**QUERIES / QUESTIONS & GENERAL INFORMATION LOG**

**Updated 3/11/20**

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The information in this log has been shared in good faith by our own and some national units and is correct at the time of sharing. The date when queries and questions are posed is in the brackets immediately following the question.

If you wish to add further information, or update entries against your unit details, please send this to [sarahgraham3@nhs.net](mailto:sarahgraham3@nhs.net)

**NEW INFORMATION ADDED SINCE LAST CIRCULATION IS IN GREEN**

**1. COVID-19**

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| Brief overview report and recommendations from the CLAP study (led by Cath Montgomery), which we undertook to understand the experiences of staff working in ICU during the pandemic. (Oct 2020) |
| C19 SPACE Programme and ESICM Trainers (Oct 2020) |

**2. STAFFING AND TRAINING**

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| ***Q: Who employs Band 4 nursing staff on critical care (July 2019)*** |
| University Hospitals Birmingham |

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| ***Q: ITU Staff Moves - can trusts share their protocols or sops that they have in place when their staff support their wider trust. (July 2019)*** |
| Royal Wolverhampton Hospital:  University Hospitals Birmingham: we will deploy staff of all grades to support the wider Trust if dependency allows. We do not have an SOP, Protocol or Guidelines. The Band 8a Site manager has the overall responsibility of patients and staff safety for the Trust and they escalate across the Divisions when they feel there is a real risk to patient and staff safety.  Each Division looks at its staffing capabilities and deploys either an RN or HCA to support when and where possible. The clinical areas are all aware that a Critical Care nurse will not be familiar with ward processes and may not be able to for fill all the role and responsibilities of the other embedded ward staff and therefore this is considered when allocating the Critical Care Staff. All staff deployed are supported by the Critical Care Leads if they feel their own practice is compromised or at risk. We sometimes have to agree to close a Critical Care capacity bed if the risk outside of the service is greater than within the Critical Care units eg ED,AMU or 1x RN on a ward.  In most cases we send staff just to support and not to take over patient groups. In most cases we have found that when staff are deployed, although they have found it a challenging experience, they also gained a greater insight into the global Trust pressures and expectations on ward staff. They often feedback that they feel well supported and safe within Critical Care Services when comparing the support staff receive in other specialities. As service Lead I always ask for the names of any staff deployed and personally thank them in order for them to be recognised as being ambassadors for our service and for their CPD.  University Hospitals Leicester:  Russell’s Hall Hospital: We are currently re-writing this protocol but it basically says that if capacity allows a Critical Care Nurse will be able to help in specified areas only such as Vascular HDU, Medical HDU.  This nurse will then return to Critical Care should the need arise and would not be expected to take care of a group of patients.  Northampton General Hospital: |

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| ***Q: NURSING ASSOCIATES - do other hospitals in the network have or are considering incorporating nursing associates into their critical care establishment? If so, how is this fitting in with the national standards for staffing? (Nov 2019)*** |
| University Hospitals Birmingham: UHB currently have 5x Nursing Associates within Critical Care Services who the organisation have trained in conjunction with Birmingham City University. We have a further 6 due to in 2020 and we are hoping to recruit 15 across our 3 Critical Care Hospital sites per cohort next year (3 x cohorts). Potentially this would result in an annual intake of 40 across 7 units. UHB are now scoping the next level of training we can offer these NA’s so they can be facilitated to undertake their RN training if they choose to. |

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| ***Q: Who is the decision maker for coding in your trust? Is it a medical person/consultant? Or does the ICNARC clerk complete the coding after appropriate training? -Can I please have a copy of the Job Description and Banding of your ICNARC clerk in your trust? (Sept 2019)*** |
| Walsall Hospital - the coding is done by the Band 5 Team Leader with support from a band 5 link nurse from ICU. We are currently recruiting to a Band 3 DQO who will also have some involvement, so I have attached their JD/PS.    Glenfield Hospital - The decision maker for coding is either the Consultant on for AICU or an ST (or above) registrar.  The ICNARC clerk does not complete coding. I have attached the JD for the ICNARC audit clerk.    Kettering General Hospital - I have a band 4 part time ICNARC Audit clerk this member of staff is also an AP for the remainder of her hours hence the banding this was an historical posting pre my time. This member of staff has completed the audit since the roll out of ICNARC so has a clear understanding. In addition I have a full time band 3 ICNARC audit clerk I did try and get this post uplifted to a band 4 to be fair and equitable, as I understand in the larger trusts i.e. UHL they are band 4s however I have struggled as this role at KGH has been job matched as a band 3.  They have both attend the ICNARC centre for updates and training.  The reports are checked by our lead clinician for any obvious anomalies.  I have attached the JD and PS for the band 3 ICNARC audit clerk |

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| ***Q: ODPs in CC - Can I ask the network if they have ODPs working in their ICUs, in what capacity and would they be prepared to share a job description? (June 2020)*** |
| Kettering General Hospital: We have ODPs working with us on ICU at KGH as part of the redeployed team that came to work with us as part of the pandemic we don’t have a job description but going forward we also would consider ODPs working in our team.  Northampton General Hospital: We have had ODP’s on our Critical Care department for 20 plus years. The lead band 7 ODP and I have 5 x Band 6 ODPs that solely cover Critical Care. We currently work 12 hour daytime shifts 7 days a week. We are hoping to expand this to cover nights as well in the near future. Our job roles cover many aspects both clinical and non-clinical. I have attached our job description for our band 6’s |

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| ***Q: For those units that offer an interventional critical care outreach service, can you share with me how you have structured your teams in terms of AFC bandings, the number of staff on each shift and anything specifically that differentiates your bands if there is a hierarchy within it. Jul 2019 National Request*** |
| Calderdale and Huddersfield: CCOT are currently all Band 6's. However, this structure has been analysed and a change is unfolding. We are currently under a work force analysis/review. A business case is being created with our Clinical Lead for ICU and our managers are negotiating with the finance team to firstly recruit a Band 7 lead nurse for our CCOT, who can then lead on the team's development, to hopefully to all gaining Band 7, possibly 8A status.  The Christie Hospital: 12 in the team, working 24/7 currently four 7’s, seven 6’s and one 8a lead. Currently in discussions about moving to and all 7 team structure for those currently working at band 6 but financially not in a position to do so yet.  Hull Hospital: Hull has 1 Outreach team to cover two hospitals. We have 1 nurse covering each site 24/7 (so 2 on a day and 2 on a night, one at HRI and 1 at CHH) There are 13 WTE in the team. The lead nurse is an 8a- only since the last year since taking the job description to a matching panel The other 12 are band 7’s except new starters that have a probationary period at band 6 until they complete their competencies.  Isle of White: Here on the IOW – I have modelled the team as below; Please complete and return this form to Karen.berry@mft.nhs.uk 4 weeks following request for information. We cover 24/7 We are a nurse led service and the team consist of 1 WTE – Consultant Nurse 5 advanced clinical practitioners – 8A 5.69 WTE CCOS clinical assistants – Band 3 My team also leads H@N and awaiting approval of a business case for 3.69 wte band 7 H@N clinical co-ordinators that will sit within CCOS.  Liverpool Royal: At Liverpool Royal we have a flat hierarchy – we are a team of 6 band 8A (4.6WTE) we cover a 7 day service during daytime – out of hours referrals are dealt with by ITU trainees. We are all MSc Advance practice graduates and non-medical prescribers.  Southampton: Structurally I lead the adult team, I am band 8a and my team are currently all band 7. I employ at band 6 to train into a 7. The banding is dependent on achieving MSc in Advanced Nurse Practitioner. I have 12 whole time equivalent staff and we cover 24/7 for over 1000 beds and there are two members of staff on duty at all times.  Wigan: Operate a 24/7 service with a band 7 practitioner on each shift. There are also band 6 assistants who are in training to be a band 7 but the lead primarily lead the shift. |

**3. TREATMENT RELATED**

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| ***Q: What other units around the region do / document for observations of the hand / distal limb when an arterial line is present. (Oct 2019)*** |
| Royal Wolverhampton Hospital: Have written a SOP which is going through governance and have produced red stickers that go on the patient’s bed side charts ‘brachial A line’. We also document colour and warmth to the Observations charts hourly. It is also on the band 7 daily quality walk round to check all this is completed and the question raised, ‘can we change its position?’  Royal Shrewsbury: Checked regularly on every shift.  Russell’s Hall: checks done once per shift. Where mittens are being used, these are removed routinely 4-hourly.  University Hospitals Birmingham: At UHB we don’t formally document perfusion more frequently than 4 hours. Perfusion is checked at each use also. |

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| ***Q: How many units use disposable bronchoscopes? (Nov 2019)*** |
| Worcester Acute Trusts: single use, Ambus |

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| ***Q: Medicines at the Bedside - We historically have had saline and water for injection ampules kept in the bedside trolleys in ITU however we have been told we can no longer have theses there and should be locked away with other medicines as per CQC recommendations. Can you ask other units if this is the practice they use or do they keep such medicines at the bedside, or if they have had this issue how have they managed it? (Aug 2019)*** |
| Northampton General Hospital: We have risk assessed our emergency drugs and fluids at the bedside but ampoules of H20/NaCl have not been included as yet. I have attached it for your information. It has been agreed with pharmacy and governance. We have trolleys with lockable drawers at the patients’ bedside where these items are kept and are in a locked unit.    Wye Valley Trust: we have completed a risk assessment for medicines used on ICU whereby do not comply with national standards for locked medication. We have not had this formally critiqued by CQC, but has been acceptable trust practice, as per other risk assessments which highlight for mitigations    Glenfield Hospital: we also keep water/ saline ampules in the bedside trolley. I have discussed this with our pharmacy and we previously risk assessed this as safe because there is always a nurse present at the bedside, therefore never unattended. |

**4. POLICIES, GUIDELINES, PROCESSES OR PROCEDURES**

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| ***Q:******What current processes,******policies and procedures are in place for the disposal of controlled drug infusions within your Trust? (Jan 2020)*** |
| **Kettering General Hospital: All controlled drug infusions are disposed** **of using the drug destruction kits this is witnessed by two members of staff and the wastage of unused drug is documented in the controlled drug book.**  Glenfield Hospital: the disposal of our CD infusions is into our DOOP/ DOOM bottles. We do not record this disposal in the CD book (although pharmacy have suggested this may change). Once the DOOP bottle is full this goes into a sharps bin for disposal. This is in line with our CD policy and Waste management policy.  Shrewsbury & Telford Hospitals: Our Trusts Medicine Code, which states without quoting:  The surplus must be rendered irretrievable by emptying the contents into a sharps bin or denaturing kit. The emptied vial/ampoule/pre-filled syringe/bag should also be placed in the sharps bin. This process should be witnessed and documented in the Controlled Drug Record Book by x 2 register health care professionals. |

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| ***Q: Do you have a Do Not Escalate / Treatment Escalation Plan document? (Aug 2019)*** |
| Warwick Hospital - we use standard RESPECT forms, but Medway look like they have a nice TEP form:  <https://bmjopenquality.bmj.com/content/7/4/e000268>  <https://bmjopenquality.bmj.com/content/bmjqir/7/4/e000268.full.pdf> |

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| ***Q: Would it be possible to ask the network if they use ear plugs and eye masks in their critical care units and if so do they have guidelines etc in place for their use? (Oct 2019)*** |
| Kettering General Hospital: we do use ear plugs and face masks this is part of our rehab, reduction in delirium programme.  In regard to documentation its part of the care plan and it is also within the delirium protocol.  I hope this helps if you require further details you may want to link in with Caroline Simcoe our senior sister that leads on this [Caroline.Simcoe@kgh.nhs.uk](mailto:Caroline.Simcoe@kgh.nhs.uk) she has done lots of great work around reduction of delirium and promotion of rehab and recovery.  Northampton General Hospital: as a trust we offer ear plugs and eye masks in a sleep pack for all patients who wish to use them including those in critical care. I am not aware of a guideline for this.  Glenfield Hospital: we do use eye masks and ear plugs, no hard and fast rules or policies on their use, if a patient can’t sleep we all know to offer them. They are supplied regularly through our weekly stores.  We have also offered headphones and music in the past if it is a busy/ emergency bed space next door with a chest reopening etc. |

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| ***Q: ICU Leaflets (Nov 2019)*** |
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| ***Q: PPE ENQUIRY) - We continue working in full PPE in Covid and non-Covid “green” areas and are trying to get this reviewed so that we reduce the level of PPE to surgical masks and goggles/visors in the “green” areas to help with sustainability/staff wellbeing without putting staff at risk.  I am told this is already happening in some critical care units but would be interested to find out who has changed? (Jun 2020*** |
| National Link - <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe>  Royal Wolverhampton Hospital: We are wearing PPE in both clean and COVID areas as IP have said the PHE guidance is to carry on. I agree we too would like to reduce the wearing to surgical mask etc. for staff wellbeing and sustainability but IP say no…I would be very interested in the evidence other ICU’s have to support surgical masks etc to take to the RWT IP team J  Kettering General Hospital: At KGH ICU our green annexe area are wearing theatre masks only this was a trust IP decision as this is what is worn on the wards. If we have patients admitted via ED and there are concerns they are admitted  to the Red ICU and once receive negative swabs are transferred to green ICU nursed in side room as quarantined,  full  PPE is then worn until a repeat negative swab or 14 day isolation.  All nurses on ICU were fitted for respirators which they are allowed to wear on green ICU if they choose.  Walsall Hospital: we are wearing full PPE for patients who are positive for covid, those who are awaiting swab results are full PPE if AGP are present, otherwise, surgical masks, apron and gloves. Surgical masks, apron and gloves for negative patients if 2 metre distance cannot be maintained. Although I believe this will change to surgical masks being worn whenever in the hospital.  Wye Valley Trust: We wear gown and gloves as per PEE guidelines – apron over the top for patient contact, following patient contact we remove apron and gloves and wash hands (leave gown on) replace gloves. We do not double glove.  Worcester Acute Trust: we double glove to go into the unit, and treat the underneath gloves as 'your skin' then the top gloves are treated the same as usual and changed between patients and wash the underneath gloves as you would your hands, if that makes sense?  Royal Wolverhampton Hospital: We are currently having a drive on PPE and Hand Hygiene as it has been picked up in audits that double gloving  was practiced at times by different disciplines. We are ensuring PPE then apron and glove changed between all patients.  University Hospitals Birmingham: If I am honest there has been varying practice during the pandemic but what we have learned is that we must practice IPC as per guidelines to prevent cross contamination of other organisms and so in addition to full PPE Staff are asked to wear a disposable apron over their gown for patient care.  Following intervention/care and between all patient’s staff are required to remove the apron and their gloves, wash their hands and don a new pair of gloves.  Some staff would argue that water may ‘dribble’ down the sleeve of the gown, but this is why staff should wash from elbows down upon doffing.  We have re-commenced hand hygiene audits on all units including Covid in order to challenge and confirm practice according to the guidance.  National replies - |

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| ***Q: Request for eye care policies? (Jul 2019)*** |
| Glenfield Hospital: I believe it follows the ICS ophthalmic guidelines. The poster may be of some use though    Russell’s Hall Hospital: If used please acknowledge the Dudley Group of Hospitals Trust. |

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| **Q: Are there any units who have downgraded e.g. ITU to HDU or frrom HDU to ESCU (Enhanced Surgical Care Unit)? Oct 2020** |
| Chase Farm, London: CFH did down grade from ITU to HDU before I started in 2015. In 2017, we further downgraded from HDU to ESCU (Enhanced Surgical Care Unit) when Barnet ITU pulled out it's staff.    We use an enhanced NEWS2 scoring system to identify deteriorating patients early and have a transfer policy that reduces delays. We have no return to theatre or PART team on site. Out of hours we have 1 RMO and the site manager + ward nurses.The NEWS2 scoring is built into our EPR system. The CQC looked closely at these in 2018 and were happy. All transfers off-site are reviewed via a transfer group |

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| **Q: Is anyone able to share their policy for taking C-diff samples in ITU/HDU staffing please?**  From Royal Orthopaedic Hospital: |