

The Ergonomics of a Functional Day on the ITU

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Neurocritical Care Unit

- Our Unit

- Established 1993
- > 1050 admissions per year
- 9 ITU beds & 6 HDU beds

- Our Patients

- Trauma
- Stroke
- Spinal injuries
- Post op care

- Our Team

- 4 consultants
- 7 trainees
- Nurses
- Physiotherapists
- Speech & language therapists
- Pharmacist
- Microbiologist



My Role in Neurocritical Care

- Clinical
 - Appointed in 1994
 - Wednesdays + On Call duties
 - 2 days a week anaesthesia major neuro-oncology, skull base
 - GA MRI list
- Non clinical
 - Clinical Lead for Quality & Governance
 - Deputy Clinical Director
 - Lead for Clinical Audit

My day on the NCCU

- Pre ward round
- Ward round
- After Action Review
- Outreach
- Ad hoc walk around
- Relatives
- Bereavement
- Emergencies
- Hand over



0800 - Pre-ward round

- Nurse in charge
 - who's sick? – immediate attention
 - post op discharges to ward from HDU
- Capacity and Demand
 - Sick patients on ward
 - Subarachnoid haemorrhage
 - How many beds for the day
 - How many beds needed (theatres / neuroradiology)
- If beds available < beds needed
 - Neurosurgeons and neuroradiology negotiate
 - Decision for the day!

1000 - Ward Round

- Consultant
- Nurse in charge
- Trainees – up to 3 Grade / Speciality varies
- One trainee on a long day 8.00 to 20.00
- No disturbances – relatives / neurosurgeons
- All present including patient's nurse
- Lasts between 1.5 to 2 hours
- Outreach
- Physiotherapist
- Pharmacist
- Microbiologist

The Process

- Introductions to awake patient
- Presentation – the details!
 - Past medical history
 - Quality of life and social issues
 - Medical history of current illness
 - Events so far
- Look at imaging
- Problems / issues
- Neurosurgical plan!
- Communication with relatives
- MDT discussion – patient's nurse

The Plan for the Day

- Clear with options
- Repeat to ensure all clear
- Documented by one trainee
- Clarify with nurse by bedside
- Any other issues?

My 'to do' list

= consultant level discussions



Ward Safety Checklist

Carry out a pre-round briefing to discuss issues and expectations of the round. Similarly, carry out a post-round debrief to explore issues arising and potential improvements to the effectiveness of future rounds.

Introduction

☐ Preparation

Coats removed, ties tucked, arms bare below elbows, hands washed

☐ Introduction

An introduction of team to patient, including names and roles as appropriate

☐ Confirm patient identity

Name, DOB, Hospital number

☐ Continue your ward round as appropriate to your specialty

Time Out

☐ Pause

Check for agreed team understanding of patient status

- ☐ Observation chart, concerns/ triggers
- ☐ Fluid balance, urine output, fluid in take, speech/ swallow assessment, nutritional intake
- ☐ MRSA status and treatment plan
- ☐ Infection control (temp, markers, source) MRSA, Antibiotics (duration and compliance with policy)
- ☐ Results/scans checked
- ☐ Allergies
- ☐ Drugs, review of chart for accuracy, clarity and necessity
- ☐ VTE risk and treatment plan
- ☐ Drips/Catheters, IV sites review: is there still a need?
- ☐ Falls, skin care, pain, mobility
- ☐ Area specific issues (e.g. oncology, AAU, etc)

☐ Pause

Check that every member of the team has no issues or concerns

☐ Confirm patient understanding

Discuss plan for care and management with the patient, answer any questions

Actions

☐ Document and Action

- Check documentation completed, signed and dated accurately
- Confirm ownership of tasks, with timescales

☐ Confirm Discharge Objectives

- Measures and timescale
- TTA completed

☐ Communicate

Communicate actions and timescales to absent members of the team. Share information with other teams and services as appropriate.

☐ Affix patient label here or enter

Name: _____

DOB: _____

Hosp No: _____



Ward Safety Checklist 7 (May 2011) Yogi Amin, Dave Greenwood, Steve Andrews, Aiden Halligan

University College London Hospitals **NHS**
NHS Foundation Trust

Ward Safety Checklist at UCLH

- Use by multidisciplinary team on ward round
 - Follows principle of WHO Safe Surgery Checklist
 - Team have collective responsibility for completion
 - Not designed to add work, but to focus
 - Document in notes when used
-
- Introduction – patient identification & introductions
 - ‘Time out’ – checklist, confirm understanding of team and patient
 - Actions – ongoing plans

J R Soc Med 2012; 105:377-383

1200 -After Action Review

- Structured reflection
- All on ward round
- No hierarchy
- Coffee
- Quiet room
- 5 – 20 minutes
- All contribute



After Action Review

- What was expected?
- What actually happened?
- Why was there a difference?
- What has been learnt?
- Good days and bad days
- Feedback for all
- Learning
- Problems
- Teambuilding

Results of AAR for Neurocritical Care Unit

- Change to handover sheet to wards
- New history sheet on coloured paper to easily identify in notes
- New Junior doctor shifts
- Improved communication with radiology
- Team make changes not me. I enable / support the process



The rest of the day.....

- Clarify the list of tasks for the day and who will do them
- Outreach review on the wards
- Regular catch up throughout the day
- Door of office always open for questions

Time for the relatives

- Meetings to give updates on patient progress
 - Scheduled and unscheduled
- Breaking bad news
 - Quiet room
- Brain stem death tests
 - Performing the tests
 - Communicating the results
- Organ donation
 - Liaising with the in house donor co-ordinator



Bereavement clinic

- Established 10 years ago
- Patients often with us for many days / weeks and have huge input from staff during difficult time
- Large volume of complex information which is difficult to process
- After death no input
- In some cases complaints process is used to get information
- A death sends ripples into any family, we wanted the experience to be as positive as possible

Setting up the clinic

- Right staff
 - Consultant lead
 - Teaching programme skills to break bad news
 - Nursing staff recruited
- Dedicated time
 - Appointments made at time when consultant available
 - No interruptions
- Point of contact
 - Telephone number and email address



Staff of the Surgical Intensive Care Unit extend their sincerest sympathy.

Our Bereavement Service provides an opportunity for you and your family to meet with an intensive care consultant and nurse to talk about any aspect of your relative's illness and care.

If you feel it would be of benefit to you, please complete and return the enclosed card to make an appointment.

Alternatively, you can email the Bereavement Service at situfollowup@uclh.nhs.uk



Bereavement Service

Please return this slip if you would like to make an appointment

The Bereavement Service
Neurosurgical Intensive Care Unit
The National Hospital for Neurology and Neurosurgery
Queen Square
London WC1N 3BG

You will be contacted to arrange a suitable time

Name: _____

Contact telephone number: _____

Benefits of the clinic

- 15% uptake rate
- Card sent 6 weeks after death
- Appointment with consultant and nurse
 - Choice of venue
 - Up to 2 hours
- Other clinicians if needed e.g. neurosurgeon
- Clinical notes
- Families rarely take up follow up appointments
- Reduced complaints
- Immediate feedback to staff



Children

- Developed concerns during training for bereavement clinic that we could be more child friendly
- Encourage relatives to bring children of patients to the unit as reality is never as bad as imagination
- Remove all unnecessary equipment from the bedside
- Drawing and painting equipment
- Keep books for children and adolescents of all ages
- We encourage involvement
 - Memory boxes
 - Hand prints / locks of hair

1800 - Handover

- Final ward round with nurse in charge and trainee
 - Completed tasks
 - Outstanding problems
 - Plans for overnight – identify well patients who could go to the ward in an emergency
- Handover plans to consultant overnight
- Communicate issues to consultant for the next day

*Thank you to all the staff on the
Neurocritical Care Unit at Queen
Square*

