Great achievements by dedicated nurses

In the second of our monthly series which celebrates modern nursing roles across the regions in the RCN’s centenary year, Alison Whyte talks to nurses in the south east of England

Like many nurses, those featured here are motivated by a desire to do everything they can to give high quality care to their patients. Nurses are often reluctant to seek recognition for their achievements, but by talking publicly about the difference they have made, Gillian Elwood, Anja Templin and Sandra Wood are helping to share good practice.

RCN regional director Patricia Marquis has no doubt that nurses in south-east England deserve greater recognition for their remarkable achievements: ‘In this region many of the pressures affecting the NHS are even greater, as trusts struggle with the high cost of living and the draw of higher profile organisations in London,’ she says.

‘But these challenges, along with the variety of work, make it a great place to nurse and also attract the talents of some of the best nurses in the country.’

‘I FOLLOWED THE PATIENT FROM ARRIVAL TO DEPARTURE’

Gillian Elwood, matron in outpatients at Buckinghamshire Healthcare NHS Trust, put together new guidelines to ensure the dignity of frail, older and immobile people.

‘I became aware of a problem concerning immobile and frail elderly patients who were dropped off unescorted in outpatients.

‘I decided to follow the next vulnerable patient brought in by patient transport from arrival to departure. I wanted to observe everything so that I could see what changes needed to be made. The patient’s experience was distressing. She was transferred from a stretcher to a trolley in a public corridor, and although my staff put screens around her, she had no privacy or dignity. Something had to change.

‘At a meeting with the trust’s ambulance liaison officer, I discovered that in the past, the ambulance crew would remain with the patient during their stay in outpatients, however the system had changed and the crew no longer provided a “wait and return” service. Outpatients is not a good place for these patients. Because there are no beds for patients on stretchers, they are placed in the corridor. If they want to use the bathroom or get something to eat or drink, they need help. Even with screens and doing our best, it is a bad experience. So with no escort, and a staff to patient ratio of between 1:20 and 1:40, who is looking after the patient?

‘It was clear we needed guidance. I created two procedures – one for the care of patients brought in on stretchers, the second for patients who needed an appropriate escort.

‘First of all, the consultant must confirm that the patient needs to be seen. If the care home declines to send an escort, the ambulance crew can refer to the procedure and they can refuse to transport the patient without one. The patient’s carer and the outpatients department’s senior nurses liaise to ensure the patient’s dignity is maintained at all times.

‘These guidelines have been shared with local providers so they have a clear understanding of our expectations.

‘Before becoming a matron, I spent a number of years working in business and finance in the US. This gave me a different perspective. I positively embrace change! If you ask for things the worst that can happen is that people say no.

‘We have to make sure that the patient remains at the centre of everything.’
Sandra Wood, specialist nurse, Berkshire Healthcare NHS Foundation Trust, leads the Health Outreach Liaison Team in Reading. She is passionate about homelessness and says we could all be just one decision or one pay cheque away from being there ourselves.

‘We provide an outreach service and run a daily health drop-in. I am team lead, and we have a mental health nurse, a senior support worker and an administrator. What makes us unique is that we are nurse-led, and we offer physical and mental care.

‘The drop-ins are in day centres and hostels. We do an initial mental and physical health assessment, offer treatment, make referrals and try to get them into mainstream services. They can have a shower, a hot meal and new clothes. It is a positive experience.

‘We see chest infections, blisters, sores, abscesses, leg ulcers, skin conditions and asthma. Alongside drug or alcohol dependency, they have stress and anxiety, low moods or suicidal thoughts. I recently became a nurse prescriber, so we can reduce the appointments they have to attend and prevent hospital admissions.

‘We get 65 new referrals a month. Their ages range from 18 to 80, about one quarter are women and most are white British, though we have some Polish clients.

‘As well as some sad outcomes, there are positive stories – people who move on, get housed, find a job.

‘We chair a health forum for all our partner agencies and are developing a discharge pathway for homeless people. We are providing training on this pathway in hospitals and with the local housing department.’

Next month: innovative nurses in the northern region

‘RUN BY THEATRE NURSES FOR THEATRE NURSES’

Anja Templin, senior thoracic theatre sister, University Hospital Southampton NHS Foundation Trust, devised and runs a national course for thoracic theatre nurses.

‘I enjoy my job as much as I did when I started 15 years ago. Our thoracic team may be small but we have managed to improve our service greatly.

‘In 2013, I ran our first video-assisted, thoracoscopic surgery (VATS) lobectomy course for theatre nurses. The sixth is scheduled for May.

‘We follow the patient pathway from diagnosis to discharge, considering the patient at every step of the way. We have presentations from surgeons, anaesthetists, thoracic case managers, theatre and recovery nurses.

‘What makes our course different is the fact that it is run by theatre nurses for theatre nurses. It develops nurses’ leadership skills and builds their confidence. We also set up the Thoracic Charity Fund so that income can be used to buy equipment to improve patient care. I would say that the whole team is proud of our course.

‘This team ethos has helped me to introduce other improvements. Before August 2014, we would often work late or cancel elective patients at the last minute when we had run out of time. It was stressful. I decided to audit our theatre utilisation. Each month, I present data to the team on delays and cancellations and we pick it all apart. We don’t have a 24-hour system so every minute counts. A small delay for the ward is a big delay for us. A lot comes down to communication.

‘Now we have changed the way we collect patients from the ward, we always aim for a prompt start. The lists reflect a realistic workload, and the team decides at the morning briefing when the last patient needs to be in theatre. List overruns have reduced significantly.

‘To improve clinical practice, I have designed a new performance feedback form so that we can praise excellence, as well as identify learning needs.

‘Implementing change takes time, but it is worth all the effort.’