A.L. Davydova

Critical Care Nursing in Ukraine and United Kingdom: are they different?

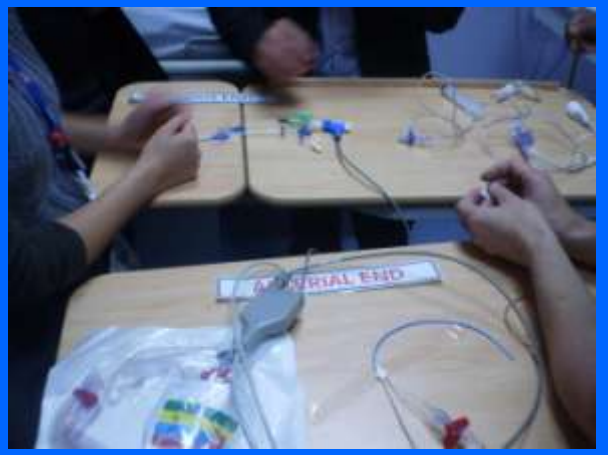
The British and Ukrainian critical care teams

The place of my training course

SICU in National hospital of Neurology and Neurosurgery

My british friends-education nurses of SICU Jilly and Charlotte

Workshops in SICU



Everyday work in SICU

The nurses working place

Medical documents in SICU

Microbiologic control in SICU

Outreach service- it is ICU without walls

ADVERSE CLINICAL SIGNS IN NEUROLOGICAL AND NEUROSURGICAL PATIENTS

Do not hesitate to 'fast bleep' the Anaesthetic SpR (**Bleep 8131**) or other junior doctor via Switchboard in emergencies and contact Outreach Team (Mon-Fri 0900-1700 **Bleep 8277** or 'out of hours' via SITU / MITU)

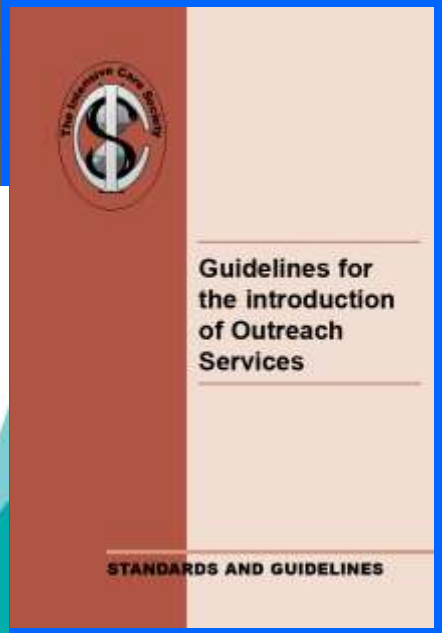
ADVERSE SIGN	ASSESSMENT	ACTION PLAN
▪ **Decreasing GCS by two points or more** ▪ **Seizure activity** In non-epileptic and **all** neurosurgical patients – first epileptic seizure of any form In known epileptics – repeated seizure within 1 hour of first seizure **or** – seizure lasting more than 10 minutes **or** – failure to be orientated in time / place within 15 minutes of seizure	**A**irway **B**reathing **C**irculation **D**isability **E**xposure Blood **G**lucose *The patient **must** be assessed **immediately** by the nurse-in-charge / senior ward nurse who **must** instigate the **Action Plan** if appropriate* ***Increase frequency of observations** in any patient who has an adverse clinical sign* *Remember that assessment can be facilitated by the use of **continuous monitoring** (ECG, NIBP, SpO_2) and monitoring is **mandatory** prior to transferring the patient to another area* *Patients with a poor GCS (≤ 8 or falling) **must** be assessed by an anaesthetist prior to transfer to another area*	Nurse–in-charge to inform Neurology or Neurosurgical SHO **immediately** ↓ SHO **must** attend patient within **15 minutes** and document their findings and plan of action in the medical notes and discuss the patient with their SpR ↓ If SHO fails to respond / attend within **15 minutes** contact SHO again ↓ If no response within **5 minutes** contact SpR ↓ If SpR does not respond within **5 minutes**, contact Consultant on call
▪ ***GCS of 8 or less** – if this is a new finding **or** – on initial assessment of a patient admitted as an emergency to the ward		***If GCS 8 or less*** Nurse-in-charge to follow directions above but Anaesthetic SpR (bleep 8131) **must** also be informed **immediately**
▪ **Oxygen saturation < 90%** ▪ ****Heart rate < 50 or > 110/min** ▪ ****Respiratory rate < 8 or > 25/min** ▪ *****Systolic BP < 100 or > 180mmHg** ▪ **Urine output < 100ml or > 1000ml in 4 hours** ▪ **Temperature > 38.5°C** ▪ **Vital capacity < 15ml/kg** ▪ **Na^+ < 125 or > 150mmol/l** ▪ **K^+ > 6mmol/l** ▪ **Glucose < 3 or > 20mmol/l** ▪ **Poorly controlled pain** ▪ **'Worried about patient'**	***Troubleshooting tips*:** • ***If SpO_2 ↓*** – *reposition patient and sit up if allowed* – *oxygen therapy* – *if patient has a tracheostomy follow emergency procedure algorithm* – *consider saline / salbutamol nebuliser* • ***If BP / urine output ↓*** – *give normal saline or gelofusine 250ml IV +/- repeat* – *consider bladder washout if urine output ↓* • ***If urine output ↑ check specific gravity*** • ***If sudden ↑ in temperature** consider sepsis* – *send cultures as appropriate* – *consider IV fluids*	
▪ **Autonomic dysreflexia in spinal cord injury** Sudden and potentially lethal surge in BP in patients with spinal cord lesion at or above T6 Triggered by noxious stimulus These patients often have low BP **∴'normal' BP may represent significant rise** **Intervention definitely** indicated if **patient symptomatic** ***Also* consider** intervention if **BP 30% above baseline**	***Autonomic dysreflexia*** ***Signs** and **Symptoms** include* – *Severe pounding headache* – *Flushed appearance of skin above level of lesion* – *Extensive sweating above level of injury* ***Treatment – must be initiated quickly*** – *Sit patient upright* – *Correct problem (e.g. blocked catheter, etc)* – *May require urgent medication to reduce BP* • *GTN sub-lingual spray / infusion if needed* • *Avoid beta blockers* – *Record BP every 5 minutes until episode resolves (see Protocol)*	The Anaesthetic SpR and Outreach Team are available at any time for advice if required

** Some patients with brain injury may have had individual heart rate and respiratory rate limits set by the Intensive Care Team before discharge to the ward

***Patients having assessment of their autonomic nervous system may have different limits set for their systolic BP

January 2009 *(for review January 2010)*

Outreach Protocols



- NICE – National Institute for Clinical Excellence
- NPSA – National Patient Safety Agency
- NCEPOD – National Confidential Enquiry into Patient Outcome and Death
- Intensive Care Society

NHS Early Warning Score (NEWS)

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Pulse	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Consciousness Level				A			V, P, or U
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			

Clinical Response to NEWS Triggers

NEWS SCORE	FREQUENCY OF MONITORING	CLINICAL RESPONSE
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
Aggregate 1-3	Minimum 4 hourly	• Inform trained nurse who must assess the patient; • Trained nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required;
Aggregate 4 or more **or** **3 in one parameter**	Increased frequency to a minimum of 1 hourly	• Trained nurse to immediately inform the medical team caring for the patient; • Urgent assessment by medical / surgical / critical care outreach team with core competencies to assess acutely ill patients; • Clinical care in an environment with monitoring facilities;
Aggregate 6 or more	Continuous monitoring of vital signs	• Trained nurse to urgently inform the medical team caring for the patient – this should be at least at Specialist Registrar level; • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills; • Consider transfer of Clinical care to a level 2 or 3 care facility, i.e. higher dependency or ITU;

INFECTION CONTROL IN ICU

Proteus mirabilis

Candida albicans

The nurse, that spreads nosocomial infections

braslet

No gloves

Long nails

watch

Mobile telephone

No aprone

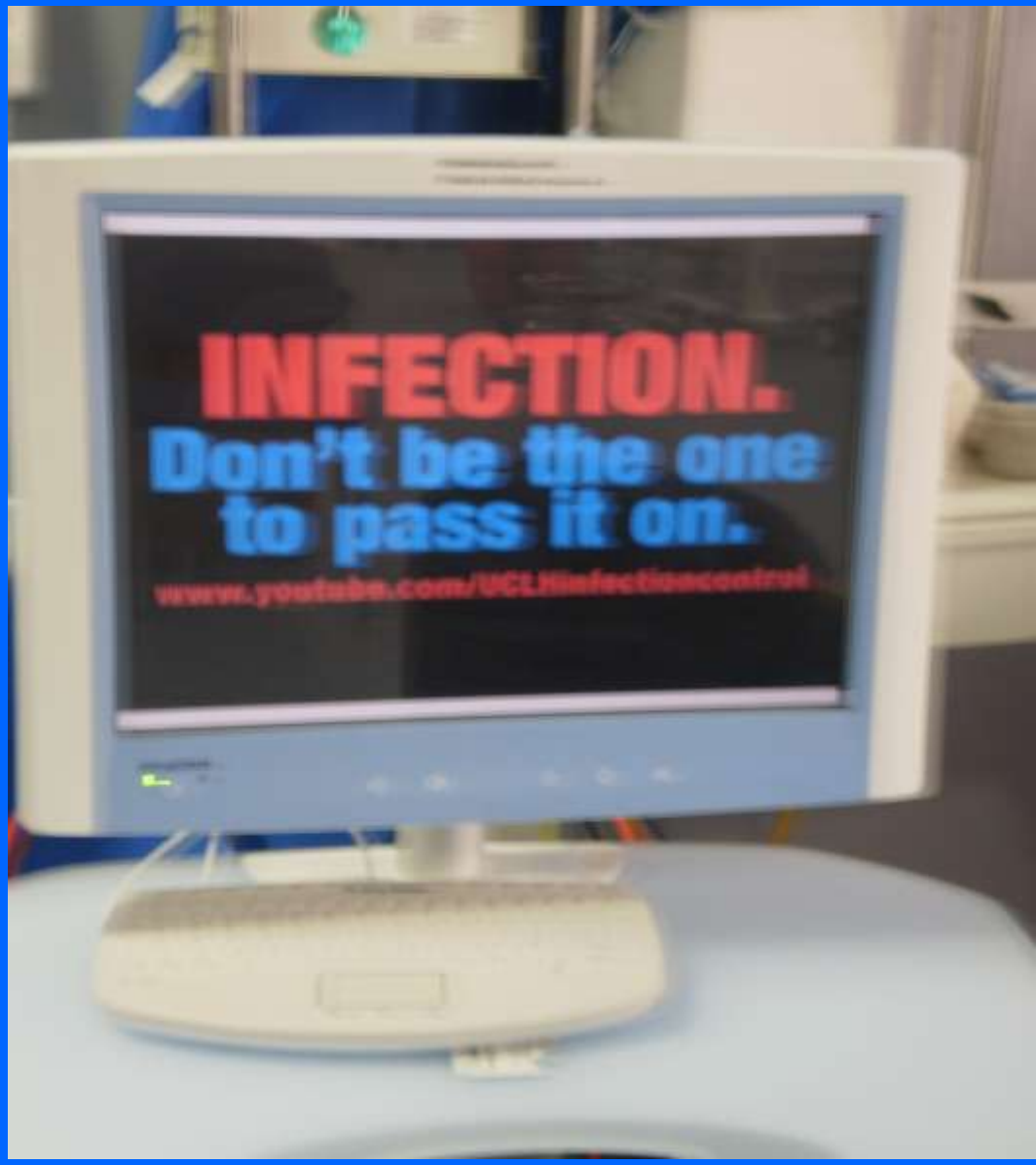
White coat with long sleeves

The right nurse

Hand washing place

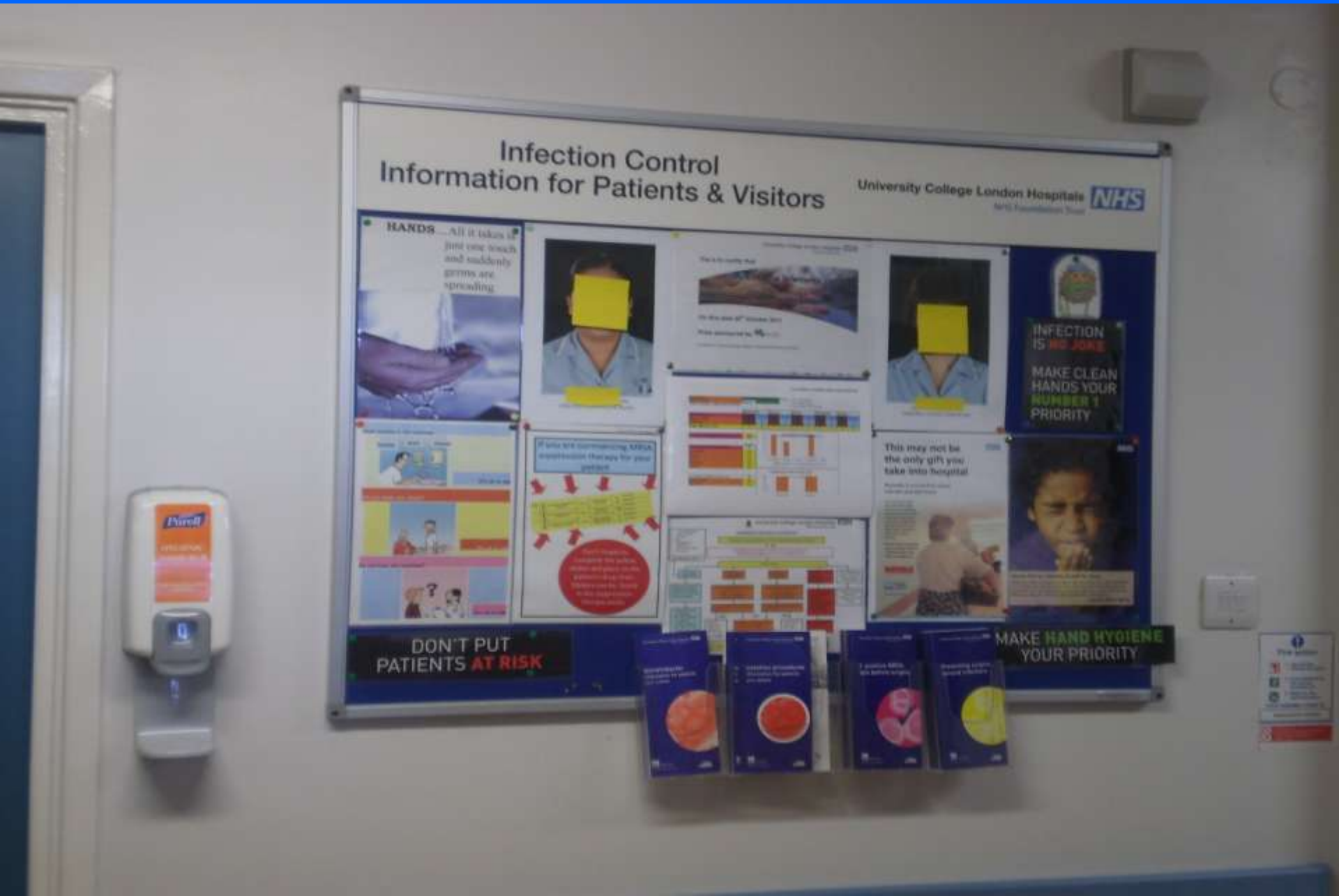
Visualization method

Posters about infection control - everywhere



Posters about infection control even on the floor

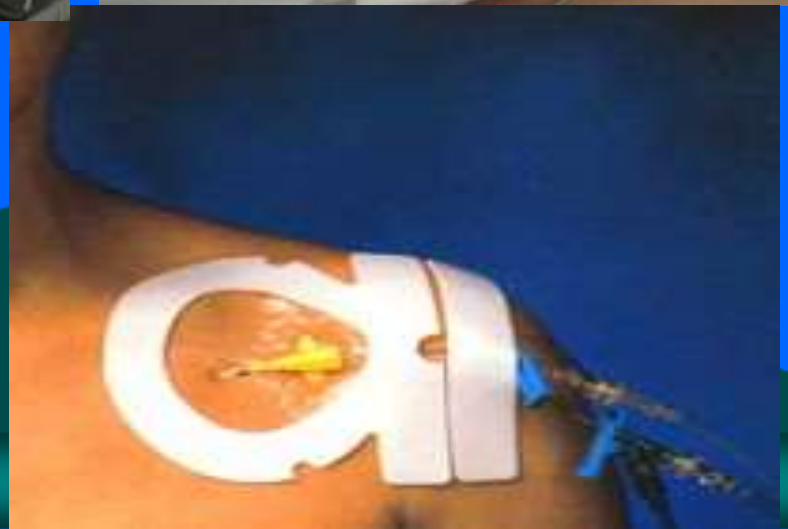
Information for relatives and visitors



Infection control- VAP prevention

Prevention of oropharyngeal colonization

Prevention of catheter-associated infection

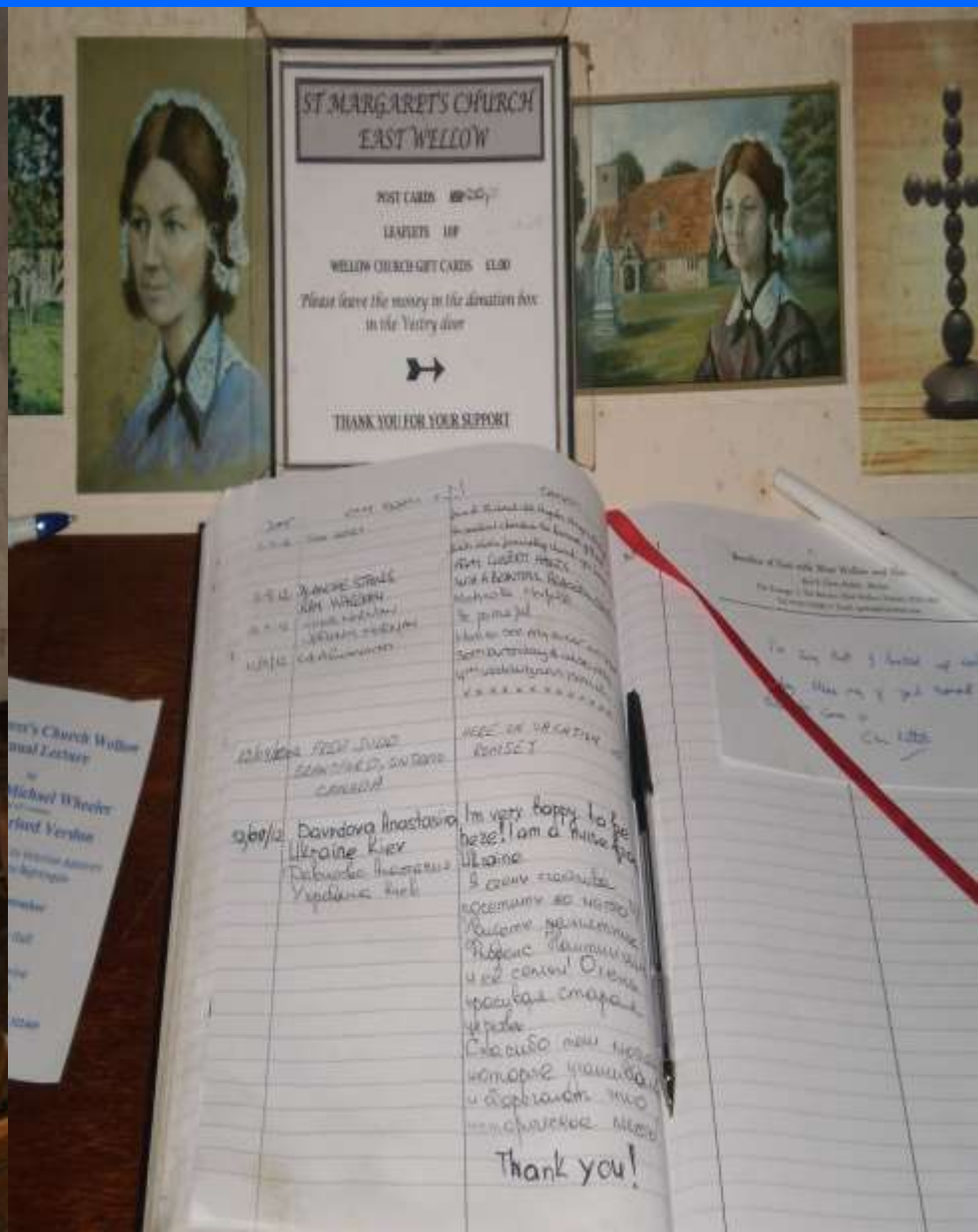


The first British nurse

Florence Nightingale museum

Florence Nightingale grave

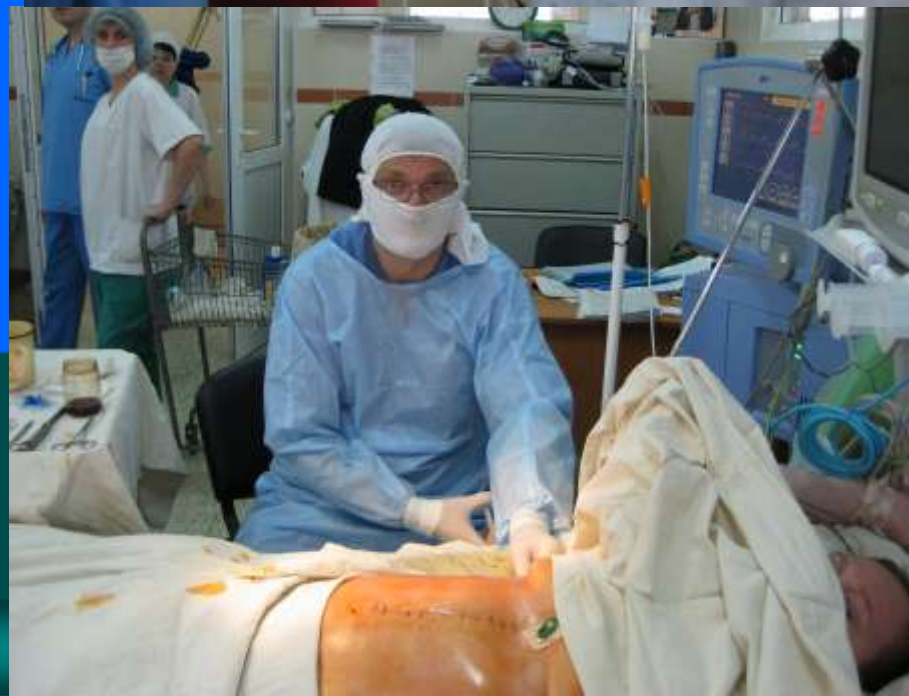
The Florence Nightigale church



Sandra Fairley, Florence Nightingale and me

With professor Martin Smith, British doctors and nurses

Our professors



Thank You for Your attention!