of priority will be:

Registrars sitting exams - exam time only
Registrars presenting at conferences
Registrars getting married and Parental leave
Annual leave

We will endeavour to grant 3 weeks leave to all staff during the rotation and if there is more available we will happily negotiate.

If we cannot grant your request you will be informed as soon as possible, this will be related to no available relief staff. We are happy for you to organise an appropriate swap providing you do not

place yourself in contravention to the RDA Collective Agreement. **It is imperative that Di TD is informed of ALL roster swaps and transactions, before they are undertaken**. They must also be recorded on the roster before completing the shift. If additional duties are required or sought, these need to be agreed before the shift is worked.

We would not expect all leave requests to always coincide with your rostered nights. Bear in mind when you take leave you are relying on your colleagues to cover your absence, and everyone will hold the relieving role while working in the CCD.

2 Course and Conference Forms

If you are wishing to take leave for a conference or a course, you will need to fill in a Course and Conference Form. This absence will be prioritised against what else is booked at this time. This request needs approval from the Manager and should to be given to Di Takiari to facilitate this process. There needs to be direct evidence this links back to your career plan and you should expect to provide a copy to support your request if asked.

The department requires you to complete the form including the back page where you write your preferred flights in and accommodation. This will then be forwarded to the travel office for booking. If this is a problem then please discuss with Colleen prior to booking. Please do not book your own way, this process needs to be done through the hospital.

Approximate costing:
I will approve approximately $200.00nz/night, negotiated, for accommodation adjusted for international rates – which will be booked through the hospital. You may make your selection and the hospital will book it.

3 Staff Expense Claim Forms

This form is required if you are claiming for your work related expenses such as your College Registration, APC, course or conference expenses. Your approval form must also accompany the expense claim form. They must be accompanied by the appropriate receipts for reimbursement. The Department expectation is these are claimed back with in the month of the expense being generated. I cannot reiterate enough, the forms need to be completed correctly.

APC reimbursement, must accompany a sighted and signed copy of your original. This must be done by the Manger or CD.

4 Additional Duties

When you work additional duties you need to complete an “additional duties” claim form. Please complete the form properly with start and finish times, why you are doing additional duties and sign it. You will be paid at your MECA rate for hours worked, I do not complete these for you so incomplete forms will be returned to you. They will be checked against the roster prior to signing them. Just to be clear, night shift is paid from 2200 hours until 0600 hrs.
If you collect up all your extra shifts for the rotation and submit all at once, do not expect it to be paid urgently. My expectation is they are submitted fortnightly.

The HDC Code of Health and Disability Services Patients' Rights

The Code of Health and Disability Services Consumers' Rights became law on 1 July 1996. It grants a number of rights to all consumers of health and disability services in New Zealand, and places corresponding obligations on providers of those services.

Patients have Rights and Providers have Duties

Every patient has the rights in this code and every provider is subject to the duties.
Every provider must take action to –
a) Inform patients of their rights; and
b) Enable patients to exercise their rights.

The Code:

RIGHT 1: To be Treated with Respect
Every patient has the right to be treated with respect and to have his or her privacy respected. Every patient has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

RIGHT 2: To Freedom from Discrimination, Coercion, Harassment, and Exploitation
Every patient has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 3: To Dignity and Independence
Every patient has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4: To Services of an Appropriate Standard
Every patient has the right to have services provided with reasonable care and skill and that comply with legal, professional, ethical, and other relevant standards. They have the right to have services provided in a manner consistent with their needs and that minimises the potential harm to, and optimises the quality of life of, that patient.

Every patient has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5: To Effective Communication
Every patient has the right to effective communication in a form, language, and manner that enables them to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

This includes an environment that enables both patient and provider to communicate openly, honestly, and effectively.

RIGHT 6: To be Fully Informed

1) Every patient has the right to the information that a reasonable patient, in their circumstances, would expect to receive, including -

- An explanation of his or her condition; and the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
- Advice of the estimated time within which the services will be provided and
- Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
- Any other information required by legal, professional, ethical, and other relevant standards; and
- The results of tests and of procedures.

2) Before making a choice or giving consent, every patient has the right to the information they need to make an informed choice or give informed consent.

3) Every patient has the right to honest and accurate answers to questions relating to services, including questions about -

- The identity and qualifications of the provider; and
- The recommendation of the provider; and
- How to obtain an opinion from another provider; and
- The results of research.

4) Every patient has the right to receive, on request, a written summary of information provided.

RIGHT 7: To Make an Informed Choice and Give Informed Consent

Services may be provided to a patient only if that patient makes an informed choice and gives informed consent.

Every patient must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing the patient is not competent. Where a patient has diminished competence, that patient retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

Where a patient is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the patient is available, the provider may provide services where -

- It is in the best interests of the patient;
- Reasonable steps have been taken to ascertain the views of the patient;

And either, -

- If the patient's views have been ascertained, and the provider believes that the provision of the services is consistent with the informed choice the patient would make if he or she were competent; or
- If the patient's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the patient and available to advise the provider.

Every patient may use an advance directive in accordance with the common law.

Where informed consent to a health care procedure is required, it must be in writing if -
a) The patient is to participate in any research; or
b) The procedure is experimental; or
c) The patient will be under general anesthetic; or
d) There is a significant risk of adverse effects on the patient.
Every patient has the right to refuse services and to withdraw consent to services.

Every patient has the right to express a preference as to who will provide services and have that preference met where practicable.

Every patient has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

RIGHT 8: To Support
Every patient has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another patient's rights may be unreasonably infringed.

RIGHT 9: In Respect of Teaching or Research
The rights in this Code extend to those occasions when a patient is participating in, or it is proposed that a patient participate in, teaching or research.

RIGHT 10: To Complain
Every patient has the right to complain about a provider in any form appropriate to the patient, and the provider must facilitate a fair, simple, speedy, and efficient resolution of complaints.

Reference
The Code of Rights (full). (2009). Retrieved from http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full)

Quality & Patient Safety

Q&PS in CCD

Waikato DHB defines quality as providing safe healthcare which:

- Is responsive to the patient's individual needs
- Meets professional standards of clinical excellence
- Meets national standards of healthcare service delivery
- Is continuously monitored and improved

What do our patients/families expect from us?

Respect, courtesy, compassion and support	Provided with understandable information
Access to care	Completeness of information about what was happening
Skilled and competent care providers	Satisfaction of CCD experience, care and atmosphere
Management of pain, breathlessness, agitation	Being taught about condition, treatment, medication and self-care
Providers who communicate effectively	Being treated with respect
Honest and consistent information	Adequate time to address concerns and answer questions.
To be included and supported in decision-making	

Wall, R et al. (2007). Family satisfaction Questionnaire. Critical Care Medicine, 35(1)
Health & Disability Commission. (2009). *Code of health & disability services consumer's rights*.
Retrieved from http://www.hdc.org.nz/the-act--code/the-code-of-rights

How do we ensure we meet the needs and expectations of patients/families? By:

- Providing leadership, resources and role modeling
- Setting and monitoring standards of practice
- Addressing deficit in the standards
- Reviewing processes and procedures whilst remember nothing changes until it changes (Grant Howard 2013)

What tools/forums does the Department use to monitor its service performance?

- Mortality and morbidity review
- Quality meeting monthly with a review of:
    - complaints from colleagues, patients, families
    - incidents reports / adverse events report
    - compliance against certification of national/professional standards
    - Audits
    - Surveys: family and staff satisfaction
    - Direct observation/inspection
    - Peer review/second opinion:
- Radiology and Microbiology meeting

As Clinician's you contribute to the quality service of the Department by:

- Providing competent and safe care to patients/families
- Meet/exceeding needs of patients/families
- Maintaining professional expectations /responsibilities
- Participation in audits/surveys by completing and submitting them
- Report potential and real incidents so that others can learn from them
- Get involved in quality activities in any way you can e.g.
    - Clinical audit of your choice
    - Reviewing and updating service area procedures/guidelines
    - Become a champion of a project
    - A member or representative in extra-unit activities
    - Submitting a suggestion

Health and Safety in the CCD

The aim of Health and Safety is to ensure staff safety is maintained and to improve the environment in which you work.

- We are always looking to:
    - Improve staff health and safety in the workplace
    - Improve workplace satisfaction
    - Make quality improvements to the service that helps create a safe working environment
    - Write policies, procedures and educational programmes that support health and safety
    - Improve the management of health and safety and reduce environmental risks

As an employee of the Waikato DHB you have a role in health and safety in the work place to ensure your own safety and the safety of others.

You can help with general health and safety within the CCD environment by highlighting any H&S risks to the ACNM on duty, fixing any problems you come across, making recommendations for change, reporting incidents and reading the incident education board and incident feedback.

We keep a 'hazards register' in each unit (HDU – in the workroom / ICU - in the ACNM office). It lists all the substances (chemical and non-chemical) we use in the Department that are potentially harmful. You need to be able to use this register in case you need to deal with a chemical spill.

We have the Datix computerised incident reporting system which you need to know how to use. The information collected from the staff incidents is used to look at what we can do to prevent further incidents, improve care and prevent harm.

In an emergency the Department has a response plan and evacuation procedure. You need to know where this is kept (HDU – in the Disaster Station in the main nursing station/ ICU - in the ACNM office). You also need to know what your actions would be if you hear the fire alarm in CCD and what you need to do to prepare to evacuate your patient.

We also have a Health & Safety focus board that is updated every six weeks to highlight the main themes from incidents investigated over that period. This is located in the ICU on the wall opposite bed space G3 and in HDU outside the Drug Room.

You should remember that health and safety is everyone's responsibility and is no accident.

Incident Reporting Process in the CCD

The definition of an 'Incident' is any event which is not part of the standard operation of the service and which causes, or may cause, an interruption or a reduction of the quality of the service. An incident may involve anything from a 'near miss', to a product fault, to patient harm.

When incident reports are reviewed we try to understand why errors and near misses have occurred. This assists us in designing systems to reduce risk, prevent harm and improve patient safety. It is not a punitive system.

You must complete the DATIX process, a system found on any unit PC intranet page. Once you have completed an incident form it gets investigated by the ACNM, who may come and talk to you about it. All the CCD incidents are discussed at the CCD quality meeting held every 6 weeks.

Every six weeks a focus board is produced, which is used to highlight the main themes from incidents for that period.

Summary points:

- Incidents help us identify problems and learn from our mistakes.
- We all have a responsibility to report incidents as soon as they occur.
- If you think you have an incident to report discuss it with the ACNM on duty. You can discuss what actions need to be taken.

It is important that you put as much information as you can on the form:

- What did you find?
- What did you do about it?
- What were the product numbers?
- What is the size, depth, grading of pressure sores or wounds?
- What were your interventions?
- What are you recommendations for prevention?

Infection Control Management

Introduction
Infection Control is the responsibility of **every staff** member in the CCD. There are a number of initiatives in place supporting infection control management such as 'The 5 Moments of Hand Hygiene' and the 'CLAB project'.
The Ministry of Health sets standards around infection control for example the 5 Moments of Hand Hygiene in which the 'moments' are continuously audited by our Department Gold Auditors (Christine Carter – ICU ACNM, Emma Johnson – ICU RN and Gwyn Basset – HDU RN), then these results are collated and reviewed quarterly. Hand Hygiene New Zealand (2012) has set a target of 80% compliance to the 5 Moments of Hand Hygiene for each DHB in New Zealand.

Considerations
To ensure your hand hygiene is effective it is important to:

- Remove bracelets, wrist watches and rings with stones or ridges when providing clinical care. Only flat rings may be worn during patient care activities. If worn, the surfaces under rings must be washed and dried frequently to remove bacteria
- Make sure your sleeves are above the elbow and do not interfere with effective hand hygiene practice
- Keep nails short and clean and do not wear nail polish. Artificial nails (gel or acrylic) are not permitted
- Cover any breached skin (cuts, dermatitis or abrasion) with a waterproof film dressing
- Avoid long ties and lanyards. If wearing a tie ensure it is tucked in or secured

If you experience any skin problems you must inform your manager and complete an Incident Form immediately.

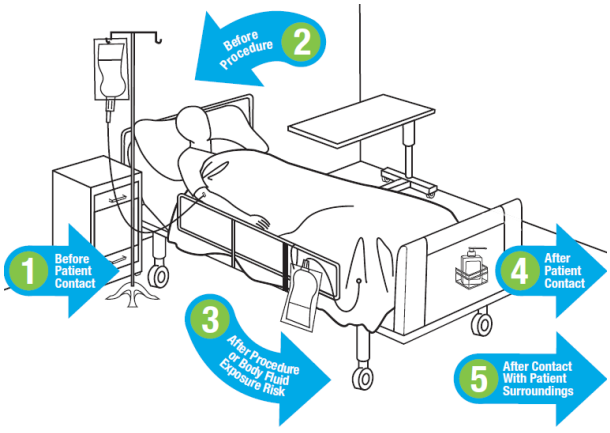
Expect to be challenged by the team if you are under performing

Five Moments of Hand Hygiene
Moment 1: Before patient contact
Why: To protect the patient against pathogens carried on your hands

Moment 2: Before a procedure
Why: To protect the patient against pathogens, including the patient's own, from entering his/her body

Moment 3: After a procedure or body fluid exposure risk
Why: To protect yourself and the healthcare environment from patient pathogens

Moment 4: After patient contact
Why: To protect yourself and the healthcare environment from patient pathogens



Moment 5: After contact with patient surroundings
Why: To protect yourself and the healthcare environment from patient pathogens

CLAB Project
The Critical Care Department is part of a national collaborative between the Health Quality and Safety Commission and the Centre for Health Innovation and Improvement Ko Awatea to prevent Central Line Associated Bacteraemia (CLAB). The project consists of two main parts – the Insertion Bundle and the Maintenance Bundle.

Insertion Bundle
The Insertion Bundle includes an Insertion Checklist which is stored on the CVL Trolley (Located in the store room in CCD/in the patient conservatory in HDU). The checklist must be completed for all patients having a CVL inserted in the CCD. The top section of the checklist covers general information regarding the unit in which the line is inserted in (CCD or HDU), the insertion site, catheter type, line coating and insertion date and time. The bottom section of the checklist covers aseptic and sterile techniques used by the Dr inserting the line. This area is completed the person observing the line insertion (this is usually the patients primary nurse). Following line insertion both the observer and the Dr sign and date the form. This section of the form highlights the significance of using correct aseptic and sterile techniques in preventing CLAB. The completed forms are then put in the Clinical Nurse Mangers mail tray which is located in the reception areas of both units.

Maintenance Bundle
The Maintenance Bundle includes the Maintenance Checklist which is stored in the filing cabinets in CCD and in the central filing area in the HDU nurses station. The checklist must be completed for all patients with a CVL line and is filled in once per shift by the primary nurse. The top section of the checklist is completed on the day of insertion (day 0) and the following sections are completed for each subsequent day. The top section of the Maintenance Checklist documents whether the patient has TPN running and if it is being infused via a dedicated port, it also looks at whether the injection ports have been wiped with alcohol swabs prior to being accessed. The following sections include a daily review of the line for necessity and checking the site for inflammation. If the line is removed this needs to be documented on the form. The completed forms are then put in the Clinical Nurse Mangers mail tray.

References
5 moments for hand hygiene. (2012). Retrieved from http://www.handhygiene.org.nz/index.php?option=com_content&view=article&id=9&Itemid=109
Infection Control Management

Care in Our Department

Families in CCD

When someone becomes critically ill, care must extend beyond the traditional clinician -patient relationship and into a clinician -family relationship, due to the majority of CCD patients being unconscious, semi-conscious or sedated (Kelleher, 2006) or recovering from anaesthetics. Family

members play a valuable role in the patient's recovery and should be considered members of the extended healthcare team.

Families contribute to the patient's well-being in a number of ways such as:

- Providing a link to the patients personal life
- Advising the patient in health care decisions or functioning as a decision maker when the patient cannot
- Providing positive and caring support (Lewis, Heitkemper & Dirkson, 2004)

Following admission of a patient to the CCD, family members often experience high levels of stress (Lee and Lau, 2003), which can be exacerbated by poor communication causing anxiety and contributing to less than optimal recovery after discharge (Russell, 1999).

- Try to keep family members up-to-date with any changes in the patient's condition and offer to arrange a family meeting (as appropriate) if the relatives feel that they need further information. Please ensure all meetings are documented in the clinical notes or on the family care plan to ensure consistency of information.

Sleep Pattern Disturbances

Sleep deprivation is common among the critically ill due to the nature of the critical care environment with patients experiencing frequent disturbances often leading to broken sleep patterns (Figueroa-Ramos et al., 2009., Tembo & Parker, 2009).

Sleep disturbances are classified into four main areas:

- Environmental – including noise from pumps, ventilators, SCD machines and other equipment, as well as staff voices and ringing telephones
- Interventional – such as patient turns and cares, and necessary medical procedures
- Modes of mechanical ventilation and associated procedures e.g. suctioning
- Intrinsic factors – such as the severity of the patient's illness (Tembo & Parker, 2009)

Sleep deprivation can lead to both physiological and behavioural consequences such as:

- Increased pain sensitivity
- Impaired attention span
- Increased daytime sleepiness
- Impaired mood (Figueroa-Ramos et al., 2009)

Care
Sleep deprivation is an important consideration when caring for a critically patient. The goal of clinical care should be attempting to limit the number of disturbances experienced by patients, especially during the night hours by grouping cares and allowing for adequate periods of rest.

Delirium Management

Delirium is characterised by an acutely changing or fluctuating mental status, inattention, disorganised thinking, and an altered level of consciousness that may or may not be accompanied by agitation (Anonymous, 2000). The reported incidence of delirium in the critical care environment varies widely, from 16% to 89% (Devlin et al., 2007).

In the critically ill patient, delirium is associated with prolonged stays and higher rates of mortality; therefore recognition of delirium is important (Spronk et al., 2009). Although not proven, many risk factors have been described as predisposing a person to the development of delirium. These can be categorised into these main areas:

- Pre-existing conditions
- Age > 70 years
- Visual or hearing impairment
- History of depression, dementia, congestive heart failure, stroke or epilepsy
- Acute condition
- Drug overdose/illicit drug use
- Sepsis
- Hypoxemia
- Environmental factors
- Use of physical restraints, tubes and catheters

(Spronk et al., 2009)

We are using the CAM-ICU screening tool and you will be informed of any new or significant clinical developments. This does not mean we expect you to chart medication, but to be aware of the changing clinical picture for our patients. HDU use the hospital CAM tool for delirium assessment.

End of Life Care

It is important to consider issues associated with “end of life” care in the Critical Care environment given that approximately one quarter of all critically ill patients will die (Woodthrow, 2006). Our mortality rate is around 12%.

Customs surrounding death and dying vary widely between cultures. Understanding and making every attempt to accommodate the family’s cultural traditions is important when caring for a dying patient.
Grief experienced by family members following the death of a relative is highly individualised and influenced by a number of factors such as:

- The relationship between the grieving person and the deceased
- Whether the loss is sudden or anticipated
- The support systems available to the grieving person
- The persons religious and cultural beliefs (Lewis, Heitkemper & Dirkson, 2004)

Organ Donation

The Critical Care Department has made a commitment to supporting and engaging families in discussions surrounding organ donation. The ICU has three Organ Donation Link Nurses. Their role is to support staff, both nursing and medical, in facilitating these discussions, while working together to ensure the donor and the family are treated with respect and dignity throughout the donation process.

Organ donation most commonly takes place when a person has suffered a severe and irreversible injury to the brain. However more recently organ donation has become possible when a patient has a non-survivable head injury but does not fit the medical diagnosis of brain death. In these circumstances organ donation may be able to occur immediately after death, which is known as Donation after Cardiac Death (DCD).

There may be an education session on the Tuesday teaching day for more around organ donation, including the nurse consent practices for tissue, eyes, heart valves and skin. If, however, you are faced with a situation prior to this time you can refer to the ICU information folder and the Protocols, Procedures and Guidelines Folder. Alternatively, speak to one of the CCD Link Nurses or an ACNM.

The Role of the Coroner

It is important to be aware of the role the Coroner plays in the Critical Care environment.

The coroner's role involves carrying out:

- A formal enquiry to ensure the identity of the deceased
- The cause of death is established
- Time and place of death
- To gain an understanding of the cause and circumstance of death.

At the end of this process the coroner makes recommendations to enhance public safety in future.

- The Police will want to speak to family members, so it's important to ensure the family remain in the Department until the Police arrive.
- The Police will interview medical staff which may include the primary nurse, to get more information about the circumstances surrounding the death.

Any cultural needs that the family has will be recognised, but these must be clearly communicated to the Police as soon as possible (Coronial Services of NZ, 2012).

Registrar Responsibilities

When a patient dies in the CCD there are a number of things you are required to do:

1 Ensure your duty consultant is aware of the patient death. Often death in ICU is anticipated.

2 Notify the primary team's registrar +/- consultant. Ensure you document the name of the person you informed in the clinical notes. A frequent source of complaint from some specialists is they are not informed of their patient's death. If you have informed the primary team registrar, it is their responsibility to inform the consultant. If you have documented the name, these complaints are easy to address.

3. If needed, inform the coroner. Around half of our cases require coronial referral. Those patients that require coronial referral are described in the act however we do not expect you to make this decision – get clarity from the Duty consultant.

If referral to the coroner is deemed necessary, fill in a RECORD OF DEATH form. These forms are located in the bottom draw of the main unit filing cabinet, or in the top filing cabinet in the work room. Once you have filled in the form, fax it to the coroner using the preset buttons on the fax machine. Please do not dial the number.

a. Await a phone call from the coroner as to whether they will accept or decline jurisdiction. If they decline jurisdiction then fill in a Death Certificate at main enquiries.

b. If the coroner chooses to take jurisdiction, **do not** complete the death certificate.

c. Inform the family the police will arrive to escort the body to the mortuary and will meet the next of kin as a matter of formality.

d. Phone the police to inform them of the death and advise them it is a coronial investigation.

e. Await the arrival of the police to escort the body to the mortuary.

f. The police will request a short summary from you, which you can give. You **MUST NOT** copy any parts of the notes and give it to them – they need to request this through the usual process, which involves a written request on police letter-head to medical records or the Intensive Care Unit's clerical staff.

Most coronial cases require a formal report to be written. In our Department this is a designated consultant responsibility. Grant Howard oversees this process. If you receive a request for a coronial report take it to Grant. Except in the case where an explicitly named registrar has been directed by the coroner to write a report he will allocate to a suitable specialist.

4. You must write a letter to the GP informing them of the death. This must be done within a week, preferably on the same day. Include in the letter the date of admission to hospital and ICU; date and time of death; the cause of death if it is known; significant events during the admission; any significant acute or chronic underlying conditions; whether the case was referred to the coroner; and whether or not a post-mortem was performed or is to be performed.

Reading:
Coronial services of New Zealand. (2012). Retrieved from http://www.justice.govt.nz/courts/coroners-court

Acknowledgements

Spheres of Influence
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Jewel Barlow-Armstrong

Images retrieved from:
www.wikipaedia.com

Enjoy your Run
Take as much as you can from it and give everything to it. Working together will ensure everyone wins