



North of England
Critical Care Network

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**North of England
Critical Care Network
Annual Conference
15th October 2019
Stadium of Light,
Sunderland**

**Poster Abstracts
2019**

Poster Abstracts - NoECCN Conference 15th October 2019

Stadium of Light, Sunderland

	Name	Unit/Hospital	Email	Abstract Title	Date abstract submitted
1	Heather Irving, Vicki Prudhoe & Rosie Gylde	Newcastle Upon Tyne Hospitals NHS FT	Heather.Irving@nuth.nhs.uk	Complimentary Therapy within the Critical Care setting	24/05/2019
2	Anita McGuire	Newcastle Upon Tyne Hospitals NHS FT	Anita.Mcguire@nuth.nhs.uk	The use of Symbol at End of Life	12/07/2019
3	Alison Clark & Fiona Laughland	CITU JCUH, South Tees NHS FT	alison.clark1963@outlook.com	Setting up a Cardiothoracic Intensive Care Unit in Ghana, a medical Mission	25/07/2019
4	Caroline MacFie, Anita McGuire, Kathy Walton, Lucia Pareja-Cebrian, Jennifer Collins, Michelle Permain, Caroline Cullerton	Peri-operative and Critical Care & Microbiology Newcastle Upon Tyne Hospitals NHS FT	caroline.macfie@nuth.nhs.uk	Implementation of Direct CPE PCR for Peri-Operative ICCU patients at the Freeman Hospital	04/09/19
5	Maite Babi-Galan, Leigh Dunn, Verity Calder	Perioperative & Critical Care Research Team	Maite.Babio-Galan@nuth.nhs.uk	Is every clinician a researcher? Embedding research into clinical practice	05/09/19
6	Laura Wishart, Emma Urwin, Andrea Mockler	North Tees & Hartlepool NHS FT	Laura.Wishart@nth.nhs.uk	Implementing Treatment Escalation Plans.	07/09/19
7	Lucy Pedley	South Tees NHS FT	Lucy.Pedley@nhs.net	Cardiac pacing in the Cardiothoracic Intensive Care Unit.	09/09/19
8	Dr Keryn Hall	County Durham & Darlington NHS FT	keryn.hall1@nhs.net	Intensive Care Compliance with National Patient Safety Agency Nasogastric Tube Guidance	09/09/19

9	Susie Chrystal, Rebecca Edmondson & Nicola Robinson	Gateshead Health NHS FT	Susie.chrystal@nhs.net	Humanising Critical Care	10/09/19
10	Steph Room, Joanne McStay, Alison Mielnik, Claire Mair, Emma Darling-Cooper, Laura King, Bethany Quinn, Jordan Thompson, Joanne Sunderland, David Elliot, David Edwards, Lorna Barton	Northumbria NHS FT	Lorna.Barton@northumbria-healthcare.nhs.uk	AKI Alerting - Can Outreach improve the care of inpatient with Acute Kidney Injury?	17/09/19
11	Rebecca Thomson, Jill Devereux & Barbara Salas	Ward 38 and Ward 18, RVI Newcastle Upon Tyne Hospitals NHS FT	rebecca.thomson@nuth.nhs.uk	Learning from Vanderbilt. CAM-ICU and Implementation of the ABCDEF bundle	10/09/19
12	Claire Randell and the NuTH Critical Care Stop the Pressure Task Force	The Newcastle upon Tyne NHS FT	Claire.Randell@nuth.nhs.uk	Stop the Pressure in Critical Care!	19/09/19
13	Jayne Haley and Janine Brallisford	South Tees NHS FT	jayne.haley@nhs.net	'Catch the Kidneys'	19/09/19
14	Lisa Spires	Gateshead Health NHS FT	lisa.spires@nhs.net	15 seconds 30 minutes	10/09/19
15	Rachel Thomson	Newcastle Upon Tyne Hospitals NHS FT	Rachel.Thomson@nuth.nhs.uk	Can we meet patients energy and protein requirements with standard parenteral nutrition bags via a midline?	20/09/19
16	Victoria Bello	South Tees NHS FT	victoria.bello@nhs.net	An Exploration of the Support Services Offered to Long Term Intensive Care Unit Patients Post Discharge	21/09/19
17	Dr Iain Cummings	University Hospital of North Durham	iaincummings@nhs.net	Improving the quality of Intrahospital patient transfer documentation using audit	29/09/19
18	Joseph Vernon, Greg Morris, Helen Overton	South Tees Foundation Trust	helen.overton1@nhs.net	Evaluation of electronic solutions for sepsis alerting and the management of sepsis patients	27/09/19



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Please submit your abstract to
Jan.Malone@northumbria-healthcare.nhs.uk or
Sarah.Gray@nth.nhs.uk
by 20th September 2019

Name(s): Heather Irving Vicki Prudhoe Rosie Glyde
(max 300 characters including spaces)

Organisation: Newcastle Upon Tyne Hospitals NHS Trust
(max 300 characters including spaces)

Abstract Title: Complimentary Therapy within the Critical Care Setting
(max 300 characters including spaces)

3 Key words: Complimentary Therapy patients
(max 100 characters including spaces)

Background: We have been providing Complimentary Therapy on the unit once a week for the last 18 months, we offer a variety of aromatherapy and massage treatments which enable the critical care patients to relax, de-stress and remove themselves from environment around them
(max 1000 characters including spaces)

Implications for Practice: Putting the patients mental health at the centre of our practice
(max 1000 characters including spaces)

References:
(max 3 references, 600 characters including spaces)



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by 20th September 2019

Name(s): Anita McGuire
(max 300 characters including spaces)

Organisation: Newcastle Upon Tyne NHS Trust
(max 300 characters including spaces)

Abstract Title: The use of a Symbol at End of Life
(max 300 characters including spaces)

3 Key words: Symbol
End of life care
Communication
(max 100 characters including spaces)

Background: There are no second chances when it comes to end of life care; therefore it is essential that we get it right. Providing individualised care, delivered with compassion, which involves the patient and their significant others is fundamentally the principles of good end of life care. Health professionals have a duty to ensure that patients are cared for with dignity, respect and compassion until they die. In a busy ward environment it is anticipated that the use of a symbol displayed at the entrance to the dying patient's bed space would create an atmosphere of calm and prepare staff for interactions with grieving relatives. On seeing the symbol staff should be considerate of their activities in this area and in any encounters with relatives.
(max 1000 characters including spaces)

Implications for Practice:

The use of a symbol displayed at the entrance to a dying patients bed space alerts the wider multi-professional team to imminent end of life. It promotes privacy and dignity by preventing inadvertant disruptions to patients and their significant others at an important time in their care.

The implementation of the symbol helps to create an atmosphere of calm and prepare staff for interactions with grieving relatives. On seeing the symbol staff should be considerate of their activities in this area and in any encounters with relatives.

(max 1000 characters including spaces)

References:

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by 20th September 2019

Name(s): Alison Clark, Fiona Laughland
(max 300 characters including spaces)

Organisation: CITU, James Cook University Hospital, Middlesbrough
(max 300 characters including spaces)

Abstract Title: Poster presentation - Setting up a cardiothoracic Intensive Care Unit in Ghana, a Medical Mission.
(max 300 characters including spaces)

3 Key words: Team work, poverty, making a difference
(max 100 characters including spaces)

Background: My colleague and myself were invited to join a team from JCUH to assist on the setting up of a cardiac surgery programme in Ghana. The mission was the vision of one of our surgeons who originates from Ghana. The project itself was self funded from charity nights etc and could only take place due to the generosity of the people of the North East.
(max 1000 characters including spaces)

Implications for Practice: Spreading best practice, trying to bwcome a more cost effective workfooce in reducing wastage. Giving something back, realisation that the NHS is an amazing organisation!
(max 1000 characters including spaces)

References:

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by 20th September 2019

Name(s): Caroline MacFie¹, Anita McGuire¹, Kathy Walton², Lucia Pareja-Cebrian², Jennifer Collins², Michelle Permain², Caroline Cullerton²
1. Peri-operative and Critical Care NUTH, 2. Microbiology NUTH
(max 300 characters including spaces)

Organisation: The Newcastle upon Tyne NHS Foundation Trust
(max 300 characters including spaces)

Abstract Title: Implementation of Direct CPE PCR for Peri-Operative ICCU patients at the Freeman Hospital.
(max 300 characters including spaces)

3 Key words: CPE
PCR
(max 100 characters including spaces)

Background: Carbapenemase Producing Enterobacteriaceae (CPE).
Cause serious & life-threatening infections.
Results in increased costs of patient screening & patient isolation, extra staff time, personal protective equipment, environmental decontamination, bed/ ward closures, cancelled operations, unnecessary disposal of theatre equipment, & increased length of patient stay.
In 2013 Public Health England issued a 'CPE Toolkit' stipulating that any patient who has been an inpatient in an 'at risk' hospital within the last 12 months should be screened for CPE on hospital admission.
Stool culture takes up to 48 hours. In order for a patient to be deemed CPE negative, three negative screens taken a minimum of 48 hours apart are

required.(1) I.E. ONE WEEK MINIMUM with processing logistics. Cost £4.53.

FH37ITU explored the use of rapid testing using PCR. Cost £36.60, test duration 50 minutes.

Director IPC confirmed one negative CPE PCR sufficient for IPC precautions to be stepped down.

6 month pilot.

(max 1000 characters including spaces)

Implications for Practice:

66 negative results by PCR & culture (100% concordance).

No op cancellations due to CPE issues since PCR testing began.

No delay in discharging patients from ITU due to delay in ward cubicle availability due to unknown CPE status.

No patients later proved positive after 2nd & 3rd culture. Improved patient satisfaction due to reduced delays & isolation. Rapid results allowed step down of 45 patients from Level 3 to Level 2. This amounts to 156 bed days in total.

Nursing requirements at Level 3 care ≈ £1900 per night compared to £857 for Level 2.

Resultant saving ≈ £162,708.

In addition 6 patients stayed overnight in PACU. The reduced CPE risk allowed further £3000 saving.

Additional testing cost for PCR x66 swabs = £2117.

Domestic services cost savings: deep clean estimated at £30 more in labour than standard clean therefore conservative estimate £1760 (not including additional materials).

CPE cleans are down by ~40%.

TOTAL SAVING TO DATE ≈ £165,351 IN 6 MONTHS IN ONE DEPARTMENT.

(max 1000 characters including spaces)

References:

Public Health England, (2013), Acute trust toolkit for the early detection, management & control of carbapenemase-producing Enterobacteriaceae, London: Crown.

Jim O'Neil 2014, Antimicrobial Resistance: Tackling a crisis for the health & wealth of nations, HM Government.

Kate Wighton 2016, 'Superbug outbreak costs an NHS hospital one million pounds, says new study', <https://www.imperial.ac.uk/news/175741/superbug-outbreak-costs-nhs-hospital-million/>

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Name(s): Maite Babio-Galan. RN
Leigh Dunn. RN
Verity Calder. RN
Perioperative and Critical Care Research Team
(max 300 characters including spaces)

Organisation: Newcastle upon Tyne Hospitals NHS Foundation Trust
(max 300 characters including spaces)

Abstract Title: Is every clinician a researcher?
Embedding research into clinical practice
(max 300 characters including spaces)

3 Key words: Research, staff-engagement, quality improvement
(max 100 characters including spaces)

Background: Critical Care poses particular challenges to the delivery of research studies. Interventions are often time critical and highly specialised, involving a vulnerable patient group. To ensure this group of patients are given the best opportunity to participate in research, as required by the NHS Constitution (2013), the delivery team developed a series of strategies:

- Research topic introduced on Mandatory training sessions.
- Journal Club to promote evidence based practice
- Trial novel communication methods
- Define and develop the role of the research champion

The project followed a PDSA cycle framework and staff questionnaires were used

to collect data.

(max 1000 characters including spaces)

Implications for Practice: Integrating the clinical and research teams has allowed for safe recruitment, delivery of interventions and follow up throughout the patient's journey, including out of hours.

The questionnaire results suggest that increasing research awareness allows the clinical team to play a proactive role in the delivery process.

(max 1000 characters including spaces)

References: NHS Constitution 2013, Health and Social Care Act 2012.

Quality, Service Improvement and Redesign Tools:

Plan, Do, Study, Act (PDSA) cycles and the model for improvement. Available on <https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf>

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Name(s): Laura Wishart, Emma Urwin, Andrea Mockler
(max 300 characters including spaces)

Organisation: North Tees and Hartlepool NHS trust
Critical Care Outreach Team at North Tees Hospital
(max 300 characters including spaces)

Abstract Title: Implementing Treatment Escalation Plans
(max 300 characters including spaces)

3 Key words: Treatment escalation plans, reduce cardiac arrest rates, improve patient outcomes
(max 100 characters including spaces)

Background: A pilot 24/7 CCOT team was introduced into the trust in November 2018. One of the main aims of the team is to challenge and improve patient care and safety. In order to illustrate the effectiveness of the pilot, we began to collect data that would support the improvement of patient safety and care but also demonstrate the requirement for a permanent 24 hour CCOT service.

Within this aim, the team began to collect patient escalation status pre and post CCOT reviews. This allowed the team to audit the effectiveness of each clinical review and highlight the requirement of the patients treatment escalation of care. Because of this audit, many themes emerged; improved NEWS, increase in DNAR discussions, decrease in cardiac arrests rates, palliative care collaborations, improvement in communication between the MDT and out of hours working. Due to the positive data collection, it has given the CCOT team the opportunity to create and implement a treatment escalation form within the trust.

(max 1000 characters including spaces)

Implications for Practice: Challenging senior medical teams to prompt discussion of treatment escalation and patient outcomes whilst standardising the approach to escalation planning.

(max 1000 characters including spaces)

References:

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Name(s): Lucy Pedley
(max 300 characters including spaces)

Organisation: James Cook University Hospital
South Tees University Hospital Trust
(max 300 characters including spaces)

Abstract Title: Cardiac Pacing in the Cardiothoracic Intensive Care Unit
(max 300 characters including spaces)

3 Key words: Cardiac Pacing Guidelines
(max 100 characters including spaces)

Background: The majority of cardiac surgical patients require pacing in the post operative phase of their recovery. There was a lack of cardiac pacing guidelines in the Cardiothoracic Intensive Care Unit at James Cook University Hospital. The guidelines were produced to improve practice and safety, give background information regarding pacing and standardise patient care.
(max 1000 characters including spaces)

Implications for Practice: To improve the safety of cardiac surgical patients and standardise patient care in the Cardiothoracic Intensive Care Unit.
(max 1000 characters including spaces)

References: Oxford Handbook of Cardiac Nursing Kate Olson 2014

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by 20th September 2019

Name(s): Dr Keryn Hall
(max 300 characters including spaces)

Organisation: Intensive Care Unit, University Hospital North Durham,
County Durham and Darlington NHS Trust (CDDFT)
(max 300 characters including spaces)

Abstract Title: Intensive Care Compliance with National Patient Safety Agency Nasogastric
Tube Guidance
(max 300 characters including spaces)

3 Key words: Nasogastric tube
Never event
Patient safety
(max 100 characters including spaces)

Background: Administration of substances through a misplaced nasogastric (NG) tube has remained a National Patient Safety Agency (NPSA) alert since 2015 and is listed as a never event (1). Between 2011 and 2016 32 deaths occurred in the UK associated with food, fluid or medication given via a misplaced NG tube (1). Although this is rare given the number of tubes inserted during that time, the consequences have been shown to be devastating. The NPSA requires strict practice and documentation surrounding NG tube insertion. This includes the documentation of best interest decisions, appropriate confirmatory techniques (initial and daily) and senior review.

CDDFT have recently implemented new pro forma for NG tube documentation (LOCSIPPs) in order to increase compliance with NPSA guidance. LOCSIPPs are to be completed alongside the existing NG tube pathway. This audit was conducted to review the effect LOCSIPPs have had on the quality of

documentation/ safety of practice surrounding NG tubes.

(max 1000 characters including spaces)

Implications for Practice:

This audit has shown that documentation remains substandard. Although no unsafe practice occurred during the audit period, this is not reflected in the records. For example, all chest X-rays were correctly reviewed and misplaced tubes identified, but only 44% documented all x-ray findings.

9% had documented best interest decisions in regards to NG tubes. Again this discussion may have taken place, but there is no evidence. Inserting an NG tube is a high risk procedure, the risks and benefits should be discussed and documented in order to adhere to medical ethics and law.

Work has begun to simplify and combine the NG pathway and LOCSIPP as introduction of the LOCSIPP adversely affected compliance with the pathway. LOCSIPPs were designed to mimic pre-flight safety checklists, decrease reliance on memory and therefore reduce errors. By formulating any easy to follow agenda with specific prompts we hope to eradicate safety errors and eliminate never events involving NG tubes.

(max 1000 characters including spaces)

References:

(1) National Patient Safety Agency (2019). Nasogastric tube misplacement: continuing risk of death and severe harm. [online] Improvement.nhs.uk. Available at: https://improvement.nhs.uk/documents/194/Patient_Safety_Alert_Stage_2_-_NG_tube_resource_set.pdf [Accessed 5 Sep. 2019].

(max 3 references, 600 characters including spaces)



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by 20th September 2019

Name(s): Susie Chrystal, Rebecca Edmondson & Nicola Robinson
(max 300 characters including spaces)

Organisation: Gateshead Health NHS Foundation Trust
(max 300 characters including spaces)

Abstract Title: Humanising Critical Care
(max 300 characters including spaces)

3 Key words: Humanising
Delirium
Compassion
(max 100 characters including spaces)

Background: Critical care is a frightening place for patients and relatives. At the Queen Elizabeth Hospital, Gateshead various new initiatives have been introduced to help reduce the affect of the frightening environment and the potential dehumanising that can occur with patinets being referred to as numbers and conditions rather than their names.

Open visiting has been in place for over two years now and has had positive impact on patients, relatives and staff. Introduction to me leaflets are used for all intubated patients so that the MDT can know a little more about the patients they are looking after. An ex patient has been visiting as a volunteer to share his experience and encouragement. A musician from Music in Hopsitals and Care plays the ukelele once a month to patinets, relatives and staff.

(max 1000 characters including spaces)

Implications for Practice: improves patient experience
reduces delirium
improves staff morale and engagement

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References:

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by 20th September 2019

Name(s): Steph Room, Joanne McStay, Alison Mielnik, Claire Mair, Emma Darling-Cooper, Laura King, Bethany Quinn, Jordan Thompson, Joanne Sunderland, David Elliot, David Edwards, Lorna Barton
(max 300 characters including spaces)

Organisation: Northumbria NHS Foundation Trust
(max 300 characters including spaces)

Abstract Title: AKI Alerting - Can Outreach improve the care of inpatient with Acute Kidney Injury?
(max 300 characters including spaces)

3 Key words: AKI
Alerts
Outreach
(max 100 characters including spaces)

Background: Acute Kidney Injury (AKI) is common. Identification and care of these patients is commonly substandard. Patients with stage 2 and 3 AKI in our Trust have a mortality rate, similar to other Trusts, of around 40% (NHS Kidney Care) at one month.

AKI was made a Trust priority in 2019. As part of this workstream, Outreach started to receive email alerts (through the ICE pathology system) highlighting all inpatient with Stage 2 or 3 AKI. The practitioner reviews the patient, implements a new care bundle and educates and supports the ward team. They provide a patient information leaflet and a 'kidney' logo to display on the patient's door. They promote treatment escalation planning conversations.

Education and training is well received with excellent feedback. Outreach have established a monthly deteriorating patient link nurse group focusing on practical

learning from SUIs and real cases. Outreach have supported AKI awareness events and education programmes across the Trust.

(max 1000 characters including spaces)

Implications for Practice:

40% of patients with AKI stage 2 and 3 would not have triggered an Outreach alert through NEWS2.

Outcomes including 30 day mortality and need for Critical Care are monitored monthly. The process of care shows improvements. With Outreach review:

-appropriate documented review of nephrotoxic drugs has increased from 29% to 80%

-appropriate fluid balance initiation has improved from 65% to 93% with IVT given appropriately from 65% to 91%

-U&Es rechecked by 15 hours has increased from 29% to 54%

We have shown that clinical Outreach input into our AKI patients has improved the basic quality of care. This has increased workload. The high training quality and staff engagement has been recognised and expansion of training hours coupled with clinical Outreach posts is being considered.

With the expansion of e-obs alternative biochemical alerts alongside NEWS should be trialled.

With increased alerts close relationships with palliative services are important.

(max 1000 characters including spaces)

References:

1. Stewart J, Findlay G, Smith N, Kelly K, Mason M. Acute Kidney Injury: Adding Insult to Injury. NCEPOD, 2009.
2. AKI Audit of Outcomes and Care Processes Report. NHS Kidney Care, 2019.
3. AKI and Sepsis Collaborative www.uclpartners.com/patientsafety

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by 20th September 2019

Name(s): Rebecca Thomson
Jill Devereux
Barbara Salas

(max 300 characters including spaces)

Organisation: Newcastle Upon Tyne Hospitals NHS Foundation Trust. Ward 38 and Ward 18, RVI

(max 300 characters including spaces)

Abstract Title: Learning from Vanderbilt
CAM-ICU and Implementation of the ABCDEF bundle

(max 300 characters including spaces)

3 Key words: Delirium, detection, prevention

(max 100 characters including spaces)

Background: The team were invited to travel to Vanderbilt University hospital in Nashville, Tennessee to visit the medical ICU and delirium research team. We had the opportunity to shadow the ICU team and observe how they implemented the ABCDEF bundle into daily practice to prevent incidence of delirium in critical care.

(max 1000 characters including spaces)

Implications for Practice: Learning from world leaders. Sharing best practice. Identifying areas for improvement in the detection, prevention and management of delirium in critical care.

(max 1000 characters including spaces)

References: www.icudelirium.org

(max 3 references, 600 characters including spaces)



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by 20th September 2019

Name(s): Claire Randell and the NuTH Critical Care Stop the Pressure Task Force
(max 300 characters including spaces)

Organisation: The Newcastle upon Tyne NHS Foundation Trust
(max 300 characters including spaces)

Abstract Title: Stop the Pressure in Critical Care!
(max 300 characters including spaces)

3 Key words: Pressure Ulcers, Collaboration, Safety
(max 100 characters including spaces)

Background: Despite a previous successful quality improvement programme, followed by a period of sustained stability the incidence of pressure ulcers (PU) in critical care started to increase resulting in the need to implement further interventions.

The aim of the collaboration was to reduce the rate of PU in 4 adult critical care units in the Newcastle upon Tyne NHS Foundation Trust.

A mixed method approach was used. It included

- Re-establishing and improving membership of the Critical Care Stop the Pressure Task Force
- QI methodology
- Scoping exercise to identify key areas for improvement

Education
Collaborative working
Product testing
Understanding data

So far the group has

- Developed and delivered training on induction and mandatory training days
- Shared progress locally, nationally and internationally
- Identified products for testing and developed criteria for use
- Shared meaningful data

Early findings show a reduction in pressure ulcers

(max 1000 characters including spaces)

Implications for Practice:

Preventing pressure ulcers in the critically ill is a multi-professional responsibility with continuous staff engagement being imperative to success

The mixed-method approach used in this project is simple and transferable to other specialties.

Future work includes preventing pressure ulcers caused by medical devices and introducing education to the MDT on preventing pressure ulcers in the critically ill

(max 1000 characters including spaces)

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Name(s): Jayne Haley and Janine Brallisford
(max 300 characters including spaces)

Organisation: South Tees NHS Foundation Trust
(max 300 characters including spaces)

Abstract Title: 'Catch the Kidneys'
(max 300 characters including spaces)

3 Key words: Acute Kidney Injury
(max 100 characters including spaces)

Background: Within our CCO team 47% are non-medical prescriber. Throughout this course, and on trust prescribing forums the importance of adequate knowledge when prescribing for renal patients is emphasised. It is of particular importance given the high percentage of patients with AKI's which are referred to our team, whether this is the primary reason for referral or a secondary problem. As an expanding team, with a recent intake of starters new to the role of CCO, whom are not yet non-medical prescribers, we identified the management of AKI to be an area where development of a tool may be beneficial to help with initial treatment of AKI. The purpose being to support newer members of staff, improve patient's outcomes, and prevent further deterioration in kidney function. From reviewing other available toolkits nationally and discussing with junior members of the team we decided upon a simple check list for medicine optimisation, which also highlights the main causes and treatment of AKI.
(max 1000 characters including spaces)

Implications for Practice: The ability to have a simple toolkit/checklist to refer to when assessing a patient with an AKI will allow efficient and timely treatment of the patient. Whether this be identification of nephrotoxic medication that could be the cause of the AKI, identification of medication that should be adjusted in AKI as not doing so could cause adverse effects , or just prompting the practitioner to consider the other potential causes of AKI . As the role of CCO is to ultimately prevent the deterioration of patients anything such that helps speed up this process should ultimately improve our service and patient outcome. Although it is acknowledged that the members of the team who are not medical prescribers cannot be responsible for the changing of prescription, having this checklist should hopefully give them enough knowledge to discuss it with the medical professional responsible for the patients management.

(max 1000 characters including spaces)

References: Guidelines for Medicines Optimisation in Patients with Acute Kidney Injury, 'Think Kineys' 2016
Acute Kidney Injury Medicines Optimisation Toolkit, Renal Pharmacy Group March 2015

(max 3 references, 600 characters including spaces)



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 by 20th September 2019

Name(s): Lisa Spires
 (max 300 characters including spaces)

Organisation: Gateshead Health NHS Foundation Trust
 (max 300 characters including spaces)

Abstract Title: 15 seconds 30 minutes
 (max 300 characters including spaces)

3 Key words: Mindfulness reduce frustration increase joy
 (max 100 characters including spaces)

Background: social platform outside departmental/organisational structure seeking out respected influences on a department who can facilitate a change
 calls on every staff member to come up with their own plan using their specific knowledge
 bridges gap between leadership and workforce
 (max 1000 characters including spaces)

Implications for Practice: reduce frustration increase joy
 empowering staff
 improve teamwork
 develops leadership skills
 quality improvement

overcomes the idea of 'its not my job'

(max 1000 characters including spaces)

References: 15s30m

(max 3 references, 600 characters including spaces)



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by 20th September 2019

Name(s): RACHEL THOMSON
(max 300 characters including spaces)

Organisation: NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
(max 300 characters including spaces)

Abstract Title: CAN WE MEET PATIENTS ENERGY AND PROTEIN REQUIREMENTS WITH STANDARD PARENTERAL NUTRITION BAGS VIA A MIDLINE?
(max 300 characters including spaces)

3 Key words: PARENTERAL NUTRITION ADEQUACY
(max 100 characters including spaces)

Background: Midlines are commonly placed to deliver parenteral nutrition, (PN) if no central access is available. Clinical observations have shown patients frequently fail to meet their energy and nitrogen requirements with the only standard peripheral PN bag available in the trust. This standard bag provides a maximum of 1750kcal, and 10g nitrogen. The aim of this audit was to determine if patients being solely parenterally fed were meeting 100% (+/- 10%) of their estimated energy and nitrogen requirements (as calculated by the Dietitian) from the prescribed standard peripheral PN bag.

Twenty five consecutive patients, (16 male, 9 female) commenced on a standard PN bag via a mid line from November 2018 were included. Only 50% and 4% of patients met 100% (+/-10%) of their estimated energy and nitrogen requirements respectively. The mean daily energy deficit was 269kcal, (SD 173kcal) and the daily nitrogen deficit 5.9g/day, (SD 2.7g). The mean time period on standard PN bags was 12 days.

(max 1000 characters including spaces)

Implications for Practice:

The definition of nutritional adequacy and what is an acceptable deficit is of much debate. A limitation is energy requirements were estimated, rather than measured. Energy deficit is associated with loss of both lean body mass and poor patient outcomes¹. Achieving at least 80% of prescribed protein intake maybe associated with improved survival and shorter time to discharge alive in critical illness². There is currently a lack of capacity and resources available to place peripherally inserted central catheters (PICC) as well as lack of familiarity and concern regarding their use in the acutely unwell. A midline service has recently been initiated in the trust with a vision to expand to PICCs. In theory, if central access were available, this cohort of patients would have met 88% and 67% of their energy and nitrogen requirements with standard central PN bags. Positively this project has supported future developments of the trust wide line service to improve nutritional adequacy.

(max 1000 characters including spaces)

References:

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2. Nicolo M, Heyland D K, Chittams J et al. Clinical outcomes related to protein delivery in a critically ill population: A multicentre multinational observation study. *JPEN J Parenter Enteral Nutr*, 2016; 40: 45-51
3. NICE (2006) Nutrition support for adults: Oral nutrition support, enteral tube feeding and parenteral nutrition, CG32

(max 3 references, 600 characters including spaces)



ABSTRACT SUBMISSION FORM
North of England Critical Care Network
Annual Conference

15th October 2019

Please submit your abstract to
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by 20th September 2019

Name(s): Victoria Bello
(max 300 characters including spaces)

Organisation: South Tees NHS Foundation Trust.
(max 300 characters including spaces)

Abstract Title: An Exploration of the Support Services Offered to Long Term Intensive Care Unit Patients Post Discharge
(max 300 characters including spaces)

3 Key words: Qualitative Study
Rehabilitation after Critical Illness
Exploration of patient experiences
(max 100 characters including spaces)

Background: The development of this research derived from being a nurse working in critical care and the identification of long term patients suffering from psychological distress, anxiety, depression, withdrawal, physical weakness and delirium. This prompted research and a concept analysis on wellbeing which highlighted to the researcher the concept of RACI. A passion to help these patients and make positive changes to practice then came naturally. In order to drive this change research needed to be conducted to generate knowledge around the patients' individual experiences and how to best help them. Four participants were recruited into this phenomenological research study. Participants were recruited through a gatekeeper from ICU Steps support group. One to one, semi-structured interviews were performed and recorded on a dictaphone. Recordings were transcribed and analysed using a descriptive phenomenological approach and key themes were highlighted.

(max 1000 characters including spaces)

Implications for Practice: Participants received various and inconsistent methods of support post discharge. RACI clinics were valued by participants who attended. All participants found the support they received beneficial and especially valued speaking to other people with similar experiences at ICU Steps. Discharge summaries and better compliance with patient diaries are additional strategies that can be fairly easily implemented. A key theme identified was that patients wanted reassurance and a source of information if they needed it. Three participants said they would have found a follow up phone call beneficial.

(max 1000 characters including spaces)

References: This research was conducted as part of an MSc dissertation with many references.

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by 20th September 2019

Name(s): Dr Iain Cummings
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Organisation: University Hospital North Durham
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Abstract Title: Improving the quality of intrahospital patient transfer documentation using audit
(max 300 characters including spaces)

3 Key words: Intrahospital Transfer, checklist, safety
(max 100 characters including spaces)

Background: Within the hospital setting, critically ill patients frequently need to be transferred between clinical areas such as the emergency department, wards, theatres, radiology, and critical care. As with transfers between hospitals, intrahospital transfers come with inherent risks; adverse events involving patients, staff and equipment occur in up to 80% of intrahospital transfers. Choi et al showed that using a standardised intrahospital transfer checklist dramatically reduced the number of adverse events. The recent Guidelines for the Provision of Intensive Care Services (GPICS v2) from the Faculty of Intensive Care Medicine and the Intensive Care Society, sets out the standards expected for patient transfers, making little distinction between inter and intrahospital transfers. The document covers not only the organisation transfer, but what is expected during the transfer, as well as the clinical governance of the transfer process. Current practice was audited against GPICS standards.
(max 1000 characters including spaces)

Implications for Practice:

Records were found to be poor with few transfers documented at all in the medical notes. A standardised proforma based on Brunsveld-Reinders et al was introduced and its use was encouraged to act both as a pre-transfer checklist as well as a record of the patient's observations and interventions en route. The audit loop was then closed by repeating the original study. The repeat audit showed that not only was it possible to integrate an intrahospital transfer proforma into routine practice but in doing so, the quality of the documentation of the transfer process was greatly improved and demonstrated adherence to national guidance. Rolling this intrahospital transfer paperwork out across the whole transfer network should be considered.

(max 1000 characters including spaces)

References:

- Jia L et al. High incidence of adverse events during intra-hospital transport of critically ill patients and new related risk factors: a prospective, multicenter study in China. *Crit Care*. 2016; 20:12.
- Choi HK et al. A before- and after-intervention trial for reducing unexpected events during the intrahospital transport of emergency patients. *Am J Emerg Med*. 2012; 30:1433-40.
- Brunsveld-Reinders, A.H., Arbous, M.S., Kuiper, S.G. et al. A comprehensive method to develop a checklist to increase safety of intra-hospital transport of critically ill patients. *Crit Care* 2015; 19: 214.

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Name(s): Joseph Vernon, Greg Morris, Helen Overton
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Organisation: South Tees Foundation Trust
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Abstract Title: Evaluation of electronic solutions for sepsis alerting and the management of sepsis patients
(max 300 characters including spaces)

3 Key words: Electronic sepsis alerting
(max 100 characters including spaces)

Background: Adopting electronic solutions for the recording of physiological observations is a task which has been embedded into the organisation since 2014. In review of local data to compliance of sepsis screening and care, an electronic alert was developed to increase compliance to achieve both local and national targets. Following the introduction of these alerts, we reviewed a small sample of patients in whom a 'sepsis alert' had been generated. We specifically looked at the performance of these alerts and whether agreed standards care was met (if a diagnosis of sepsis had been made or the patient had a qSOFA score of 2 or greater).
(max 1000 characters including spaces)

Implications for Practice: The activation of the sepsis alert within the electronic solution is activated by the end user completing the physiological observations. Sepsis alerts are automatically generated if certain abnormal physiological observations are

inputted by the end user. Audit shown relatively few patients with a clinical diagnosis of sepsis had a qSOFA score of 2 or more, there was an insufficient number of patients with a clinical diagnosis of sepsis. Alerts are not reliable and do not require actioning or escalating within the system. Further development is required to close the loop and escalate the acutely ill sepsis patient to senior nursing and medical staff. Although the alert remains within the system to prompt health care professionals when undertaking physiological observations to further assess and escalate the care of these patients as per local protocol.

(max 1000 characters including spaces)

References:

(max 3 references, 600 characters including spaces)