Care to Share

Issue Six
August 2019

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Welcome to August’s edition of Care to Share. I am pleased to observe we achieved many of our ambitions at milestone 3 in developing our Nursing Service Framework (NSF). This edition explains what we have, and still need to achieve, over the coming months.

One key topical NSF ambition relates to our understanding of “culture”. To achieve this we have partnered with an international company, Best Practice Australia. This will not be, “just another survey”, instead this is “OUR” survey and it is designed to discover your experience of the culture in which we work.

We have clear ambitions to achieve our vision of continually improving patient experiences and outcomes, as well as creating a great place to work. To ensure we achieve this, our survey and feedback approach has been developed to seek out your thoughtful input. This is an opportunity for you to share your views and help us understand what it is like to be a nurse or midwife at RWT.

Your opinions will help us to improve communication, leadership the professional working environment and also to be part of crafting the future of nursing and midwifery at RWT. We wanted to try something a little different and we hope you will take a little time to share your views.

We are currently piloting the survey and aim to roll it out across the Trust in September 2019.
Congratulations to...
Advanced clinical practitioner Mark Dawes has just returned from China (Shanghai and Nanjing) where he spent nine days providing emergency care for the Premier League Asia Trophy Football Tournament. He was approached by the Premier League’s medical director to help support the teams with on-field emergency medical care and in situations where injured players needed to be taken to hospital.
Mark was present for the Manchester City, Wolves, West Ham and Newcastle training games and matches; supporting the doctors and physios with a UK level of care. Great work!
For more about the tournament visit www.premierleague.com/asia-trophy

Robin McMahon, advanced neonatal nurse practitioner, has been appointed as Defence Specialist Advisor (DSA) Paediatrics for the Armed Forces. This supersedes his current post of Specialist Nurse Advisor (Army) Paediatrics. Congratulations Robin!

Congratulations to Elaine Wharton, learning disability specialist nurse, who was recently invited to the Houses of Parliament to celebrate 100 years of learning disability nursing. The event was hosted by Baroness Sheila Hollins in partnership with NHS England, NHS Improvement, Health Education England, Beyond Words, and the British Institute of Learning Disabilities.

Have you seen a pink bin in your area?
These new bins are provided by ‘The Homeless Period - Wolverhampton’ - a charity aiming to provide sanitary wear to those experiencing period poverty across the city.

The team collect sanitary items, new underwear, hygiene wipes and toiletries to distribute; relying heavily on donations from the public and organisations such as ours.

Maternity Services have three bright pink bins located in Delivery Suite, Antenatal Clinic and Maternity Theatre while bins can also be found in building 12 reception area and the WMI foyer.

Find out more about the other ways in which you can donate: www.thehomelessperiod-wolverhampton.co.uk

This can really make a difference to women living in period poverty in Wolverhampton, so please help where you can.

You can follow the charity on Twitter at @TheHomelessPer1 or on Facebook @TheHomelessPeriodWolverhampton

Thanks
Jessica McArthur, RM, Delivery Suite

Shared Governance
your chance to win £50

Shared Governance is an exciting initiative piloted within the Trust in 2017/18. It promotes frontline decision making and improves both staff and patient experience.

Traditionally in the NHS decisions are made by senior people who may not be directly involved in looking after patients. The idea behind Shared Governance is that the people who are closest to patients get more involved in decision making.

Councils were established in these areas:
- Maternity Ward
- C19
- Fairoak Ward
- Cardiothoracic Ward
- Anticoagulation Outpatients
- Paediatric Outpatients

Council members attend two days training to prepare themselves for the role. They organise their own meetings, keep minutes, action logs and manage their own time. Practice Education Facilitators support the councils and there is a Trust wide forum for Chairs to attend to share best practice and get help with problems.

We recognise staff have a great deal of talent and ideas for improvement so are relaunching this project so that everyone can get involved.

If you and/or your area are interested in becoming a council or you would like more information please email us on the Shared Governance email address:

rwh-tr.sharedgovernance@nhs.net

Competition time!
If you are thinking the name ‘Shared Governance’ is a bit off putting, we would agree!
We are looking for ideas for a new name as part of the relaunch. If you can think of a name that is exciting and punchy please let us know.

You could win £50 in gift vouchers!
Send your suggestion, name, job title and contact details to: Alison Wells, Head of Nurse Education (Acting), Corporate Services Building (Building 12) New Cross Site or via email to awells1@nhs.net by 15th September 2019 and your suggestion will be put into a prize draw.
Right staff in the right place at the right time:

- Our vacancies have reduced by circa fifty percent during the first three milestones of NSF. We continue to run local recruitment events alongside recruitment job fairs. We prospectively recruit newly qualified nurses and have made a number of new clinical fellow position appointments. We have struggled to meet the ambition of one hundred new appointments per quarter, yet positive developments have been made.
- A number of meeting forums have been reviewed with the ambition to assure we are able to deliver outstanding quality and responsive leadership.
- A peer review of patient acuity was undertaken during June 2019, which will aid and inform staff skill mix review.
- Phase one of the “Safecare” module has been rolled out to trial ward locations and has been well received.

Team structure:

- We have consulted on leadership structures via our professional forums and Care to Share. These are now being ratified and aid developments within our workforce.
- A report on our various staff recognition programmes has been drafted. This provides an overview to what we currently offer in recognising and rewarding staff for their contributions towards patient care and excellence in practice. Recommendations will be made toward consideration of other recognition programmes to complement our strategy.
- Work around advancing practice and clinical nurse specialist roles have been scoped and will help inform the direction for training and development within these specialist positions.

The education faculty:

- A repeat baseline of academic qualifications has commenced and was planned for completion by the end of July. Please submit your team’s information, if not already done so.
- A number of internally delivered educational programmes have been scoped for accreditation by universities, such as Making the Leap, OSCE, and Continence. We have found gaining accreditation challenging and all avenues are still being considered.
- Staff competency programmes are under review and external materials have been considered versus developing our current materials internally.
- We expect a further increase in student numbers, with circa 166 students due to commence Sept 2019; this is well over a 50% increase. Clinical placements have been audited to ensure a high standard of education and experience remain. Other universities are also starting to place their students with us at RWT.

Excellence in care:

- MyAssurance programme for Nurse Sensitive Indicators (NSI) is now embedded and phase one of the project is complete. Phase two commenced July which includes widening clinical participation, increase breadth of audits and enhancing reports.
- Two clinical areas have invited external peer reviews and received valued feedback. Other areas for peer review are being considered.
- IP are driving inclusion of catheters on VitalPAC. We are not at the 90% inclusion at this time; however there is a 20% increase to 74% compliance which is very possible.
- Shared Governance drive to increase councils had to be paused, yet this work has restarted July 2019.
- The falls business case was placed on hold whilst employing a CQI approach to develop our learning. Positively falls numbers have decreased to 56 across the organisation during June, which is around 20 less.
Research & technology:
- We have welcomed inspirational speakers to help inspire our research agenda.
- During this milestone we have published at least four research papers in a wide range of topics and journals.
- A number of research protocols are in development to underpin our work with NSF, end of life care and use of technologies. These pieces of work will help evidence our strategies to improve our care.
- We have started to baseline/test our cultural survey within pilot locations. This will aid us in starting to truly understanding culture and how we might develop our culture.
- Electronic observations (VitalPAC) software updated and NEWS2 launched Trust wide. There is a further phase to roll out into new clinical locations. This work should improve sensitivity towards deterioration, improve the identification of patients with sepsis and provide better quality clinical audit.

Communication:
- We developed our Nursing and Midwifery intranet webpage to better aid communication.
- We have further implemented our new Nursing Newsletter with the 5th edition published June 2019.
- We continue to hold monthly forums to update Nurses, Midwife and Health Visitors on various topics and initiatives.
- We aim to provide more blogging style approaches to ensure we share our news.

There are many other work streams outlined within our NSF. If you would like to take part in any of these, please feel welcome to contact the appropriate clinical lead for each work stream, or if unsure our quality team will help link you in.

Please review our ambitions for milestone 4 on your copy of the NSF or on the intranet.

The Functional Skills programme

If you do not currently hold Maths and English Certificates at Grades A – C and are looking to progress your career through apprenticeships or improve your skills, but do not hold evidence of this, then this is the course for you.

All apprenticeships and courses from Level 3 and above require you to hold Maths and English or equivalent to meet Higher Education / University entry requirements.

Functional Skills are transferable skills that help you develop your Maths and English. This enables you to develop some key skills around self-management, reflection, problem solving, team working and creative thinking.

Functional Skills is delivered by a highly qualified and dedicated tutor, who will help you on to the next step to developing your career path.

- The sessions will be between 2-4 hours every other week, for a 24 week period. Of this 12 weeks are self-directed course tasks and 12 weeks are classroom teaching and exams.
- Initial assessment and diagnostics assessment will be carried out prior to commencement to determine current skills and targets for learning.
- There will be final assessment sessions where learners will sit tests. You will be expected to do some work at home, revision and practice tests.
- On completion you will receive a Functional Skills certificate at the level they have been achieved. This will be accredited by the awarding organisation City & Guilds.

Once enrolled learners are expected to attend all sessions to their maximise success on programme.

To request an application form contact the Work Based Learning Team now on ext 8220 or email rwh-tr.wblapprenticeships@nhs.net
We have all been in that lengthy meeting or lecture where we start to fidget; our natural way of relieving pressure to maintain comfort is to move when we feel uncomfortable.

There are many patients who are unable to do this and without assistance, will most certainly be at risk of developing pressure ulcers. It is therefore important to safely reposition them.

There have been many advances in technology to help prevent ulcers, for example pressure mapping, which indicates a pressure increase while a patient remains in the same place. If pressure increases, a patient should be encouraged or assisted to move.

Ideally at each reposition, the skin should be checked (with consent). If their skin has no signs of marking in two hours and the patient has no pressure ulcers, the plan could possibly extend to a longer period of up to three hours and then eventually four hours.

Repositioning at night however is an ethical dilemma, and where there is an ethical dilemma, there is often no black or white answer as the solution.

Yes, moving someone at night disturbs their sleep, alternatively not moving them to regain comfort and relieve pressure, could also limit their sleep.

There needs to be a fine balance based on holistic needs, the risks involved, skin tolerance and individual care planning, which may differ at different times of the day. Day to day this is a real challenge, especially when considering waking patients during the night.

There are three elements to obtaining consent, these are:
- Capacity to understand information and risks
- Information about reasons for the interventions and risks - this must be on going
- Consent must be voluntary

You could argue - “Do patients have capacity to understand when they are asleep?” or “Is this a deprivation of liberty?” This is a real dilemma, particularly when we need to safeguard our patients.

If there are patients without capacity, then decisions need to be made in their best interests, but these patients need sleep too and sleep is an important element to consider in the delivery of safe and effective care.

In an ideal world each Trust would have technology that shows when a patient has moved significantly and a device that tilts and turns them from side to side if safe, as well as alternating from heel to head frequently. Without such equipment existing, we must minimise the pressure sore risk by using other techniques and resources.

Nurses and carers need to consider the following factors:

**These include:**

**Assessment** - continual holistic assessment; understanding the risks and the patient’s individual needs

**Skin inspection** - look for early signs of pressure ulceration and modify the plan accordingly

**Surface** - right surface at right time to enhance the holistic care. Don’t forget to check under medical devices for early warning signs!

**Keep moving** - start at two hourly interventions if in 24 hour care; look at the patient and check their last recorded position. Have they moved? If so, record their new position and any comfort related interventions.

If the skin appears normal, then increase to three or four hourly for a position change, but still check their comfort two hourly as they may need assistance with other elements of their care.

Reduce the frequency again if their skin marks. Frequency may reduce if they are at the end stage of their end of life condition.

Complete the intervention chart indicating the plan and actions, using the codes or write a rationale if an action if omitted.

**Incontinence and moisture** - holistic continence management for the patient. They may need assistance in the early hours of the morning, ask them what time do they usually wake to urinate and plan this time to move them and toilet them.

**Nutrition and hydration** - some patients take a drink to bed at night and may need assistance with this.

**Giving information** - this is an essential element. Listen to the patient and work out a sensible plan, gaining verbal consent if you need to move them at night or inform their next of kin.

Communicate the individual care plan and modify as the patient needs change. Give the information leaflet to read, if they have the ability. If they decline a change of position, ask why and compromise with a plan.

It is important to steer away from task-orientated care, but in a busy health environment, this can be an everyday challenge. Promotion of the holistic-care approach is paramount to meet the needs of the patient, whilst promoting patient autonomy.

The new operational policy OP96 will be launched very soon, which details the Trust’s expectations around safeguarding patients.

The Trust has come a long way to reduce the number of pressure sores in patients, and through quality improvement measures and teamwork, we can look to reduce them even further.
I have to stop and think for a moment because I have never questioned myself on this – caring, for me comes naturally!

Where I worked before I constantly heard: “You care too much”. I believe we cannot change our nature and we shouldn’t have to change it, if others can benefit from it in some way.

Some people are born with a caring nature and for others, it comes with time.

Being a good carer is not about how much education you have or the certificate that hangs on the wall, it’s not about the awards or how experienced you are. Caring for me is the essence of our job, and I admit that I don’t like to call it a job because it is definitely something more; it is a passion, a dedication and a deep love for others.

Caring as a dedicated healthcare professional means focusing on safeguarding patients; to protect, comfort and help where possible.

Caring, for me, is going above and beyond the call of duty for patients, to empathise with them; recognising the solitude of a hospital bed so far from their family or loved ones and the fear they may be experiencing.

We all have felt the anxieties that can come with being a patient - waiting for an appointment letter, waiting in a clinic or in the emergency department, waiting for test results etc.

Care is all about empathy in these situations.

Caring is also:
- The absence of judgement
- Listening and understanding
- Seeing the invisible
- Being there in difficult circumstances

How to build sustainability in care?

Good care is a foundation, on top of which we place our skills and knowledge.

Caring is staying over if it needs be, swapping a shift or going that extra mile.

Caring is team work, and again, we know how vital everyone’s role is! A doctor will always need a skilled nurse and a nurse under pressure will always need help from a brave healthcare assistant. Not forgetting our precious domestics; without their brilliant and dedicated work, the hospital would not function - cleaning is caring!

Caring can’t distinguish between a Band 2 and a Band 8 and it doesn’t recognise the colour of the uniforms.

The more you love, give and care, the more you will receive back, just like a boomerang.

We need to give our time, skills, knowledge, values, love, dedication, passion and more to provide relief to those in need, particularly those more vulnerable groups such as children and older people.

We are not dealing with numbers, goods or objects - we are dealing with individual lives. Let your care be special for all patients, be they on chairs, beds, wards, in theatre or in their own homes.

It does not matter what it is, the act of caring always makes a difference. A glass of water, a smile, a helping hand, a word of encouragement, listening with patience; all are beautiful, caring acts.

Patients can be in your care for hours, days, weeks or months, but they may remember your name and your smile for the rest of their life.

“Let’s be the nurse we would love to have as a patient.”

What does care mean?

Manuela Pana, Health Care Assistant
As a student nurse I never had any idea about where I wanted to be based or where I would work - I always say that urology chose me.

I was lucky enough to be given three placements on the urology ward, so I had to learn about this speciality. The ward staff were welcoming and friendly with consultants taking the time to teach nurses by showing us x-rays and explaining about surgery. Just before I qualified - in 2001 - a job arose on the ward and naturally, I applied for it.

After two years I gained an E grade position (equivalent to Band 6) and a year after that I became a member of the urology ‘hospital to home’ team. This was a team of three senior nurses who were based on the urology ward, but visited patients at home to conduct post-op ‘Trial Without Catheter’ and teach clean intermittent self-catheterisation and dilatation. This new service resulted in reduced length of stay and has now been expanded to include post Trans Urethral Resection of Prostate, Holmium Laser Enucleation of Prostate and UROLIFT reviews, as well as pre-op counselling for men undergoing Robotic Assisted Laparoscopic Prostatectomy.

This broadened my scope of responsibility as I was suddenly working alone in an unfamiliar environment. Not having a team around me to check decisions with was challenging, yet rewarding. There was the added benefit for patients as they were seen in their own home and not in the ward environment.

I have always been enthusiastic regarding student nurses and feel we really should be promoting our profession and passing on the knowledge that we have. I applied for a secondment with the University of Wolverhampton as a clinical skills facilitator; this was for a period of a year and I was able to maintain my clinical skills by alternating one week at the university and one week back in my current role. I was saddened when this secondment came to an end as it provided me with great variation and satisfaction!

In 2007 I applied for another secondment, this time as the urology ward manager. This role was completely different to anything I had ever done before and to date I would still say this was my most challenging role.

Managing yourself is quite easy; you have your own standards which you work to uphold and you manage your working day accordingly; managing a team however is quite different. Being unable to be completely responsible for the actions of others who have acted in a way which they deemed best and not by your own standards was difficult to grasp.

Managing sickness levels and conducting sickness reviews along with route cause analysis investigations and at a time when introducing High Impact Interventions was a whole new ball game! I did however, feel as though I managed well and was given recognition for lowering the sickness levels on the ward. As this was a secondment, the year soon went by and a full time ward manager was appointed. It was during this time that I decided not to take the management route and chose to maintain and develop my clinical skills and hands-on patient care. I become a clinical nurse specialist!

Taking a leap of faith I left the local district general hospital where I had trained after working there for seven years. In 2008 went to work at a university teaching hospital which acted as the main centre for treating our military personnel.

Working as a benign urology CNS (Band 6) I assisted in stone management and lithotripsy, nurse led erectile dysfunction clinics, bladder over activity, interstitial cystitis and nurse led lower urinary tract assessment. I witnessed surgeries and treatments which I had never seen before and injuries in soldiers which I couldn’t have imagined. I look back fondly on the six years I worked here.

I was helped to develop into a CNS and was supported by my manager and consultants to do this. It is here where I truly developed my problem solving skills, my ability to make treatment plans and what it meant to be a nurse specialist. My line manager at the time was teaching on British Association Urological Nurses study days and it was during this time that I learnt how valuable BAUN was to help underpin my knowledge. A range of resources was made available to me that I had previously been unaware of and I was able to liaise with other colleagues who worked in the same profession as me via conference, free study days and the members’ chat room online.

Becoming a urology advanced nurse practitioner – my career progression

Kelly Kusinski, Urology Advanced Nurse Practitioner
Networking became essential in learning even more about my speciality.

I was approached in 2013 by a more local district general hospital to apply for a Band 7 urology CNS post. The hospital currently had no urology CNS at all and I looked at this as a great challenge for me. I hoped to implement nurse-led services and improve the patient journey; at the same time getting my teeth into something new. Here I was able to implement review clinics and support other staff in their own career development by training them in this speciality.

I had kept in touch professionally with many of my previous colleagues, and one of these, a urology advanced nurse practitioner, was aware of the roles I had undertaken and of the experience I had gained. When I applied for the role of clinical nurse specialist on the cancer side of urology, at the hospital where she worked, she was confident of my skills and knowledge-base. I was successful in getting the job!

Having prior knowledge of the benign side of urology was of great benefit and I hit the ground running. I was able to start clinics quickly whilst being supported to expand my knowledge in urological cancer management. Over the past four years my skills have developed even further and I am now in the position of Urology Advanced Nurse Practitioner (Band 7).

I conduct fast-track nurse led clinics for suspected prostate cancer patients, undertake trans-rectal ultrasound guided prostate biopsies, manage prostate cancer patients on active surveillance, review post-operative Robotic Assisted Laparoscopic patients, and run an erectile dysfunction clinic along with a lower urinary tract assessment clinic.

This is all alongside supporting urology cancer patients in their journey. I have recently been instrumental in facilitating an Afro-Caribbean and ethnic minority support group for men and their families with prostate cancer.

I feel privileged to work in this role and in a team who genuinely support each other and promote the development of nurse-led services and education.

Many student nurses or staff nurses ask me how I managed to become an ANP. It is easy to say that I completed my nursing degree and then my Master’s degree, but nursing is not just about qualifications. It is vital as nurses that we carry out evidence based practice and keep up to date with the latest research as well as proving the level we can work at by undertaking Masters degrees. However there is nothing as important as clinical experience. Take a leap of faith as I did and try new things, you never know where this may lead you in the future.

Urology may not initially sound as exciting as some other specialties, but there are so many avenues within this speciality covering five tumour sites as well as all of the benign conditions. You are able to develop your skills and make a difference to the patients experience by providing autonomous holistic care, undertaking nurse prescribing and training in advanced skills such as transrectal ultrasound guided prostatic biopsy and nurse led flexible cystoscopy, therefore leading to great job satisfaction.

Register with us by the 30th of August 2019 and create a Sepsis Awareness Board in your area for the upcoming Sepsis Week - 9th to the 13th of September 2019!
Email: rwh-tr.sepsisenquiries@nhs.net

Do you have the passion and are you able to influence change in your area? Be the change… Be a local SEPSIS STAR!

If interested please get in touch with the Sepsis Team:
Sony Thattil
Sepsis Nurse
Tel (extn): 70-4639
Email: rwh-tr.sepsisenquiries@nhs.net
2018-19 has been busy with more and more nursing and midwifery staff signing up to become ambassadors in their field; there are now more than 2,000 nursing and midwifery ambassadors across the country with many local networks being developed.

Ambassadors are creative in solving difficult or complex problems at work; looking beyond our own communities for different perspectives and views. They consider who will strengthen our approach to problem solving by making better use of others’ experiences, skills and uniqueness; creating an environment where people can flourish.

Ambassadors have a virtual forum on Zoom (an online conferencing tool) so that nurses and midwives can join from wherever they are to network, connect and prepare for initiatives. It is a great way for ambassadors to reach out and support each other.

Some organisations have even taken on the Nursing Now England programme, a three-year project, run in collaboration with the International Council of Nurses and the World Health Organisation, which aims to empower nursing staff across the globe to address the most pressing health challenges of the 21st century. Others are still building momentum and working in smaller groups or alone.

Some of the myths about who can be a nurse are built into us during our early years. Ruth May, Chief Nursing Officer for England, launched ‘mini’ gender neutral uniforms earlier this year at her first CNO (Chief Nursing Officer) Summit. The Horizons Team, a specialist group within the Strategy and Innovation Directorate of NHS England, took these uniforms home and their children were delighted to wear them, regardless of gender or heritage:

Perceptions of who can be a nurse can start as children with who wears what from the dressing up box, and what those around them do or say. One ambassador, Pete Towns, had an idea about creating a children’s story book to show children, parents and other adults reading books with young children, that boys can be nurses too when they grow up.

Building on this idea, the Nursing Directorate at NHS England has commissioned Butterfly Books to design “My Daddy is a Nurse”. The author also has a book series called ‘My Mummy is….‘ which features mums having careers in engineering, science and plumbing. ‘My Mummy is a Solider’ was launched in March of this year.

This book will be the first with the title ‘My Daddy is…’ and will be aimed at Key Stage 1 and 2, complementing the resources being developed for primary schools. The aim is to launch the book in December 2019 so that it is ready for the ‘Year of the Nurse 2020’.

A working group has been created on the ambassador’s platform to shape the storyline over the coming months. To help inform the content we are looking for letters from children of nurses who are male to tell us about their daddy as a nurse. Please email yours to maria.glover1@nhs.net.

There are many ways you can sign up or get involved:

Get on Twitter and check out a number of great resources, connections and networks!

Search the hashtags:
#NursingNowEngland
#FutureMidwifery
#teamCNO

Join the Facebook group by searching:
Nursing Now England Facebook group
Transforming Perceptions of Midwifery Facebook Group

Got questions?
Ask Maria Glover, nursing and midwifery ambassador for RWT, on maria.glover1@nhs.net
Ask Bev Matthews, Transformation Associate at NHS Horizons on bev.matthews@nhs.net

“My Daddy is a Nurse”
The out of hours practitioner team: Supporting patients, clinical service and staff

Sister Deborah Edwards and Matron Maria Tan

The Out of Hours Nurse Practitioner team (ONPs) is a service within Division 2 that supports patient care, clinical service and staff – both medical and nursing.

The team has six Band 6 nurse practitioners led by a Band 7 senior sister, who are all highly skilled clinically with vast knowledge on different medical specialities.

Two of the nurse practitioners are rostered overnight to support the medical inpatient areas.

Their mission is to ensure the highest standard of clinical support for the Trust during out of hours. This support includes advice for relatives, patients, staff and members of the multidisciplinary team (MDT).

Clinical Skills
The team supports the inpatient areas with various clinical skills such as venous cannulation, venepuncture, arterial blood gas sampling, first-line patient assessment, verification of expected death, male and female catheterisation, management and care of Hickman lines, central lines, PICC and midlines.

The nursing team is also competent in confirming nasogastric tube placement with X-ray readings. All ONPs are Advanced Life Support trained and are members of the Trust’s resuscitation team; responding to all 2222 calls and medical emergencies out of hours.

They are competent with Intraosseous and LMA insertion in the event of a cardiac arrest.

Education
The ONP team:
- Deliver BLS Level 2 training to unregistered nurses
- Offer educational opportunities for students on placement
- Provide training on Verification of Expected Deaths for registered nurses
- Support the competency assessment of various clinical skills for ward staff
- Support junior medical staff, newly qualified nurses and new employees of the Trust
- Take part at both nurse and medical staff Trust inductions.

Leadership
The Out of Hours Practitioners Team assists in difficult circumstances, for example when breaking bad news or during a conflict. They are a forward thinking group, constantly striving to improve patient care and experience.

Our hours of service are:
Monday – Friday, 5pm – 7am
Saturday and Sunday – 24 hour cover from Friday at 5pm until 7am on Monday morning.

Get in touch:
Bleep: 7435 / 7317
Office: Renal corridor, route C8
Telephone: ext. 6458 / 6456.

Let’s celebrate your achievements!
RWT is very proud of its staff and would like to hear about your achievements, big or small and wish to create a registry to log them all. This will help the wider trust to celebrate and recognise staff’s hard work and dedication.
You can inform us of your achievements by completing an e-form on the nursing and midwifery web site.
The opportunity to discuss Infection prevention in the Care to Share bulletin seemed an ideal opportunity to share the team’s current developments, concerns and invite readers to share their experiences.

Engagement and supportive working with clinical teams has been the way of working at RWT for more than a decade. This approach has resulted in the successful reduction of cases of MRSA, *C. difficile*, and dramatically reduced cases of bloodstream infection associated with devices; reducing harm that is associated with healthcare.

Successes include minimising the effect of circulating seasonal outbreaks such as norovirus and influenza which has prevented ward closures. This too has been achieved by working together to develop and sustain improvements in the way we deal with emerging threats to normal service. Infection prevention knowledge for all staff either clinical or non-clinical is essential to provide the high level of care we want for our patients’ day in and day out. Resources are available online as well as adhoc training can be arranged with the team if needed.

The June bulletin celebrated the success of the IV team ‘5000’ lines and the benefit of having the correct device for longer term IV therapy, improving the patient experience by eliminating the need for multiple short term cannulae.

**DRHABs and scrutiny**

For those patients needing short term devices maintaining them safely from insertion; using 2% chloraprep in alcohol to decontaminate skin and monitoring for potential phlebitis are key steps to eliminate infection related to indwelling vascular devices. Bloodstream infection (BSI) are among the most serious consequences of using indwelling devices for our patients so if a BSI does occur this is identified in the Trust as a DRHAB (device related healthcare associated bacteraemia). We review each case with ward teams to try and understand what went wrong and learn from it. Scrutiny meetings are held with the clinical areas involved to discuss and share how or why it happened to identify learning and if local or Trustwide actions are needed. Common themes are; incomplete documentation onto the vitalPac electronic system or gaps in checking VIP scores which makes it difficult to demonstrate where best practice took place.

Learning from scrutinising incidents such as DRHAB’s or increased numbers of cases with particular organisms in a ward or department called a PII (period of increased incidence) helps us to try and understand how the increases occur and instigate additional actions to prevent recurrence. These may be increased environmental cleaning, decluttering environments, education or changes to practice.
Mainstay standard IP practices underpin all caring activities so; decontaminate hands in line with 5 moments before and following patient activities, safe disposal of sharps, waste, linen, correct use of personal protective equipment as ‘standard precautions’ are key everyday essentials.

MRSA

Cases of MRSA colonisation have increased recently (since April 2019) in some areas with patients found to have MRSA that was not identified on admission screens. Where admission screens are incomplete and bacteria are present on subsequent samples we consider being acquisitions in healthcare. Increased numbers are a warning that things may be going wrong or practice is less optimal in an area so additional support or scrutiny is needed. Microbiological testing can identify if samples have the same type of bacteria which indicates cross infection from one patient to another has taken place by some means. Usual suspects when this occurs are failing to decontaminate hands properly and also sharing equipment that has not been cleaned from a previous patient. For June the reported number of MRSA acquisitions was 12 which is concerning. MRSA colonisation can be treated but equally can progress to patients developing an infection either in a wound for example or more seriously a BSI. Cases of C. difficile have also increased across the health economy with 12 cases also reported in June 2019.

Wipes

Patient environments also play a role in reducing the risk of transmission or cross infection which is why we audit cleanliness. Environmental cleanliness and patient care activities done correctly are essential, cleaning effectively can become more difficult if there is clutter to deal with during cleaning. In response to the increased incidence in cases it has been decided to revert back to the disinfectant wipes manufactured by Clinell to increase the level of cleaning available in most areas. The exceptions to this are areas that reported equipment thought to be linked to the solution in the product. The Clinell team will be onsite to provide additional support and refresher training for correct use of the wipes.

Hand hygiene

Mealtime observation by the team revealed that the majority of wards do provide a method of hand decontamination at mealtimes for patients. Unfortunately many hand wipes returned on meal trays unused or were thought to be for after meals; some patients seem to be unlikely to use without prompting. Reminding and assisting patients to clean hands before eating and after using the toilet are worthwhile attempts to promote healthy habits. Adherence to the dress code and hand hygiene policy with regard to nail polish and hand jewellery was disappointing in some areas with staff wearing wristwatches, stoned rings and activity trackers (they do actually still function in pockets). Being ‘bare below the elbows’ in clinical environments has generally improved as you cannot wash hands properly with sleeves or watches at the wrist, but hands that sparkle are also a risk. It is unclear why this gets overlooked in teams as we know that stoned rings will harbour bacteria and that nail extensions have been implicated in outbreaks of infection. Respectful challenge within teams and role modelling is an important part of team working so it can be frustrating if we in IP can spot them why hasn’t anyone else?

CPE

CPE screening has evolved to a more rapid test which can produce a result within a few hours if taken and labelled correctly. Posters have been distributed showing the new swabs. It now involves inserting two swabs simultaneously and unlike the older test minimal faeces is needed to complete the test-too much actually invalidates it.

Glove use

Wearing gloves between tasks and sometimes between patients is an action that can add to the risk of transferring bacteria between patients and yourself. Gloves are single use items for one activity and then they should be discarded. Overuse can give a false sense of security that you are not at risk but sadly the risk is higher if you keep them on longer than you need to.

We would like to mention from some of the peer review audits and visits how well staff remember to wash hands after removing gloves- so well done. It is easy for bacteria to transfer from gloves to hands when you take them off so it important to always do this.

What’s new?

Urinary catheter project

This is an interesting new project to focus upon another common contributor to the DRHAB totals and constitutes the largest number other than IV lines. Indwelling urethral catheters are devices that can support patient management at parts of their journey in healthcare but on occasion contribute to increasing harm/morbidity.

The project is using quality improvement techniques to identify learning for how we can simplify the process for patients who do need catheterisation during and possibly following their hospital journey.

Ultimately the aim for the project is to minimise the harm this indwelling device can do, and to identify how we can offer alternative solutions to catheterisation in the first instance i.e. avoid insertion where possible and remove as promptly as possible.

If you are looking after a patient with a urinary catheter,

1. Do you know why it was inserted,
2. Is it recorded on the electronic VitalPac system so we can have accurate data to monitor improvements for reducing the time they remain in our patients as the risk of infection increases with time?
3. Does the patient still really need it?
4. How long it is planned to stay in place is there a plan to keep or remove?
5. Are they suitable to try and remove it? (Hydrated and not constipated which is a common reason for failed TWOC)
A day in the life of a cardiac rehabilitation specialist nurse

Michelle Bartlett, Sister

I qualified in 1997 and have worked within the speciality of cardiology for 20 years.

This has seen me work in a number of areas including the cardiology ward, the cardiothoracic ward and in the cardiac assessment team (CAT). The experience of working in these areas has stood me in very good stead for my current role as a sister in cardiac rehabilitation, which I have done for the last 10 years.

I work within a team of six nurses, alongside two exercise physiologists and a health promotion therapist. The team of nurses aim to see all patients who have been admitted to the Heart & Lung Centre with a variety of cardiac conditions, including emergency, elective, stable and unstable, as well as all cardiac surgery.

As a team we provide education, guidance and support to all patients admitted to the Heart and Lung Centre, following British Association Cardiovascular Prevention Rehabilitation (BACPR) and National Service Framework (NSF) guidelines. Patients who live out of the locality are referred onto our cardiac rehabilitation colleagues across the country to ensure continued care; for this we have set up a robust and successful referral system using an NHS.net account.

For all patients that reside in the Wolverhampton and Cannock areas we offer:

• Cardiac rehabilitation education and support programme (including families)
• Telephone updates (up to three days following discharge)
• Nurse led clinics at both hospital sites
• Nurse led home visits
• Cardiac exercise programme(s) at both hospital sites as well as in a variety of community venues
• Stress management programme
• Referral to colleagues within the multi-disciplinary teams e.g. nutrition & dietetics, lipid & familial CHD, wound care and endocrinology.

On a daily basis we review patients on the wards (predominantly in the Heart & Lung Centre) to identify who requires Cardiac Rehabilitation (CR).

The role offers the opportunity to work autonomously, organising and planning nurse led clinics at New Cross Hospital and Cannock Chase Hospital, as well as CR education days also at both hospital sites. As a team we rotate between all aspects of CR services which offers a varied and enjoyable workload; no two days are the same.

We are a busy team and I thoroughly enjoy the challenges I face each day and the interaction I have with patients and their families. It’s nice that this continues after discharge and we can see how they have recovered after their cardiac event.

As a team we are heavily involved with the Wolverhampton Coronary Aftercare Support Group (WCASG) who is the charity for the Heart and Lung Centre; it is a wonderful partnership and we thank them as they continue support our services.

Looking to the future, we are hoping to set up more nurse led clinics, in particular focussing upon Lipid Management and Secondary Prevention. We have also started to take CR services out into the community, as part of outreach programmes; in these we share our experiences, knowledge and expertise. These continue to develop and have been well-received.

This is a very rewarding role, with exciting times ahead!

If you would like to find out more about the CR service please do get in touch. Email: michelle.bartlett@nhs.net
Welcome to Fairoak Rehabilitation Ward, Cannock Chase Hospital

Who are we?
Fairoak is a 27 bedded rehabilitation, consultant-led ward at Cannock Chase Hospital, level two.

We take patients after their acute medical or surgical stay and work with them to set realistic rehabilitation goals; helping them to get their life back on track. The expectation of the ward is that all patients will get dressed and moving from day one, so it is really important they have their own clothes and footwear.

We take patients from 18 years and over with South Staffordshire addresses.

We are not a complex discharge ward or long stay facility.

Our aim:
We aim for our patients to return home approximately 2 – 3 weeks after admission, working closely with South Staffs social services to provide a safe and timely discharge.

How to refer
From the 1st October 2018, we changed our referral process and all referrals are now completed via the D2A form on Clinical Web Portal.

Each referral is reviewed to ensure Fairoak is able to meet the needs of each patient and we may ring for further information before accepting them.

How you can help to ensure the patient has a smooth transition to Fairoak
Please send all of the patient’s medical notes in the skinny file.

If the individual is on medication, including insulin, please send it with them.

We have a pharmacist onsite until 5pm, Monday to Friday, but for out of hours or weekends, supplies are accessible via the on-call pharmacist.

Please send the treatment sheet or a print out from EPMA - we are not currently live on EPMA so this will help our doctors when prescribing medication.

Good to know:
Telephone: 01543 576040/8
Visiting hours: 12pm – 7pm
Sudoku

The nine letter word from word wheel puzzle June edition: Curiosity

If you would like to write for the newsletter email us at: rwh-tr.nursingnewsletter@nhs.net

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