10th June 2022 | Clinical Skills Centre |
Coach Lane Campus – West | Northumbria University

The Faculty of Intensive Care Medicine

ACCP Conference Delegate Handbook

WELCOME!

We extend a warm welcome to all delegates joining us for the FICM ACCP Conference 2022 at Northumbria University. We are very excited to welcome you back to our face-to-face conference provision!

We are privileged to welcome inspiring clinicians and academics from across the UK who will be sharing their work with us across the day. We are also proud to exhibit the high caliber quality improvement and research achievements of our ACCP colleagues through the oral poster presentation competition.

During the conference, please feel free to tweet us:

FICM Twitter Handle: @FICMnews
Conference Hastag: #FICMACCP22

We will be using the **VEVOX app** for interactive polling & questions throughout the conference. You can pre-register for this ahead of the conference.

Join us at: vevox.app ID: 133-672-379, or use the QR code below.

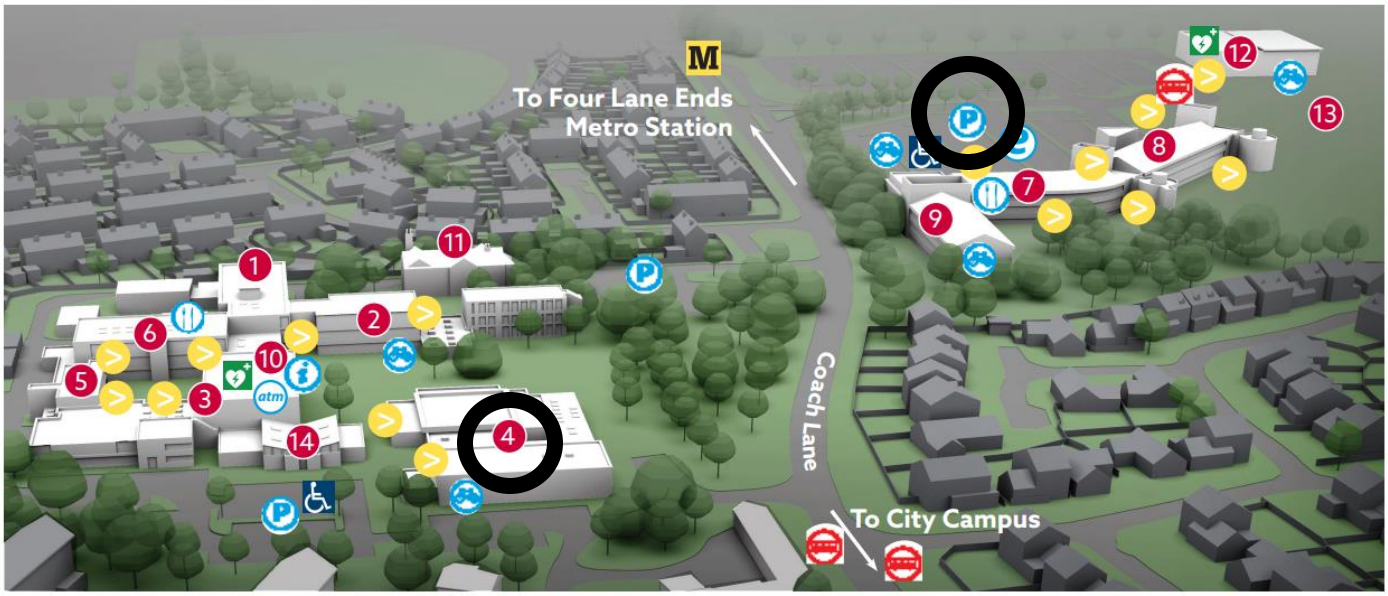
We hope you enjoy the day.

LOGISTICS

Coach Lane Campus is located just 3 miles outside of Newcastle city centre. The campus has two distinct sites; east and west. Parking for the event is situated on the east side, whilst the conference will be held in the Clinical Skills Centre (4) on the west side of the campus.

Click here for the Google maps pin direct to the designated visitor car park for this event.

Click here for the google maps pin direct to the Clinical Skills Centre.



Key

1 A Block
2 B Block
3 C Block
4 Clinical Skills Centre
Security
5 D Block
6 E Block
7 G Block
8 H Block
9 F Block
Library
Student Central
Ask 4 Help
10 Main Reception
11 Manor House
12 Coach Lane Sports Centre
13 Sports Pitches
14 Students' Union

Reception/Information
Parking
Cycle Parking
Electric Vehicle Charge Point
Disabled parking
Accessible Building Entrance
Designated No.1 bus stop for free travel for students to and from City Campus
Café
ATM Machine
Automated External Defibrillator

Travelling to the University

There are a number of ways to travel to the campus. Please visit our extensive information page for further details.

Parking Charges

Parking at Coach Lane East is based on automatic number plate recognition. A day rate fee = £3.00 and can be paid via the apcoa connect app, or online at **www.apcoaconnect.com**.

LOGISTICS

Electric Vehicles

Electric vehicle charging points are available at both City Campus and Coach Lane Campus via the PodPoint app. You will need to have a Hunt and Park permit to use the chargers at City Campus, or a Coach Lane permit and made an appropriate pay and display ticket purchase to use the chargers at Coach Lane Campus. Please contact s.diamond-fox@northumbria.ac.uk to arrange said permit.

Refreshments

Refreshments will be provided throughout the conference, but if you wish to visit our campus facilities, we have a number of options:

- **Communitea** (08:00 - 15:00pm) A selection of hot and cold breakfasts with mid-morning indulgent offers and Starbucks coffee. Famous for its lunchtime deli filled sandwiches.

- **Foragers Food Service** (11:30am - 14:00pm) Delicious hot meals (including Coeliac accredited meals) with choices including freshly baked potato with hot and cold fillings, classic comfort food with sides such as bolognese, ratatouille, sweet and sour chicken or Quorn and fish-Friday as well as soup of the day and fresh bread. Salad Bar with a range of vegan, vegetarian and gluten-free options and monthly themed meals, including Noodle Bar, Vegan Bites, Burritos and Pie Week at the Pop-up Kitchen.

- **Foragers POD** (08:00 - 15:00pm) A selection of hot breakfasts and bakery items. Foragers Coffee Pod offers hand prepared artisan fresh coffee and hot drinks with a selection of house special wraps and sandwiches.

Lockers

The Clinical Skills Centre has ample lockers for storing your belongings. We politely ask that delegates utilise the lockers provided during all workshops.

Charging Points/Sockets

There are a number of electrical sockets throughout the building suitable for charging laptops and mobile phones. Please ask one of our conference organising team for further information.

CLINICAL SKILLS CENTRE

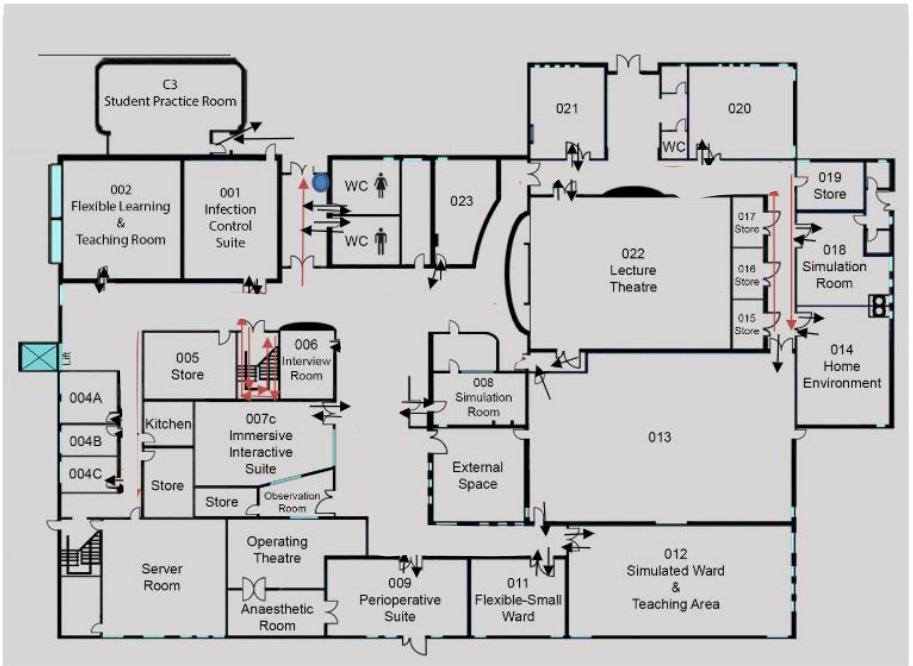
Finding your way

Our Clinical Skills Centre is one of the largest simulation centres in the North East of England, therefore it can be tricky navigating around!

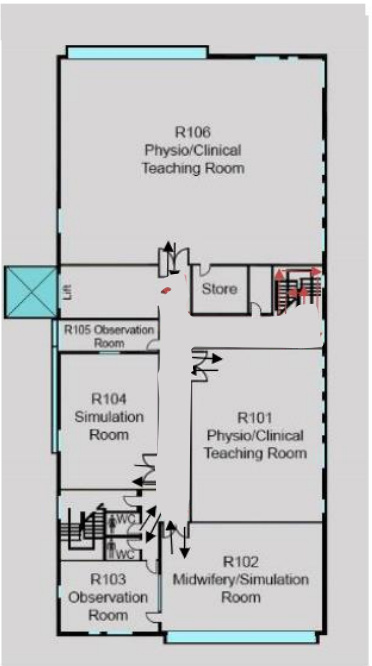
Please look for our conference signs throughout the building. Our ACCP faculty will also be on hand throughout the day to show you around.

Centre Map

Ground Floor Plan



First Floor Plan



Quiet Spaces

We have a designated quiet space for the day, rooms 014. Please feel free to use this room for prayer or quiet contemplation. If you require a more private room to breastfeed or lactate, please speak to one of our conference team.

PROGRAMME

08.30 – 09.15	**Registration**	Atrium	-
	Refreshments	013 & 012	-
09.15 - 09.30	**Welcome & housekeeping**	022	Alison Pittard & Sadie Diamond-Fox
09.30 – 10.15	**NECTAR**	022	Dr Tom Payne-Doris
10.15 – 10.45	**Sustainability**	022	Dr Richard Hixson
10.45 – 11.15	**Refreshments**	013 & 012	-
11.15 – 12.15	**Clinical reasoning**	022	Dr Martin Hughes
12.15 – 13.15	**Lunch**	013 & 012	-
12.30 – 13.10	**NAACCP AGM**	022	Carole Boulanger, Alex Gatehouse & Hannah Conway
13.15 – 14.45	**Workshop 1: SIM 1**	009 & 010	Dr Gavin Hardy, Dr Tom Payne-Doris, Dr Natalie Jones, Dr Alan Platt, Barry Hill & Newcastle ACCP faculty
13.15 – 14.45	**Workshop 1: SIM 2**	R101	
13.15 – 14.45	**Workshop 2: Antimicrobial Stewardship**	020	Dr Ali Robb
13.15 – 14.45	**Workshop 3: Who benefits from ICU admission?**	R106	Dr Phil Laws
13.15 – 14.45	**Workshop 4: Weaning - The good, the bad and the ugly airway**	002	Rachael Moses and Jen Murphy
13.15 – 14.45	**Workshop 5: ACCP CPD prioritisation – The practitioner's perspective**	001 & 021	Sonya Stone, Brigitta Fazzini, Hannah Conway, Carole Boulanger & Sadie Diamond-Fox
14.45 – 15.15	**Refreshments**	013 & 012	-
15.15 – 16.45	**ACCP Abstract Presentations & Competition**	022	Jane Poynter & Sadie Diamond-Fox
16.45 – 17.00	**Closing address**	022	Carole Boulanger

SPEAKER BIOS

SPEAKER BIOS

Dr Ali Robb

Dr Ali Robb
MBBS, MRCP (UK), FRCPath, DipClinEd
Consultant Microbiologist and Infection Control Doctor, Newcastle Hospitals

Ali trained in Newcastle and has been a Consultant Medical Microbiologist at the RVI in Newcastle since 2010. She chaired the Trust's Antimicrobial Steering Group from 2011 to 2018, acting as the lead for Antimicrobial Stewardship within the Trust. In that time the AMS team led numerous new initiatives including a smartphone guideline app, monthly ward based antibiotic audits, multi-professional teaching 'roadshows', trainee AMS leads and QI 'antibiotic superheroes'. Ali is now Infection Control Site Lead for Estates at the RVI. Her clinical interests also include cystic fibrosis, intensive care medicine and surgical infections.

Ali also has a keen interest in Medical Education, completing the Diploma in Clinical Education in 2010 and previously acting as Trust Medical Education Tutor for Safe Prescribing. She is a former Training Programme Director for Medical Microbiology and is currently Head of School for Laboratory Medicine and Associate Dean for Quality and Revalidation for Health Education England in the North East. She received an RCPath 'Excellence Award' for Contribution to Education in 2019.

Dr Martin Hughes

Martin is a consultant in Intensive Care Medicine and Anaesthesia at the Royal Infirmary, Glasgow.

He is a past president of The Scottish Intensive Care Society and has also edited Advanced Respiratory Critical Care, a multi author textbook. He has a longstanding interest in critical thinking, clinical reasoning and diagnostic error, co-organising the only UK conference on Diagnostic Error, and has written 3 book chapters on the subject. He is co-lead for Clinical Reasoning for the University of Glasgow Medical School.

SPEAKER BIOS

Dr Richard Hixson

Dr Richard Hixson FRCA FFICM has been a Consultant in Anaesthesia and Critical Care Medicine at County Durham and Darlington NHS Foundation Trust since 2001, and is a past Deputy Medical Director.

His portfolio includes: NHS England Clinical Entrepreneur and designer of CPDmatch, Trust Clinical Lead for Sustainability, Northeast 'ICS' Sustainability Group lead for 'people', member of Durham County Council's Climate Emergency Strategic Board, the Intensive Care Society's Sustainability Working Group, NHS England's Sustainable Procurement and Supplier Forums and the UK National Committee for the UN Decade of Ocean Science for Sustainable Development.

Richard co-founded Healthcare Ocean as his main interest is Global Goal 14, Life Below Water and how anthropogenic activities including healthcare procurement, container shipping and molecular pollution adversely affected the marine environment. His goal is to ensure oceans, coasts and inland waterways are never forgotten in NHS net zero planning as without healthy oceans, it will simply be impossible to successfully tackle the climate crisis.

Rachael Moses

Rachael is a Consultant Respiratory Physiotherapist by background with areas of expertise including complex ventilation, airway clearance techniques and advanced care planning for patients with long term conditions. Rachael is currently Head of Clinical Leadership Development at NHSE/I and is National Clinical Advisor for Respiratory with the Personalised Care Team at NHSE/I. She is passionate about inclusive leadership and raising awareness regarding equity, diversity and inclusion.

Rachael is very proud to be the first non-medic BTS President taking her tenure in November 2021 and hopes this encourages others to apply for such roles.
She is also fortunate to sit on a number of national organisations and Co-Chairs the national HMV-UK committee, is a Placement Co-ordinator for Medical Aid for Palestinians, Multimedia editor for Thorax BMJ and member of the CSP LGBTQIA+ Network.

In the 2021 Queen's Birthday Honour's List Rachael was made an Officer of the Order of the British Empire (OBE) for her services to the NHS.

SPEAKER BIOS

Jen Butler

Jen Butler is a Highly Specialist Speech and Language Therapist (SLT) for voice and laryngeal disorders, including inducible laryngeal obstruction (ILO), refractory cough, and dysphagia. She leads continuous laryngoscopy assessments for people with unexplained cough and breathlessness, and contributes to Severe Asthma and Bronchiectasis multidisciplinary clinics. More recently Jen has worked with the home non-invasive ventilation team to explore how laryngeal disorders affect breathing in progressive neurological disorders. Jen recently led the SLT cancer waiting times (CWT) pilot, in which SLTs conducted initial laryngoscopy assessments for patients referred to ENT on the CWT pathway.

In addition to clinical roles, Jen is a lecturer at Newcastle University, and contributes to specialist registrar training for Otolaryngologists and Respiratory Physicians. She completed a Masters' degree in Health Service Research in 2020 and has since received three academic funding awards. Jen's research has explored how ILO affects healthcare utilisation, and how clinicians can best support people with upper airway disorders, with a key focus on behaviour change techniques. She also contributed to the Royal College of Speech and Language Therapists' (RCSLT) Upper Airway Disorders Position paper and produced the RCSLT Upper Airway Disorder Factsheet, to raise awareness about upper airway disorders.

Dr Tom Payne-Doris

Tom is an ICM Consultant in Newcastle and lead for NECTAR (The adult & paediatric critical care transport service for the North East & Cumbria).

He did his undergraduate training in London (St Bartholomew's & The Royal London), before moving to the North East for specialty training. He has worked for many years (both as a registrar and consultant) for the Paediatric retrieval service at NECTAR. He is interested in fully realising the potential for adult critical care transport services (ACCTS) to benefit our ICUs and their patients.

Tom has worked with many inspirational ACCPs in the ICU setting and is keen to bring all that they have to offer to ACCTS. Other interests include aeromedical retrieval, palliative & end of life care in the ICU and Longer term ventilation.

Dr Phil Laws

Dr Phil Laws MB BChir MA
Consultant in Intensive Care Medicine and Anaesthesia

Escaped the North East in 1993 to read medicine and work as a junior doctor in East Anglia only to return in 2004. Taking exams as a pseudo hobby MRCP, FRCA, EDIC, DICM/FFICM, DipClinEd until consultant appointment in 2009 to Newcastle General.

Clinical lead for the first ACCP program at Northumbria University and Newcastle Hospitals, helping develop the content, assessments, approach and deliver educational and clinical supervision. Stepped down after appointing the third cohort at Newcastle Hospitals . Phil spent 5 years as Clinical Director for Patient Safety and Quality, Deterioration patient lead, Quality Improvement lead consultant. He stepped down last year from management to enjoy a better work life balance and continue to dabble with triathlons, the Wainwrights and life out of work.

Brigitta Fazzini

Twitter: @fazzini_b
https://orcid.org/0000-0003-3569-1203

Brigitta is an Advanced Critical Care Practitioner in the Adult Critical Care Unit at the Royal London Hospital. Essentially a clinician passionate in intensive care medicine, ultrasound enthusiast and young researcher within an international network. She is also the Deputy chair of the ICS Professional Advisory Group for Advanced Practitioner in Critical Care and part of the chair team of the Advanced Clinical Practitioners Academic Network (ACPAN) in UK.

Brigitta graduated in Italy with a BSc (Hons), and she moved to London in 2014 to start her critical care training. During these years she has developed and consolidated 10 years of experience in intensive care and critical care outreach alongside a solid academic pathway including the Critical Care MSc and the Advanced Clinical Practice MSc. Additionally, interested in humanitarian healthcare and global health, she holds the Professional Diploma in Tropical Nursing. She is an ultrasound enthusiast and, holding FUSIC (heart and lung) accreditation, she teaches and mentors doctors, nurses and physiotherapists undertaking their ultrasound accreditation. Passionate about improving care for critically ill patients, she is involved in clinical research focused on acute respiratory failure and translational medicine. Her highest hope is to proactively shape the future of intensive care speciality with an inclusive multidisciplinary approach promoting effective quality changes, education and research.

SPEAKER BIOS

Hannah Conway
Twitter: @cardiacACCP

Hannah is an Advanced Critical Care Practitioner who specialises in cardiothoracics and ECMO. Her clinical expertise is in critical care echocardiography and ultrasound, with over a decade of experience in this field. She sits on the UK Intensive Care Society Committee for Focussed Ultrasound in Intensive Care (FUSIC) and is a BSE examiner. Hannah runs a successful ultrasound education company 'g&h CritCareEcho' who deliver monthly courses covering the FUSIC, FAMUS and BSE curriculum.

Hannah is a keen clinical researcher and is currently conducting a study into the use of telemedicine to aid echocardiography mentoring on intensive care. Another research interest is characterisation of right ventricular (RV) injury. Hannah is co-chair for PRORVnet, an international RV centric research network and is proud to be an RV defender!

Hannah is also an Assistant Professor of Advanced Clinical Practice at the University of Nottingham, Deputy Chair of the Intensive Care Society's (ICS) Advanced Practitioners in Critical Care Professional Advisory Group (APCC PAG), ICS Education committee member and Co-Chair of the Advanced Clinical Practitioners Academic Network (ACPAN) in UK. In what spare time Hannah has, she enjoys carp fishing and is looking forward to getting back on the bank soon!

Sonya Stone
Twitter: @StoneyACCP

Sonya is an Advanced Critical Care Practitioner in the cardiothoracic ICU at Nottingham University Hospitals. She is also Assistant Professor of Advanced Clinical Practice (ACP) & programme director for ACP at the University of Nottingham. With a strong passion for all things education, Sonya also holds the Clinical Lead post for FICM's eLearning for Intensive Care Medicine (e-ICM). Sonya's passion for education delivery extends nationally via her role as Co-Founder and Co-Chair of the ACPAN.

SPEAKER BIOS

Carole Boulanger

Carole is a Consultant ACCP/Nurse at the Royal Devon University NHS Foundation Trust. She has been involved in the development of the ACCP role since inception as one of the original pilot trainees for New Ways of Working for Critical Care. Alongside practicing as an ACCP in her ICU Carole has had active involvement in the developing the role nationally via: The national Competency Framework for ACCPS, the RCoA via the Allied Professions related to anaesthesia group .

Currently Carole Co Chairs the FICM ACCP Advisory group responsible for development of the role nationally including the FICM ACCP curriculum and represents ACCPs on the Faculty Board and holds Fellowship of FICM. Carole is also the current chair of the National Association of Advanced Critical Care Practitioners (NaACCP).

Carole also works for HEE SW as Supervision and Assessment lead and nationally to support creation of funding streams to support sustainable ACCP education going forwards. Carole has an active role in the Nursing & AHP Committee for the European Society of Intensive Care Medicine leading being the first female and non-medic to receive the ESICM Society medal for outstanding contribution to ICM.

ACCP Abstracts

We are proud to exhibit the high caliber quality improvement and research achievements of our ACCP colleagues through the oral poster presentation competition. Our ACCP colleagues have a dedicated slot to present their work this year and have the chance to win a £20 Amazon voucher and the chance to work with the 'Advanced Clinical Practice' editorial team at the British Journal of Nursing to tur their abstract into a publication within said series.

Please use our online polling system at vexox.app to vote for the winner.

ID: 133-672-379

or use the QR code below:

ACCP Abstracts

Alice Hodgson

'A qualitative study exploring intensive care consultants' experiences of treatment escalation plans'

Alice Hodgson

A qualitative study exploring intensive care consultants' experiences of treatment escalation plans'

Background

Treatment Escalation Planning (TEP) is a necessary aspect of patient care, yet it is extremely difficult to do. It is important to establish what care patients would want and to explain to them how they might benefit in case of deterioration. Often these decisions are left until the patient is too unwell which means relying on relatives to assist with decision making. Intensive Care doctors are often called upon at these times to help make decisions about who should be admitted to the Intensive Care Unit (ICU) or not. This can be difficult when the ICU team do not know the patient and these decisions have to be made in an emergency. Research has been conducted on using certain TEP documents, how TEPs reduce the incidence of unnecessary harms, however, no research has explored the complexities of TEP planning from ICU consultants' perspectives.

Methods

Semi-structured qualitative interviews were carried out with 12 ICU consultants from the same NHS trust to explore their experiences of TEPs. Participants were recruited via snowballing. Interviews were conducted remotely via Microsoft Teams, transcribed verbatim and coded using NVIVO version 12. Framework Analysis (1)(2) was used to analysis the data.

Results

The results demonstrated that three main themes were identified where TEP plans could be implemented (Figure 1). These were pre-ICU (in the Emergency Department), within ICU and Post-ICU (in a ward setting). Within these themes there were 19 subthemes making up barriers and enablers to TEP planning with some commonalities across themes (e.g. poor communication, hospital culture and time pressures). Enablers identified within the three themes were clear communication, a Multidisciplinary Team (MDT) approach and education. Within ICU the results demonstrated that TEP plans were not favoured for patients being discharged unless they had an irreversible disease process. Macro themes (Figure 2) identified as barriers were legal aspects, the media, hospital processes and documentation.

Discussion

This is the first study to explore TEP planning from an ICU consultants' perspective. It has highlighted the complexities involved with TEP planning from an ICU consultants' perspective in one NHS trust. Participants perceive a need for TEPs but they reported that it was important that they were completed properly with the patient in mind. Future research should be structured around exploring ICU clinicians' perspectives in other departments in different trusts using the same topic guide as in this study. This will help identify similarities and differences between hospitals and establish what can be done to improve TEP planning for patients.

Discussion

This is the first study to explore TEP planning from an ICU consultants' perspective. It has highlighted the complexities involved with TEP planning from an ICU consultants' perspective in one NHS trust. Participants perceive a need for TEPs but they reported that it was important that they were completed properly with the patient in mind. Future research should be structured around exploring ICU clinicians' perspectives in other departments in different trusts using the same topic guide as in this study. This will help identify similarities and differences between hospitals and establish what can be done to improve TEP planning for patients.

Acknowledgements

Professor Jo Armes & Dr Athena Ip

References

1. Ritchie J, Spencer. Qualitative Data Analysis for Applied Policy Research. London : Routledge ; 1994.

2. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Medical Research Methodology. 2013;13(1).

ACCP Abstracts

Helen Torry

'Weaning the Oldham Way: A quality improvement project based on Kotters model of change'

ACCP Abstracts

We are proud to exhibit the high caliber quality improvement and research achievements of our ACCP colleagues through the oral poster presentation competition. Our ACCP colleagues have a dedicated slot to present their work this year and have the chance to win a £20 Amazon voucher and the chance to work with the 'Advanced Clinical Practice' editorial team at the British Journal of Nursing to turn their abstract into a publication within said series.

Helen Torry
'Weaning the Oldham Way. A quality improvement project based on Kotters model of change'

Case Description
A quality improvement (QI) project was commenced with the aim to improve the experience of weaning from mechanical ventilation.

An initial coalition was formed between interested parties who had a belief in the need and the ability to improve weaning. To build a sense of urgency and to create a strategic vision a one-day rapid improvement event (RIE) was organised which gathered a group of experts and stakeholders, with a shared purpose of improving the experience of weaning for patients and staff. There were presentations from industry and subject -matter experts, in-house specialists, as well as from a previous patient with lived experience. There were breakout sessions for discussions around vision and for development of ideas.

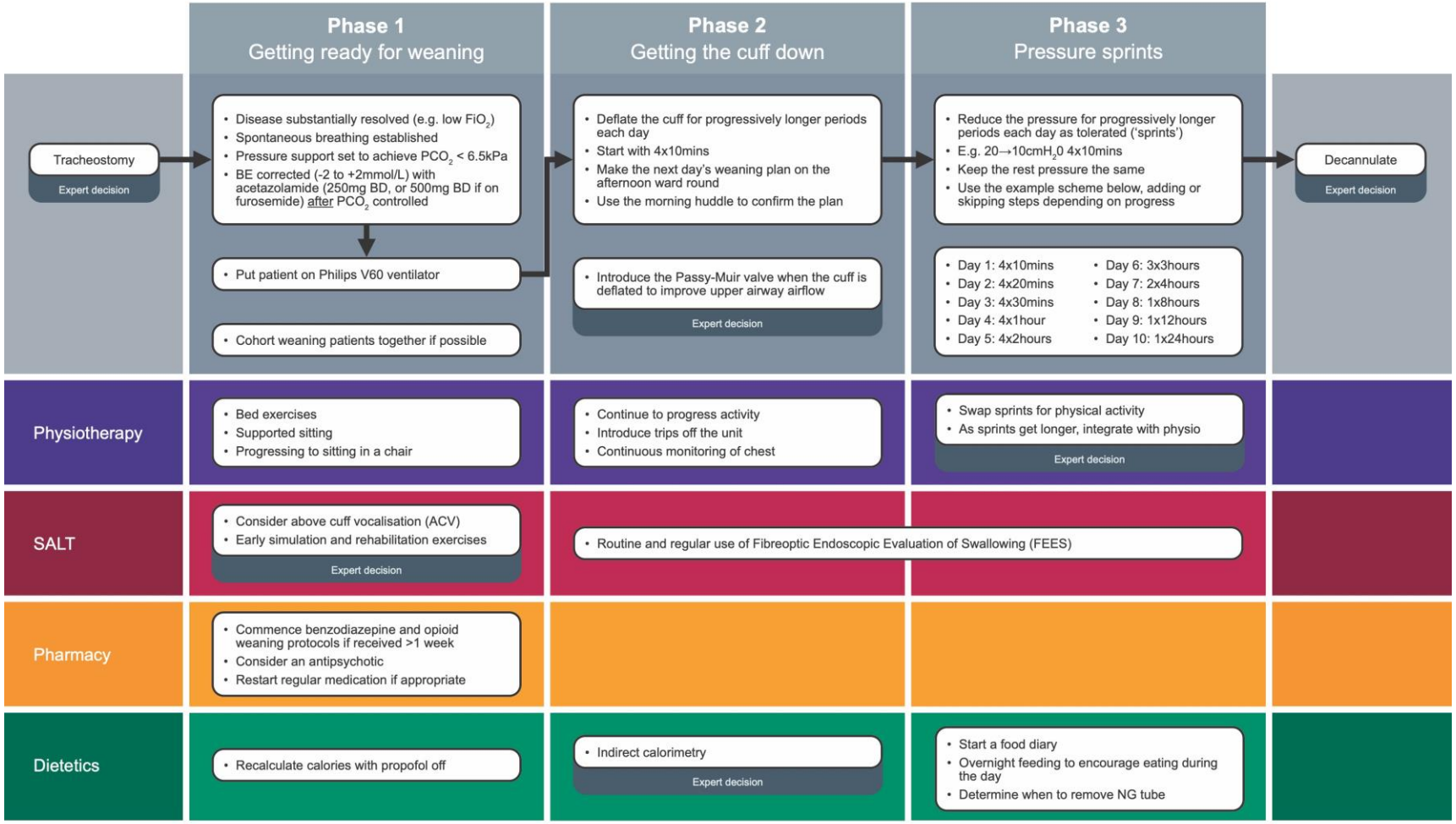
The event was the catalyst for a programme of work undertaken by the QI team. A process map was developed which resulted in 3 phases of weaning being identified. Within these individual disciplines had a "swim lane" with specific considerations for that stage.

Outputs of the process were the development of new guidance and updated paperwork to support a smoother and more successful wean from mechanical ventilation. The poster that was designed was a comprehensive guide which was easy to follow and implement. Documentation was also updated which improved communication as well as data recording. Patients were cohorted as much as possible to assist in continuity and gain momentum for the implementation.

Continued overleaf...

Weaning from ventilation: the Oldham way

NHS
Oldham Care Organisation
Northern Care Alliance



Version 1. Design by the Oldham ICU improvement team.

Intensive care unit weaning booklet

▸ For patient's who are ready to wean and established on a Philips V60 ventilator

Patient's name:

Date of birth:

Hospital number:

Date:

Delirium and drug weaning

☐ CAM-ICU negative/sedated, **or** ☐ CAM-ICU positive

☐ Enteral diazepam wean in process

☐ Enteral opioid wean in process

Morning blood gas

PCO_2 (kPa): Base excess (mmol/L):

☐ Acetazolamide in use, **or** ☐ Not prescribed

Plan (what we want to happen)

Rest setting (to keep PCO_2 < 6.5kPa):

Sprints:

☐ Cuff down 'sprints', **or** ☐ pressure 'sprints'

Start time: Initial:

Report (what actually happened)

Times:	Achieved?	Reason, if failed:

Physiotherapy achieved today No PT today ☐

☐ Exercises in bed

☐ Sat on edge of bed

☐ Sat in chair

☐ Other:

SALT interventions carried out N/A ☐

☐ Above cuff vocalisation (including by nursing staff)

☐ FEES - see separate report

☐ Cuff down ☐ PMV

Date:

Delirium and drug weaning

☐ CAM-ICU negative/sedated, **or** ☐ CAM-ICU positive

☐ Enteral diazepam wean in process

☐ Enteral opioid wean in process

Morning blood gas

PCO_2 (kPa): Base excess (mmol/L):

☐ Acetazolamide in use, **or** ☐ Not prescribed

Plan (what we want to happen)

Rest setting (to keep PCO_2 < 6.5kPa):

Sprints:

☐ Cuff down 'sprints', **or** ☐ pressure 'sprints'

Start time: Initial:

Report (what actually happened)

Times:	Achieved?	Reason, if failed:

Physiotherapy achieved today No PT today ☐

☐ Exercises in bed

☐ Sat on edge of bed

☐ Sat in chair

☐ Other:

SALT interventions carried out N/A ☐

☐ Above cuff vocalisation (including by nursing staff)

☐ FEES - see separate report

☐ Cuff down ☐ PMV

Version 5 Design by the ICU improvement team.

Patient's name:

Date of birth:

Hospital number:

Date:

Delirium and drug weaning

☐ CAM-ICU negative/sedated, **or** ☐ CAM-ICU positive
☐ Enteral diazepam wean in process
☐ Enteral opioid wean in process

Morning blood gas

PCO_2 (kPa):	Base excess (mmol/L):

☐ Acetazolamide in use, **or** ☐ Not prescribed

Plan (what we want to happen)

Rest setting (to keep PCO_2 < 6.5kPa):

Sprints:
☐ Cuff down 'sprints', **or** ☐ pressure 'sprints'

Start time:	Initial:

Report (what actually happened)

Times:	Achieved?	Reason, if failed:

Physiotherapy achieved today

No PT today ☐

☐ Exercises in bed
☐ Sat on edge of bed
☐ Sat in chair
☐ Other:

SALT interventions carried out

N/A ☐

☐ Above cuff vocalisation (including by nursing staff)
☐ FEES - see separate report
☐ Cuff down ☐ PMV

Terminate sprint early & seek help if any one of:

PCO_2 > 6.5kPa	RR > 36/min
PCO_2 rise > 1.3kPa	HR > 110/min
FiO_2 > 0.6	Diaphoretic (sweating)

Example of an enteral diazepam wean

	Day 1	Day 2	Day 3	Day 4	Day 5
00:00	10mg	7.5mg	5mg	2.5mg	2.5mg
06:00	10mg	7.5mg	5mg	2.5mg	
12:00	10mg	7.5mg	5mg	2.5mg	
18:00	10mg	7.5mg	5mg	2.5mg	2.5mg

Example of an Oramorph wean

	Day 1	Day 2	Day 3	Day 4
00:00	20mg	20mg	15mg	10mg
04:00	20mg	15mg	15mg	10mg
08:00	20mg	15mg	10mg	10mg
12:00	20mg	15mg	10mg	10mg
16:00	20mg	15mg	15mg	10mg
20:00	20mg	20mg	15mg	10mg
	Day 5	Day 6		
00:00	10mg	5mg		
06:00	10mg	5mg		
12:00	10mg	5mg		
18:00	10mg	5mg		

Audit tool - completed by SALT only

Tracheostomy performed on:
Achieved swallow outcome on:
Achieved speech outcome on:
Initials:

Discussion

Weaning is an essential and frequent occurrence within the intensive care unit, guidance is that structured plans should be in place2. In Oldham weaning plans were historically person dependant without a protocolised approach, with adhoc coordination between disciplines resulting in frequent changes which impacted the consistency of care and frustrations for staff.

Feasibility of the project was improved with the fortuitous introduction of V60 ventilators, they enabled development of skills such as cuff down weaning and increased passy-muir valve because of their leak compensation mechanism2. Having a MDT QI team well established meant a "volunteer army"1 was already available. The RIE enabled all interested stakeholders to be involved, ideas to be heard and a general "buzz" developed, this led to greater backing of the project and more successful implementation.

The projects aim was to improve experience. This was measured in something meaningful for the patient- early speech and return of swallow. For staff it was through surveying. The project saw improvements in both these areas and was deemed a great success, providing a more consistent and thorough approach to weaning as well as a boost to team morale through a project with rapid wins1 .

Next steps are to complete a post-implementation audit using the measurable data of speech and swallow achievement time.

Acknowledgements

Dr David Palmer- Lead Consultant for the initiative and process owner.
Rui Maricato (QI facilitator)
Attendees and speakers for the day event and members of the Royal Oldham QI team.

References

1. Kotter JP. Accelerate. Harvard Business Review Press; 2014
2. FICM & ICS. Guidelines for the provision of Intensive Care services. 2nd Edition. 2019
3. Phillips Guide to V60 ventilators. Accessed from https://www.philips.co.uk/healthcare/product/HC850008/v60-plus-ventilator ; 2022

ACCP Abstracts

Rebekka Brunner

A Quality Improvement (QI) project in Critical Care (CC) to reduce the incidence of accidental removal of central venous catheters (CVC).

Rebekka Brunner

A Quality Improvement (QI) project in Critical Care (CC)to reduce the incidence of accidental removal of central venous catheters (CVC).

Case Description

n 2019 Datix Incident Reporting indicated an increase in accidental CVC removals in our CC area.

The aim of the project was to determine the reasons for accidental CVC removals, to compare our incident rate with the national average and most importantly to identify and action procedures to reduce the incidence of accidental CVC removals. We adhered to the QI methodology which applies a systematic use of methods and tools, and ensures clinical effectiveness and patient safety focus throughout a project (1).

A team consisting of a consultant, senior registrar and a clinical fellow was formed and then lead by myself. To ensure adherence to this QI methodology and gain more support for the project, I participated in a local QI course. Through this I regularly presented our progress to the local QI Academy. We received helpful and timely feedback for our driver diagram, process mapping, and for the multiple PDSAs we conducted.

For data collection we utilised the Datix system. We identified three main themes as reason for the loss of CVCs. Prior to analysis we hypothesised that patients agitation was the main reason for CVCs being accidentally removed. This was not confirmed. Insufficient securing of the lines was identified to be the main reason of accidental removal of CVCs.

We developed a guideline for securing CVCs and distributed it to all members of the CC area. Furthermore the Anaesthetic QI team was involved to also achieve a common approach when securing CVCs in a Theatre setting prior to CC admission.

Discussion

Since the start of the project we have been able to achieve an overall reduction of accidental CVC removal (Figure 1). Most notable is the reduction of CVC losses due to inadequate securing(Figure 2). The number of accidental removal by patients has overall increased. Itis hypothesised that this is likely due to current staff shortages. Analysis is ongoing. Even after an extensive literature search we could not determine a national average of CVCs lost per year in the CC arena. Therefore no comparison of our incidences could be made with a national average. The QI methodology ensured we followed a structured approach. Therefore we were able to present data to the CC team which provided evidence of the success of an intervention.

Continued overleaf...

Discussion

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By using and analysing PDSA cycles we recognised when planned interventions did not work or when one intervention had effects on other areas which we initially did not anticipate. The project required multiple interventions, such as education of medical and nursing staff, changing documentation of line insertions and collection of data. As an ACCP I am in a position where I have access and insight to both groups and their responsibilities, this makes this role ideal to lead such a complex project. The project is ongoing, and the biggest challenge is sustainability with the acute staff shortage across the CC area.

Acknowledgments

Dr Gregor McNeill, ICU Consultant, NHS Lothian
Dr Matthew Parks, NHS Lothian NHS Lothian Quality Academy

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ACCP Abstracts

Roberta O'Donnell

'Improving humidification during ventilation: A quality improvement project'

Roberta O'Donnell

Improving humidification during ventilation: A quality improvement project

Background

It is well established that humidification is necessary during ventilation of critically ill patients to prevent hypothermia, epithelium disruption, atelectasis and tenacious secretions (1, 2) .This can be provided either passively by heat moisture exchanges (HME) or actively using heated wire humidifiers.

In 2020 the intensive care unit at the Royal Alexandra Hospital had 7 level 3 beds which were rapidly upscaled to 17 during the pandemic. Humidification during ventilation was solely provided by HME devices during invasive ventilation and non-

invasive ventilation (NIV). However it was observed that particularly for Covid-19 patients, there was an increased incidence of endotracheal tube occlusion and issues with CO2 clearance.

Methods

As part of a quality improvement exercise to improve humidification, we initially collected data of the NIV usage in our unit. We did an exhaustive literature search, critically appraising the available evidence. We conducted a telephone survey of Scottish intensive care units.

Results

Baseline data collection (Table 1): There was an increase in the number of patients that we provided NIV to when we compared our use over the last three years.

Literature Search: We identified six studies (3,4,5,6,7,8). Although limited evidence, there was no difference in rate of intubation or incidence of ventilator associated pneumonia between the two methods but active humidification provided more reliable humidification and improved alveolar ventilation.

Survey (Graph 1): We had an 80% response rate with 16 out of 20 units participating. The survey revealed that 9 units use active humidification in both invasive and non-invasive ventilation. 3 units use active humidification for invasive ventilation. 1 use active humidification for NIV and 3 units do not use active humidification at all.

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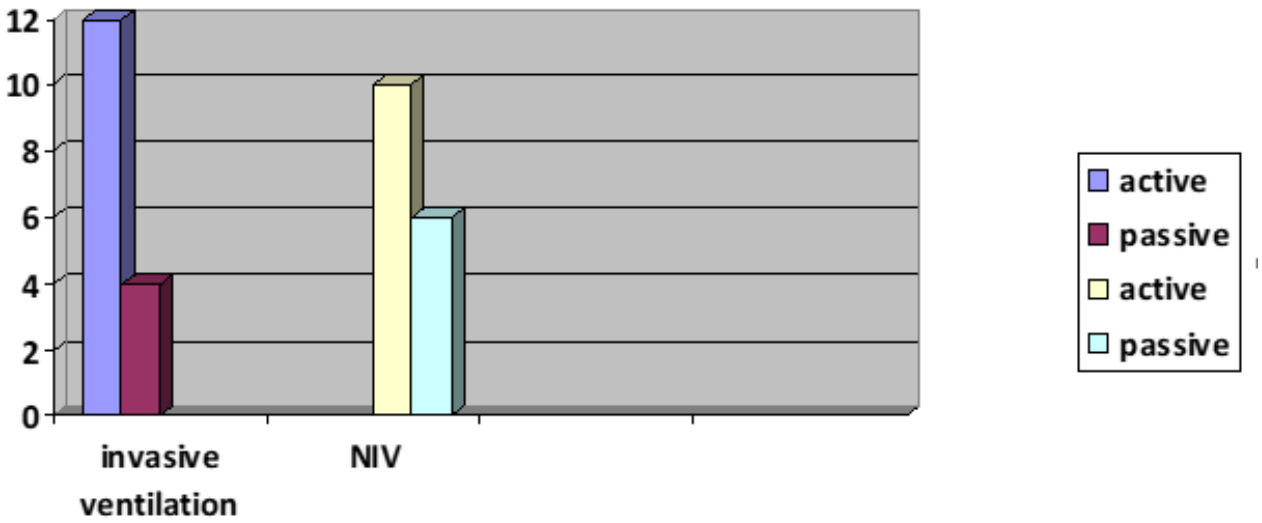
Results

Table 1: Usage of NIV and NHFO in RAH ICU

	2019	2020	2021
Total patients (n)	218	288	335
NIV (days)	0	13	154
CPAP (days)	0	10	122
NHFO (days)	247	275	320

Graph: Use of active and passive humidification in Scottish intensive care units 2021



Discussion

Appraisal of the current evidence suggests that active humidification provides adequate and reliable humidification (37 deg c, 44mg/L H2O), decreases dead space, PaCO2 and plateau pressure during protective lung ventilation (9). The newer technology circuits such as the Armstrong Aquavent VT are associated with less condensation and "rain out", which decrease risks of transmission of infection by reducing circuit breaks, condensation and aerosolisation. Ventilator circuits with the option for use in NIV and nasal high flow therapy once patients are extubated simplify equipment requirements and reduce infection risk from the handling multiple circuits. This multipurpose use also saves valuable consumable resources.

Our view of current practice has prompted a practice change with the introduction of heated wire humidifiers for NIV and consideration for use after one week of invasive ventilation. We are applying QI methodology and collecting real time data on use, endotracheal tube occlusion and set up time while introducing an education training package.

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Acknowledgements
Radha Sundaram, John Hunter and Alison Sharp

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INVITATION TO PARTICIPATE IN A PRIMARY RESEARCH STUDY

'A national evaluation of the Advanced Critical Care Practitioner (ACCP) role: a practitioner's prioritisation perspective of continuing professional development (CPD) needs'

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'A national evaluation of the Advanced Critical Care Practitioner (ACCP) role: a practitioner's prioritisation perspective of continuing professional development (CPD) needs'

The aim of this study is to generate systematic data to inform the understanding of the perceived continuing professional development (CPD) needs of Advanced Critical Care Practitioners (ACCPs) and how a wider national project may aid in supporting future workforce development in these areas. Despite the extensive utilisation and expansion of the ACCP role across the UK and the investment in extending their clinical scope of practice through the Faculty of Intensive Care Medicine's (FICM) Optional (clinical) skills Frameworks (OSFs), little is understood about what support and investment ACCPs perceive to need when progressing across all pillars of their advanced practice careers, which forms the overall rationale for this study.

This study is being undertaken as a partnership between Northumbria University, the Faculty of Intensive Care Medicine (as part of the Royal College of Anaesthetists) and the Advanced Clinical Practitioners Academic Network (ACPAN) and is not directly funded by any of these institutions. The study design has been informed by previous work conducted by said parties.

You are being invited to participate in this study because you have registered as a delegate at the upcoming 'FICM ACCP Conference 2022'. This research study is attached to Workshop 5 that will be taking place during the conference: ***'Workshop 5 - ACCP CPD prioritisation: The practitioner's perspective'***. The focus group will last approximately 45 minutes whereby structured and unstructured questions will be asked in informal group setting. The session will be recorded, anonymised, transcribed and analysed.

Before you decide whether you would like to participate in this study, it is advised that you understand why the research is being undertaken and what it would involve from you. If you consent to your involvement in this study, all the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for your consideration.

Yours sincerely,

Sadie Diamond-Fox

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