Sharing Experiences & Learning

Volume 2 - Building on Strong Foundations

A directory of best practice from those that serve the people of Grampian
I am delighted to launch volume two of the very popular resource *Sharing Experience and Learning*, which has been expanded through inviting a wider group of staff to contribute. As we strive to provide patient focused care it is important that we have a greater understanding of each others roles and the developments that are occurring within different setting, staff groups and services. I think you will agree when you review the content of this volume that this is certainly one way of achieving this goal.

Volume One was commended, by NHS Quality Improvement Scotland (NHSQIS), as an example of best practice when they visited us to review our progress against the generic standards. They also challenged us to look at how we might build on the excellent nursing and midwifery resource to include the rest of our staff. Not only have we taken on this challenge but we have also received contributions from our education partners at The Robert Gordon University and our colleagues at Grampian Local Health Council.

I am particularly pleased to see a wide range of contributions from services that were not represented last time. Also I would like to offer my congratulations to those that took up the challenge of maintaining their momentum from volume one and adding further new and innovative content to this volume.

As Chairman of NHS Grampian I meet a wide range of people and staff both within Grampian and wider afield. During these meetings I often make reference to this excellent yet simple source of innovation and experience. It offers a small insight into the culture of care here in Grampian. It helps give a flavour of the excellent practice that is, for the vast majority of patients in our care, the norm.

Finally, I would encourage you not to simply flick through the pages of this volume but to consider carefully as you read each entry what we can learn from one another. I would encourage you to make contact with those that have tackled issues and challenges similar to any you might be facing. We have great expertise available and through this resource we are better placed to improve services through making connections with each other.

Jim Royan OBE
Chairman, NHS Grampian.
Title

Comparisons and Contrasts of Follow Up Services

Brief Summary

Issues
The service in Aberdeen was established on the 29th January 2001 and is a nurse led initiative. The service was set up to provide the perceived “missing” support to nursing staff caring for ITU patients following discharge to the ward and HDU environments. The service was named “Follow Up” but functions similarly to the “Outreach” Services set up at approximately the same time elsewhere in the U.K.

Action
The aim of the study is to compare how and why the Follow Up/Outreach service was developed and initiated in other trusts within the United Kingdom, and how they have since developed with the view to lead innovation within our own practice. We are looking to our European colleagues as a contrast to patient management of the critically ill patient, HDU care and support given to ward staff.

This study has been made possible by the support of the Florence Nightingale Travel Scholarship and sponsored by the British Heart Foundation.

Outcomes
• To develop the service we provide and ultimately improve the nursing care of ITU patients following their discharge within the Trust.
• Reduce the number of readmissions to ITU due to sub-optimal ward nursing care.
• Enable readmissions, if unavoidable, to be more timely.

Addition Reading/Information
• Haines S (2001) Providing Continuity of care for patients transferred from ICU Professional Nurse. 17:1, 17-21
Sharing Experiences & Learning

Name: Jane Reid
AHP Professional Development Facilitator

Contact Details: School of Health Sciences
Robert Gordon University
Garthdee Road, Aberdeen

Tel. No: 01224 263268
E-mail: j.reid-h@rgu.ac.uk

Title: Right Skills at the Right Time Project

Brief Summary

Issues
Recruitment and retention is recognised as a major problem for Allied Health Professionals, however many potential returners are nervous of taking that first step back to practice. The project is aimed at encouraging returners by assisting them in identifying their Learning Needs and from there instituting a Learning Programme to support them whilst allowing them to be employed and therefore earning. This then ensures that staff have the Right Skills at the Right Time to be able to do their job effectively thereby ensuring quality care for the patients.

Action
A Learning Needs Assessment Tool has been developed through collaboration between NHS Grampian and Robert Gordon University. The Tool is an internet-based self-assessment tool aimed at identifying gaps/deficits in the knowledge and skills of returners to practice and new starts. The Tool can be completed at an individual’s own pace and wherever they can access the internet. Once Learning Needs are identified there are mechanisms within the project to support an individual’s learning and objectively assess their ongoing competence. This will, in turn, assist in the forthcoming re-registration requirements of the Health Professions Council.

Outcomes
• Learning Needs Assessment Tool developed and hosted on RGU Virtual Campus for the 7 AHP groups involved in the project within Grampian
• Possibility of rolling the project out across Scotland with the potential to include Nursing staff also.
• Opportunity to validate learning in practice and to improve skills of professionals via distance

Addition Reading/Information
• The 7 AHP groups involved in the Project are: Dietetics, Occupational Therapy, Physiotherapy, Podiatry, Radiography, Radiotherapy and Speech & Language Therapy.

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Title**

Information Needs of Patients receiving Hyperbaric Care

**Issues**

Patients receive pre-treatment information by nursing staff prior to their treatment in the hyperbaric medical unit. The purpose of this study was to audit, via a questionnaire, whether the pre-treatment information given to patients was accurate, easily understood and delivered in the best possible manner.

**Action**

A questionnaire was devised in conjunction with the clinical effectiveness department, and distributed to patients on completion of treatment.

**Outcomes**

- As a direct result of the audit, unit policy on distribution of patient information was amended.
- A letter confirming date of treatment is sent to patients with a patient information sheet enclosed.
- Patients are visited the day before treatment by a hyperbaric nurse, given general information about the treatment using a patient checklist, shown hood and neck seals used in treatment and given a patient information sheet.
- There is a very significantly improved information/education and advice service now provided as a consequence of this action. Hyperbaric oxygen therapy is a very complex and technical treatment regime requiring much participation and understanding by the patients.
- The process of patient information-giving is now continually assessed and will be modified as possible improvements identified and re-audited.

**Addition Reading/Information**

Title

**Patients as stakeholders in decision making**

**Brief Summary**

**Issues**
The Dermatology Department is facing a number of challenges, such as long waiting lists, lengthy waiting times for some treatments and a shortage of consultants. It is currently going through a process of ‘redesign’ and as part of this exercise we have chartered new waters by involving patients, who use the service, to help us plan for the future by sharing their ideas and experiences. The themes of redesign have been a day treatment centre, reduced in patient beds, waiting list reduction, and the extended role of the nurse.

**Action**
In collaboration with our Local Health Council we used a number of tools to involve patients and seek their views. The starting point was an Electronic Opinionmeter in the outpatient department. This was set up with 8 questions around the redesign themes. Focus groups were then set up by the Local Health Council and a group of patients with Psoriasis were targeted. (Psoriasis is one of the main skin diseases treated). Again structured questions were asked around the redesign project. Finally a Patients Panel was formed to allow a regular dialogue with Nursing and Medical staff. Initially this was facilitated by the Local Health Council.

**Outcomes**
- **The Opinionmeter** highlighted Patient preference for weekday morning clinics would prefer most of their care at their GP surgery – G.P’s now being trained. Would be willing to be seen by nurse if it reduced the waiting time – Pilot Nurse Led Day Treatment centre opened
- **Focus Groups** participants felt nurses had the knowledge and should be more involved would like to be seen ‘drop in’ if skin flared – Work towards this in nurse led service. Also G.P access
- **Patients Panel** regularly meet every two months – actions so far include working on a patient hand held record. Involving patients in information leaflet production.

**Addition Reading/Information**
- **Peake L.** Personal record for community Dermatology booklet. Greater Derby NHS 2002
- **Sutherland L.** Opinionmeter Pilot Project Grampian Local Health Council 2000
- **Chesson R. Adams L.** Professional perceptions of patient involvement. Grampian Primary Care NHS Trust 2002

**Category**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
**Sharing Experiences & Learning**

**Name**  
Jane Ormerod

**Contact Details**  
Professional Development Unit  
Westburn Centre  
Foresterhill  
Aberdeen

**Tel. No**  
01224 559367

**E-mail**  
Jane.Ormerod@arh.grampian.scot.nhs.uk

**Title**  
Education for Practice: Florence Nightingale Travel Scholarship

**Brief Summary**

**Issues**  
The opportunity afforded by an accessible Travel Scholarship provided a chance to visit a range of centres in the UK and Europe to compare practice in relation to the recruitment, support and retention of newly registered practitioners. This resulted in a great networking opportunity and a rejuvenated view of work in this area on my return to Aberdeen.

The transition from student to registered nurse is difficult and stressful. Many centres approach this by providing some kind of development and support for new practitioners. In Aberdeen we have offered a programme for 5 years and were keen to network and share work as well as finding out what was going on elsewhere that might influence our current and future development in this area.

**Action**  
The application process for the Florence Nightingale scholarship is easy and accessible and should not put off prospective applicants. Following a successful interview I set about arranging my visits to the UK and Scandinavia. Through helpful contacts I arranged a study tour over 6 weeks and visiting 7 different centres.

**Outcomes**  
The study tour enhanced my knowledge of development programmes; there were arrangements in place in all the centres visited for development for this group of staff. They ranged from formal and rotational to less formal and non-rotational. Preceptorship was commonly in place as well as other supportive processes, such as clinical supervision and peer learning groups. There was often linkage between these programmes in the form of a ladder of development.

One crucial insight I gained was that we do some really good things in Grampian but do not share good practice enough. I came back from my study tour with renewed energy and enthusiasm.

**Addition Reading/Information**

**Category**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity

**Architect of Change**

Vol. II
Sharing Experiences & Learning

**Name**  
**Linda Caie,**  
Parkinson's Disease Nurse Specialist

**Contact Details**  
Ward 40,  
Aberdeen Royal Infirmary

**Tel. No**  
01224-556854

**E-mail**  
Linda.Caie@arh.grampian.scot.nhs.uk.

**Title**  
**Apomorphine in Parkinson’s Disease**

**Brief Summary**

**Issues**

An audit of patients receiving Apomorphine administration in Ward 40, Aberdeen Royal Infirmary over the last two years was undertaken. Indicating ad hoc recording/documentation of information and education given to patients regarding this medication which must be given subcutaneously.

**Action**

- Development of documentation to ensure best practice in recording of information.
- Apomorphine Challenge Protocol, Care Plan, Motor fluctuations recording chart and patient education protocol devised.

**Outcomes**

- Uniformity of information and education given to patient.
- Documented evidence of above.
- Improved confidence and competence of staff.

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name  
Linda Caie,  
Parkinson's Disease Nurse Specialist

Contact Details  
Ward 40,  
Aberdeen Royal Infirmary

Tel. No  
01224-556854

E-mail  
Linda.Caie@arh.grampian.scot.nhs.uk.

Title  
Nurse Led Clinics for Parkinson’s Disease

Brief Summary

Issues

• Parkinson's Disease can be difficult for patients/carers to understand and cope with.
• Lack of knowledge on Parkinson’s Disease - patients, carers and health professionals.

Action

• Establishment of Nurse-led Clinics to provide timely support, information and education (Elgin, Fraserburgh, Banff, Aberdeen).

Outcomes

• Timely support for patients/carers near to their home.
• Effective use of Parkinson's Disease Nurse Specialist time.
• Opportunity for patients/carers to discuss their illness and receive information/education on P.D. as required, encouraging and enabling patients to take an active role in their own care.
• Educational/development opportunity for multi-disciplinary team members to shadow and attend clinic.
• A user survey conducted - indicated a high level of patient satisfaction

Addition Reading/Information

• HAYES, C (1999) The specialist nurse role in Parkinson's Disease Professional Nurse 14:11, 765-768

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity

Engines of Change

Architects of Change

Subjects of Change
**Title**

**Guidance on Restraint: Issues for nurses working in Neuroscience Units**

**Brief Summary**

**Issues**

The issue of restraint poses a difficult dilemma for nurses attempting to provide safe and competent care for patients following brain injury. It was felt that guidance was required to ensure that vulnerable patients were appropriately assessed to enable causes of agitation to be addressed. As a result nurses should be guided to use the minimum degree of restraint necessary to facilitate good care. National guidelines would provide nurses with a recognised framework within which to practice.

**Action**

- Participation in a working party chaired by RCN Scotland Policy Convenor (from Jan 1999)
- Multi-centred involvement from nurses within all Scotland Neuroscience Units.
- Extensive literature review
- Sharing guidelines with ward colleagues & Moraig Leys, then Director of Nursing

**Outcomes**

- Development of Restraint Assessment and Record Tool
- Accompanying Neuroscience Benchmark: The Use of Restraint
- Induction of Wanderguard Monitoring System to minimise the risk of vulnerable patients leaving ward unobserved and unattended

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name
Rosie Crighton
Health Visitor

Contact Details
Westhill Clinic
Westhill Drive
Westhill
Aberdeen AB32 6FY

Tel. No
01224 746982

E-mail
rosie.crighton@skene.grampian.scot.nhs.uk

Title
Men’s Health

Brief Summary

Issues
Until recently men’s health has been the ‘poor relation’. Despite advertising, men either cannot or choose not to access services. Rural men in particular are unlikely to attend their GP, therefore it was felt that a mobile service should be developed meeting men in their own rural environments.

Action
The multi-disciplinary nursing team became involved and enthusiastically offered to support the project. Following a literature review, Health Promotions provided information leaflets, information boards, and anatomical models for practical demonstrations. The leaflet topics included physical and emotional health and agricultural health and safety. ‘MOT’ certificates were produced to provide the men with a record of their height, weight, body mass index, blood pressure, and any other relevant information. An information pack was developed for the staff, providing BMI charts and general information. The team attended a Vintage Tractor Weekend, with the collaboration of the owner of the local agricultural store. Without this support and enthusiasm the project would have failed, and the mobile team has been invited to return to next year’s event.

Outcomes
- Development of a multidisciplinary mobile team to promote Men’s Health.
- Raising awareness of health issues and risk taking amongst rural men
- Offering limited health screening (BP, Ht. & Wt., BMI)
- Information sharing and advising when to see G.P
- 50 men seen in 6 hour period at first session
- Very well received and supported

Addition Reading/Information
www.menshealthforum.org.uk www.malehealth.co.uk

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Architect of Change
Title

Continence Care Flow Chart “Back to Basics”

Brief Summary

Issues

Incontinence is a problem affecting many people, both young and old, in the community. Patients who present to their G.P. are often referred, inappropriately to the Community Nurses for assessment for absorbent products. It is then left for the Nurses to initiate the completion of the Frequency Volume Chart and the Continence Assessment Form. GPs may then have little further input, it being considered that the absorbent product will solve the problem. Following several inappropriate referrals to Community Nurses/Health Visitors, it was decided to develop an algorithm to aid the diagnosis of incontinence and choose an appropriate referral pathway.

Action

A multi-disciplinary, multi-agency team was set up to look at the current literature and other continence care pathways. Several algorithms were considered and one was developed which met local needs. GPs should initiate a frequency volume chart, and hand this to the patient when seen in the surgery. For the project 10 plastic jugs were purchased, one to be given each to the first 10 patients presenting with continence problems, for the purpose of measuring urine. Each GP was given an information pack containing samples of appropriate patient information, a colour laminated copy of the Continence Flow Chart, and other relevant information regarding completion of the Frequency Volume Chart.

Outcomes

• Development of Continence Care Flow Chart
• “Back to Basics” – encouraging GP’s to carry out basic assessment of incontinence
• Reduction of inappropriate referrals from GP’s to Community Nurse Team.
• Raising awareness of continence issues amongst GP’s
• Encouragement of holistic continence assessment and incontinence management

Addition Reading/Information

DOH (England) 2000, Good Practice in Continence Services
Continence Foundation, Incontinence – a challenge & an opportunity for Primary Care
Name                 Keith Farrer  
Lead Cancer Nurse for Orkney  
Peter Gent  CNM/ Head of Service  

Contact Details  
Anchor Unit  
Aberdeen Royal Infirmary  
Tel. No  
01224 551189  
E-mail  
p.gent@arh.grampian.scot.nhs.uk  

Title  
Shared Chemotherapy Care for Curable Colorectal Cancer Patients between Orkney and Shetland.  

Brief Summary  
Issues  
Throughout Grampian, Orkney and Shetland around 400 patients annually are diagnosed with colorectal cancer. Of these we treat at least 12 per year with adjuvant (post surgery chemotherapy where cure is possible) from Orkney. The treatment entails a total of 6, 48hr infusions, each at two week intervals. For patient who live in Orkney this involves considerable traveling and for those who live rurally within Orkney the situation is exacerbated.  

Action  
A six month project to jointly share care between Orkney and Shetland which is predominantly nurse led is in progress in an attempt to bring improved cancer services to rural communities.  
- Address ethical issues concerning cancer in rural communities.  
- Need to rationalise travel disruption to patients and costs incurred by the service.  
- Utilise professional skill and knowledge in remote cancer centres.  
Patients receive alternate treatments in Orkney and toxicity assessment and management is undertaken by skilled island based nurses. A toxicity assessment protocol was developed for joint management and local nurses are empowered to determine treatment decisions.  

Outcomes  
- Better services for patients  
- Small number of patients but a significant financial saving due to the high costs of travel (around £9000 on flights based on 12 patients).  
- Utilisation and development of local/rural based skill  
- Improved collaborative working.  

Addition Reading/Information  
- Audit of Cancer Chemotherapy (2002)  

Category  
Delivering Quality Care  
Shaping a multi-Disciplinary Future  
Developing Capability and Capacity  

Engine of Change  
Vol. II  
Architects of Change  
Architects of Change  
Architects of Change
Sharing Experiences & Learning

Name          Justine Collie  Unit Development Nurse
Tanya Learmonth, Chemotherapy  Sr.
Peter Gent, CNM Head of  Service

Contact Details        Anchor Unit
Aberdeen Royal Infirmary

Tel. No            01224 551189
E-mail            Justine.collie@arh.grampian.scot.nhs.uk

Title        Shared learning opportunities for community nurses in acute based oncology, haematology and palliative care

Brief Summary

Issues
The spread of population across Grampian ensures that almost 50% of cancer care takes place rurally or at least outwith Aberdeen City. There is great reliance upon community staff to provide ongoing ambulatory care and continued patient support. It is a fact that cancer incidence is on the increase and the nature of therapy for the future is moving swiftly towards day case and ambulatory therapy therefore the impact across NHS Grampian is significant. Furthermore, as a professional group caring for cancer patients, nurses must share the burden and experience of care and in doing so extends our professional networks.

• There is a need to share knowledge and update clinical skills
• We must work in partnership and seamlessly
• The science of acute haematology, oncology and palliative care is rapidly developing

Action
A week long ANCHOR based education and training programme was developed incorporating all members of the multi-disciplinary team and all aspects of clinical care within the unit. The programme was offered to community staff via GPCT lead nurses.

Outcomes
• Two members of community staff attending programme alternate weeks
• Programme fully subscribed for first full year
• Programme evaluation built in
• opportunity for enhanced clinical learning.
• Optimise professional advise/information available to patients on the whole service.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Architect of Change  Architects of Change  Architects of Change
**Community Medication: Weekends and Out of Hours**

**Brief Summary**

**Issues**
Administration of medication through a syringe pump is common place, for patients in the terminal stages of illness in the community. Where possible this is a planned procedure. On occasions these procedures can occur, unexpectedly, at weekends and out of hours. In our rural area delays have been experienced in getting the necessary medication, at weekends and out of hours, causing frustration for staff, patients and relatives. It was felt that a central point of access to a starter pack of relevant medication, would alleviate unnecessary delay and time wasting for the local GP’s, Community Nurses and out of hours service. This service does not replace the regular agreement with the local pharmacy where medication is normally provided using GP10.

**Action**
- Discussed possibilities with Dr J Anderson (local GP aligned to palliative care service provision), contacted community pharmacist, locality manager and ward manager at Chalmers Hospital to see if it would be possible to access to relevant.
- The drugs would be accessible to GP’s, Community Nurses and out of hours service (trained nurses only) and would be accessed only by prescription sheet, or fax from G Docs.
- Prescribed drugs signed out from ward with ward staff checking expiry dates and replace used drugs.
- Review regularly at an agreed time, with users and relevant GP’s will replace drugs by stock order.
- Information relating to community pharmacist who normally provided out of hours medication available at base, this service would be ongoing.
- Community Pharmacist will provide a local guideline for users.

**Outcomes**
No further delays in accessing prescribed medication has occurred and the service is accessible to all local GP’s, Community Nursing Teams and out of hours service. Eliminate unnecessary anxieties for staff, patients and relatives.

**Addition Reading/Information**
Title

Integrated Care Pathway for Prevention and Treatment of Dry Skin

Brief Summary

Issues

226 children (under 5 years) in a practice population circa 22,000 prescribed emollients in 2002 implying the need for a dry skin clinic. (Average waiting time for a dermatology appointment at that time was approx 9 months).

Action

A review of the literature illustrated that research has shown dry skin clinics are an effective way offering support to clients with dry skin while improving family dynamics e.g. improvement with sleep patterns and a better understanding of dry skin conditions. Development of an integrated care pathway is an effective way of working together within the primary health care team.

Outcomes

- An integrated Care pathway has been developed
- Dry skin clinic for children 0-5 years run by health visitors in liaison with the GP’s has been established

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name Ethel Wilson
Contact Details Peterhead Health Centre
Tel. No 01779 482557
E-mail ethel.wilson@peterhead.grampian.scot.nhs.uk

Title Wound Care Development Group

Brief Summary

Issues
- To standardise wound assessment, treatment, evaluation and documentation within Peterhead Locality.
- To identify and address educational needs.
- To disseminate information regarding wound care research, initiatives and treatments.

Action
- Group consists of actively interested representatives from each area of nursing i.e. district nursing, treatment room / practice nursing, GP acute ward and long stay ward.
- Group meets every eight weeks.
- Sub-groups are formed to work on specific areas as requested/required.

Outcomes
- A group member has achieved RGU certificate in Wound Care.
- Education needs are constantly identified and addressed as required.
- Feedback from GPCT Clinical Development Nurse is discussed and disseminated to departments.
- Departments have implemented SIGN guideline 26 for patients with leg ulcers.
- Establishment of networking within and outwith departments to “deliver best practice” holistic wound care.

Addition Reading/Information

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
**Sharing Experiences & Learning**

<table>
<thead>
<tr>
<th>Name</th>
<th>Fiona Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Details</td>
<td>Casualty Dept, Chalmers Hosp</td>
</tr>
<tr>
<td>Tel. No</td>
<td>01261 819127</td>
</tr>
<tr>
<td>E-mail</td>
<td></td>
</tr>
</tbody>
</table>

**Title**

**Nurse Led Wart Clinic**

**Brief Summary**

**Issues**

Viral warts are often considered a minor skin condition by health professionals, but to the infected client they can be a major problem causing pain, embarrassment and worry. When treatment is sought by a client a holistic approach should be adopted. Treatment choice should be acceptable to the client and dependant on the clients age type, site, and number of warts.

**Action**

- Develop research based client assessment protocol determining suitability of cryotherapy for treatment.
- Increase staff knowledge of wart histology and treatments available through training.
- Produce client centred information booklet on viral wart management.

**Outcomes**

- Provision of information booklet enabling clients to make an informed treatment choice.
- Increased success rate in wart resolution.
- Improved level of confidence in staff’s knowledge and treatment of warts.
- Provision of an improved level of care and service.

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Title

**Drop in Clinics**

Brief Summary

**Issues**
In October last year, after discussion with the GP’s, we started a ‘Drop in’ clinic for the elderly. It was designed so that anyone over 65 years could access the community nursing team for advice on any aspect of health care either before they became eligible for an over 75 health check or if any problems arose between health checks. The kind of things we envisaged people would use it for was advice on: - Diet; Exercise; How to access Social Services; Benefits; PAM’s; Continence Problems; Bowel Management and BP checks. It also gave us the opportunity to ask mobile patients with wounds, in particular, leg ulcers to attend the clinic rather than us visit them and to follow up over 75 health checks. For instance if anyone presented with a raised BP or ear wax we could ask them to come along to the drop in clinic rather than refer them on to the practice nurse.

**Action**
A time was arranged when the treatment room was free and in addition to putting up posters in the clinic and the local chemist we advertised the service in the practice leaflet.

**Outcomes**
- In the months we have been running the clinic most of the people we see have been asked to come either by ourselves or by the GP, mostly for wound care. Very few have just ‘dropped in’. This may be because of lack of awareness of the service. Although it was included in the yearly practice leaflet sent to every patient very few people when asked, were aware of it.
- In conclusion, although the original concept of a drop in clinic has not materialised the community staff find it useful to have this one-hour a week access to the treatment room to see patients we would otherwise have to visit at home or refer to the practice nurse. Also in view of the fact that the over 75 health check as it is at present is likely to disappear, it may in future provide patients with no particular chronic condition with an opportunity to see a nurse.

**Addition Reading/Information**

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering Quality Care</td>
</tr>
<tr>
<td>Shaping a multi-Disciplinary Future</td>
</tr>
<tr>
<td>Developing Capability and Capacity</td>
</tr>
</tbody>
</table>
**Sharing Experiences & Learning**

Name: Moira Milne

Contact Details: Buchanhaven Ward, Ugie Hospital

Tel. No: 01779 472011

E-mail: ugie.hospital@gpct.grampian.scot.nhs.uk

**Title**

Core Nursing Assistant

**Brief Summary**

**Issues**
Identified that patients were receiving insufficient diet and fluids at breakfast time due to existing structure. All breakfasts given previously whilst patients were still in bed.

**Action**
Appointed 2 core nursing assistants who work from 8am – 4pm, over 7 days per week. Their main duties consist of attending to dietary needs of all 30 patients at breakfast. Breakfast time ranges from 8am till 11am and this informal approach to breakfast allows patients to be up and dressed and sitting in the dining area, where appropriate, instead of being fed in bed.

**Outcomes**
The introduction of the core ‘A’ grade nursing assistants has improved the breakfast experience for the patients on the ward. In addition it has increased the dietary and fluid intake and has made it a more social event for patients.

**Addition Reading/Information**

Category

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Title  
Banff & Buchan Nurse Led Secondary Prevention Clinics in Primary Care

Brief Summary

Issues

- Banff & Buchan has a high incidence of CHD.
- Project proposed to introduce structured care for patients with established CHD. Focusing on areas where there is good scientific evidence that intervention is of benefit.

Action

- After funding and acceptance from NHS Grampian and the Scottish Executive, a lead group was established and a managed clinical network developed.
- Set up local training for Nurses and GPs
- Set up local support networks
- Visited all 14 Practices to give support.

Outcomes

- 12 out of 14 Practices now running structured CHD Clinics.
- The extra funding has enabled Practices to increase nurse time to provide local services ensuring patients receive the most appropriate care in the most appropriate setting.

Addition Reading/Information

- Thain, Campbell and Deans 1997 Cardiac Clinic and Nurses Manual

Category

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Tracy Johnston
Enrolled Nurse

Contact Details: Ravenscraig Ward, Ugie Hospital
Tel. No: 01779 472011
E-mail: ugie.hospital@gpct.grampian.scot.nhs.uk

Title: Care Planning Standardisation of Documentation

Brief Summary

Issues

After receiving documentation audit from Terry Walton, SHAS Coordinator, it was highlighted that there were no clear systems of documentation being followed by the Primary Nurses on Ravenscraig Ward.

Action

During a ward meeting documentation was discussed and documentation guidelines agreed and set out. E/N Robertson who has special interest in care planning, devised standard statements of care which should be expected whilst on the ward. Also, folders with care plans are now kept at patients’ bedsides for ease of reference.

Outcomes

There is now a clear, standard documentation on the ward which is individualized to the patient’s needs in conjunction with patients and relatives.

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Title

**SVQ3 Training in Care Diagnostic and Therapeutic**

**Brief Summary**

**Issues**

The Government’s strategy and policy to maintain and support the Older Person at home for as long as possible would require increased input from Carers, Physiotherapists, Occupational Therapists and Podiatry. Each Professional body has difficulties in recruiting to their speciality.

**Action**

- To identify 5 or 6 nursing auxiliaries to undertake SVQ3 training in Care and Diagnostic and Therapeutic Care.
- To identify Assessors to support staff and lead them through Nursing, Physiotherapy, Occupational Therapy, Podiatry Units.
- To arrange Training sessions with the Professional Development Team to cover aspects of the syllabus eg. First Aid programme would cover the unit regarding emergencies.
- To arrange block training sessions with Physiotherapy, Occupational Therapy and Podiatry.

**Outcomes**

- To develop a team of staff with wide ranging skills.
- To allow the team to support clients in their own homes should they require intensive therapy and not necessitate a hospital admission.
- To support the AHPs by continuing treatment to patients, in the hospital, during their absence, hopefully resulting in early discharge from Hospital.

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Volunteering in a hospital environment

Brief Summary

Issues

There are many ways in which volunteers can enhance a patient’s stay in hospital, without encroaching on nursing or therapy duties. We are continually searching for ways to involve the public in our Organisation and this is another way to do so.

Action

• We have already identified a number of young adolescents interested in participating with patients.
• We need to identify others eg. Mature adults, young children.
• Contact with NAVN [North Aberdeenshire Volunteer Network]
• Contact with Nurseries.
• Advertise in Local Press for interested parties.
• Identify areas that will enhance the patients quality of life eg. Reading to patients, taking patients for walks, hand massage - to name a few.
• Set up meeting with volunteers to ascertain their skills and what they may have to offer.
• Arrange appointment to these roles as per The Trust’s Policy.

Outcomes

• To have a group of people wishing to interact with patients in Ugie and Peterhead Community Hospitals, enhancing and stimulating their quality of life.
• By inviting and encouraging the public to work alongside Health staff, we would be fostering good relationships.
• At a very basic level, the public will start to have an understanding of the functions of the Community Hospitals.

Addition Reading/Information

**Sharing Experiences & Learning**

**Name**  
Diane Noble & Findlater Staff

**Contact Details**  
Chalmers Hospital, Banff

**Tel. No**  
01261 819173

**E-mail**  
Diane.Noble@gpct.grampian.scot.nhs.uk

**Title**  
Supporting the care for elderly people in our community suffering from memory problems.

**Brief Summary**

**Issues**
Our unit supports assessments for memory problems in the elderly, this allows us to support their families, whilst they remain in an area, which is familiar to them, thus facilitating more accurate assessment of their needs. Many admissions to the unit are directly from the GP Acute Units in the Community Hospital (46% in the last three years). This helps ensure full physical screening is done initially locally. The people assessed within the unit only travel to Aberdeen for a (S.P.E.C.T) scan, this is done as an outpatient and is less traumatic as either family or familiar ward staff accompanies them. Being in the unit facilitates consistent results following assessment, as the persons life has been less disrupted than it would have been had transfer to Aberdeen been necessary (good family contact can be maintained and this is vital in assessing a persons memory).

**Action**
We have worked along with the Community Psychiatric nursing staff and are using the same assessment tool in the unit. This then allows us along with the resident, Consultant, relatives/carer, social work/care management to look at the best package of care for that person. Open communication with all disciplines involved is the key to good future care for people with memory problems. It is important to realize that the care package should be one that can allow that person to be cared for, for a considerable length of time in the environment that we, as part of the team, feel is best suited to meet that persons needs.

**Outcomes**
- Transfer to either Residential/Nursing Home Care, or remaining within our Unit if more specialized care is needed and has been identified following assessment.
- Making sure our elderly folks can spend their twilight years in the best possible and most comfortable place, which recognizes all their needs.
- To ensure that people in our community suffering from memory problems receive the best care for them at that particular stage of their illness.

**Addition Reading/Information**
- Understanding Dementia Richard Cheston & Michael Bender.

**Category**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
All Day orientation for Student Nurses in Orthopaedic Trauma

Brief Summary

The orthopaedic trauma unit regularly receive students on placements. It was identified that there was a need to standardise their induction/orientation so as to ensure that for example health and safety issues were covered to an appropriate standard. It was hoped that by developing an all day orientation duplication of effort could be eliminated and hence time saved.

Action

Clinical and Development Nurse Practitioner has developed an all day orientation for groups of student nurses commencing in orthopaedic trauma.

Outcomes

- Very positive evaluation from students
- Improved quality of orientation/induction
- Reduction in duplication of effort
- Important Health & Safety issues addressed
- Better preparation and education in orthopaedic nursing care

Addition Reading/Information

Brief Summary

Issues
The project was taken over by the HV’s in Sept 2002. All agencies/professionals involved with teenagers in Westhill were consulted. Project achievements to date were considered. Other teen health projects ongoing in Aberdeen and Aberdeenshire were contacted. The results of previous teen health surveys carried out locally were also analysed. Lots of good work with teenagers in the area is being carried out by independent agencies. However there was; overlap of activities; lack of communication between agencies; and little understanding of each others roles within the community

Action
A facilitated development day was organised for members of each agency to meet together and to establish a multi- agency group. The LEAP (Learning, Planning & Evaluation) process was used as a tool to identify how the project can progress.

Outcomes
Multi-agency group that meets on a monthly basis was formed, young people’s views are required to be determined and more directly involved in the development of services. The aim of the group is ‘to work in partnership with young people to promote healthy lifestyles and to develop appropriate services
The objectives are:
• to understand the scope of each others roles within the service;
• to develop a co-ordinate and complimentary approach
• to involve young people and to look at mechanisms of engaging them in the project
• to determine all of the services hat are already in place for young people in Westhill
• to determine availability of these services
• to research and learn from other projects locally and nationally
• to increase community awareness of the project

Addition Reading/Information
• Stewart, Donna (2002) “Our Young People are saying – ‘what we need is help wi’ life basically’
Sharing Experiences & Learning

Name
Jill Ferbrache

Contact Details
Tutorial Room, Basement,
Main Theatre Suite
Aberdeen Royal Infirmary,
Aberdeen

Tel. No
01224 553444

E-mail
Jill.ferbrache@arh.grampian.scot.nhs.uk

Title
Theatre Clinical Standards Group

Brief Summary

Issues

This group was established to identify standards in theatre nursing practice, to review and develop clinical standards and to provide guidance on best practice to all staff involved in invasive procedures. Issues within procedure areas can vary considerably; some of the issues the group have and are considering are patient transfer, theatre attire and patient safety.

Action

The group meets monthly to discuss issues relating to practice within areas undertaking invasive procedures. Core membership of the group consists of representatives from ARI (Main theatres, Day surgery, Radiology, GI, WD 38) Woodend, AMH and RACH. The first document to be produced sets the standard for the safe transfer of patients to and from procedure areas. The group is currently considering theatre attire and some of our medical colleagues have joined the group to discuss this standard.

Outcomes

- Consistency across all procedure areas
- Improved quality of care for patients
- Standardisation of practice for staff

Addition Reading/Information

• NATN Principles of Safe Practice
• Safeguards for Invasive procedures: The management of Risks. NATN, BARNA, MPS, CNORIS and RCN

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity

Architect of Change

Architect of Change

Architect of Change
"Sharing Experiences & Learning"

Name: Lorna Boyle  
District Nurse

Contact Details: Crimond Medical Centre

Tel. No: 01346 532215

E-mail: lorna.boyle@crimond.grampian.scot.nhs.uk

Title:

**Chronic Oedema Keyworker Clinic, Banff & Buchan - established 2001.**

Brief Summary

**Issues**

Keyworker clinics provide assessment for all patients with chronic oedema and treatment for all patients with mild uncomplicated oedema.

**Action**

- Keyworker clinic is held at Saltoun Surgery, Fraserburgh every second Monday – screening patients of Banff & Buchan.
- Referrals are accepted from GP’s, Consultants and Breast Care Nurses

**Outcomes**

- Treatment may consist of skincare, exercise, the fitting of compression garment and teaching the patient simple lymphatic drainage.
- Patients with moderate – severe and complicated oedema are referred to the Specialist Service in Aberdeen.

**Addition Reading/Information**

- David Carroll’s Palliative Care Guidelines on Intranet - Lymphoedema section Contact/Referral Details – 01224 558131

**Category**

Delivering Quality Care  
Shaping a multi-Disciplinary Future  
Developing Capability and Capacity
Name: Moira Wilson
Contact Details: Collieburn Day Hospital, Ugie Hospital
Tel. No: 01779 472011
E-mail: ugie.hospital@gpct.grampian.scot.nhs.uk

Title: Information Booklet Collieburn Day Hospital

Issues

Local Health Council identified the need for information for both clients and their relatives. Need was also identified by relatives themselves via our informal relatives support meetings.

Action

Information appropriate to the Day Hospital was gathered and compiled by staff then sent to Reprographics for an initial draft to be done. The draft was then circulated within the Old Age Psychiatry team for comments and copy sent to the Local Health Council.

Outcomes

- Draft completed by Reprographics

Addition Reading/Information

Category

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name          Kirsteen Coady
Contact Details  Macduff Health Centre
Tel. No         01261 833777
E-mail          kirsteen.coady@macduff.grampian.scot.nhs.uk

Title

Blood Pressure Clinic

Brief Summary

Issues
Due to the implementation of coronary prevention clinic within primary care, it was felt a new service was necessary to maximise services to patients and increase available Practice Nurse time. A joint BP/phlebotomy clinic would fill this need. This would develop staff and increase skill mix.

Action
An action plan was written and agreed. Essence of such was to ensure phlebotomist happy with developing role; training; education in blood pressure measurement; formulating a protocol; organising of clinic times; ensuring informed consent for patients (leaflet for patients indicating – new service with limitations); evidence based practice and to audit the service.

Outcomes
- Implementation of plan
- Phlebotomist welcomed increasing scope of role
- In house training implemented
- Phlebotomist to attend structured BP course
- Patients aware of new service and appointments with Practice Nurse and GP maximised
- Service to be audited 3/12 by practice manager
- Consider use of evaluation questionnaire

Addition Reading/Information

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity

Architects of Change
Sharing Experiences & Learning

Name
Rachel Unwin, Sue Spencer & Moira Gordon
Macmillan Nurses

Contact Details
Peterhead Community Hospital, Banff Health Centre & Fraserburgh Clinic
Tel. No
Peterhead 01779 482568, Banff 01261 819182, Fraserburgh 01346 585274
E-mail
rachel.unwin@gpct.grampian.scot.nhs.uk,
sue.spencer@gpct.grampian.scot.nhs.uk,

Title
Developments in Macmillan Nursing Service in Banff and Buchan

Brief Summary

Issues
Undergoing a settling in process with new staff members in the service and being part of current changes within Banff and Buchan in the field of Cancer and Palliative Care.
• Macmillan Service to work as a cohesive Team
• Improving services for people in the field of Cancer and Palliative Care
• Development of PMS Palliative Care Strategy Group with lead GPs.

Action
• To establish a coordinated approach within the Macmillan Nursing Service throughout Banff and Buchan.
• To work with the PMS+Palliative Care Strategy Group and local Cancer and Palliative Care Groups to improve services in the field of Cancer and Palliative Care.
• In conjunction with the above groups to be part of planning and implementation of education packages for health care professionals.
• Setting up clear processes for evaluating change and audit.

Outcomes
• These are yet to be measured but this will be pursued in due course.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Sharing Experiences & Learning

Name          Una Lyon
Assistant Director of Nursing

Contact Details Management Suite
Basement Main Theatre Suite
Aberdeen Royal Infirmary
AB25 2ZB

Tel. No      01224 553257
E-mail       una.lyon@arh.grampian.scot.nhs.uk

Title
Demand Management Down Under - An Allan Brooking Travel Fellowship

Brief Summary
Issues
The problems facing the NHS are real and need practical solutions. They include the inexorable increase in demand for emergency healthcare, an increase in the average length of stay, the effect of delayed discharges on capacity and progressively more challenging waiting list targets. Creative solutions are needed to manage demand.

Action
To visit Victoria Australia as their Hospital Demand Strategy is innovative, creative flexible and integrated focussing on a whole systems approach. In Feb 2003 I travelled with Deb Grant, Assistant Chief Executive to Melbourne and spent the first 7 days working with the Department of Human Services at the State Government of Victoria. They had prepared an extensive and at times exhausting itinerary which involved visiting different hospital sites and travel out into the bush.

Outcomes
We experienced initiatives developed as part of the Hospital Demand Strategy. These were aimed at improving people health outcomes and reduce the rate of growth in demand for public hospital services.

• We were impressed by RAT Teams based in A&E. These multi professional rapid assessment teams had prevented admissions to acute settings and increased the number of referrals to community services.
• Day of surgery admission rates were around 95% and included all surgical procedures. Robust pre admission championed by an anaesthetist meant that most patients presented on the day of surgery freeing up precious bed space.
• Medi Hotels co-located with receiving units where patients could undergo various assessment or investigations.
• Hospital In the Home which allows patients to have acute care undertaken in their own home and represented 11% of all acute activity.

Addition Reading/Information

• Demand Management www.dhs.vic.gov.au/ahs

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name                **Kirsteen Coady**

Contact Details       Macduff Health Centre

Tel. No               01261 833777

E-mail                kirsteen.coady@macduff.grampian.scot.nhs.uk

Title

**Coronary Prevention Clinics**

Brief Summary

Issues

Coronary heart disease is a major cause of death in Scotland. If this significant problem is to be addressed there is a need to provide a coronary prevention clinic with primary care ensuring equity of service and holistic approach to care. The target group included all patients who have ischaemic heart disease irrespective of age.

Action

- Plan of action formulated and agreed.
- Included – nurse time, creation of BP clinic, phlebotomy time, audit time.
- Recall system Training and Education
- Resource for home visits for elderly/housebound.
- Multi disciplinary approach. Skill Mix.
- District Nurses involved in combining with over 75’s.

Outcomes

- Holistic clinic within primary care implemented.
- Cluster clinics re co-morbidity implemented to avoid medicalisation of health states that is CHD clinic integral to diabetes service.
- Will re-evaluate in 3/12 and annually audit service and evaluate questionnaires considered to elicit patient views.

Addition Reading/Information

- Thain & Deans (1997) Cardiac clinic a nurse’s manual

Category

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Title
Implementation of guidelines for patients at risk of falls or who have fallen including guidelines on restraint

Issues
The Elderly and Rehabilitation service provides care for elderly patients and those receiving rehabilitation. Many of these patients are at risk of falls by definition of their disease process or underlying pathology.

- Many patients admitted to the Elderly and Rehabilitation Service are at risk of falls for many reasons. It was agreed with the Ward Managers that we would develop local guidelines which would improve patient care by assessing the risk of falls and addressing this as far as is practicably possible.
- There had been complaints from relatives that they were not always informed when the patient had fallen. This was particularly distressing if an injury was sustained which resulted in facial bruising or required further treatment.

Action

- A standard was agreed with all staff that relatives would be contacted as soon as possible after the patient fell to ensure that open communication was achieved.
- Guidelines were developed to ensure that staff knew what to do if a patient fell, when to seek medical support and when to alert the family of the event.
- The guidelines also enabled staff to undertake a risk assessment of the patient, identify any supportive action in managing the risk and how to produce a falls map.
- The guidelines also identify options around methods of restraint and the consent issues around managing this.

Outcomes

- The management of patients who fall has improved.
- Staff no longer think of cot-sides as a solution to patient falls but use nursing skills to identify causes of falling and potential solutions and or interventions to reduce the risk.
- Patients and relatives receive more open communication from nursing staff in relation to adverse events and options for their management.

Addition Reading/Information

- Guidelines available from Carole Ledingham
- Downton, J. Falls in the Elderly, 1992
- Willis, S, Falls in Elderly People: is the risk suitably assessed?, British Journal of Nursing 1998, Vol 7, no 20

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**The outcomes of recognising the relevance of postural management**

**Brief Summary**

**Issues**

MRU is a 16 bedded unit specialising in the rehabilitation of neurological diseases. Many of the patients receiving care within the unit have postural management issues which if unmanaged adversely impact on their wellbeing. Poor postural management over a period of time increases the risk of deformity and leads to individuals requiring intense care in the community. To reduce these incidents, maintain skin integrity and better maintenance over a prolonged period we have concentrated on sharing the values of positive postural management with all carers involved with the patient.

**Action**

The postural management team evolved within MRU to highlight issues associated with poor posture and the effect this had on the patient group. The team consists of a Consultant in Rehabilitation Medicine, Occupational Therapist, Physiotherapist, Specialist Registrar and a Staff Nurse. Regular meetings are held to assess patients’ needs and improve the delivery of care. The Integrated Care Pathway used in MRU has been revised to accommodate the postural management programme.

**Outcomes**

- Improved documentation in regard to postural management
- Information given to community staff re postural management needs
- Laminated photos of recommended programme beside bed, in NHS case Notes and given on discharge to the patient for care staff in the community to use as a reference tool
- All staff, patients and carers are aware of the importance of effective postural management.

**Addition Reading/Information**

- Information available in MRU in respect of positional management, Interhecal injections and use of Baclofen

**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Carole Christie
Ward Manager

Contact Details: Maidencraig Rehabilitation Unit,
Woodend Hospital,
Aberdeen

Tel. No: 01224 556216
E-mail: Carole.christie@arh.grampian.scot.nhs.uk

Title: Training for staff in relation to the management of patients displaying severe behavioural problems

Brief Summary

Issues
There has been an increase in the number of patients requiring neurological rehabilitation with severe behavioural problems. This was causing problems with the management of these patients and the level of care able to be delivered to this extremely challenging group.

• An increase of the number of adverse incidents involving staff being reported on a daily basis
• Stress levels amongst the nursing staff were obviously increasing
• Injuries were noted and in some cases resulted in absence from work
• Other patients were becoming affected by the intensity of the behavioural problems of other patients and were struggling to cope with this.

Action
• Risk Management Team provided specific training for staff in relation to Violence and Aggression
• Dianne Roberts from RMAS played an active part in supporting the staff by visiting the ward to oversee the situation and advise on future action to reduce adverse incidents.
• On going training for staff in the management of Violence and Aggression at Level 3 is provided for all staff

Outcomes
• Proper management of patients and staff in relation to Health and Safety and Risk Assessment of the individual
• Staff are confident and able to support each other thus reducing work related stress
• Staff have a different perspective in relation to dealing with patients with challenging behaviour. They are confident in conducting and individual needs assessment which involves the selection of appropriate staff to oversee the patient and set time limits on each member of staff’s involvement to reduce the onus on each staff member.

Addition Reading/Information

• Information available from MRU and Dianne Roberts at RMAS

Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Architects of Change
Architects of Change
Architects of Change
Title

Adaptation of environment to suit patient needs

Brief Summary

Issues
Maidencraig specialises in rehabilitation of neurological impairment, chronic and acute disorders including acquired brain injury. A change in patient culture and behaviour instigated the necessary action.

- Patients requiring 4 – 6 members of staff to keep them in bed
- Patients requiring constant close supervision in the ward area
- Patients requiring constant supervision from a distance due to behavioural issues
- Patients being admitted from home who were independent at crawling in their home setting and who found adapting to a hospital environment challenging

Action

- Discussed increasing problems with management of patient group with CNM
- Spare mattresses freed up from reprovision of post acute services were delivered to the unit
- Beds were removed from the rooms of affected patients and floor space covered in mattresses to allow patients to have more freedom and use less staff - Risk assessments completed for patients and staff and
- Input from Manual Handling & Risk Advisors ensured health and safety issues kept to a minimum.
- Assessed patients are nursed on the floor on mattresses without the need for constant supervision

Outcomes

- Patients sedation can be reduced without the need to keep them in bed
- Rooms can be altered to suit individuals needs. Some have padding on the walls to reduce injury to themselves.
- Costs for additional nursing staff is almost eliminated
- Less risk of violence and aggression towards staff as a result of improved patient management
- With the successful management of this patient group following a pilot period, gymnasium type flooring was purchased (as suggested by the Director of Nursing). This specialised flooring allows easy and effective cleaning , reduces the risk of staff and patients injuring themselves falling through the gaps in the mattresses and ensures that the patient is nursed in an appropriate and safe environment

Addition Reading/Information

Taped Handovers

Brief Summary

Issues
Staff on the ward generally felt that the amount of time spent on giving the report was time that could be used doing other things. Also with the different shifts that staff are now working there are staggered start times that meant the report was having to be repeated therefore leading to further wasted time.

Action
The actual amount of time spent giving the report was audited over a period of time. We also tried to find any articles that addressed this issue and discussed among the team how we might save time while ensuring accurate and up to date information was readily available to staff coming on duty. As we do not have a huge turnover of patients on a daily basis we felt that using tapes would work. We wrote guidelines for the tapes and we also wrote a standard to be adhered to.

Outcomes
Considerably less time is now spent in giving reports. Taped handovers are available for every member of staff coming on duty and for bank staff there is also a printed sheet that they can keep during their shift that highlights relevant information that they need and will indicate when they need to refer to care plans for more information. All staff receive accurate and up to date information when they come on duty regardless of the time of day.

A more detailed tape made following the weekly case conference is available for staff to listen to when coming back from days off or leave. A daily changes tape is done towards the end of each shift outlining relevant changes in condition or care only.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Use of Photography to aid positioning and handling of patients.**

**Issue**
Due to the complex nature of stroke, many patients have very specific requirements in relation to their positioning and the management of muscle tone. Specialised seating is often used and guidance from the other members of the multi-disciplinary team is vital for optimum outcomes. The nursing staff often found that very detailed instruction had to be given in order to maintain a patient's position particularly when numerous items such as pillows, wedges and other chair/wheelchair attachments were involved. Care plans are always kept up to date but for less experienced staff it could be difficult for them to visualise how the patient should be positioned.

**Action**
Time was spent on in-service training within the ward so nursing staff would have a good understanding of the importance of tone management and the need for good positioning whether in bed or seated. A Polaroid camera was purchased from ward funds as it was felt that a visual prompt of how the patient should look when in their optimum position would be of great use. Discussion took place within the team as to how to manage the issue of using photographs and where they should be kept. Patients were also asked their views.

**Outcomes**
Photos are used when there were complex positioning issues to be addressed and are positioned on the patient’s wardrobe door right at the bedside for very quick and easy reference. Photos are dated when taken and if new ones are needed as positioning requirements change old ones are destroyed unless the patient wants to keep them. Care plans are still used to describe the way in which the patient should be positioned and reference to the photos are made. We have found that using photographs has enhanced patient care, as there is now no question as to how the person should be positioned. It has also acted as a prompt to relatives who will come and let us know if for example an arm has slipped from its correct position. We can then reposition the patient promptly and hopefully reduce the risk of damage to the limb.

**Addition Reading/Information**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Adaline Harvey
Title: Medical Support Nurse
Contact Details: Ward 6, Woodend Hospital, Eday Road, Aberdeen
Tel. No: 01224 556204

Hypodermoclysis Best Practice Guideline

Brief Summary

Issues
- Lack of evidence based practice for the delivery of hypodermoclysis
- Improve standards for patients receiving hypodermoclysis
- Evidence base for Hypodermoclysis in practice

Action
- Audit of Hypodermoclysis in practice
- Research and review of current literature on hypodermoclysis
- Training days planned and actioned
- Best practice document produced
- Cascade training pack developed and held on wards 4 ARI, 6, 15 and 21, Woodend and Beech Ward, Westview

Outcomes
- Each ward within the Elderly and Rehabilitation Service have a copy of the Best Practice Guidelines for hypodermoclysis
- Staff have attended ½ day study on hypodermoclysis
- Cascade training of Hypodermoclysis taking place at ward level
- Improvement of knowledge and understanding of issues surrounding hypodermoclysis
- Practice of Hypodermoclysis is now evidence based
- Staff more confident to undertake Hypodermoclysis in daily practice

Addition Reading/Information

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name  
Jean Stewart, Adaline Harvey  
Sally Kirkbride, Ruth Bryan

Contact Details  
Ward 6,  
Woodend Hospital,  
Eday Road, Aberdeen

Tel. No  
01224 556204

E-mail

Title

Nail Care Resource Pack

Brief Summary

Issues
The purpose of this work was to develop a resource pack and provide training to enable nursing staff to deliver skilled nail care.

- Patients with physical disability unable to care for own toe and finger nails.
- Detrimental effect of inadequate finger nail care: loss of esteem, risk of secondary infection, risk of trauma to patients or staff from long, badly maintained nails.
- Detrimental effect of inadequate toe nail care: risk of trauma, risk of secondary infection, risk of trauma to patients or staff from long, badly maintained nails.
- Detrimental effect of inadequate toe nail care: risk of trauma, risk of secondary infection, effect on rehabilitation from ingrowing or over long nails.
- Limited availability of Podiatry.

Action

- Nail Care Group set up.
- Evaluation of current practice.
- Development of Nail Care Resource Pack.
- Planning of training days.

Outcomes

- Each ward in Elderly and Rehabilitation Services has a Nail Care Resource Nurse, a Nail Care Resource Pack and Nail Care kit.
- Improved links with Podiatry Service.
- Podiatry service receiving more relevant information.
- Prompt action for patients whose nails require attention.
- Staff more confident when dealing with nail care.

Addition Reading/Information


Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Title

**Oral Care Resource Pack**

**Brief Summary**

**Issues**

This summary reports the development of resource pack and provision of training in Oral Care for the Elderly and Rehabilitation Service

- Lack of evidence and best practice guidelines as regards delivery of oral care.
- Links with dental staff.
- Standard of oral care.
- Evidence base for oral care practice.

**Action**

- Oral care resource group set up.
- Research of current literature on oral care.
- Series of training days arranged.
- Resource pack developed.

**Outcomes**

- Each ward in Elderly and Rehabilitation Services has an Oral Care Resource Nurse.
- Each Ward in Elderly and Rehabilitation Services has an Oral Care Resource Pack.
- Improved communication between Nursing Staff and Dental Services.
- Practice in oral care updated and follows current evidence as to best practice.
- Improved understanding of issues surrounding oral care and the effects of inadequate care.

**Addition Reading/Information**

**Sharing Experiences & Learning**

**Name**  
Jackie Williams  
Community Rehabilitation Nurse

**Contact Details**  
Horizons Rehabilitation Centre  
2 Eday Walk  
Aberdeen  
AB15 6IN

**Tel. No**  
01224 556884

**E-mail**  
Jackie.williams@arh.grampian.scot.nhs.uk

**Title**  
“Sexuality” – Empowering professionals to talk about sexual health issues with their patients.

**Brief Summary**

Issues
Rehabilitation nursing addresses not only the physical wellbeing of people with disability but also their psychological, social and cognitive needs. Sexuality is an integral part of an individual. One of the strengths of rehabilitation nursing is the opportunity for nurses to assess patients’ needs and plan them in a holistic way.

- Attitudes make it difficult for people to address sexuality/sexual health with patients. There are many myths and attitudes surrounding sex.

Action
- Sexual health addressed on assessment at first meeting with a new referral to CRNT
- A dialogue or script drafted and used if required.
- In-Service training for rehabilitation wards and a sexual health training pack available.
- Training/Workshops on use of P-LI-SS-IT model, basic awareness, erectile dysfunction and other rehabilitation nursing issues provided to nursing homes, community hospitals and other community colleagues.

Outcomes
- Sexual health needs addressed formally.
- Changes attitudes.
- Good therapeutic relationships established between patients and staff.
- Offers more choice to patients with disability.

**Addition Reading/Information**

- RCN Guidelines – Sexuality and Sexual Health in Nursing Practice March 2000

**Category**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Moira Bowie
& Substance Misuse Service Team

Fulton Clinic
Royal Cornhill Hospital
Aberdeen

01224 557877
Moira.Bowie@gpct.grampian.scot.nhs.uk

A Development Opportunity—Twelve Week Programme

This programme has enabled nursing staff at ‘D’ Grade and above to enhance their knowledge and skills relating to substance misuse. This has led to those completing the programme to successfully securing posts within the service. Others have returned to their existing post with greater understanding of substance abuse and treatment options.

Nursing staff are advised to discuss this initiative with their Line Manager as identified in their Performance, Appraisal and Development. The programme is advertised and circulated to all areas in Royal Cornhill Hospital.

Outcomes

• Three nurses have successfully secured posts in Substance Misuse Service and the programme has greatly assisted their transition into the Service.
• Ward staff who have experienced this initiative have greater understanding of assessment procedures and formulation of care plans.

• ‘Drug Misuse and Dependence – Guidelines on Clinical Management’ Department of Health, the Scottish Office Department of Health 1999, Pages 18-24
• Effective Interventions Unit, Substance Misuse Division, September 2002, Pages 75-139

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Architects of Change
Architects of Change
Architects of Change
Community Directory

This client group has a variety of complex social, emotional and physical needs which cannot be met within session times. Whilst referring them to other agencies within the city, it was felt that clients could access additional help and support from other services. There were also uncertainties regarding contact numbers, names of opening hours of such services.

Action

It was felt that a community directory was needed. A group was formed which met on a regular basis to obtain and discuss information leaflets from services known to the Substance Misuse Service. Some members of the group even visited some of the lesser known services.

Further information was obtained from Grampian Caredata which revealed more names, organisations and support networks. Other services and organisations were also invited along to give our staff an overview of the services on offer. The information was then condensed on A4 pages and kept in a ring binder known as ‘Community Directory’.

Outcomes

- A comprehensive, user-friendly Community Directory is now available to all staff within the SMS.
- First hand information can be accessed by our clients to enable them to access other agencies.
- Staff with the SMS are able to cater for more of the clients’ needs.

Addition Reading/Information

**Individual and Group Social Time**

**Issues**

Through a health promotion programme a need was identified to provide quality time to clients, to bring structure to their day, to look at holistic care and to motivate clients to take up hobbies they did prior to hospital admission.

**Action**

Staff identified a process of planned time being spent on an individual or group basis. All time spent is recorded on an individual chart, length of time etc in order to audit and evaluate the service. Over time the time spent and activities offered increased as staff and clients witnessed the benefits of spending time outwith hospital setting.

**Outcomes**

- Staff and clients have better therapeutic relationship.
- Staff gained confidence to take clients on holidays, highlighting the change in the clients outwith hospital settings.
- Less incidents of aggression as quality time was being spent with clients, what they wanted to do.

**Addition Reading/Information**

- Journal of Gerontological Nursing April 1998 ‘Nurses know that to change behaviour, more than information is necessary. Have you found any motivational strategies that are particularly successful?’
**Sharing Experiences & Learning**

**Name**  
Tracy McCabe

**Contact Details**  
Substance Misuse Service  
Fulton Clinic  
Royal Cornhill Hospital  
Aberdeen

**Tel. No**  
01224 557877

**E-mail**

---

**Title**  
Safe Injecting

**Brief Summary**

**Issues**  
Not all clients accessing the Substance Misuse Service are abstinent from IV Heroin use. As well as our service providing substitute treatments, there is a need for the education on and promotion of safe injecting and raising the awareness of the possible complications of IV use. Many clients attend A&E departments or are admitted to hospital due to their lack of knowledge on the correct action to take if complications arise.

**Action**  
A Substance Misuse Service keyworker with a sound knowledge of safer injecting and the possible complications compiled an information document. A copy of this was given to all Substance Misuse keyworkers. Following this, care plans were devised with each care plan focusing on one complication e.g. abscesses, deep vein thrombosis, and the actions that should be taken and advice to be given by the client’s keyworker.

**Outcomes**

- All staff have their own information document for reference. New staff members will be given the document and will therefore be aware from the onset of the possible complications, reasons for the complications and advice to be given to the client on safe injecting.
- The care plans ensure that all staff follow the correct procedures, and that the correct advice is given to clients and documented.
- With all staff having a greater awareness and understanding, abscesses etc are treated quickly and effectively, therefore reducing the risk of further, more serious complications and hospital admissions.

**Addition Reading/Information**

- The Safer Injecting Handbook  
  www.saferinjecting.org
Sharing Experiences & Learning

Name  
Brian Smith  
& Specialisms Directorate  
Management Team

Contact Details  
Fulton Clinic  
Royal Cornhill Hospital  
Aberdeen

Tel. No  
01224 557843

E-mail  
Brian.Smith@GPCT.grampian.scot.nhs.uk

Title  
Service Improvement Process

Brief Summary

Issues
A joint review of health, social work and voluntary sector services for substance misuse in rural Grampian.

• The introduction of Generic Standards by the Clinical Standards Board for Scotland.
• The Joint Futures Initiative, which aims to integrate health and social care in substance misuse treatment.
• Opportunity to develop evidence-based practice in a new service.
• The need for common assessment tools and procedures for the new integrated service.

Action
An audit tool was devised following a short pilot audit which aimed at gathering the right kind of information in a logical and meaningful way. The audit involved sensitive negotiation of access to the notes of clients from the nursing service, local authority, social work drug team and a voluntary sector counselling service.

Outcomes
• Significant reduction in waiting list.
• Development of assessment tool.
• Development of Care Pathways.
• Identification of issues for further research.
• Implementation of CSBS standards.
• Baseline scores for quality of assessment, planning and documentation.
• Identification of best practice.

Addition Reading/Information

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Sharing Experiences & Learning

Name
Rehab Outreach Team

Contact Details
Rehab Outreach Department
Old Admin Building
Royal Cornhill Hospital
Aberdeen

Tel. No
01224 557601

E-mail

Title
Staff Safe Call System

Brief Summary

Issues

- To provide a safe call system for community staff in the Outreach Team.
- To ensure staff safety at end of working day.

Action

One member of the team is nominated every week to hold pager. All staff are allocated numbers and at the end of the day they page in those numbers. The person holding the pager calls into 24 hour staffed unit to report their safety. If there is not a call from any member of staff then there is a checklist of actions eventually leading to contacting police.

Outcomes

- All staff are accounted for at the end of the day.
- A safe working environment is provided.
- Staff are more aware of personal safety.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Clinical Area Profile**

**Issues**
Ward Managers and Heads of Department within Specialisms Directorate, GPCT, were found to be functioning at inconsistent levels with one another. A system needed to be put in place in order to ascertain a baseline at which each manager would be operating from and it would constitute their profile.

**Action**
- An audit tool was devised to monitor nursing practice and standard.
- Directorate Management Team working with, and supporting ward based staff in improving standards.
- Audit tool centres around all aspects of the day to day running of the Ward/Department involving: Staffing, Policies & Procedures, Patient Care, Training & Development.

**Outcomes**
- Ensure that nursing practice meets quality assurance and evaluation in keeping with recommendations of evidence based methods.
- Be open and transparent to users and carers of the service.
- Consistently deliver the highest quality and most appropriate care to each patient.
- Ensure that managers and their staff are following clear guidelines within current national legislation, NMC and NHS Grampian Policies & Procedures.

**Addition Reading/Information**
- ‘Designed to Care’ Scottish Office 1999, April
- ‘Clinical Governance’ NHS MEL (1998) 75
- ‘Goals for Clinical Effectiveness’ MEL (1999) 76
Title
Development of a clinical governance template for lone workers

Brief Summary

Issues
It was clear that the ability to demonstrate effective clinical governance with lone or single workers was difficult. A template to assist these staff was developed in conjunction with the staff concerned, the CNM and the Clinical Governance Manager. Clinical Governance and role competency is an integral of the appraisal mechanism within the Elderly and Rehabilitation IPDR framework. Staff working alone wished to be able to demonstrate that they were cognisant of the issues affecting them and develop a strategy for managing this.

Action
The staff affected by this met together and identified the problems they were experiencing and the concerns that they had. It was clear that many of the issues were the same and that a clinical governance template for the staff to use would be beneficial. It was agreed that this template should be a live document and that staff should be able to add to it as issues arise and file issues as they are resolved or completed.

Outcomes
A template was devised by the group and agreed for use. It is a simple tool which divides up in to the six main clinical governance categories of audit, risk management, evidence based practice, staff performance, review and feedback and ‘my job’. Each category is divided in to three; a section for ‘completed’ a section for ‘on-going’ and a section for ‘developing’. This has proved to be very useful for staff and is included as part of the on-going individual performance and development review.

Addition Reading/Information


Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Development of scald prevention guidelines in elderly care

Brief Summary

Issues

Guidelines were developed to reduce the incidence of scalding injuries in the Elderly and Rehabilitation Services. A number of patients had been identified through the Occurrence Reporting system as having sustained a scalding injury whilst in hospital. These injuries were usually sustained on the patient’s chest region or in their lap resulting in significant levels of pain and reducing the ability of the patient to be able to participate in their own rehabilitation or take part in therapies. It was felt that we were lacking in an essential element of patient care by not addressing this issue.

Action

An initial audit was undertaken of all Occurrence Reports to identify the size of the problem. Fortunately the numbers involved were small but the impact of the event was significant for all involved. An audit was undertaken to identify the temperature that patients were served hot fluids at by the audit team from the Facilities Department. An assessment tool was devised providing a risk score for patients based on their clinical condition and other related pathology. A ‘safe’ level of 55°C of provision of hot fluids was agreed with the Health and Safety Department as being palatable for patients deemed at risk of scalding and within acceptable limits in terms of scald prevention. A method of ensuring that fluids offered to at risk patients was devised and Domestic staff were educated in the preparation of fluids to meet the 55°C rule. Patients were risk assessed and a symbol placed above their bed to inform of their level of risk. A similar symbol was attached to the Tea Trolley to provide information for patients not at their bed side if hot fluids were offered.

Outcomes

- To date no patient who was identified as being at risk of scalding from hot fluids has sustained an injury as a result of spilled hot fluids.
- Family members are educated on this information regarding their nearest and dearest before discharge from hospital and shown how to provide fluids at the 55°C rule.

Addition Reading/Information

Name: Julie Davidson & Pauline Donaldson, 
Child Health Practice Educators

Contact Details: Office 2, Management Block, 
Royal Aberdeen Children’s Hospital, Aberdeen, AB25 2ZG

Tel. No: 01224 552799

E-mail: julie.davidson@arh.grampian.scot.nhs.uk

Title: Child Health Staff Nurse Development Programme

Brief Summary

Issues

- Support for newly registered nurses
- Understand and practice the concepts of holistic care through the child’s journey
- Encourage flexible, confident working and the use of transferable skills in different areas of the hospital.
- For the registered children’s nurse to follow a competency based framework to a level of emancipation.

Action

Newly Registered Paediatric Nurses have had the opportunity to undertake a Development Programme since 1997. The Development Programme was designed to ease the transition from student to registered nurse, as well as to promote life-long learning. The Aim of the Programme is to provide a structured pathway for all newly registered children’s nurses, promoting and encouraging personal and professional development.

Outcomes

- We are currently the only Paediatric Hospital in Scotland offering a Development Programme of this kind for Newly Registered Nurses.
- The supporting documentation has evolved and now comprises of orientation, preceptorship, continuing professional development, appraisal, competencies, reflective practice, core mandatory training days, study sessions.
- Recruitment: applications from out-with Grampian appear to have increased significantly, the factor common to all enquiries is the Development Programme.

Addition Reading/Information

- Nursing & Midwifery Council (2002) Supporting Nurses and Midwives through lifelong learning

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
**Constipation in Children**

**Issues**

Children with constipation are admitted to the ward for bowel clearout. However it was found that many of these children were requiring further admissions for bowel clearout. The aim is following bowel clearout, to treat constipation with minimal intervention in the home setting, preventing re-admission.

**Action**

- We provide telephone support and advice to parents whose children suffer from constipation and also see them informally on the ward.
- Liase with Health Visitors, School Nurses and medical staff
- In liaison with medical staff, dieticians, pharmacists and incontinence advisor, an information package is being compiled for GP’s, school nurses and Health visitors, along with a package for parents.

**Outcomes**

- Fewer acute admissions to the medical ward
- Fewer repeat admissions
- Better supported & informed parents

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Title
Play Preparation for Children undergoing Dental extractions

Brief Summary

Issues
A visit to the Dentist, especially for dental extractions can cause a lot of anxiety in both children and their carers. Play Preparation given by a Play Specialist has been proven to help alleviate these anxieties and to help the child and their carer cope with their experiences. There are increasing numbers of children attending for dental extractions and because of the quick turnover of patients, it was found that there was rarely enough time to prepare the children sufficiently. Many of these children, because of the nature of the procedure, were found to be quite anxious on arrival.

Action
To provide Play Preparation for all children attending the Dental suite for dental extractions. This has now commenced.

Outcomes
- Children and their families are prepared at an appropriate level for their understanding, in a relaxed and child friendly environment.
- Families are satisfied with this service
- Many Anaesthetists and Dentists are satisfied with this service

Addition Reading/Information
Title

**Intermittent urinary catheterisation in children.**

**Brief Summary**

**Issues**

It was identified that support for carrying out catheterisation in children within the home setting was required. Inconsistency in communication between community and clinical professionals was also occurring. Any child who requires intermittent catheterisation attends the ward for teaching, either as an inpatient or day-case, depending on their geographical location. Documentation has been devised and implemented to allow seamless communication with all members of the multi-disciplinary team involved in the care of the child. This includes members within the acute, primary and community care settings.

**Action**

- Pre admission information and phone call
- Act as named nurse during child’s inpatient period
- Liaison with adult continent advisor, discuss discharge plan to ensure smooth transition from hospital to home setting.
- Follow up patient at home through telephone contact.
- Liaison with identified community staff member. This can be a Health visitor, district nurse or community nurse.

**Outcomes**

- Reduced length of hospital stay.
- Improve communication with all multi professional members involved with the child’s care.
- Identified family support. A named practitioner within the community setting is contacted. The child and family therefore have a named community and hospital named contact.

**Addition Reading/Information**

- Foulkes J E, Catheterisation in Schools, Astra Tach, Stonehouse.
Title

Use of lip balm to flavour facemasks for inhalation induction

Brief Summary

Issues

We have been using lip balm (Lypsal) to add a pleasant smell to our standard facemasks. A generous smear of lip balm on the inside of the mask gives off a strong smell, which can be washed off with detergent and water. Children are often anaesthetised by gaseous induction. Often these children are put off by the smell of the anaesthetic vapour and can be frightened of the appearance of the mask.

Action

• To improve the experience for all children undergoing gaseous induction.
• By offering them a choice of flavours to choose from, for their own facemask.
• Quite a ceremony can be made of the selection of a flavour, providing useful distraction and involvement of an anxious or reluctant child.

Outcomes

• This technique has proved popular with both children and their families.
• The children are more willing to have the facemask over their face.
• Many anaesthetists are satisfied with this service.

Addition Reading/Information

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Title

Play Preparation Programme for Children (Out Patients) attending MRI

Brief Summary

Issues

An audit showed that the play preparation programme for paediatric in-patients requiring MRI scan can help alleviate the need for a general Anaesthetic by empowering the child and family to undergo the procedure. The MRI scan requires children to lie still and be relaxed, as the scanner is noisy and children have to go in the tunnel. Many children also require an injection of contrast during the scan. It was suggested that children attending the department as Out Patients should also have the preparation service.

Action

To improve the experience of MRI scan for children and their families attending the department as Out Patients. We began to liaise and deal with referrals from MRI to see the family prior to their appointment and offer a play preparation session to help children deal with the experience.

Outcomes

- MRI staff now advise families to use Emla Cream if their child will require an injection. Referrals are sent to Play Department and many children are seen prior to the scan.
- The families are more informed and relaxed about the procedure. A Play Specialist may also accompany some children to offer extra support.
- Families are very satisfied with the service
- MRI department Satisfied

Addition Reading/Information

Paediatric Basic Life Support Training

Brief Summary

Issues
Paediatric and Adult Basic Life Support Training commenced in January 2003, for all multi-disciplinary staff. Alternate fortnightly, two hourly teaching sessions are held covering:

- Infant, child and Adult Basic Life Support.
- Choking infant, child and adult and 1st Line equipment.

Sessions are delivered by staff, who are all Basic Life Support Cascade Trainers.

Action

- Recommended that all staff caring for children have an annual update on basic life support.
- Throughout Child Health it was felt that clinical pressures are making it difficult to allow time to deliver Basic Life Support sessions.
- The sessions have a good attendance, and are on a first come first serve basis. Three places are kept available and can be pre-booked by staff who may have to travel a distance.
- Training is open to all disciplines - trained / untrained staff within NHS Grampian.
- Time is allocated during these sessions for open discussion and update of resuscitation issues.
- This session is also used to monitor and support our Cascade Basic Life Support Trainer skills

Outcomes

- The Trust Resuscitation Department supports and assists in delivering Adult/Paediatric Basic Life Support Training.
- Members of the multidisciplinary team learn together and share knowledge.
- Each candidate receives a teaching pack/Resuscitation Training Record Card
- An evaluation form is completed by the candidates at the end of each teaching session.
- Training is taught in a safe teaching environment with the appropriate equipment.
- The opportunity is provided for communicating, educating and developing skills within NHS Grampian

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Paediatric Intravenous Therapy Study Day

Brief Summary

Intravenous Therapy Training did not exist for Paediatric Nurses.

Action

In 1999 in conjunction with Jenny Mosely, Pharmacist RACH and Sister Sue Miles, the Paediatric Intravenous Therapy Study Day was devised. A pre-course workbook must be completed prior to attending the study day and clinical competencies achieved following attendance.

Outcomes

- A competency based training programme, empowering nursing staff to deliver safe, informed and effective care
- Exploring the possibility of delivering this course to student nurses
- An adapted version of the course has been delivered once to medical staff who currently receive no training on intravenous therapy – it is hoped that this will become a regular session, delivered to medical and nursing staff at the same time

Addition Reading/Information

- Nursing & Midwifery Council (2002) Guidelines for the administration of medicines

Category

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Paediatric Patient Controlled Analgesia Training

Brief Summary

Issues

There was an identified lack of formal training in the use of PCA/NCA devices within Child Health Services.

Action

• Audit of PCA training needs
• Development of a training pack by multi agency team
• Delivery of training sessions

Outcomes

• 3 monthly analysis of meeting training needs
• Increased awareness of delivery of PCA
• All trained staff competent and confident in the use of PCA/NCA devices
• Improvement in care delivery to patients

Addition Reading/Information

Sharing Experiences & Learning

Name
Heather Beattie, Leigh Ryrie, & Brenda McSporran

Contact Details
Play Department
Royal Aberdeen Children’s Hospital
Aberdeen

Tel. No
01224 553891

E-mail
HeatherBeattie@arh.grampian.scot.nhs.uk

Title
Play Specialist Clinic

Brief Summary

Issues
Medical and surgical procedures cause great anxiety in both children and carers. The Play Preparation programmes offered by Play Specialists have proved successful in helping families understand and cope with their experiences. Many individual children are referred by all disciplines for specialised play. Most having specific fears, concerns or postoperative issues. These children were seen in busy ward/play areas. Interruptions and lack of privacy was having a negative effect on the therapeutic sessions and proving stressful for families.

Action
To develop an Out Patient based Play Specialist Clinic. After discussions with Out Patient Manager and medical records staff, the Play Staff began promoting the clinic

Outcomes

- Referrals can now be assessed at a weekly Out Patient Clinic. This provides a more family friendly environment.
- We can now offer a more flexible effective service to meet the children’s and families needs
- Increase in referrals
- Families/Children well prepared for procedures/treatments
- More structured referral process
- Effective multidisciplinary working
- Families very satisfied

Addition Reading/Information


Category
Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
**Royal Aberdeen Children’s Hospital: ARCHIE’S PRE-ADMISSION**

**Brief Summary**

**Issues**
Pre-admission visits have been established in many paediatric hospitals over the last 15 years, and are recognised as beneficial in providing a high standard of family care and education. Pre-admission visits are also important in the context of worry mitigation as they offer an opportunity to inform and educate. Therefore in April 2000 the Royal Aberdeen Children’s Hospital ARCHIES PRE-ADMISSION CLUB was commenced in attempt to alleviate the child and their family’s anxieties prior to their admission.

**Action**
ARCHIE’S PRE-ADMISSION CLUB is held every Saturday morning between 10 – 11a m in the Day Case Unit. One Staff Nurse and one member of the Hospital Play Team typically run the club. Twelve children who will be attending hospital for a variety of treatments are invited to attend. The activities include (all with a hospital theme): dressing-up, puzzles, ‘playing’ with equipment, video, tour of theatre and wards. The atmosphere is relaxed and informal so those attending are able to ask questions.

**Outcomes**
Children and adults have found the club to be extremely beneficial. This has assisted the health care team to make the hospital admission a less daunting, stressful time for all. Fear of the unknown need not exist.

**Addition Reading/Information**

- Take heart: setting up a pre-admission day. Paediatric Nursing, February, 1997
Sharing Experiences & Learning

Name: Alison Leslie

Contact Details: A&E Department, Community Hospital, Peterhead

Tel. N°: Ext. 482421

E-mail: Alison.Leslie@gpct.grampian.scot.nhs.uk

Title

Soft Tissue Infections

Brief Summary

Issues

Due to the lack of appointments in the health centre many patients were presenting in the A&E department with non-emergency skin infections. In Peterhead A&E department the nursing staff also provide a treatment room service for the GPs, creating slight confusion for the patient in need of medical attention. After consultation with Medical colleagues it was identified that experienced nursing staff may diagnose soft tissue infections and an antibiotic prescription issued on a nurse’s clinical judgement.

Action

Key people (Senior nurse in A&E and Clinical Director of Community Hospital) worked together to develop a checklist for patients presenting with symptoms of soft tissue infections. This checklist identified

- Patient Details e.g. name, address, registered GP, date of birth and today’s date.
- Symptom Check e.g. duration of onset, surgical intervention, precipitating factors, anatomical area and size of infected area
- History Check e.g. allergies, oral contraception, current medication, diabetes, pregnant, epilepsy, eczema, immunosuppressed or hepatic impairment.
- Treatment e.g. swab to lab, prescription given, dressing, review date, nurses signature and Dr consulted.

Information gathered led to the development of an algorithm, giving nurses a framework to work from. Key people identified which nurses would be involved and the age group to be treated with this local policy.

Outcomes

To date 14 patients have been treated successfully using the protocol. Several benefits have emerged from this local development e.g patients can get quicker treatment without a GP appointment, it has improved communication between treatment room nurses and medical staff, it saves appointments in the health centre and new documentation implemented ensures safe practice and consistent treatment. It has also given the nurses an opportunity to plan care for follow up treatment.

Addition Reading/Information


Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Brief Summary

In Peterhead it had been identified there were a number of patients who had attended the Accident and Emergency Department with acute exacerbation of asthma and in need of urgent medical treatment. This situation had occurred out of hours when there was no Doctor on site. It highlighted the need for Nursing staff to identify and categorise these patients depending on their presenting condition and initiate immediate treatment without a Doctor.

Action

Key people, with special interests in Asthma were identified to work on this project and gather information, which complied, with the Asthma Sign Guidelines (Feb 2003). This led to the development of algorithms, which would allow the nurse to categorise the patients and initiate immediate treatment. The need for a Patient Group Direction was identified to allow Nursing staff to administer Salbutamol via a nebuliser. This document had to be submitted by the Medicines Unit for Grampian Primary Care NHS Trust. To ensure safe practice drug administration and accurate documentation were identified as training issues.

Outcomes

This project has been in place since March 2003. It has improved patient care by allowing Nursing staff to initiate medical treatment in an emergency situation, without a Doctor. It has promoted a systematic approach to treating asthmatic patients and it has standardised documentation ensuring base observations are recorded prior to treatment. This initiative has also led to the development of a Patient Group Direction for the administration of Salbutamol via a nebuliser, which has now been shared across Grampian. Identified training has increased knowledge and improved clinical practice, which provides a safe and better service for the patient.

Addition Reading/Information

Minor Injury Audit – Grampian Wide

Brief Summary

Issues
The development of Minor Injury Units across Grampian has been a successful initiative since 1997. The aims were to improve the quality of care provided to patients with minor injuries, reduce waiting times, improve patient satisfaction, provide individualised care by ‘named nurse’ practitioner and reduce the need to travel to the major acute hospitals. However, local audit and monitoring projects has highlighted a need to re-visit, on a Grampian wide basis, several areas associated with the Minor Injury service i.e. clinical governance, clinical grading and level of service provided.

Action
The Director of Nursing requested via the Trust Wide Clinical Governance Co-Ordinator that a Minor Injury Group be formed to look at the current level of service, and gather evidence to provide each local area with information from which to formulate action plans to take forward. This developed a working relationship with the Clinical Effectiveness Research Team who developed and implemented a 3-month audit. The aim was to visit all of the 14 Community Hospitals in Grampian, gather information and implement data for recording.

5 Projects were identified:
• Nurse Led Treatments at Minor Injury Units
• LHCC Demographics
• Competency levels and Level of Practice
• Documentation Audit
• Patient Satisfaction

Outcomes
The gathering of data is complete and a written report is in draft version. Results of the audit will be released to each LHCC for future development as soon as possible.

Addition Reading/Information
Interdisciplinary learning in a pre-registration nursing programme

Brief Summary

Health and social care professionals need to provide effective interdisciplinary care. Student nurses must be prepared for partnership working. There is a need to strengthen education to facilitate this.

Action

The Faculty of Health and Social Care (including the School of Nursing and Midwifery) (RGU) and Faculty of Medicine (Aberdeen University) participated in a pilot project to introduce students to the roles of the interdisciplinary team. Learning was facilitated in small groups drawn from all the disciplines. The purpose was to generate an appreciation of interdisciplinary working through the use of a case study. Students were asked to describe the likely range of health and social care needs of the patient and to discuss the contribution of the different disciplines.

Outcomes

Discussion took place around the potential challenges in collaborating and interacting with all healthcare professionals and ways in which mutual respect and communication can be enhanced through the recognition of the contribution and skills of other professionals. Qualitative student evaluation was positive and focused mainly on the value of developing knowledge and understanding of other professional roles at an early stage.

Addition Reading/Information

Sharing Experiences & Learning

Name

Llinos Gass
Senior Lecturer Practice Development

Contact Details

The Robert Gordon University
School of Nursing and Midwifery
Garthdee Campus, Garthdee Road
Aberdeen AB10 7QG

Tel. No 01224 262972

E-mail l.gass@rgu.ac.uk

Title

Standards to Support Student Learning in Practice

Brief Summary

Issues

In response to Caring for Scotland (2001) NHS Education for Scotland (NES) developed and published Quality Standards for Practice Placements (2003). Similarly the Quality Assurance Agency (QAA) Precepts 1-8 (2001) define the structure required of and for clinical learning locations - within the university and the clinical setting. The School and Service needed to review its current position with regard to the standards.

Action

In January 2000 a School and Service representative audience identified the current, future provision and development of the standards to support learning in practice from the perspective of strengthening three key areas and processes; Placement allocation to clinical learning - in the school; Learning in the practice setting; Post clinical placement experience – in school and service. The overall aim being to clarify the roles and responsibility of the school, service and students for effective learning in practice to occur and meet the standards defined by NES and QAA.

Outcomes

The current systems, processes, communication frameworks and quality of existing standards to support student learning in practice were examined. These were evaluated against those required by NES and the QAA precepts. New local standards were identified and prepared. These relate to the School, the placement location providers, mentors, students and to joint role involvement of School and placement location providers. The roles of each are defined pre, within and post clinical learning experience. The Shared Ambitions Collaborative Group support the standards generated as the desired requirements of the School of Nursing and Midwifery at the Robert Gordon University and NHS Grampian, Orkney and Shetland to support effective learning in practice by students. The Standards have been circulated for implementation both within the School and in clinical placement locations via each CLET. It is expected that user groups will develop action plans and an audit review process to reflect the achievement of the standards one year on from Sept 2003.

Addition Reading/Information

- NHS Education for Scotland (2003): The Development of Quality Standards for Practice Placements. NES Edinburgh

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Providing quality learning experience in the practice setting is viewed and valued by most and viewed as the key to preparing future competent practitioners. Over the years the School and Service have provided clinical learning opportunities to achieve this. However, there was no uniform system to ensure consistency, equity of learning opportunity offered and a method to share and reflect mentoring experiences.

**Action**

The managers of NHS Grampian, Shetland, Orkney and the Private sectors and the Head of School supported a proposal to develop Clinical Learning Environment Teams (CLETs) which would reflect the clinical grouping and management structure of the services provided used for the allocation of students. The CLET purpose being to: plan, develop and support student learning in practice and serve as a platform for communication and development activity with regard to evident based research, practice experience and teaching in the clinical area.

**Outcomes**

- 14 CLETs established

**Addition Reading/Information**

**Sharing Experiences & Learning**

**Name**  
**Fiona Work** Nurse Lecturer &  
**Dora Ashcroft** Lead Nurse

**Contact Details**  
The Robert Gordon University  
School of Nursing and Midwifery  
Garthdee Campus, Garthdee Road  
Aberdeen AB10 7QG

**Tel. No**  
01224 262956

**E-mail**  
f.work@rgu.ac.uk

**Title**  
**Supporting Students in Community Settings**

**Brief Summary**

**Issues**
A working group was set up to look at the issue of student’s community experience. Mentors within the link areas were very anxious how they could offer a quality placement. Clinical staff expressed frustration at students who “shadowed” them with no obvious purpose or clear learning outcomes. Ways of devising innovative practice which relieved the mentors of the extra burden of more students yet gave a quality experience were needed. Another issue was lack of internet access for students for literature searching.

**Action**
Dora Ashcroft at Portlethen Medical Centre devised individual learning objective/s and timetable with the student. From the objective/s the most effective method of achieving these was formulated. An exemplar could be a student wanted to learn more about care of a patient with multiple sclerosis. The mentor can time the student two days to formulate a care plan and deliver a summary of the aetiology, pathophysiology and care of the client. The student can access the internet, visit voluntary organisations or agencies or access the patient’s records. On the third day the student and mentor visit the client as a joint visit. After the visit the mentor and student spend time discussing the issues and care of the client. The mentor is able to facilitate bridging the theory/practice gap and is able to spend a shorter but better quality direct contact time with the student. The student is empowered and facilitated to become self directed in their individual learning style. The link teacher can provide the mentor with support or guidance to deliver innovative methods of teaching.

**Outcomes**
Innovative teaching in community placements; Mentor satisfaction in teaching role; High quality individualised learning experience for students; Short term solution for dealing with large student numbers met and became long term practice; Students now have Internet access whilst on placement; Students evaluated the experience positively; Students able to access literature for evidence based care.

**Addition Reading/Information**

**Category**
Delivering Quality Care

- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Rosemary McKechnie
Contact Details: Ward 40
Aberdeen Royal Infirmary
Forsterhill
Aberdeen
Tel. No: 01224-553260
E-mail: rosemary.mckechnie@arh.grampian.scot.nhs.uk

Title: A personal view of the RCN Leadership Programme

Brief Summary

Issues
12 month programme for nurses working across all aspects of front line patient care. It is an ideal opportunity to lead and affect change within the healthcare organisation.

Action
Focus on
- What patients and their families’ value through observations of care and patient stories
- Personal development and in turn whole team development
- Sharing of knowledge/support and challenge through action learning
- Increased political awareness

Outcomes
- The techniques used in this programme were new to me.
- I have found the emphasis on a patient focused approach to analyse issues, a powerful tool.
- The increased confidence to challenge appropriately in support of maintaining high standards of patient care.
- In this sometimes difficult climate, the support and camaraderie of the other participants is particularly valuable and I am confident that this will continue in the future.
- The training was particularly valuable to me as I was promoted to Clinical Nurse Manager during the programme. I feel that it has helped me to settle and develop in the role. I would strongly recommend everyone who is preparing to seek promotion and those already promoted to consider the programme.

Addition Reading/Information

Category
- Delivering Quality Care ✔
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity ✔
Sharing Experiences & Learning

Name: Susanne Raeburn-Burgess
Assistant Nurse Manager

Contact Details: Main Theatre Suite,
Aberdeen Royal Infirmary,
Aberdeen AB25

Tel. No: 01224 559511
E-mail: susanne.raeburn-burgess@arh.grampian.scot.nhs.uk

Title: Senior Nurse Forum

Brief Summary

Issues
There was an identified need to empower and support Senior Staff in their Leadership
competencies and duties and to facilitate a protected platform for reflection of their role and
performance. The Forum provides Senior Staff with an opportunity to share experiences and
learn from each other through discussions and academic input.

Action
The Forum meets regularly every 3 weeks for the 15 Senior Staff in General Surgery, Main
Theatre and Ambulatory Care. The sessions contain a range of internal and external speakers to
various topics related to leadership and managerial issues. In addition Senior Staff are asked to
reflect and critically appraise leadership and managerial theories and to bring them into context
with their daily work and performance. It also enables them to gain insight and knowledge of
leadership skills from out-with the health care setting and let them apply this knowledge to their
work area.

Outcomes
- Opportunity for Senior Staff to further develop leadership skills through enhanced self-
awareness
- Network within Clinical Group to share experience and gain an understanding of leadership
and management within various health care settings
- Exposure to leadership and management styles out-with the health care settings leading to
enhanced understanding and applications of core principles of leadership

Addition Reading/Information
Sharing Experiences & Learning

Carol Rollo

Name

Bed Management
Ward 31
Aberdeen Royal Infirmary

Contact Details

Tel. No 01224 552229
E-mail carol.rollo@arh.grampian.scot.nhs.uk

Title
Bed Utilisation within the Cardiac Clinical Group
(Coronary Care Unit Wards 19,20,32)

Brief Summary

Bed Management issues were of daily concern for the cardiac clinical group. It was decided to carry out an Audit to determine ways in which bed utilisation could be maximised.

Action

Following discussion with Senior members of Staff a Two month Audit was carried out to
- Determine reasons for closure
- Reduce the frequency of closure

Outcomes

Findings indicate that with
- Improved Communication
- Prompt involvement of Bed management
- Early identification of patients that could be decanted outwith the Cardiac Department

Bed utilisation within the Cardiac Unit could be maximised.

Addition Reading/Information

- Decanting a patients perspective audit available on GUHT intranet

Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Architects of Change
Name: Kathleen Duncan

Contact Details: Bed Management
Ward 31
Aberdeen Royal Infirmary

Tel. No: 01224 559210
E-mail: KDuncan@arh.grampian.scot.nhs.uk

Title: Nurse Led Admission Line for Acute Medical Admission Unit

Brief Summary

Issues
Emergency Admissions Project Team with GP were tasked to streamlining the medical admission process.
- To reduce junior doctor hours
- To free time for patient assessment and instigate management of patient
- To have continuity of contact, improving communication channels

Action
- Bed Management Team approached to participate in the introduction with this project with very favourable response.
- Meetings with pertinent members, pilot to be carried out — 4 weeks duration—07/10/02 until 01/11/02
- Referral form designed
- Evaluation of Pilot after 4 weeks -involved questionnaires to users of the Line — Internal and External
- Ongoing audit throughout the Pilot.

Outcomes
- 75 % of service users believe there are benefits to the patients
- 89 % of Jnr. Drs felt a positive improvement to their working pattern on the daytime receiving shift
- 94 % of junior doctors felt that their stress levels has decreased significantly
- 67 % of service users believed their calls were answered more timely
- 62 % of service users believed their calls were answered more promptly
- 100 % of junior doctors would like the pilot to continue
- 100 % of nurses in AMAU believe the information they get about admissions is timely and appropriate
- 100 % of nurses on AMAU feel there is benefit to the junior doctors
- 77 % of nurses on AMAU feel there is benefit to the patients
- Extension of Nurse Led Admission Line in AMAU planned for the period of 09/12/02 until 31/03/02

Addition Reading/Information

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name          Kathleen Duncan, Trish Hughes
               Janet Seaton, Caroline Gault

Contact Details   Bed Management
                   Ward 31
                   Aberdeen Royal Infirmary

Tel. No          01224 59210

E-mail          Kduncan@arh.grampian.scot.nhs.uk

Title

Decanting “A patients perspective” Audit

Brief Summary

Issues
Decanting is the term used to describe when a patient is moved from their own ward (Parent Ward) to another for the purpose of freeing up a bed for a patient whose condition necessitates admission to that ward.

The audit was taken to gain the patient’s perspective of the process.

• To assess the use of the decanting policy
• To monitor the patients being decanted – ensuring that they are generally moved only once

Action

• Decanting Check List redesigned on Formic & Bed Management Form designed
• Patient’s Diary designed – LHCC involved in this process
• Information packs delivered to each ward within ARI
• Bed Management completed their forms
• Patients visited by a member of the Bed Management Team and invited to complete a diary
• Wards visited from Monday – Friday to collect the Checklists

Outcomes

There were 586 episodes of Decanting within the period of the Audit.
Date collated for 416 patients.

• 363 (87.2%) of patients were decanted only once
• 59.5% of diaries were returned

• It was most reassuring to know that 88% of patients decanted continued to feel “cared for” whilst outwith their parent ward.
• 78% of patients had not been concerned about being decanted.
• Discharge planning continues to be an issue of concern

Addition Reading/Information

• Involving patients and carers patient Diaries http://www.modern.nhs.uk/improvementguides/patients/5_4.html
• National patient Survey-AcuteTrusts http://www.doh.gov.uk/acuteinpatientsurvey/

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity

Architects of Change
Getting people nearer to their own home - Community Hospitals

Brief Summary

Issues

- Patients can be transferred to their nearest Community Hospital for rehabilitation.
- Nurse Led Service.
- Joint working between acute and Primary Care.
- Improved Bed Utilisation.

Action

- Visit the patients referred to gain update on their condition
- Daily Bed State from Primary care available on PAS.
- Good multidisciplinary liaison between acute and Primary Care.
- On going audit reflects discharge planning within ARI and highlights any training issues at the Community Hospitals

Outcomes

- Patients are able to recover from their illness nearer their home
- Easier for relatives and friends to visit
- Improved bed utilisation at ARI and the Community Hospitals

Addition Reading/Information

- Community Hospitals Information pack available from Trish Hughes
- Audit results available from Trish Hughes

Category

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Learning To Lead

Issues

This submission describes a new short leadership programme developed for E and F grade staff nurses at GUHT. GUHT is well aware of the many policy drivers for leadership development for nurses and currently delivers the RCN Clinical Leadership Programme for G grades but has no provision for more junior staff wishing to develop leadership practices. Feedback received from senior nurses that filling this gap would be very desirable in order to deliver the modernisation agenda, to prepare junior staff for senior roles and to improve recruitment and retention at these grades.

Action

Pilot introductory leadership programme developed, to run for two separate intakes starting August 2003, 36 nurses in total. Funding received from NES to support the pilot, which they see as being innovative and providing a clear career pathway in clinical leadership for nurses in Grampian. Initial evaluation from participants wholly positive and enthusiastic. Evaluation report to be sent to NES in February 2004.

Outcomes

- Participants report greater awareness of role they have to play as leaders.
- More information will follow once the pilot programme has been evaluated in January/February 2004.

Addition Reading/Information

Sharing Experiences & Learning

Name: Alison Brown, Jason Nicol & Grahame Wright
Contact Details: School of Nursing and Midwifery, Robert Gordon University, Garthdee Road, Garthdee, Aberdeen, AB10 7QG
Tel.: 01224 262000 ext 2960
E-mail: a.m.brown@rgu.ac.uk
Title: Articulation of RGU students moving and handling teaching with practice within Grampian

Brief Summary

Issues

Concerns had been raised that within RGU, as we advocated and taught students the principles of safer handling, there was a theory practice gap occurring between Faculty of Health and Social Care and NHS Grampian. There were also differences between Schools within the Faculty.

Action

Multi-agency meetings were established to facilitate the development, sharing and adoption of common principles and core moves in relation to moving and handling.

Outcomes

- A core group has been established which meets on a monthly basis.
- Core moves and outline of moving and handling outcomes per year of the course are being developed.
- Principles and moves being taught throughout the Faculty are being standardised in order to mirror the teaching of moving and handling within NHS Grampian.
- Further developments to articulate more closely with risk management is ongoing.

Addition Reading/Information

Sharing Experiences & Learning

Name     Louise Brown
          Macmillan Lung Nurse Specialist

Contact Details     Clinic C
          Aberdeen Royal Infirmary
          Foresterhill
          Aberdeen

Tel. No     01224 554494

E-mail     louise.brown@arh.grampian.scot.nhs.uk

Title     Macmillan Lung Nurse Specialist and
          the Added Value of Nurse Prescribing

Brief Summary

Issues
The ultimate need to improve symptom control for patients with lung cancer or other respiratory illnesses and the evolution of nurse prescribing is recognised as an opportunity to improve the quality of care for patients with respiratory and oncological needs.

Action
• Need to recognise the importance of an integrated approach to change
• Open communication with pharmacy and ward medical and nursing staff
• Development of guidelines that adhere to trust policies.
• Ongoing education, training, networking, audit and evaluation.

Outcomes
• Smooth integration of new role as nurse prescriber into mainstream clinical team.
• Consistent knowledge and experience at times when junior medical staff and nurses are new to respiratory and oncological services.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name: Louise Brown
Macmillan Lung Nurse Specialist

Contact Details:
Clinic C
Aberdeen Royal Infirmary
Foresterhill
Aberdeen

Tel. No: 01224 554494
E-mail: louise.brown@arh.grampian.scot.nhs.uk

Title: The Role of Electronic Patient Record in improving communication and prospective care audit

Brief Summary

Issues
The need to improve communication between secondary and primary care is a critical element in delivering quality service. As part of a prospective audit to track all cancer patients through their journey of care the need for an Electronic Patient Record has been recognised.

Action
- The importance of using an integrated approach to change in both primary and secondary care was recognised.
- Open communication with all those personnel involved with patients and their families were acknowledged.
- Work towards the development of an Electronic Patient Record (EPR) system pilot has been initiated and after review is likely to be rolled out to other cancer types.
- Ongoing education, training and evaluation after five months with appropriate review.

Outcomes
- Smooth integration of new system into management team.
- Support staff involved in training and support of system.
- Ability to conduct prospective audit of SIGN and QIS guidelines in place.
- Improved communication with primary care.
- Improved communication and increased access of written information with patient.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Title  
Respiratory Clinical Support Nurse: a response to the problem of Junior Doctor’s Hours.

Brief Summary

Issues
The need for this post is the initiative to reduce junior doctors hours and to secure consistent quality of patient care. The evolution of this post offers continuity of the bronchoscopy service that previously alternated between junior doctors. The need to improve efficiency within the respiratory unit and associated wards for all patients requiring bronchoscopy has been acknowledged.

Action
• The importance of an integrated approach to change has been recognised
• Open communication between senior personnel essential to ensure agreed requirement has been established.
• Development of guidelines that adhere to trust policies has been initiated.
• Ongoing education and training through in-house provision with other disciples has been commenced.

Outcomes
• Smooth integration of newly created post into establishment of existing management team has been achieved.
• Appropriate allocation of resources facilitates the delivery of standards of care that meet patient expectations.
• Consistent knowledge and experience at times when junior medical staff are new to respiratory speciality.

Addition Reading/Information
**Sharing Experiences & Learning**

**Name**  
Christine Young

**Contact Details**  
Inverbervie Medical Centre  
Church Street  
Inverbervie  
DD10 0RU

**Tel. No**  
01561 361378

**E-mail**  
christine.young@inverbervie.grampian.scot.nhs.uk

**Title**  
Treatment Room Phlebotomy Clinics (Nursing Auxiliaries)

**Brief Summary**

**Issues**

Within Primary Care with more emphasis being placed on chronic disease management, the two practice nurses were looking at ways in which to free up time in order to provide clinics for patients with diabetes, asthma and coronary heart disease.

**Action**

Following discussion within the Primary Health Care Team it was agreed that the two community nursing auxiliaries who already did venepuncture in the community for housebound patients would provide the same clinical service within the medical centre. A protocol was devised and agreed with the team leader and practice nurses.

**Outcomes**

- From July 2002 a nursing auxiliary provide phlebotomy clinics 9.00 am – 11.00 am every Tuesday and Wednesday. 10 minute appointment intervals allow for 24 appointments per week.
- The practice nurses have gained an additional 4 hours per week (minus the 20 minute preparation of blood form requests the previous day, for each clinic) to devote to chronic disease management. N.B. The nursing auxiliary is not responsible for any clinic decision making, only for recognising which collection tubes require to be used for the request analysis.
- Less likelihood of patients having to wait as the appointment system is not being slowed by patients presenting with multiple health needs.
- The nursing auxiliaries have benefited from recognition of their role.

**Addition Reading/Information**

- GPCT Code of Behaviour Nursing Support Staff NHSG  
  Venepuncture Version 4

**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Helen Bedford
Seconded from clinical midwifery practice in GUHT

Contact Details: NHSQIS
Elliot House
8-10 Hillside Crescent
Edinburgh EH7 5EA

Tel. No: 0131 623 4286
E-mail: helen.bedford@nhshealthquality.org

Title: The Scottish Woman-Held Maternity Record (SWHMR) Project

Brief Summary

Issues
A unified, woman-held maternity record has been eagerly anticipated in Scotland for many years. This vision is finally being achieved as part of the implementation of ‘A Framework for Maternity Services in Scotland’ (SEHD, 2001). This exciting project is devising the SWHMR and associated guidance for staff. A sister project to develop an electronic version of the record (the eSWHMR) is also underway within NHS Scotland.

- Collaboration with a wide range of key stakeholders in maternity care who represent professional and lay interests
- Engaging with maternity units across Scotland
- Developing an integrated SWHMR and eSWHMR

Action
- Analysis of current maternity records
- Establishing a core clinical data set
- Developing the SWHAR and guidance
- Collaboration between the SWHMR and eSWHMR project teams
- National consultation on the proposed SWHMR and guidance

Outcomes
- A unified, multidisciplinary maternity record for Scotland, that is accessible to women and professionals
- A companion ‘secure’ electronic record, used for communicating, storing and accessing high quality maternity data
- The SWHMR Project is scheduled to report to the Scottish Executive Health Department in March 2004

Additional Reading/Information
- www.nmpdu.org

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Kate Campbell
Community Nurse Specialist for homeless People in Aberdeen City

Contact Details: Homeless Health Team
187 King Street
Aberdeen

Tel. No: 01224 644660 pager 07625460495
E-mail: Kate.Campbell@aicc.grampian.scot.nhs.uk

Title: Nurse Led Primary Care Health Service for Homeless and Hard to Reach people in Aberdeen

Brief Summary

Issues
Homeless and hard to reach people have for many reasons difficulty in accessing mainstream health care services. As a result of funding over the past 8 years, specialist health services for homeless people have been developed and led by the Community Nurse Specialist Team in Aberdeen City. Whilst we acknowledge the need for specialist provision of health services for homeless and hard to reach people it is important that access to mainstream health services is supported and further developed to prevent further marginalisation of this very vulnerable group of society.

Action
Services for homeless and hard to reach people include:
- An open surgery at 187 King Street with a GP available from Monday to Friday 12 noon – 1pm
- A substance Misuse CPN for drug and dependent clients on Wednesdays 9am-12noon
- An assertive outreach podiatry/chiropody service provided at 5 key locations on a rotational basis on Thursdays at 9.30am
- An assertive outreach dental service provided at 2 key locations on a rotational basis, using a mobile dental unit 1 day per fortnight
- One full time and one part time Community Nurse Specialists provide assertive outreach at various locations for homeless and hard to reach people
- A vacancy for a full time assertive outreach CPN is currently being processed

Outcomes
- A flexible user friendly service appropriate to the needs of homeless and hard to reach people
- Ease of access to other mainstream health services via advocacy from the Homelessness Health Service Team
- Addressing social inclusion

Addition Reading/Information

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
**Sharing Experiences & Learning**

**Name**  
Joan Rae  
Haemophilia Specialist Nurse

**Contact Details**  
Ward 16, Haematology Day Unit  
Aberdeen Royal Infirmary  
Aberdeen, AB25 2ZN

**Tel. No**  
01224 553357

**E-mail**  
Joan.rae@arh.grampian.scot.nhs.uk

**Title**  
Haemophilia Carrier Clinic

**Brief Summary**

**Issues**

I was identified that there was a need to establish a clinic to identify a group of women who are the sisters, mothers and daughters of haemophiliac men or boys who are not viewed as patients but are obligate or potential carriers of haemophilia.

**Action**

- To provide accurate information to allow these women to make choices on the reproductive risk and the feasibility of prenatal diagnosis in the first trimester of pregnancy.
- To identify carriers in whom there is a risk of bleeding and offer treatment or support as required

**Outcomes**

- Genetic testing offered to establish carrier status with follow up appointment to discuss the test results.
- Opportunity to increase awareness and educate females on inherited bleeding disorders.
- Discuss treatment options with haemophilia carriers who may have a risk of bleeding and make a plan to manage such episodes.
- A patient questionnaire is routinely used to assess quality of information given

**Addition Reading/Information**

- Kadir et al, Obstetric management of carriers of Haemophilia, Haemophilia, 2000, 6, 33-40
- United Kingdom Haemophilia Directors Organisation Guidelines, UKHDCO, 1997
- Tedgard, Carrier testing and prenatal diagnosis of haemophilia, Haemophilia, 1998, 4,356-695

**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name          Joan Rae
Haemophilia Specialist Nurse &
Scottish & Northern Ireland Haemophilia Nurse Group

Contact Details  Ward 16, Haematology Day Unit
Aberdeen Royal Infirmary
Aberdeen, AB25 2ZN

Tel. No 01224 553357

E-mail Joan.rae@arh.grampian.scot.nhs.uk

Title  Scottish & Northern Ireland Haemophilia Nurse Group :-
Peer support for specialist nurses

Brief Summary

Issues
• Working in a specialist area often means only one nurse for a large geographical area.
• Feeling of isolation, need for support, peer review.
• Need for sharing and comparing practice, service, protocols.
• The distance from colleagues in the rest of the UK, need to develop group which was easy to
  access.
• Differences in healthcare and legal systems from rest of UK therefore understanding at local
  and national level. Improve inter-centre relationships.

Action
• Haemophilia nurses from Aberdeen, Edinburgh, Dundee, Glasgow, Inverness and Belfast have
  met three times a year. We meet at a different centre for each session giving that nurse the
  opportunity to organise the venue and the guest speaker.
• Our group offers a forum locally to discuss clinical issues and acquire professional support
  which we believe is both valuable in our personal and professional development.

Outcomes
• Development of protocols and guidelines within centres.
• Sharing of information with patients about new developments and services.
• The specialist haemophilia nurse utilises the group as a phone advice service.
• They can refer patients to each other e.g. for holiday cover.
• Local knowledge of who to contact for further information.

Addition Reading/Information
• Manley K. (2000) Developing a culture for empowerment
  nursing in critical care. Journal of nursing and
  management 4:2, 327-328
• Sundin (2001) Information strategies and professional
  identity, a study of nurses experiences of information at
  the workplace; the Swedish school of library and
  information studies, Boras, Sweden

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name: Leslie Quirie
Contact Details: West Lodge
              Dr Gray’s Hospital
              Elgin
Tel. No: 01343 567340
E-mail:

Title: Clozapine Clinic

Brief Summary

Issues
The administration of Clozapine requires regular blood monitoring. Weekly, two weekly or four weekly blood tests were carried out on different days. It could be difficult accessing SHO’s to take blood samples.

Action
• It was recognised there was a need to coordinate Clozapine Clinic.
• All patients now attend on same day.
• Physical monitoring can also be done in a systematic way.
• Bloods are now taken by a Phlebotimist.

Outcomes
• Less stress for the patient.
• All information kept at site of clinic
• No waste of nursing time.

Addition Reading/Information


Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name
Leslie Quirie

Contact Details
West Lodge
Dr Gray’s Hospital
Elgin

Tel. No
01343 567340

E-mail

Title
Manic Depression Self Support Group

Brief Summary
Issues

There was no local support group in Moray. Those who experience manic depression had to travel to Aberdeen for support

Action

• Invite sufferers to elicit interest in supporting a group.
• Identify suitable premises. Attend MDF Conference to introduce ourselves and gain knowledge for forming the group.
• Invite an M.D.F. Officer to attend inaugural meeting.
• Initial meetings were held in West Lodge supported by volunteer staff.

Outcomes

• Sufferers have a Moray based Self Support Group and meet in the Resource Centre
• Meet every second Tuesday evening.
• Are affiliated to M.D.F. Scotland.

Addition Reading/Information

Sharing Experiences & Learning

Name
Alison Hamilton
Anne Spence & Wendy Gemmell

Contact Details
Community Psychiatric Nursing Service
Adult Mental Health.
Royal Cornhill Hospital

Tel. No
01224 557277

E-mail

Title
A Community Resources Directory for Mental Health Services

Brief Summary

A Community Resources Directory for Mental Health Services is available within Aberdeen City. To provide information to primary care professionals around what alternative resources could be accessed before referral to secondary mental health care.

Action

Contacted the varied care providers within the city to ascertain their purpose and routes of access to their service. Complied a directory including all appropriate services available. Distributed the resource to the community mental health team and primary care team in the area.

Outcomes

• More appropriate referrals to the team.
• This directory is now in its fifth year.
• Used by multi-professionals within the mental health service.
• Accessible on the psychology intranet site.

Addition Reading/Information


Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Architects of Change
Title: The Implementation of a Dependency Scale to demonstrate the level of dependence of patients with both physical and mental health needs

Brief Summary

Issues

Patients' needs have changed dramatically over the last 10 years. Traditionally, the Ward was a long-stay dementia facility with little turnover of patients. Over the last 3 years, the Ward has changed its focus to offer not only long-term NHS care, but also Assessment and Respite care. This change in care focus has not been matched with changes in staffing or skill mix. Staff had expressed increased levels of anxiety and stress and perceived their workload had increased, although they had no formal tool to help support their claims.

Action

- Establish what, if any dependency scales currently exist to assess the dependency of elderly patients with psychiatric needs.
- The only tool was REPDS, which is very time-consuming and hence would increase the workload. Staff wanted to utilise a tool that was quick and easy to use.
- Devise own tool, first stage was to analyse activities that take staff time, including challenging behaviours, communication problems, and physical dependence.
- Use data collected to devise own table that was simple to use.

Outcomes

Data collected one year apart has shown a slight change in dependency. Further benefits noted that the tool could be used to identify care plan needs. It could also be used when planning future care options with care managers, as it was found that patients with low scores could be cared for either at home/sheltered housing/residential care. Patients with medium scores could be cared for in Residential/Nursing Homes with high scores usually identified the continued need for closer supervision within a long-stay NHS bed.

Addition Reading/Information

Sharing Experiences & Learning

**Name**
M Ogden  L Grant  
E Bews  C Leitch  K Polson

**Contact Details**
Infant feeding department  
Aberdeen Maternity Hospital  
Aberdeen

Tel. No
01224 552615

E-mail
margaret.ogden@arh.grampian.scot.nhs.uk

**Title**
Breastfeeding Centre

**Brief Summary**

**Issues**
The health benefits of breastfeeding to both mothers and babies are well documented. Although more Scottish mothers are initiating breastfeeding there is still a growing need for consistent advice, support and information. Presently there is a wide variety of support available for mothers and an increasing interest in breastfeeding centres. These specialist centres can offer additional support to mothers and health professionals.

**Action**
In April 2003 a group was formed with the aim of providing a breastfeeding centre within AMH for both in and out patients. The centre opened on the 10/06/03 as a pilot project for 8 weeks. During this time audits were carried out on mothers satisfaction, ward staff satisfaction and activity within the centre. To date 200 mothers and babies have used the centre. Development plans for the centre are ongoing.

**Outcomes**
- Promotion and support of good breastfeeding practice.  
- Enabling mothers to gain confidence and skills in breastfeeding from professionals in a relaxed unhurried environment.  
- Identifying potential problems in the postnatal period and delivering consistent practice. Giving ongoing support to mothers whose babies are in the Neonatal Unit.  
- Providing a learning and resource centre for in-service education and staff support

**Addition Reading/Information**
- HEBS – Breastfeeding publications

**Category**
Delivering Quality Care  
Shaping a multi-Disciplinary Future  
Developing Capability and Capacity
Sharing Experiences & Learning

Name: Cathy Howden  
Deputy Ward Manager

Contact Details: Corgarff Ward,  
Royal Cornhill Hospital.  
Aberdeen

Tel. No: 01224557626

E-mail: kathy.howden@gpct.grampian.scot.nhs.uk

Title: Student Information Leaflet

Brief Summary

Issues

A leaflet containing ward philosophy, routine, policies and related issues has been produced in a concise format.

Action

Approximately two years ago, several staff on the ward brainstormed ideas and compiled a student information leaflet which details areas relevant to students whilst on placement, for example Observation levels, emergency facilities, dress code, hours of work.

Outcomes

Students have made comment on the leaflet being informative and useful in assisting them to adapt to a new environment.

Addition Reading/Information


Category

Delivering Quality Care ✔
Shaping a multi-Disciplinary Future
Developing Capability and Capacity ✔
**Title**

**Improving Patient Access To Advocacy Advice**

**Brief Summary**

**Issues**

Many reports have suggested that patients should have ready access to advocacy services. Some patients may have difficulty or do not wish to actively pursue advice from the advocacy service. One factor that could impact on this is whether or not the advocate is readily accessible and known to the patient.

**Action**

Advocacy workers now attend the ward on a regular basis, spending at least an hour, enabling easier access to their service.

**Outcomes**

- Regular Independent advice and information is available for all in-patients from advocacy workers, allowing regular easy access.

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name: Graham Lowden
Ward Manager

Contact Details: Drum Ward
Royal Cornhill Hospital
Aberdeen

Tel. No: 01224557241
E-mail: graham.lowden@gpct.grampian.scot.nhs.uk

Title: Ensuring Good Information Exchange to Student Nurses

Brief Summary

Issues

Several reports have indicated that student nurses often find it difficult to settle into a clinical placement. If students do not have sufficient information of the clinical setting, this can lead to increased anxiety and as a result, the value of the experience can be diminished.

Action

A nurse is delegated to ensure all students are allocated a practice supervisor prior to commencing their placement. A ward information pack has been compiled and is given to all students. Student information is reviewed and updated regularly.

Outcomes

- A consistently high degree of support and supervision is given to student nurses.
- Information leaflets and articles are available to trainees.
- All staff are aware of their responsibilities toward trainee supervision.

Addition Reading/Information

**Title**

Regular Weight Recording and Routine Urinalysis in an acute psychiatric Ward.

**Brief Summary**

**Issues**

Whilst routine screening and regular weight measurement might be the norm within a general hospital it can be overlooked when a patient is admitted with psychiatric or psychological problems. It was decided that there would be value in monitoring patients weight whilst in hospital and screening for potential physical problems on admission.

**Action**

All patients now have their weight taken on admission and are subsequently weighed weekly to monitor gain or loss. Urinalysis is done for all patients on admission.

**Outcomes**

- Weight gain or loss can be monitored accurately, giving early indication of possible unwanted side effects of some anti-psychotic medication (weight gain) and indicate poor nutritional intake.
- Urinalysis can exclude some physical causes of psychiatric symptoms and help early detection of diabetes.

**Addition Reading/Information**

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Title

**Ward Community Meeting**

Brief Summary

**Issues**

The purpose of the ward community meeting is to provide an interface between service users and providers of acute in-patient mental health care. It is important for users of the service to have an opportunity to discuss what they find helpful and what they would find more helpful about the service provided.

**Action**

- Each month there is dedicated time created for all staff and patients to discuss issues around the running of the ward.
- This is of a non-clinical nature and allows any group member to ask questions about day to day routines, customs and practices.
- The offer to make suggestions and comments toward improving the patient experience on the ward, is a key theme of this meeting.
- Notes are taken and specific staff are named to forward any action points.

**Outcomes**

- An example of user involvement in practice
- The ward experience can be considered and improved
- Routine is reviewed rather than allowed to age for limited good reason.

**Addition Reading/Information**


**Category**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Name: Kathy Paterson  
Ward Manager

Contact Details: Crathes Ward, 
Royal Cornhill Hospital 
Aberdeen

Tel. No: 01224557228 
E-mail: kathy.paterson@gpct.grampian.scot.nhs.uk

Title: Preceptorship

Brief Summary

Issues

It was recognised that there was a need for a system for monitoring the fulfilment of educational requirement during the preceptorship period. Various reports have identified that the period immediately following qualification is highly significant time for registered nurses.

Action

- A team of staff devised a checklist to highlight key learning objectives for a newly qualified nurse to work through with their preceptor.
- Areas include – emergency responses, escort procedure, ward policies, missing person procedure and mandatory training such as control and restraint and violence and aggression.

Outcomes

- Checklist still in the pilot period but those involved find the themes valuable and the list easy to use.
- Each nurse shares the responsibility for meeting the preceptorship period requirements.

Addition Reading/Information

Sharing Experiences & Learning

Name
Shona Burke

Contact Details
Mearns Suite,  
Royal Cornhill Hospital  
Aberdeen

Tel. No
01224557615

E-mail
shona.burke@gpct.grampian.scot.nhs.uk

Title
Electro Convulsive Therapy (E.C.T) Audit

Brief Summary

Issues

The Scottish E.C.T Audit Network (SEAN) have devised an audit database which is a care pathway for patients receiving E.C.T. Since early 2002, the E.C.T team at R.C.H has been involved in a pilot project concerning the E.C.T audit.

Action

A disc containing anonymous data is sent to a central source on a monthly basis to be collated nationally. Incorporated in the database are details about the patient, episode, treatment, review of treatment and final details.

Outcomes

- The aim of the audit is to produce and maintain improvements in the practice of E.C.T locally and within Scotland.
- Because of our involvement, the audit team has been able to fine tune the database and are currently installing it to other E.C.T sites in Scotland.

Addition Reading/Information


Category
Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Name: Shona Burke
Contact Details: Mearns Suite, Royal Cornhill Hospital, Aberdeen
Tel. No: 01224557615
E-mail: shona.burke@gpct.grampian.scot.nhs.uk

Title: Good practice in the Clozapine Clinic

Brief Summary

Issues

The Clozapine clinic is run on a multi-disciplinary approach, involving consultant psychiatrists, pharmacy staff and nurses. It was established in 2000 to facilitate the requirement to monitor blood samples, mental state and the physical wellbeing of clients using this treatment.

Action

- Blood samples are taken on Mondays as directed and a collected by courier for delivery to a patient monitoring service laboratory.
- Nursing staff at the clinic monitor a patients physical health by carrying out varied checks and tests ranging from blood pressure and weight to E.C.G and cholesterol testing.

Outcomes

- There is now a well integrated service for the ongoing care of patients receiving Clozapine therapy.

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Minor Illness Modules Clinical and Theoretical at Level 3**

**Brief Summary**

**Issues**

Numerous practices throughout Grampian have nurses providing same day consultations for a range of minor illnesses. These nurses were trained within their practices. Much time and effort went into the training by the practice as a whole and by the nurses themselves. There was no recognised standard of training and no recognised qualifications for the nurses.

**Action**

Investigate the need for nurse led surgeries in Minor Illness throughout Grampian. Questionnaire was sent out to multi-disciplinary professionals to curtain views. From that positive reaction a working group was organised to develop a course in collaboration with Robert Gordon University.

**Outcomes**

- The first Minor Illness Course will commence on 25th August 2003. There will be a Theoretical Module at level 3 gaining 15 CAT points and a Clinical Module at level 3 gaining 15 CAT points. The Clinical Module will be quality assured and credit rated by RGU.

**Addition Reading/Information**

Title  Adaptation Programme for Overseas Nurses to Work in Specialised Area

Issues
Nationally recognised shortage of trained neonatal nurses. Innovative approach by GUHT to employ overseas nurses with neonatal nursing experience to meet local need and provide recruits with equal opportunity for personal and professional development. We wanted to establish a comprehensive framework of neonatal nursing competencies that: objectively assess, demonstrate, and authenticate the overseas nurse’s skills and knowledge; identify individual need for support and/or training related to the job role, and additionally highlight potential. The neonatal nursing competencies had to articulate with the GUHT Adaptation Programme and fulfil the NMC requirements for overseas nurses to register in the UK.

Action
Overseas recruits attend GUHT core induction course prior to relevant clinical placement. A neonatal working group was set up to develop a complementary adaptation programme encompassing neonatal nursing skills and competencies. It was decided to utilise the NBS (2002) QACPD Portfolio containing descriptors of practice orientated core competencies for the delivery of high quality neonatal nursing –NBS work that we actively participated in during 2001. Evaluation of the GUHT Adaptation Programme has taken place resulting in an overall positive response.

Outcomes
- The Neonatal Nursing Competency Framework and Assessment has been integrated with the GUHT Adaptation Programme.
- Smooth integration of overseas nurse into the established multidisciplinary team.
- First overseas nurse with clinical placement in the NNU (2003) has successfully completed the GUHT Adaptation Programme and has achieved registration with the NMC.
- For the individual, a continuing professional development portfolio of evidence of achievement in the core competencies may have career development potential.

Addition Reading/Information
- To access to all previous CPD Portfolios and related documents visit the NHS Education web-site -click on ‘Publications’ followed by ‘Quality Assurance of CPD’ 26/08.02.
Name          Karen Hawcroft
Nursery Nurse

Contact Details     Summerfield Ward
Aberdeen Maternity Hospital

Tel. No           01224 554943

E-mail

Title
Infant Massage

Brief Summary

Issues
The early postpartum months are especially important for the establishment of satisfactory mother/infant interaction and for child development. (Glover et al, 2001).
Caring touch through infant massage plays an important part in this. (McClure, 1989)

Action
As part of continued professional development and having a specific interest in assisting new mothers to develop parenting skills, I gained my Instructors Certificate in Infant Massage, trained by the International Association of Infant Massage.

Infant massage is offered
• on a one to one or group basis in the postnatal ward area
• to small groups of women and their partners antenatally as part of parenthood classes
• to small groups of parents at postnatal reunion classes
• to groups of midwives/student midwives and other staff gaining experience in providing postnatal care.

Outcomes
• Empowers the parents and increases their confidence
• Helps to bring relief from wind/colic and other infant ailments
• Stimulates all the systems of the body
• Relaxing for both parents and baby
• Aids mother/father/infant interaction
• Provides professional update
• Raises awareness of the importance of infant massage as part of providing quality care in the postnatal

Addition Reading/Information
• McClure, V (1989) Infant massage – A handbook for loving parents
• Glover, V; Bond, C (2001) Infant Massage Improves Mother/Infant interaction for mothers with postnatal depression. Journal of Affective Disorders, 63:201-207

Category
Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
**AMAU – One Year On**

**Issues**
A senior nurse carries the bleep for the Acute Medical Assessment Unit. She fields all calls from GPs, G-docs, CCU, A&E, other hospitals as well as from ARI. This role is to facilitate admissions so that the patient is placed in the appropriate area. She can also link the caller to a consultant as part of an advice line service. New members joined the team and current practice was reviewed. This resulted in some additions and changes to the existing paperwork to streamline the service further.

**Action**
- AMAU Bleepholder – daily routine was updated –useful for new staff
- List of Key Questions compiled. These simple, relevant, “triage-type” questions allow the nurse to take discussion forward eg, if patient presents with a headache, it is useful to ascertain a) duration b) any history of migraines c) any dizziness d) vomiting e) neck stiffness, f) visual impairment g) photophobia
- List of abbreviations eg LOC = Loss of Consciousness. By using these shortened forms, more time is available to jot down other relevant details. The list provides a comprehensive guide which can be used by all and as such becomes a sort of AMAU glossary.
- Estimated Distances – this was compiled to help gauge the time an admission would take to arrive at the unit eg. A patient travelling from Tomintoul would take approximately 1hr 45min to reach Aberdeen.
- A list of normal ranges of blood and urine samples is available in the folder.
- Contact numbers for GP Practice Managers is available too – this helps when a carer has to be admitted to hospital and respite care has to be organised for the dependent.

**Outcomes**
Addition of material enables even more effective communication to take place. Armed with an expanse of information, the nurse can gain a full picture of the patient to be admitted and is then in a position to pass on a detailed and relevant report to the medical and nursing staff in the Unit. We are now looking at other ways to develop the service – this includes combining bed management with carrying the bleep and liaising with the Community Hospital Co-ordinator– after all, the Bed Manager is in the best position to tell us where the beds are and the Co-ordinator can forward plan care for any patients who may require a period of rehabilitation.

**Addition Reading/Information**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
**Brief Summary**

**Issues**
Issues: I joined the Bed Management Team in May 2003. My previous 28 years of nursing had been spent in wards, clinics and the community. My challenge was to cross the interface from clinical to non-clinical nursing, using skills already in place, while developing new skills and strategies to enable me to take on my new role. Issues thrown up range from the simple – from uniform to civvies - to the more complex – entering the ward to engage with staff and setting my own work time-table.

**Action**
- Orientation and support from colleagues within team.
- A reflective diary allowed me to chart my progress and examine any perceived difficulties/acknowledge positive outcomes.
- By getting involved in raising the profile of Bed Management, I gained job satisfaction and was able to embrace the vision of Bed Management in the future.
- Securing a Clinical Supervisor allowed me to share and reflect in a safe environment.
- I developed a rapport with ward staff and got to know the Clinical Nurse Managers (ongoing) - this enables me to work in partnership with my colleagues hospital-wide as, through meetings, I have also met with Service Managers and members of the GUHT Executive.

**Outcomes**
- Much improved negotiating and communicating skills and an ability to see the bigger picture within the hospital setting and beyond – we liaise with Dr Grays Hospital, Inverness, for example.
- Sound working relationships across the multi-disciplinary field.
- I have become a self-starter, in that I now use my initiative and experience to structure my day, taking into account the needs of the service and other members of the team.
- My clinical experience keeps me in touch with what is going on in the wards – remembering how busy, stressful

**Addition Reading/Information**
- Category
  - Delivering Quality Care
  - Shaping a multi-Disciplinary Future
  - Developing Capability and Capacity
Sharing Experiences & Learning

Name  
Julie-Anne Brough

Contact Details  
Plastic Surgery Dressings Clinic  
Aberdeen Royal Infirmary  
Aberdeen

Tel. No  
01224 559305

E-mail  
Julie.Brough@arh.grampian.scot.nhs.uk

Title

Nurse Led Plastic Surgery Dressings Clinic

Brief Summary

Issues

Increased number of patients waiting for wound management at already busy plastic surgery clinic resulting in a reduction in time allocated for patient/nurse communication. Concerns that continuity of care and the detection of vital patient information where being compromised.

Action

Introduction of a nurse led clinic by trained nurses specialising in burns & plastic surgery 11/2 mornings a week. Systems in place to allow direct referrals to clinic from ward 39 and A&E. Provides autonomous assessment, monitoring and evaluation of wound progress and referral to surgeons. Provides a resource base for other members of the multi-disciplinary team.

Outcomes

• Reduced patient waiting times.
• Improved continuity of care and wound management.
• Reduction in referrals to other clinics
• Improved communication and declaring of important information from patients.
• Patient centred approach to care through the combining of other multi-disciplinary team members i.e. physio & O.T.
• Reduced admissions to wards

Addition Reading/Information


Category

Delivering Quality Care  ✔
Shaping a multi-Disciplinary Future  ✔
Developing Capability and Capacity  ✔

Architect of Change

Vol. II
**Initiating a Leg Ulcer/Doppler Clinic**

### Brief Summary

**Issues**

Not all of the Practice population suffering from leg ulcers had access to best clinical practice as recommended in the SIGN Guidelines publication 26 (1998). This was due to time constraints and the need for updating staff in the necessary knowledge and skills.

**Action**

- I completed the Leg Ulcer Nurse Specialist Course (RCN) in 2000.
- I set up a Doppler/Leg Ulcer Clinic in April 2001 within the surgery, to run for two hours a month, assessing a maximum of two patients at each clinic.
- A computerised recall appointment system was set up to provide ongoing treatment and monitor leg ulcer recurrence.
- Practice and Community nurses are involved in the assessment and ongoing management of the leg ulcer patients and in the training sessions provided.

**Outcomes**

- Sign Guidelines in leg ulcer management was successfully implemented for the target group
- In the first 12 months 80% of those treated for venous ulceration were healed within 8 weeks
- Two patients with arterial disease were referred to the vascular outpatient department for further investigation.
- A programme of secondary prevention was set up recalling patients for reassessment and hosiery fitting
- Nurses have increased their knowledge and skills and have more confidence in their ability to deliver effective leg ulcer management.

**Addition Reading/Information**

- Sign Guidelines Publication Number 26 ‘The Care of Patients with Chronic Leg Ulcer’ (1998)
Breastfeeding Peer Support Group

Brief Summary
Issues
It is increasingly recognised that peer support is a key element to supporting women to initiate and continue to breastfeed. The Framework for Maternity Services in Scotland identifies as one of its actions that “NHS Boards should actively nurture the setting up of peer breastfeeding education and support groups”. UNICEF/WHO guidelines also recommend the establishment of such groups and referral to them when mothers are discharged from hospital.

Action
• Funding applied for ten women (who had a wide range of breastfeeding experiences between them) to complete a recognised and comprehensive 12 week breastfeeding training course.
• Publicity & interaction with health professionals, organisations & voluntary agencies to raise profile.
• Involvement & contacts within the local hospital and community settings to assist and sustain the group.
• Posters and contact cards produced and advertised in the hospital and local community.

Outcomes
• Successful completion of La Leche League Breastfeeding Peer Councillor course by all 10 participants.
• Raised antenatal and postnatal awareness of breastfeeding support available locally.
• Increased referrals from women requesting advice, reassurance and support on a one to one basis.
• Files produced & made available to health professionals & multidisciplinary agencies containing information & contact numbers of local B.R.A.G. (Breastfeeding, Reassurance and Awareness) group.
• Regular updates and evaluations conducted – local, national and international.
• Opportunities made available for further training – promoting good practice.
• Guidelines and recommendations given by WHO/UNICEF, the Scottish Executive in Feb 2001 and the Grampian Breastfeeding Strategy Group/NHS Scotland are being adhered to.

Addition Reading/Information
• Scottish Breastfeeding Group website www.show.escot.nhs.uk/breastfeed

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name: Amanda Watt

Contact Details: Ward 3
Dr Gray’s Hospital
Elgin

Tel. No: 01343 567531
E-mail: amanda.watt@mhs.grampian.scot.nhs.uk

Title: Blood glucose monitoring for the healthy neonate

Brief Summary

Issues
Health professionals were consistently expressing concern that increasing numbers of babies were being treated unnecessarily for hypoglycaemia. Our policy did not include healthy, low risk babies who were reluctant to feed. Monitoring of blood glucose estimations in healthy neonates is potentially harmful to parental wellbeing and establishment of successful breastfeeding. Unnecessary intervention can result in increased stress and anxiety, undermining the mother’s confidence and ability to breastfeed her baby and it can lead to sleepiness and further reluctance to feed the baby.

Action
• A working group of midwives and consultant paediatricians was set up.
• Existing policies and protocols were reviewed.
• A small literature review was undertaken.
• Quantitative and qualitative results from a recent breastfeeding survey were analyse (completed by mothers on Ward 3 who had experienced blood glucose monitoring for their babies).

Outcomes
• Guidelines and a flow chart were produced incorporating management of low risk babies who are well, but reluctant to feed.
• Reduced blood glucose monitoring.
• Policy communicated to health care staff.
• Continuing education and training provided to ensure all staff involved in caring for mothers and babies are able to provide care as directed by the policy.
• No supplementary feeds given unless medically indicated.
• Policy complies with UNICEF/Baby Friendly Initiative and World Health Organisation.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Sharing Experiences & Learning**

**Name**

Amanda Watt

**Contact Details**

Ward 3  
Dr Gray’s Hospital  
Elgin

Tel. No  
01343 567531

E-mail  
amanda.watt@nhs.grampian.scot.nhs.uk

**Title**

Young parents antenatal support group

**Brief Summary**

**Issues**
Teenage parents tend to come from deprived or socially excluded backgrounds and becoming a teenage parent tends to have the effect of exacerbating these inequalities. Pregnant and vulnerable young people not accessing antenatal care regularly.

**Action**

- October 2000 – Antenatal support group set up to address individualised needs of young pregnant women and their partners.
- Venue was arranged outwith the hospital and medical setting.
- Sessions provided within small groups and also on a one to one basis.
- Involvement of the multidisciplinary and multi-agency teams.

**Outcomes**

- Support package and provision of specialist care put in place for every client, providing individual requests and needs.
- Continuity of care throughout antenatal and postnatal period.
- Increased attendance of clients, partners and other supportive family members.
- Improved range of links and communication across local government, health and voluntary sectors.
- Recently, free creche facilities have become available for clients attending who may have other children.
- Postnatal group has now commenced at the request of parents who have attended the antenatal group – establishing further friendships and support for each other, boosting self-esteem and confidence.

**Addition Reading/Information**


**Category**

Delivering Quality Care  ✔  
Shaping a multi-Disciplinary Future  ✔  
Developing Capability and Capacity
Sharing Experiences & Learning

Name: Elaine Hutcheon & Sandra Smith

Contact Details: Crimond Surgery Fraserburgh

Tel. No: 01346 532215 or 01346 585246

Title: Triple P Parenting: Providing Positive Parenting Programme For parents

Brief Summary

Issues
An additional service was set up by the health visitors in the Banff and Buchan LHCC to provide parents with a positive parenting programme to deal with children’s behavioural problems.

Action
Health visitors in Banff and Buchan LHCC identified a problem with parents having difficulty managing their children’s behaviour. Following a literature review it was decided to provide training of the Triple P parenting programme. This programme consists of a tiered systematic approach to parenting. Levels of intervention increase according to the level of difficulty experienced by parents. The programme can be delivered as a one to one or a group approach. Triple P parenting is a positive parenting programme. A multi level system of family intervention for parents of children who have or at risk of developing behavioural problems. It is a preventatively oriented early intervention programme which aims to promote positive caring relationships between parents and their children. And to help parents develop effective management strategies for dealing with a variety of childhood behaviour problems and common developmental issues. Whilst positive parenting methods are relevant to all parents, parents of difficult to manage children who are demanding, disobedient, defiant, aggressive or generally disruptive are particularly likely to benefit.

Outcomes
- Develop positive relationships
- Encouraging desirable behaviour
- Teaching new skills and behaviours
- Managing misbehaviour

Addition Reading/Information

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Name
Elaine Hutcheon & Sandra Smith

Contact Details
Crimond Surgery
Fraserburgh

Tel. No
01346 532215 or 01346 585246

E-mail

Title
The Benefits of Baby Massage

Brief Summary

Issues
A new service was set up by the health visitors in the Banff and Buchan area to provide mothers and babies with the knowledge and practice of infant massage.

Action
The health visitors in Banff and Buchan LHCC expressed an interest in baby massage. Training was provided by the International Association Of Infant Massage. This consisted of 4 days of theory and practice followed by written assessment, running of pilot groups. On completion massage groups were set up to allow parents to practice massage their children.

Outcomes
The benefits for both parents and baby are:
- Supports and builds strong bonds between the parent and baby.
- Teaches both the parent and baby how to relax increasing quality time.
- Teaches baby that they are loved, valued and the relationship is important.
- Development of a sound personality and inner strength.
- Can strengthen the immune system increasing resistance to disease.
- Supports and helps regulate the sustaining systems: circulatory, respiratory, nervous, digestive, eliminatory.
- Develops body awareness, coordination, suppleness, alertness.
- Can provide relief from the discomforts of teething, colic, constipation, congestion.
- Can assist and releasing the trauma of a difficult birth experience.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name: Margaret Ritchie
Macmillan Neuro – Oncology Nurse

Contact Details: Wd 40, Aberdeen Royal Infirmary
Aberdeen AB25 2 ZN
Tel. No: 01224 559895
E-mail: margaret.ritchie@arh.grampian.scot.nhs.uk

Title: Macmillan Neuro – Oncology Nurse

Brief Summary

Issues
The Scottish Audit of Patients with Malignant Glioma 1997 – 1999 highlighted the need for a neuro – oncology nurse for patients with primary central nervous system tumours. To provide and co-ordinate a service of support, information and education for patients, their families and health professionals.

Action
- To establish a weekly neuro – oncology clinic, rather than separate neurosurgical and oncology clinics.
- Nurse led radiotherapy review for all patients to provide continuity of care.
- Provision of written information to meet individual patients needs.
- Improve communication between neurosurgery / oncology / radiotherapy, patient’s GP and community nurses, community Macmillan nurses and palliative care team.

Outcomes
- Patient and family empowered by provision of information and education.
- Patient only attends one outpatient clinic, may self refer, and will be assessed by appropriate member of multidisciplinary team.
- Continuity of care between primary and secondary care.
- Patient maintained on minimum dose of dexamethasone, improved quality of life for patient.

Addition Reading/Information

Category: Delivering Quality Care
Name Lynn Adams  
Macmillan Lead Cancer Nurse

Contact Details Cancer Network Office,  
Administration Block,  
Aberdeen Royal Infirmary,  
Aberdeen

Tel. No 01224 559791

E-mail lynn.adams@arh.grampian.scot.nhs.uk

Title Developing the nursing contribution to The North East Scotland Cancer Co-ordinating & Advisory Group (NESCCAG)

Brief Summary

Issues

• Cancer in Scotland: Action for Change (2001) identified Managed Clinical Networks (MCNs) as one of the most important strategic issues for cancer services in Scotland
• MCNs provide a framework for organising and developing cancer services
• MCNs bring together everyone involved in the care of a specific cancer to agree care protocols and identify areas for redesign or additional resource
• MCNs recognise that clinical staff, together with patients, are in the best position to identify local needs and priorities

Action

• To ensure adequate and appropriate nursing representation from Primary, Secondary and Tertiary Care
• Clarify the remit or representatives and lines of accountability and communication
• Identify methods of networking with colleagues in remote and rural areas
• Identify support for representatives to facilitate working across geographical, institutional and professional boundaries

Outcomes

• Each NESCCAG Focus Group has nursing representation from Primary, Secondary and Tertiary Care
• Nurses together with other clinical staff and patients are identifying clinical and service improvements required to improve cancer care
• NHS Education Scotland has commissioned a study to explore the education and training needs of individual disciplines with Managed Clinical Networks. Findings available November 2003.

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity

Vol. II

Architects of Change  Architects of Change  Architects of Change
Cancer in Scotland: A Framework for Nursing

Brief Summary

Issues
- There must be continuous improvements for patients, continuity of care must be enhanced, nursing expertise should be better focussed and development of services must be maximised.
- The contribution of specialist cancer services is significant, but most cancer care is delivered by generalists, who consequently have an enormous impact on patients’ experience of cancer care.

Action
- Cancer Nursing Sub-group of the Scottish Cancer Group established in January 2003 to provide leadership, direction and a framework for nursing people with cancer.
- Focus groups and conferences attended by nurses from across Scotland provided the content for the Framework.
- Six “key drivers” identified in the national strategy for nursing and midwifery, “*Caring for Scotland*” (2001) adopted for the documents framework.
- October 2003 – draft Framework out for consultation.
- Framework will be complementary to the work of formulating a competency framework.

Outcomes
- Publication of Framework in 2004 which will focus on patient/public needs in relation to cancer; emphasise the nursing contribution, define nurses’ ongoing education, training and professional development needs in relation to cancer care.
- The Framework and Competency Framework will jointly set out the way forward for nursing services for people with cancer in Scotland at strategic and operational levels.

Addition Reading/Information
Sharing Experiences & Learning

Name: Kate Copp
Contact Details: Colorectal Unit, Ward 50
Aberdeen Royal Infirmary
Aberdeen
Tel. No: 01224 559942
E-mail: kate.copp@arh.grampian.scot.nhs.uk

Title: Patient Information Project (Colorectal Cancer)

Brief Summary

Issues
Patients with colorectal cancer are diagnosed & treated in a variety of clinical areas throughout ARI. Their cancer pathway can involve a number of different treatment modalities & bring them into contact with many different teams throughout the hospital. A need to improve the provision and standardisation of information offered to patients diagnosed with colorectal cancer was identified. The ensuing Patient Information Project (colorectal cancer) was based on the following two premises:

- patient information should be comprehensive & relevant, accessible to both patients & families, offered at a time and in a form appropriate to them, and be available from the point of diagnosis onwards.
- the development of such information should include direct involvement of patients and their families

Action

Two groups were convened to work concurrently and feed into each other. The initial deliberations from both groups resulted in agreement to proceed to develop a Patient Information Booklet which would provide an overview of the Colorectal Cancer Pathway. A Patient Focus Group, comprised patients presently having treatment or having completed treatment, and their partners. This group drew on their own colorectal cancer experiences & was responsible for determining the preferred content & design of the booklet. A Clinical Working Group, comprised representatives from primary & secondary care, reflecting the colorectal cancer pathway. Although offering suggestions on content, this group’s main responsibility was for the accuracy and readability of the content, its relevance to NHS Grampian, & for securing sponsorship for printing 100 booklets for the ensuing pilot run

Outcomes

The booklet is presently undergoing distributed in RI, Dr Grays, Balfour and Gilbert Bain hospitals. Although formal evaluation audit results are awaited, informal feedback to date is very encouraging. If the booklet is evaluated favourably, the biggest future challenge will be to ensure equity of provision, and find ways to make the booklet available to all patients diagnosed with colorectal cancer.

Addition Reading/Information

**Sharing Experiences & Learning**

**Name**

Collette Mathieson

**Contact Details**

Eden Midwifery Unit
Chalmers Hospital
Banff

**Tel. No**

01261 819129

**E-mail**

Title

Community based action by the midwifery unit Banff.

**Brief Summary**

**Issues**

Over the last year, the Eden Midwifery Team have highlighted several areas of care with the specific aim of improving their delivery of service. The three main areas identified can be summarised as follows:

- Increase in teenage pregnancies
- Increase in sexually transmitted disease
- Poor identification of pregnant woman with major social problems

**Action**

The team also identified the need to interface with other professions and services out with the unit, namely social work department, health visitors, child support unit and the Banff New Community Schools Team. A major step forward for the team was an invitation into the family centre at the new Banff Primary School. This enables the team to meet with social workers and health visitors where the sharing of information can both target those families requiring additional support and also identify potential problems that could arise. Several midwives have been asked by Audrey Findlay (child support unit) to attend community based activities/groups such as youth clubs to discuss various important issues affecting teenagers to provide awareness education on pregnancy, contraception, STD and abortion. Following on from these discussions, several interested groups were invited into the unit to expand on the issues at first hand.

**Outcomes**

In May 2003 a new service was offered to the Banff community by the Banff New Community School Team, a multi disciplined team offering assistance and support. The midwives now feed into this initiative by providing names of interested partners who would be willing to attend a new “dads to be” support group. The team now feels they are well on the way to meeting key objectives. Future aims are to increase joint working with other groups and improve on the teenage education currently provided with regards to pregnancy etc.

**Addition Reading/Information**

- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Sharing Experiences & Learning

Ed Moreton
Porter Training Co-ordinator

Portering Service
Aberdeen Royal Infirmary
Aberdeen

Tel. No
01224 553763

Title
Portering Services Standards

Brief Summary

Issues

Three years ago my manager Ted Reid had the foresight to encourage me to develop a Portering Standards Training Program. It was following a break down in communication between a nurse and myself during a patient transfer that instigated this program. Because I had received little formal training I made an error, which could have been serious, needless to say it spurred me into a learning how to operate a Computer which was essential to start to lay down a foundation of a departmental manual. I decided then, that the manual should be predominately based on Health and Safety.

Action

I felt the need to advance my knowledge and the information I had so supported by my Manager, I went on courses run by the then Risk Management Advisory Service (risk assessor, object key handler, patient key handler and Health and Safety). It was during this training that I had the idea to develop a standards manual. The manual consisted of the need to work safely and includes instruction on all pottering tasks required by the rust. This was then supported by a two-day training course the first day dedicated to policies and procedures, health and safety, partnership, structures and working practice, and then the porter manual. The second day of the course is dedicated to The Health and Safety at Work Act, object moving and handling and patient handling techniques. We are about to move into areas that most staff have already take for granted. Personal development plans, PADS. We are developing our Risk assessments to include a new risk register and have safe systems of work put in place.

Outcomes

I could have singled out a single issue like moving and handling (injuries down by 60% since training started), patient transfer, clinical waste, specimen delivery, dealing with the public. All of these are dealt with in our training, but the best outcome for my department by far is the new culture of staff information and partnership.

Addition Reading/Information

Category
Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Provision of audio-taped consultations for patients attending the Colorectal Oncology Clinic

Issues
Information retention may be hampered by anxiety, patients do not always understand the information they have been given & may feel too inhibited to ask questions. In situations requiring the giving of complex information patients may well forget up to 70% of what they have been told. Information-giving in the colorectal oncology clinic is delivered well and sensitively by the medical oncology staff & is further supported by the presence of, and additional consultation with, the colorectal nurse specialists. However, information given about medical management is often complex and involves discussions about clinical trials, the Oncology team expressed a desire to improve this aspect of the communication process. It has been demonstrated by others that providing a tape-recording of the consultation, which then becomes the property of the patient, can be a useful tool to enhance communication and add to patient satisfaction.

Action
The initiative offers selected patients the opportunity to have their consultations with the medical & nursing staff taped. Ahead of each clinic the colorectal nurse specialists identify those patients most likely to benefit, such as new patients with whom diagnosis and treatment options will be discussed. These patients are given a letter explaining the initiative and offering the service when they check in at clinic. The tape then becomes their own property – no other copies are made – this reinforced in the letter. A further letter reinforcing confidentiality & requests permission to send out a short questionnaire evaluating the initiative.

Outcomes
Informal feedback to date has been positive. Formal feedback is currently being sought through a short questionnaire asking for comment about both the process and outcome (particularly in respect of the quality of the recording and ease with which patients can access relevant sections on the tape). We are presently working with just one tape-recorder. However, given that 14 of the 16 patients offered this service to date have taken up the offer, and that many more patients at this busy clinic could benefit, we are negotiating for a second machine.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Sharing Experiences & Learning

Name

Beth Thomson, Ruth Scott, Gwen Livingston

Contact Details

Tel. No 01224 558399

E-mail Beth.Thomson@gpct.grampian.scot.nhs.uk
Ruth.Scott@gpct.grampian.scot.nhs.uk
Gwen.Livingston@gpct.grampian.scot.nhs.uk

Title

Community Therapy Services

Brief Summary

Issues

Until January 2003, community therapy services in Aberdeen City consisted of several separate services being run via separate referral points. These services consisted of domiciliary Physiotherapy, Occupational Therapy, Dietetics, Podiatry and Speech and Language Therapy. There was duplication of some services, unequal access, age discrimination and some services were limited to 11 GP Practices.

Action

To re-design the existing services with additional delayed discharge funding to create a city wide Community Therapy Service, thus reducing unnecessary hospital admissions and facilitate safe and speedy discharge. The service accepts referrals for all disciplines, although Podiatry and Speech and Language Therapy referrals are forwarded, to be prioritised by their respective administrative systems.

Outcomes

- Development of a central referral point
- Development of a computerised patient data base
- Development of a multidisciplinary screening system for referrals
- Development of criteria admissions flow chart for each service within community rehabilitation services
- Development of multidisciplinary records
- Development of multidisciplinary library/resources on site
- Opportunity to develop career structure

Addition Reading/Information

- Local Partnership Agreement (The Bottom Line) Oct 2002

Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity

Architects of Change

Engine of Change

Vol. II

Subject of Change

Architect of Change
Title
Continued Professional Development Portfolios:-
How To Get Started

Brief Summary
Issues
Background /Aim: To educate occupational therapists on how they can start their continued professional development portfolios.

Action
I have developed easy-to-use templates for a continuing professional development (CPD) portfolio as I became aware that many occupational therapists find it difficult to start these. I presented my templates whilst on placement as a student and in my first job as a qualified occupational therapist. My aim was to show that starting a CPD portfolio need not be a daunting task and is achievable. I update the templates and presentation as new ideas emerge.

Outcomes
Results:
I have now presented the templates to over fifty occupational therapists in three healthcare trusts. The feedback I have had is very positive stating that the templates are clear, logical, well-structured and seem simple to use. The templates are also available on the computer which people find to be an efficient way of using them.

Clinical Implications:
Keeping an up to date CPD portfolio is a concise and structured way of showing your clinical competence and effectiveness.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name: Anne McCann

Contact Details: Occupational Therapy Department
Adult Mental Health
Royal Cornhill Hospital
Aberdeen AB25 2ZH

Tel. No: 01224 557244
E-mail: anne.mccann@gpct.grampian.scot.nhs.uk

Title: Adult Mental Health OT Discharge Audit

Brief Summary

Issues
Background / Aim: To audit information obtained regarding OT provision as reviewed at discharge.

Action
Information is collated from standard forms highlighting OT involvement, referral source, length of contact and uneventuated appointments. This provides baseline data for OT service.

Outcomes
On-going programme, with results being collated on a quarterly basis. Final results due January 2003.

Clinical Implications
Information may be useful for planning future OT services. Empowering service delivery.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Title: Development of an Emergency Nurse Practitioner Service in Accident and Emergency ARI

Brief Summary

Issues
- National legislation requiring reduction of junior doctors hours.
- Caring for Scotland (2000) highlighted the need to improve waiting times and the quality of care given to minor injuries patients in A&E.
- Lack of Professional Development opportunities for experienced nursing staff.

Action
- Three experienced A&E nurses have undergone recognised training at Napier University & developed clinical skills with senior A&E Medical Staff, Department of radiology and AHPs.
- Assimilation of information from other ENPs countrywide.
- Communication with other members of the multidisciplinary team including Primary Care.
- Mentorship by A&E Consultants and Clinical Nurse Manager.

Outcomes
- ENP service commenced December 2001 with 4000 patients seen in first year.
- First dedicated ENP service in an A&E Department in Scotland ie: ENPs work autonomously, complementing normal departmental activities.
- ENPs assess, diagnose, treat and discharge patients with a variety of undifferentiated minor trauma, or refer them to an appropriate speciality.
- Recent audit demonstrates the patient journey time through the department is reduced by 20%.
- Experienced A&E nursing staff are utilised to manage patient care and support junior Medical Staff.
- Improved interaction within the multidisciplinary team.
- Professional Development opportunity for experienced A&E staff – three more ENPs in training.
- Continued development and expansion of ENP Service.

Addition Reading/Information
- Scottish Executive Health Department (2000) Caring for Scotland: The Strategy For Nursing and Midwifery in Scotland

Category
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity
Developing a Night Nurse Practitioner Service

Brief Summary

Issues
Development of Night Nurse Practitioner Service within Aberdeen Royal Infirmary. Non-compliance in many clinical areas of Junior Doctors Hours of Work as a result of the New Deal for Doctors and European Working Time Regulations.

Action
• Audit done of calls made by nursing staff to junior doctors at night.

Outcomes
• As a result of audit it was agreed that many of the tasks carried out by junior doctors at night could be performed by a Night Nurse Practitioner who would also be the first point of contact for ward nursing staff apart from clinical emergency.
• These practitioners have developed knowledge and skills under the heading of ‘Extended Role of the Nurse’.
• These posts were introduced to ARI in February 2003.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a Multi-Disciplinary Future
Developing Capability and Capacity
Sharing Experiences & Learning

Name Lynne Flett

Contact Details
Ward 32
Aberdeen Royal Infirmary
Aberdeen

Tel. No 01224 552294

E-mail

Title
Staff Nurse—Empyema

Brief Summary

Issues
Lack of out-patient facilities for cardiothoracic patients who required long-term chest drainage for chronic conditions such as Empyema. District nurses required support training and supervision when dealing with these drains.

Action
Monthly out-patient clinic set up in Ward 32 seen by Empyema Nurse. Patient assessed drain, changed and information given to consultant. Seen by consultant every 6 months as a routine.

Outcomes
- District nurse can accompany patient, discuss issues of concern and be given advice.
- Provides a contact for the community service staff.
- Numbers are small so it can be kept in Ward 32.
- Requests for further investigation can be made via this clinic and Empyema Nurse.

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Title**  
**Mowbray Frame Audit – assessing male patient’s satisfaction with Mowbray toilet frames.**

**Brief Summary**

**Issues**
To gain information from male patients within elective orthopaedics at Woodend Hospital regarding their satisfaction with the use of a Mowbray toilet frame, post elective hip replacement.

**Action**
Verbal check with 50 patients on ward 10 under the care of two consultants. This was completed during activities of daily living session

**Outcomes**
Of the 50 patients interviewed, 19 (38%) stated they had no problem with the Mowbray frame. One found it preferable to a raised toilet seat, which has been issued previously. 16 (32%) had minor problems and had to adjust sitting position. 15 (30%) had major difficulties with the frame and did not use it, often removing it themselves. In conclusion, 31 (62%) patients found the Mowbray unsuitable. A future audit is planned for February 2003 with alternative Scandia frame.

**Clinical Implications**
It may be that the Scandia frame is more appropriate for male patients and would increase compliance following Total Hip Replacement. Community occupational therapists may provide/order alternate frame if this was found to be the case.

**Addition Reading/Information**

**Category**

- *Delivering Quality Care* ✔
- *Shaping a multi-Disciplinary Future* ❘
- *Developing Capability and Capacity* ❘

---

**Name**  
**Eve Cruickshank**

**Contact Details**  
Occupational Therapy Department  
Woodend hospital  
Eday road  
Aberdeen  
AB15 6XS

**Tel. No**  
01224 556044

**E-mail**  
Eve.Cruickshank@arh.grampian.scot.nhs.uk
Title

A Clinical Audit of the Outcome of Occupational Therapy Goals

Brief Summary

Issues

A Clinical Audit of the Maidencraig Rehabilitation Unit Home Link OT Service was conducted to evaluate whether desired or predicated patient outcome had been achieved through OT intervention.

Action

OT goal documentation for patients enabled calculation of total number of goals identified, problems goals related to and outcome of intervention.

Outcomes

32 patients included. 79% of goals had positive outcomes with 49% of goals fully achieved. 21% of goals not achieved.

Clinical Implications

Benefits of using and auditing goal system includes improved documentation, goal setting and evaluation of patient progress.

Addition Reading/Information


Category

Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity
Sharing Experiences & Learning

Name: Jacqui Connelly
Contact Details: Ward 45, Aberdeen Royal Infirmary, Aberdeen
Tel. No
E-mail: jacqui.connelly@arh.grampian.scot.nhs.uk

Title: Flexible Working - Compressed Hours

Brief Summary

Issues
Initially a request was made by a group of staff, trained and untrained within Ward 45 to adopt a longer working day. This involved changing their normal day of 7.5 hours to an 11.5 hour working day. A group of staff within the ward had shown interest in working a longer day as opposed to the traditional 7.5-hour day. They were keen on the idea of a fixed rota that allowed them to identify the days they would be working for an indefinite period in advance. This was preferable to traditional rostering which determined off duty for only 3 weeks in advance.

Action
• Work in partnership with staff, personnel and staff side representative
• To develop off duty that would maintain a good skill mix, working an 8 week fixed rota
• Set a trial period which of 6 months
• Identify means of measuring appropriate bench markers, use of agency staff and sickness was compared from the same period of the previous year
• Develop & issue questionnaire anonymously to all staff at end of 6 month trial period.
• Monitor flexibility and skill mix within off duty

Outcomes
• Increased staff morale
• Reduction in use of agency/bank nurses from the same period the previous year
• Improved time management
• Improved continuity of care
• Improved patient care
• Reduction in overall sick time
• Adopt flexible rota enabling the nursing team to meet the peaks and troughs of activity e.g. theatre days

Addition Reading/Information

Category
Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
**Nutrition Education Sessions for Clients with an Eating Disorder**

**Brief Summary**

**Issues**
To deliver nutrition education to patients with anorexia nervosa, bulimia nervosa and other related disorders in a group setting as an alternative to individual dietetic input.

- Long waiting list for patients referred for dietetic advice at the Eating Disorders Service.
- Much of the dietary advice is repetitive so more cost effective if patients seen in groups.
- Group setting - enables interaction and discussion

**Action**
6 week, closed group, lecture style format covering relevant topics within the areas of nutrition and physiology. Each session is evaluated in terms of increase in knowledge, application of knowledge (behaviour change), attendance rates and patient satisfaction.

**Outcomes**
- Nutrition education sessions are now an integral part of the treatment on offer at the Eating Disorders Service.
- Evaluation has consistently shown high patient satisfaction and improvement in nutritional knowledge.
- Positive feedback from key therapists.
- For some patients this has replaced the need for individual dietetic input.

**Addition Reading/Information**

**Category**
- Delivering Quality Care
- Shaping a multi-Disciplinary Future
- Developing Capability and Capacity

**Architects of Change**

**Engine of Change**

**Subject of Change**
**Sharing Experiences & Learning**

**Name**  
Laura Dodds

**Contact Details**  
Grampian Local Health Council  
Westburn House  
Foresterhill  
Aberdeen

**Tel. No**  
01224 559444

**E-mail**  
laura.dodds@glhc.grampian.scot.nhs.uk

**Title**  
**Good Practice Guidelines to improve user and carer involvement in mental health services**

**Brief Summary**

**Issues**  
Service providers now have a duty to involve service users and carers in individual care, in services and at service planning level. Although there are examples of good practice in involving people in mental health services in Grampian, many people have said it could be better.

**Action**  
Grampian Local Health Council was asked by NHS Mental Health Services Division to develop good practice guidelines to improved the way service users & carers are involved in mental health services.

A multi-agency Project Group was set up to advise the Health Council. Visits to services and groups and interviews were held to inform the content of the Guidelines.

**Outcomes**

- Service users and carers were fully involved throughout the project.
- Good Practice Guidelines booklet, leaflet and poster were developed. This includes 10 Steps to Good Practice.
- Nearly all organisations within the mental health community, including NHS Grampian, have signed up to the guidelines.
- Action Plan to ensure the Guidelines are implemented, and their use monitored, is being developed.
- Potential to use the Guidelines in other service areas.

**Addition Reading/Information**

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering Quality Care</td>
</tr>
<tr>
<td>Shaping a multi-Disciplinary Future</td>
</tr>
<tr>
<td>Developing Capability and Capacity</td>
</tr>
</tbody>
</table>

**Architects of Change**
**Torry Activity Project**

**Issues**
The Torry Activity Project (TAP) aimed to develop and deliver a weight management programme combining diet, exercise and behavioural modifications, in an area of relative deprivation. This was a joint project between dietetics and physiotherapy, in partnership with Aberdeen Local authority. Obesity is increasing and treatment is difficult, however the evidence suggests that the most effective treatment includes a combination of advice and support regarding diet, physical activity and behaviour modification.

**Action**
24 Patients were recruited to the project via their GP or self referral in response to adverts in the local paper. Focus groups were held with interested patients to determine the type of service they would like. A 12 week programme consisting of weekly drop-in clinics and support groups was established. Patients were assessed individually by the project dietitian and physiotherapist. Goals for dietary and activity improvement were agreed with the patients. Weight, BMI, dietary intake, activity levels and psychosocial measures were made at week 1 and week 12. Patients were asked to evaluate the project at week 12. Links were made with the local authority to investigate exercise opportunities for the patients.

**Outcomes**
- 19 patients completed the project (18 females). 80% patients lost weight. Patients lost an average of average 2.46kg (2.73% body weight). Reduction in BMI was significant (p<0.003). There was also a significant increase in vegetable intake (P<0.004).
- The number of patients exercising 3-5 times/week increased from 33% to 54%. All patients felt they achieved their dietary goals, 60% felt they achieved their exercise goals, and 50% achieved their weight loss goal. All patients felt the programme was useful and they would recommend it to others.

**Addition Reading/Information**

**Title**

Torry Activity Project

**Brief Summary**
The Torry Activity Project (TAP) aimed to develop and deliver a weight management programme combining diet, exercise and behavioural modifications, in an area of relative deprivation. This was a joint project between dietetics and physiotherapy, in partnership with Aberdeen Local authority. Obesity is increasing and treatment is difficult, however the evidence suggests that the most effective treatment includes a combination of advice and support regarding diet, physical activity and behaviour modification.
Title  Management of Obesity in Kincardine & Deeside: Assessment of the Views of Overweight Children, Parents, Adults & Staff Regarding Current Services for Obesity Management

Brief Summary

Issues

The aim of this project was to ascertain the views of service users (overweight adults [Deeside only], children & their carers (Kincardine and Deeside)) as well as health care staff regarding current service provision in their local area through focus groups and questionnaires. This project was funded by HIF funding from Kincardine and Deeside. The incidence of obesity is increasing and now affects 40-50% of Scottish adults and 13% children between the ages of 4-11. 1,2 The causes and consequences of obesity are fairly well understood, however effective and appropriate management is less clear.

Action

Overweight children and their parents, and overweight adults were asked to volunteer to complete a questionnaire about the current weight management services provide by NHS Grampian. Children and adults already known to the dietetic service were also contacted and asked to complete a questionnaire. Questionnaires were also sent to GP’s, health visitors, practices nurses and school nurses. 11 children & parents, 9 adults and 45 staff returned questionnaires.

Outcomes

All children had tried to lose weight using a variety of health care services. 7 parents felt the help available was not adequate & would like to see; schools doing more to help; see more groups for information sharing & support; & specific diet sheets for children. Of the adults, 7 felt help they received was inadequate & would have liked; to be seen more often; to be taken more seriously; & more exercise classes specifically for overweight people. The majority of staff indicated that they treated overweight adults & children. Most felt their knowledge & confidence in treating obesity was fair-to-good, however several requested further training, referral guidelines & treatment protocols. Staff were also concerned regarding the sensitivity of body weight & potential psychological problems of treating obesity in children. There is no clear mechanism to identify obesity in children & there is also some uncertainty as to who should be treating or instigating treatment in children, and about treatment options.

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Sharing Experiences & Learning

Name  Carole Noble (team leader)  
     Alisa Wildgoose, Fiona Geddes, & Lorna Welewski

Contact Details  Community Dietetic Dept, Westholme, Woodend Hospital, Aberdeen, AB15 6LS

Tel. No  01224 556305

E-mail  carole.noble@gpct.grampian.scot.nhs.uk

Title  Grampian Integrated Nutrition Support Service (GINS)

Brief Summary
Issues
The GINS service was set up to improve clinical practice and organisation of patient care, by providing a service to patients receiving oral nutritional supplements (ONS) and providing guidelines on appropriate supplement prescribing. There was; lack of dietetic review in primary care; lack of guidelines and procedures on the use of oral nutritional supplements in both primary and secondary care; and inappropriate prescribing practices.

Action
• Undertook GP practice searches for existing patients on ONS
• Review of current patients and new patients
• System of transfer from acute to primary care
• Development of guidelines (appropriate prescribing of ONS & prescribing in substance misuse)
• Data collection and data set-up
• Developed sip feed formulary
• Training needs assessment carried out and training package developed
• Set up a net work of dietitians undertaking similar projects

Outcomes
• Service currently ongoing but result so far - October 2003-11-07
• 449 contacts – 33% stopped
• 11% advised to reduce or change supplement
• 42% remain on supplements and will be currently reviewed
• Implementation of the above actions have resulted in cost savings

Addition Reading/Information

Category
Delivering Quality Care  ✓
Shaping a multi-Disciplinary Future  ☐
Developing Capability and Capacity  ✓

Architects of Change  Architects of Change  Architects of Change
Brief Summary

Issues

Central Government now dictate working time regulations for junior doctors. Each Trust must ensure that junior doctors receive their breaks and do not work more than the stipulated hours in their rotas. To assist in this directive five senior nurses were appointed in Aberdeen Royal Infirmary as Night Nurse Practitioners to support junior doctors. They provide at operational level, clinical support, advice, training and professional development to nursing staff in order to comply with required directives.

Action

- Core skills required were identified through Junior Doctors Bleep Audit
- Practitioners competent in Venepuncture, cannulation, ECG, catheterisation, patient examination and advanced life support.
- Liaise with medical and nursing staff as to how to optimise use of new service.
- Provide support and training to nursing staff at ward level.
- Audit of the service, thus identifying future training requirements for practitioners
- Feedback of findings and statistics to Junior doctors Hours of Work Committee at 6-weekly intervals
- Liaise with other similar schemes throughout the country.

Outcomes

- Monitoring of junior doctors in areas receiving the service has shown rota compliance
- Audit identifies how training should progress
- Junior doctors and nursing staff feel supported overnight.
- Patients are seen quicker overnight when condition changes
- Opportunities for expanding and developing service
- Interest from Scottish Executive regarding how service is progressing

Addition Reading/Information

Brief Summary
Issues
On 11th March 2003 Malcolm Chisholm the Minister for Health and Community Care announced funding for 200 Healthcare Students in 2003/04. The funding was to allow existing support staff to remain in employment while completing an HNC in Healthcare that allows direct entry into year 2 of the pre registration programme. NHS Grampian was given funding for 14 students.

Action
To create Partnerships between NHS Grampian, Aberdeen and Moray Colleges and RGU. Jointly agree on selection criteria and the process for interviewing potential students. Organise workshops to disseminate information and gauge interest. This proved to be overwhelming with over 300 staff enquiring about the course. Short-listing was undertaken in Partnership with Service and staff side and interviews held throughout Grampian. Additional funding requested form SEHD.

Outcomes
NHS Grampian has 34 Healthcare students - 3 Mental Health, 14 Primary Care & 17 Acute
There are benefits all round
• Students are rewarded for commitment to the NHS (some have around 20 years experience)
• Employers can increase the capacity of the trained workforce
• Education has a cohort of committed students & links strengthened between Higher & Further Education
• Nursing has a flexible entry into Professional Education
• NHS Scotland has a coherent way of rewarding and developing valued staff.

Commitment and enthusiasm of potential students has been outstanding and has shone throughout the selection period.

Addition Reading/Information
Mullholland H (2002) Grow Your Own Nurses Nursing Times 98:42,
Title

Audit of OT intervention in Pain Management Clinic

Brief Summary

Issues

Occupational Therapy plays in a crucial role in the assessment and treatment of patients in a multi-disciplinary Pain Management Clinic. This has been borne out by a recent audit undertaken by the OT using the Patient Generated Index (PGI).

For a Pain Management Clinic to operate effectively a multi-disciplinary approach is required. The use of the PGI has not only been a valuable outcome measure, but it also enables patients to define the areas most adversely affected by their condition. This enables the OT to help them formulate realistic goals, which form the basis of future treatment sessions, along with education re pacing, activity levels, coping strategies, relaxation etc.

Action

PGI is to be continued to be used by the OT and audited on a regular basis. The Pain Clinic at Kincardine Community Hospital is now operating an Open Referral system, therefore any patient with chronic pain, who is registered with a GP in Kincardine LHCC would be able to be seen at the Pain Clinic.

Outcomes

The results of the PGI indicate that patients being seen by the OT at the Pain Clinic had improved by an average of 27%.

Addition Reading/Information


Muriel Shaw
Clinical Nurse Educator

Cardiology  CCU/19/29/31
Aberdeen Royal Infirmary
Aberdeen

01224 552534
muriel.shaw@arh.grampian.scot.nhs.uk

Clinical Nurse Educator for Cardiology

Brief Summary

The development of this role has allowed for more structured support, education and development for mentors and students within the clinical environment. It is hoped that together we can develop and maintain a clinical environment that supports and promotes education and lifelong learning for all.

Action
- Structured orientation programme for new members of staff
- Local competency frameworks developed for all grades of staff
- Structured weekly nursing teaching sessions
- Development of ‘Best Practice’ Group within Cardiology
- Participation in research and audit
- Maintaining Standards as set locally and by NHS Quality Improvement Scotland
- Continued communication with Robert Gordon University
- Participation in teaching of Cardiology issues in liaison with the Professional Development Department

Outcomes
- Ongoing support for all members of staff/students
- Improved confidence and competence of staff
- Enhanced patient care through research and audit

Addition Reading/Information


Category

Delivering Quality Care
Shaping a multi-Disciplinary Future
Developing Capability and Capacity
Name
Morag Ewing
Nursing Supplies Coordinator

Contact Details
Main Corridor (East End)
Aberdeen Royal Infirmary
Aberdeen

Tel. No
01224 552948

E-mail
Morag.Ewing@arh.grampian.scot.nhs.uk

Title
Nursing Supplies Coordinator

Brief Summary
Issues
• This role was developed to create a link between the Users, Supplies and their Suppliers.
• To rationalise the stock held in Central Stores and to identify and make efficiency savings.

Action
• To build strong working relationships with the Staff at Central Stores
• To meet with Medical Representatives
• To set up product evaluations and collate information gathered
• To inform Users of new or alternative products through User Groups and Newsletter
• To investigate, collate and follow up reported faulty products
• To representative the Grampian on SHS Advisory Panels

Outcomes
• Good two-way communication between the Users and the Supplies Department
• The movement of Medical Representatives is curtailed within the hospitals, but relevant information is made available
• New or alternative products are evaluated in appropriate areas with the information gathered then passed to other potential users
• Well informed Users
• The Trust gets value for money. Patient safety is protected. Faulty products are replaced by the Company
• The needs of Grampian are being met on National Contract.

Addition Reading/Information
Category
Delivering Quality Care

Shaping a multi-Disciplinary Future

Developing Capability and Capacity

Architects of Change

Architects of Change

Architects of Change
It’s Down To You!

What will volume Three contain?

An opportunity to share your Experience & Learning

Bigger?
More Comprehensive?
You decide!