READ THE SIGNS
How to stop deteriorating patients dying

Empowered staff cut cardiac arrests
Improving communication at handover
How to identify and manage sepsis

News High impact actions to be made compulsory • Nurse health under scrutiny
If you’re a public sector worker there are now even more reasons to own a Honda Jazz.

It comes with a complimentary Sat Nav upgrade, to help guide you to your appointment on time.

And rear parking sensors, to help you reverse into that tight little spot when you get there.

MORE

To book a test drive, please call our public sector team on 0845 200 8006 or visit honda.co.uk/publicsector and they will arrange everything for you.

Fuel consumption figures for Jazz 1.4 i-VTEC EX manual in mpg (l/100km): Urban 42.8 (6.6), Extra Urban 58.9 (4.8), Combined 51.4 (5.5), CO2 130g/km.

Business users only. Terms & conditions: Available across entire Jazz range for vehicles leased by or registered to a public sector organisation. Offer applies to Euro rear parking sensors and Honda Compact Navigation System and is subject to availability. Cannot be used in conjunction with accessory packs or alloy wheel upgrades. Vehicle must be ordered between 2nd November 2009 and 31st March 2010, and registered by 30th June 2010. Complimentary items increase P11D value of car which will impact on driver BIK tax liability (if applicable). Offer available at participating Honda Dealers and is at the promoter’s absolute discretion. Promoter: Honda (UK), 470 London Road, Slough, SL3 8QY. Honda (UK) is a division of Honda Motor Europe Ltd. Registered in England and Wales No 857969.
All English hospitals may face fines from next year if they fail to improve against indicators of nursing quality.

The Department of Health is considering linking the amount hospital trusts get paid to how well they perform in clinical areas such as reducing pressure ulcers and falls.

Since the publication of the NHS next stage review in June 2008, the DH has developed a series of nursing quality indicators which trusts are being encouraged to implement.

As reported by Nursing Times earlier this month, chief nursing officer for England Dame Christine Beasley has called on nurses to lead the implementation of eight “high impact” actions – closely linked to some of the indicators – which the DH believes could improve care and save up to £9bn (news, page 1, 17 November).

Officials are now looking at making some of the indicators and actions a compulsory part of its “commissioning for quality and innovation” framework (CQUIN), which allows primary care trusts to withhold some payment from hospitals if standards are not met. The percentage of money to be tied to CQUIN quality payments is also expected to more than double in the next financial year and could total up to £500m.

Speaking at the Nursing Times Delivering High Quality Nursing Care conference this month, DH programme director for quality in nursing Gerry Bolger said: “CQUIN is going to be aligned to some national priorities, and we hope to see some of [the nursing indicators] in there.”

DH officials believe that tying improvements in such areas to trust finances would help nurses get support from their trust to carry them out. It would also help soften the message to staff that the NHS must save huge amounts of money in coming years.

Although it is not compulsory this year, some PCTs have already started linking payments to nursing indicators, including those in the West Midlands. For example, funding at Heart of England Foundation Trust is already tied to performance in areas including falls assessment, pressure area care and food and nutrition.

The trust’s chief nurse Mandie Sunderland, who has led the roll-out of nursing quality indicators, said she would welcome the system being spread nationally.

She said: “By making the nursing metrics part of CQUIN we are compelled as an organisation to deliver improvements in nursing care.

“For me as a chief nurse, it gives me a huge lever with my board to ensure delivery of nursing care is one of the key parts of their agenda,” added Ms Sunderland.

Additionally in the NHS Yorkshire and the Humber region, all PCTs have agreed to use pressure ulcer rates and use of malnutrition screening as a CQUIN measure.

Doncaster PCT director of quality and clinical assurance Julie Bokus said: “Requiring this nationally will be welcome if we make sure we work to the same definitions, so we can benchmark.

“One of the challenges we have had is for everyone to have the same specific data requirements,” he said.

The DH told Nursing Times that changes to CQUIN would not be confirmed until later in the year.

A spokesman said: “Information on the CQUIN framework for 2010-11, including the financial value, will be communicated through the operating framework and contract guidance.

“The CQUIN framework allows for quality improvement goals to be developed at a local level, so there is opportunity for all local health economies to use nursing indicators if they wish to do so.”

Dame Christine has sold the high impact actions, which were recommended by organisations and nurses across the country, as a way to save the health service millions of pounds without risking arbitrary “slash and burn” cuts from managers.

- No avoidable pressure ulcers
- Year on year reduction in falls sustained by older people
- Stop inappropriate weight loss and dehydration
- Increase the normal birth rate and eliminate unnecessary caesarean sections
- Avoid inappropriate hospital admission and increase people able to die in place of their choice
- Cut nursing and midwifery sickness absence to 3 per cent or less
- Increase patients whose discharge is led by a nurse or midwife
- Demonstrate a dramatic reduction in the rate of urinary tract infections
Improve performance and reclaim your professional image, nurses told

NURSING TIMES 1 December 2009 Vol 105 No 47 www.nursingtimes.net

Nurses need to “reclaim” their professional image to counter concerns about poor care, according to a member of the Prime Minister’s Commission on the Future of Nursing and Midwifery.

Chelsea and Westminster Foundation Trust chief executive Heather Lawrence started her career in nursing and is one of the 20 members of the commission.

At an event to update her trust’s staff on the commission’s work, Ms Lawrence said many of its discussions had focused on complaints about nursing that had been highlighted by the Patients Association.

The way nurses communicated with patients and relatives was often the subject of such complaints, she said.

Referring to one of the commission’s aims to build a “vibrant public image” for nurses, Ms Lawrence said: “It’s about reclaiming what people say about us.

“The image problem is what ruins it for us. It needs to be seen as an attractive profession to come into compared to other careers.”

Also being addressed by the commission is poor performance. Ms Lawrence said that, instead of waiting for annual appraisals, nurses should ask for feedback “every few months”.

There was a particular need to change the “attitude” of some nurses regarding sickness absence.

She said: “Every time someone has had a day off sick, the manager should see them and say ‘what can I do to make it easier for you to stay at work?’”

Nurses attending the event said they were unsure about a statement in the commission’s draft vision, published in October, which referred to the profession as “ordinary people doing extraordinary things”.

One group of nurses said they were “totally divided” over whether nurses should be described as ordinary.

Another said: “Anyone who decides to work in the public sector isn’t ordinary by any stretch of the imagination.”

However there was general agreement with the statement: “High quality care involves using heads, hands and hearts”.

Ms Lawrence’s comments came on the same day that concerns were raised about nursing care and infection control procedures at Basildon and Thurrock University Hospitals Foundation Trust (see page 5).

NMC stands up for staff with mental health problems

CLARE LOMAS clare.lomas@emap.com

There is “no evidence” to suggest that a nurse with a mental health problem would not be good at their profession, according to the Nursing and Midwifery Council.

The claim follows the case of nurse Penelope Rees, who last week was convicted of ill treating two elderly patients with dementia at Whitchurch Hospital in Cardiff.

The trial judge called for an investigation into why Ms Rees, who has bipolar disorder with associated psychosis, was allowed to care for dementia patients while suffering from a serious mental health condition herself.

But an NMC spokesperson said: “There is no evidence to suggest that anyone with a mental health problem – bearing in mind how broad the term is – would be incapable of being a good nurse or midwife.”

She added that responsibility for identifying health issues that could prevent a nurse from practising safely “start with the individual concerned” and that nurses must “inform someone in authority if they experience problems that prevent them from working within the code [of conduct].”

Cardiff and Vale University Health Board, which runs Ms Rees’ trust, declined to comment on whether it was aware of her illness but said a full investigation was under way.

In response to the case, Royal College of Nursing mental health adviser Ian Hulatt called for NHS organisations to provide more support and understanding for staff with mental health problems.

“People don’t tend to disclose mental illness because of the lack of understanding, the fear of discrimination and the stigma attached to mental health conditions,” Mr Hulatt said.

“If employers are serious about the health and wellbeing of staff, they have to be encouraged to look at all aspects of health and create a climate whereby staff feel able to disclose a mental health problem. This is particularly important when they are caring for vulnerable people,” he added.
NHS commits to better staff health

Staff sickness cost the NHS £355m a year through absences and the use of bank and agency staff, the report said.

It found nearly half of these absences are caused by musculoskeletal disorders, and more than a quarter are due to stress, depression and anxiety. Cutting sickness absence by a third would create an extra 33.4 million working days a year, the review found.

It also called for a qualified consultant occupational health nurse in each region.

In a letter to review chair Steve Boorman last week, health secretary Andy Burnham said: “It is imperative that NHS staff receive the same level of support for their health and wellbeing that they deliver to one million patients every 36 hours.”

He wrote: “I expect NHS organisations to implement recommendations, develop or refresh strategies, invest in their health and wellbeing services and deliver significant improvements in sickness absence and improved staff health and wellbeing.”

Royal College of Nursing chief executive and general secretary Peter Carter said: “We know that investing in proactive health and wellbeing services, in particular occupational health nurses, will save the NHS money which could be channelled into patient care.”

BOORMAN’S RECOMMENDATIONS

- NHS organisations have a prevention focused health and wellbeing strategy for staff
- Senior management made accountable for staff health and wellbeing, which will be measured as part of the annual assessments of NHS performance
- Early interventions for staff with musculoskeletal and mental health conditions

Nurses encouraged to be NICE ‘ambassadors’ for local communities

Nurses who want to play a bigger role in helping improve the health of their communities are being encouraged to apply for a NICE fellowship.

This month saw the launch of the National Institute for Health and Clinical Excellence fellows and scholars programme, designed to create more opportunities for NHS staff to work closely with the clinical adviser.

All NHS staff, including nurses, can apply to become a NICE fellow. It will award 10 three year fellowships annually to health professionals who will act as ambassadors’ for the local community.

NICE clinical and public health director Peter Littlejohns said it welcomes applications from all staff who are “committed to driving up the quality of care”.

The institute will also award 10 12 month scholarships every year to health professionals in their final years of training.

The deadline for applications is 31 December. NICE will appoint its fellows and scholars in spring 2010.
Nursing Times

MONDAY

Standards “unacceptable”
Scottish health secretary Nicola Sturgeon demanded urgent improvements at Aberdeen Royal Infirmary, after a report from the Healthcare Environment Inspectorate identified serious weaknesses in cleanliness and infection control. Ms Sturgeon said: “This report makes difficult reading. Some of what the inspectorate has found is simply unacceptable. My message to other health boards is clear – they should not wait to be inspected themselves before considering if improvements are needed.”

NHS to act on staff health
The government accepted the recommendations made by occupational health expert Steve Boorman in his review on improving the health and wellbeing of NHS staff. The review recommends that all NHS trusts develop and implement strategies for “actively improving the health and wellbeing of their workforce” (page 3).

TUESDAY

Flood rescuers get vaccines
NHS Cumbria announced an additional vaccination programme for essential workers involved in the flood rescue and recovery work in Cockermouth. The seasonal flu, swine flu and pneumococcal vaccinations are being offered to all key workers involved in the recovery operation. Dr John Howarth, NHS Cumbria’s lead GP for Cockermouth, said: “We know from experience that the risk of respiratory infections can increase following floods.”

£555m
What the NHS could save each year in sickness absence if it made significant efforts to improve the health and wellbeing of its staff

Health visiting demand
A report from the UK Public Health Association recommended “creating a reinvigorated health visiting service”. The Health Visiting Matters report recommends that health visiting should be a profession in its own right in the same way as midwifery, rather than being a post-registration nursing specialty. Including graduates from allied professions to become health visitors would improve recruitment and retention, the report said. It identified a need for leadership programmes and research on health visiting to be collated.

WEDNESDAY

Honorary doctorates given
Anglia Ruskin University awarded honorary degrees to three senior members of the nursing and midwifery professions. South West Essex Primary Care Trust director of quality and nursing Barbara Stuttle, NHS East of England chief nurse Ruth May and Dame Karlene Davis, former general secretary of the Royal College of Midwives, received honorary doctorates of health sciences awards.

Anger after attack on nurse
Nurses criticised a London mental health unit for understaffing and a lack of security after a nurse was strangled by a patient. Staff said that chronic understaffing and an inadequate alarm system at the City and Hackney Centre for Mental Health left them vulnerable to attack. The nurse, who was attacked last month, survived, but was left with neck
injuries and perforated eardrums. Nursing assistant Yonatan Mosquera told ITV’s London Tonight programme: “We have overcrowding and we have understaffing. It affects the quality of service we can provide, it affects our morale, and it is also dangerous.” East London Foundation Trust, which runs the centre, said there would be an independent inquiry into the incident.

**THURSDAY**

**College tells a story**

The Royal College of Nursing launched a book on its history. A History of the Royal College of Nursing 1916–90, a Voice for Nurse was written by Susan McGann, Anne Crowther and Rona Dougall. The book examines the “wider perspective of nursing in the political, social and economic fields” and “the empowerment of women through nursing”.

**Midwives’ £10,000 debts**

A fifth of all student midwives will graduate with debts of more than £10,000, the Royal College of Midwives said. It polled 345 students, finding that 65 per cent in their final year were in debt, 46 per cent of whom said repaying the money was a bigger concern than not getting a job. Of those owing money, almost 20 per cent were over £10,000 in debt, while a further 28 per cent owed between £7,000 and £10,000. The survey was released at the RCM’s annual conference in Manchester.

**Tories pledge on maternity**

A Conservative government would fund innovative maternity services to counteract pressures created by higher birth rates, shadow health secretary Andrew Lansley told delegates at the RCM’s annual conference. Proposals include drop-in midwifery practices in shopping centres, prospective fathers or other family members being offered antenatal sessions and a greater emphasis on women being given the option of a home birth. Mr Lansley said: “These plans will transform care for new mothers in England, from a service that is overstretched and patchy to one where every family gets the care and support that it needs.”

**Homeless help**

The Queen’s Nursing Institute started offering free resource packs to nurses working with homeless people over Christmas. QNI Homeless Health Initiative coordinator Kate Tansley said: “Because of the general economic situation and the rise in unemployment, many more people may be increasingly vulnerable to losing their home. This has implications for all areas of nursing.” She added: “A huge range of issues are covered in these free publications. We are very keen that this knowledge be shared as widely as possible.” To get a pack, send your name and contact details to barbara.walsh@qni.org.uk or call 020 7549 1400.

**FRIDAY**

**Serious failure at Essex trust**

The Care Quality Commission and the foundation trust regulator Monitor called for immediate action to rectify care failings at Basildon and Thurrock University Hospitals Foundation Trust in Essex. CQC inspectors found unusually high death rates and serious infection control deficiencies including bloodstains on floors and curtains, blood splattered on trays used to carry equipment and badly soiled mattresses.

**Swine flu update**

GP consultation rates for flu-like illness per 100,000 of the population

---

**NEW DENTAL UNIT RAISES SMILES**

Health secretary Andy Burnham looked a little uncertain when Matron Margaret Titherington presented him with a dental health pack during a visit to the Liverpool University Dental Hospital, part of Royal Liverpool and Broadgreen University Hospitals Trust. Mr Burnham was there last week to open a £6m unit with a minor oral surgery area and facilities for patients with disabilities.

‘There was smoke billowing from a cupboard from the corner of the ceiling – it was almost as though the tiles had blown in’

Brian Norton, former nurse at the Rosepark care home in Lanarkshire, speaking last week at an inquiry into a fire that swept through the home, killing 14 residents, in January 2004.

---

Sarah Brown spoke at the RCM

The prime minister’s wife Sarah Brown, addressing the Royal College of Midwives annual conference in Manchester, spoke of the knock-on effects of maternal mortality. “A mother’s survival is crucial to her baby’s welfare and often her baby’s life.”
MATERNITY AND NEONATAL

Cold limits brain damage
A cooling system to prevent brain damage in newborn babies has been introduced by staff in the neonatal intensive care unit at the Princess Anne Hospital in Southampton. Babies at risk of perinatal asphyxia – oxygen deprivation caused by obstruction of the blood supply between mother and baby – are attached to a cold body wrap and cooling machine to induce hypothermia before gradually being warmed up again. Cooling babies at risk within six hours of birth limits brain inflammation, significantly reducing the risk of severe disability and death.

www.suht.nhs.uk

LONG TERM CONDITIONS

Combined drugs in cancer
Adding the drug cetuximab (Erbitux) to chemotherapy can help shrink colorectal liver metastases that were previously inoperable because they were too big. German researchers, who studied 109 patients over two years, found that treatment with cetuximab significantly increased the proportion of tumours that could be operated on. Sixty per cent of tumours were judged to be resectable after treatment, compared with 32 per cent at the start of the study, the researchers said online in The Lancet Oncology.

www.thelancet.com/journals/lanonc

Pain is risk factor for falls
Older people with chronic pain have a significantly increased risk of falls, US researchers who studied 749 adults aged over 70 for 18 months have found. Compared with study participants who reported no pain, those who experienced chronic pain in two or more joints had a 50 per cent greater risk of falling. “Our results suggest that pain should be added to the list of risk factors for falls,” the authors said.

JAMA (2009) 302: 2214-2221

EC approves diabetes drug
The European Commission has approved the drug sitagliptin (Januvia) as an adjunct to insulin, with or without metformin, to help achieve glycaemic control in patients with type 2 diabetes. Sitagliptin is already recommended for use in patients with type 2 diabetes who cannot tolerate metformin, or for whom metformin is inappropriate. It can now be used across the whole treatment pathway.

www.nice.org.uk/IPG319

Caution on back treatment
NICE has published guidance on percutaneous intradiscal electrothermal therapy for lower back pain. The institute said evidence on the safety and efficacy of the therapy for low back pain was “inconsistent”. It should only be used with “special arrangements for clinical governance, consent and audit or research.” Clinicians wishing to undertake it should obtain permission from their trust and ensure patients understand the “uncertainty about the procedure’s safety and efficacy and provide them with clear written information.”

www.nice.org.uk/IPG319

PUBLIC HEALTH AND WELLBEING

Cut salt to lower stroke risk
Reducing salt intake by 5g a day can significantly reduce the risk of stroke and cardiovascular disease, according to Warwick University researchers. They reviewed 13 international studies involving more than 170,000 people. A 5g cut in daily salt intake reduced the risk of stroke by 23 per cent and cardiovascular disease by 17 per cent, the researchers said online in the BMJ. Europeans consume an average of 12-13g of salt per day but the World Health Organization recommends that daily intake should not exceed 5g or 6g.

www.bmj.com

Syphilis at all time high
The highest number of syphilis cases for 50 years was recorded in Scotland last year, figures from Health Protection Scotland and the Information Services Division show. There were 264 cases of syphilis, up from 249 in 2007 but the highest annual total since 1952. Three quarters of the 19,054 cases of chlamydia reported were diagnosed in under 25s, although this group made up only 13 per cent of the country’s population. The same age group also accounted for 59 per cent of cases of genital warts and 61 per cent of cases of gonorrhoea. Dr Lesley Wallace of Health Protection Scotland, one of the lead authors of the report, said: “We need to continue to encourage behavioural change, including safer sex and regular sexual health check-ups.”

www.hps.scot.nhs.uk

Guidance improves HIV care
The Independent Advisory Group on Sexual Health and HIV has made six recommendations to help improve the care and treatment of people living with HIV in the UK. In its report, Building on Progress: Enhancing the response to HIV in England, it suggests: improving prevention and testing; a coordinated approach to evidence and its dissemination to improve understanding; achieving a national cross-governmental overview of HIV; and addressing stigma and discrimination. The report also considers the effect of an ageing HIV positive population on social and health care.

www.dh.gov.uk

ACUTE CARE

Pain care shortens ICU stay
Mechanically ventilated intensive care patients who are assessed for pain have better outcomes and shorter stays in the intensive care unit than those who are not, French researchers have said. They studied 1,144 patients, half of whom were assessed for pain. The researchers found those who were assessed were more likely to have their sedation level checked, and be given nonopioids and dedicated analgesia during painful procedures than those whose pain was not assessed. These patients also had a shorter duration of mechanical ventilation (eight days compared with 11) and a shorter stay in ICU (13 days compared with 18) than those whose pain was not assessed, the researchers said.

Anaesthesiology (2009) 111: 1308-1316
X-ray gauze warning
The Medicines and Healthcare products Regulatory Agency has issued a warning over SwabX X-ray detectable gauze, manufactured by Richardson Healthcare. The agency said the X-ray filament within the swab is of insufficient tensile strength, which may cause the thread to fragment during use. Details of affected lot numbers of the product can be found on the MHRA website.

www.mhra.org.uk

CHILDREN AND YOUNG PEOPLE

Tool assesses acute illness
A pioneering online tool to improve the assessment of sick children has been launched by paediatricians at Leicester University of and University Hospitals of Leicester Trust. The website, for use in primary and acute care, teaches examination techniques of the commonest presenting complaints in acutely ill children, along with basic assessment and communication skills. Funded by the Department of Health, the site is aimed at frontline staff.

www.spottingthesickchild.com

Meningitis C plummets
The number of meningitis C cases has dropped by 99 per cent in the last decade since the childhood vaccination programme was implemented. The Health Protection Agency said that there were only 13 cases in England and Wales in 2008-09 in

England and Wales, down from 955 in 1998-99, when the meningitis C vaccination was introduced. Before the vaccine was introduced, four out of 10 cases of meningitis were of the C type and caused more than 100 deaths a year. There is no vaccine available for meningitis B, which causes almost 90 per cent of cases in the UK.

www.hpa.org.uk

BP tests hide hypertension
Blood pressure checks in children with chronic kidney disease often fail to detect hypertension, US researchers have said. They compared blood pressure readings taken at GP surgeries with those taken at home in 198 children. Almost 40 per cent of the children had “masked” hypertension – where blood pressure was normal in the GP’s surgery but high outside it – significantly increasing their risk of serious heart problems, the researchers said online in the Journal of the American Society of Nephrology.

http://jasn.asnjournals.org

Hidden cases of swine flu
Thousands of children may have been infected with the swine flu virus without being aware of it. As many as one third of school age children in some parts of England may have contracted it but fewer than one in 10 have become ill with it, according to the Health Protection Agency. Professor Maria Zambon, director of the HPAs centre for infections, said: “When we actually put together all the different pieces of information, it suggests that up to a third of children in particular regions of England were infected in the first wave.”

www.hpa.org.uk

Mental health and learning disabilities
Reminders help compliance
A pharmacy based intervention can improve antipsychotic medication adherence in patients with serious mental illness, according to US researchers who studied 118 patients with schizophrenia or bipolar disorder. Half the subjects used the Medshelp intervention, where prescriptions are due on the same date and the pharmacy sends reminders two weeks before this date, telling service users they need to renew their prescriptions. After 12 months, 72 per cent of those being prescribed medication in the usual way, the researchers said online in Schizophrenia Bulletin.

www.schizophreniabulletin.oxfordjournals.org

Service user correlation
The elderly, women and people who are black, widowed or single are more likely to use NHS specialist mental health services in England, according to a report from the NHS Information Centre. The report, based on data for the period 2004-09, shows for the first time the correlation between age, sex, marital status and ethnicity and rates of access to mental health services. The report also shows that the number of people in contact with mental health services rose 2.7 per cent between 2007-08 and 2008-09 to 1,222,400.

www.ic.nhs.uk/pubs/mhbhmnds0809

Wrong care for youngsters
Children and young people in Wales are being let down by mental health services, a multi-agency report has warned. Inspectors from four watchdogs – Healthcare Inspectorate Wales, the Wales Audit Office, Care and Social Services Inspectorate Wales and education body Estyn – found a lack of specific services led to the “widespread” practice of placing young mental health patients on inappropriate wards.

Chief Executive for Health Inspectorate Wales Peter Higson said: “There is still a considerable challenge ahead for those providing mental health services to children and young people. We hope that this landmark report will assist them in meeting this challenge.”

www.wao.gov.uk

DONCASTER SETS ITSELF A PRODUCTIVE DEADLINE
Doncaster and Bassetlaw Hospitals Foundation Trust has set a timetable for rolling out the Productive Ward: Releasing Time to Care programme. It intends to have made all of its inpatient wards “productive” by March 2011. “The programme runs over a year but the concepts and techniques developed by frontline staff will stay forever and sustain the continual improvement cycle,” the trust said. The trust started the scheme in eight wards in March, with another seven starting last month. Pictured is ward 21 staff nurse Sue Farrar with Margery Barratt.

www.ic.nhs.uk/pubs/mhbhmnds0809

Wrong care for youngsters
Children and young people in Wales are being let down by mental health services, a multi-agency report has warned. Inspectors from four watchdogs – Healthcare Inspectorate Wales, the Wales Audit Office, Care and Social Services Inspectorate Wales and education body Estyn – found a lack of specific services led to the “widespread” practice of placing young mental health patients on inappropriate wards.

Chief Executive for Health Inspectorate Wales Peter Higson said: “There is still a considerable challenge ahead for those providing mental health services to children and young people. We hope that this landmark report will assist them in meeting this challenge.”

www.wao.gov.uk

Sign up for a daily newsletter at
nursingtimes.net

NURSINGtimes.net
Could you adopt Isabella?

Isabella (DOB Oct 08) was admitted to hospital three days after birth after contracting streptococcal meningitis, which resulted in brain damage and cerebral palsy. This means that she will be developmentally delayed in the future, but given her age, the extent of this delay is still unknown. Feeling unable to care for her in the long term, her birth parents made the difficult decision to give Isabella up for adoption.

Isabella is a happy, lively and sociable little girl. She likes to ‘chat’ and enjoys being the centre of attention. She loves looking at herself in the mirror and being sang to. She enjoys bath time and swimming, and also likes the cats and dogs that live in the foster home with her.

If you have the space in your home and time in your life to adopt Isabella please contact Madeleine at Merton Council Adoption Team on 020 8545 4688 or email adoption@merton.gov.uk. You can also find out more about Isabella online at www.merton.gov.uk/who-needs-adopting
Failure to spot deteriorating patients is a growing problem. The first step to fixing this is admitting your skills may not be up to date – it is your duty to stay informed, says Dan Higgins.

Nurses are failing to detect patients whose physiological condition deteriorates in hospital. The recent Nursing Times survey showed that one in three could recall at least one situation in the previous month where this had happened (news, page 1, 13 October). Evidence suggests this can contribute to in-hospital cardiac arrest and increased mortality.

Recommendations to address this have been suggested since seminal work by McQuillan et al (1998), which identified suboptimal care on hospital wards in the late nineties. Strategies have included developing critical care outreach teams and track and trigger scoring tools, as well as specialised training in recognising the acutely unwell patient. Some of these interventions have made a positive impact, but the problem persists and may even be getting worse. The Nursing Times survey raised some worrying statistics with regard to nurses’ observation skills, which are essential in recognising deterioration.

Patient Safety First’s deterioration intervention aims to reduce harm to patients by changing practice in specific areas and suggests:
- Physiological observations are recorded by practitioners who possess competence in recording and understanding the observations appropriate to the level of care being provided;
- The use of track and trigger systems;
- Appropriate graded response to recognised deterioration using escalation protocols and communication tools.

Many factors are involved in developing competence in observations. Several causes for the failures highlighted by the Nursing Times survey have been suggested, including the quality of pre-registration education and clinical placements for students. Improvements in these should be reinforced by post registration education, mentorship and supervision using outcomes based learning for all grades of staff.

However, poor observation and interpretation skills have been evident for many years, so the question is: how many of us responsible for educating and mentoring nurses are sure of the quality of our own skills and knowledge? Do we think they are good when, in fact, they are not? Admitting we don’t know something, especially when we should, is difficult but not doing so can harm patients and contravene the Nursing and Midwifery Council’s code of conduct. To ensure we record and interpret observations competently we need to constantly question our own practice and that of our colleagues, and ensure we are open to being questioned by others. If we do not recognise our learning needs, how will we learn?

Observations must be performed accurately and nurses need to see this as an opportunity for patient contact, not something to be delegated. There are constraints when working on a busy ward but a higher prioritisation of observations would take us back to direct patient care. If the medicine round always takes place, why can’t observations?

Nurses have a duty to ensure their knowledge and skills are informed and competent. Organisational structures will have mechanisms in place to do this but the onus lies with the individual. For trusts, addressing the issue of poor observations skills should not mean simply sending a group of nurses on a couple of courses. There must be an awareness that long term investment in the workforce is needed so patient deterioration is identified and acted on.

‘We need to constantly question our own practice and ensure we are open to being questioned by others’

Dan Higgins is senior charge nurse, critical care, University Hospitals Birmingham Foundation Trust.

REFERENCE
How to measure and record vital signs to ensure detection of deteriorating patients

Staff need to recognise and act appropriately when patients deteriorate. This article gives practical advice on using basic observations to monitor patients.

BACKGROUND
It is well recognised that hospitals may not consistently be the safe place that patients and their families expect. Indeed, some literature suggests that patients may receive suboptimal care and early recognition of deterioration can be inconsistent (The National Confidential Enquiry into Patient Outcome and Death, 2005). This is supported by research on cardiorespiratory arrest in hospital, where one study showed that 60% of cardiac arrests, deaths and unplanned admission to intensive care units had detectable deterioration in vital signs (Hillman et al, 2001).

Serious incidents that were reported to the National Patient Safety Agency (2007) identified that 11% of deaths were due to patient deterioration not being recognised or acted on appropriately. The main areas for improvement were:
- Regular observations;
- Early recognition of deterioration;
- Improved communication;
- Effective response to concerns.

Observations should form part of nurses’ core skill set and provide the best early information on a patient who is at risk of deterioration. The taking and recording of observations should be seen as pieces in a clinical jigsaw to show how patients are progressing and potential areas of concern.

TACKLING DETERIORATION
The national patient safety agenda and, occasionally, individual trust agendas can sometimes feel removed from busy clinical areas where there are multiple clinical, organisational and managerial challenges to prioritise on a shift to shift basis. Drawing from clinical cases and taking practical advice from Patient Safety First will help provide solutions.

Nurses play an essential role in influencing patient safety every day. However, taking observations or measuring vital signs is increasingly being seen as a task based activity rather than the gathering of clinical information. This poses a real danger for patients. Without effective leadership from nurses in senior roles, there is the potential for patient observations not to be seen as a serious responsibility.

Heart rate: registered and non-registered staff are formally trained to feel patients’ pulse. However, once in a clinical setting, the culture reverts to recording the heart rate from an automated machine, a Dinamap or equivalent. While this is accepted practice – as it is quick and easy and, in theory, removes some of the potential for human error – it is not the most effective method of gaining clinical information about patients’ cardiovascular status. Important clinical information such as pulse volume, rate and rhythm, together with patients’ peripheral temperature picked up on touch, are all lost if equipment alone is used.

Blood pressure: most blood pressure recording is undertaken with automated machines. There are benefits as this removes some of the variability that may exist between operators. However, issues such as cuff size often feature in concerns over
accuracy. Moreover, skills in manual auscultation of blood pressure using a sphygmomanometer are lost. It is important to remember that using the incorrect cuff size in manual blood pressure measurement can also make this unreliable.

- **Respiratory rate:** many hospitals involved in monitoring their reliability in recording physiological observations, such as the Safer Patients Initiative or Productive Ward sites, have noted that the recording of respiratory rate is frequently absent, despite its importance in alerting staff to deterioration in a patient’s condition. There are many suggestions about why this might be the case, including a lack of mechanical equipment capable of recording respiratory rate and variability between observers.

- **Level of consciousness:** there are a number of ways this is detected, such as AVPU (Alert, responds to Voice, responds to Pain, Unresponsive). This quick and easy tool gives a clear guide on patients’ level of consciousness: patients are identified as being at risk if they respond only to pain or are unresponsive. This would equate to a Glasgow Coma Scale (GCS) score of 3-8 and therefore the patient would require an urgent review as their airway may be at risk. The GCS has been widely used for many years to assess consciousness level and is scored from 3 to 15, three being the worst, and 15 the best. It consists of three parameters: best eye response, best verbal response and best motor response.

- **Pulse oximetry:** an observation of pulse oximetry can often be used to confirm practitioners’ clinical view. However, this can be misleading and inaccurate in some patients, such as those with anaemia, arrhythmias, poor peripheral perfusion and those who have been exposed to carbon monoxide. Used with appropriate clinical judgement, pulse oximetry, together with respiratory rate, signs of increased work in breathing, colour and “new” patient confusion, all have the potential to consistently provide valuable information.

- **Urine output:** this is used in many trusts with some merit as oliguria is a sensitive indicator of poor perfusion, a reduced cardiac output and an early indicator of acute renal failure. This parameter often causes problems in general ward areas as many patients will not be on hourly urine measurements or may not be on fluid management charts. Getting into the habit of asking even mobile patients about urine output is not a waste of time as it can be an early indicator of causes for concern.

Boxes 1 and 2 outline case studies showing signs of patient deterioration that were not detected or acted upon.

**COMMENTARY ON CASE STUDY 1**
This is not an unusual case and illustrates some of the pitfalls of vital signs recording and track and trigger systems. Non-shockable cardiac arrests, that is, asystolic or those with pulseless electrical activity, form the majority of in-hospital cardiac arrests and carry the highest mortality. The primary cause of the event is not always cardiac in origin and so the underlying cause has to be determined and addressed for a successful outcome to be achieved. In this case the following questions should be asked:

- **Who is taking observations?**
  In many ward areas, observations are taken by a range of staff, including both registered and non-registered members of the team. It is worth reviewing the education and competency packages in use. The Department of Health (2009) has developed a framework of core competencies and skills that teams need if they are caring for acutely ill patients.

- **Can you be sure all staff undertaking observations have the necessary knowledge and skills?**
  It is easy to become complacent about vital signs when their recording is seen very much as a task to be undertaken rather than a key clinical skill in putting patient safety first.

- **What provision is there for regular updates and checking accuracy?**
  In reality this is difficult to achieve but it is, nonetheless, necessary. Ensure that your ward area participates fully in measuring compliance with observations. Plotting and tracking observations will help motivate staff to see this as important. As an example, nurses can use the Patient Safety First “check your charts template” (tinyurl.com/check-charts-template). This is a good way of involving all staff and maintaining standards.

Mr Brown’s pre-existing cardiac problems caused confusion with observations that could have been perceived as normal. Patients with atrial fibrillation and hypertension can cause confusion with track and trigger systems such as early warning scores and modified early warning scores, as there can be a tendency to accept parameters as “the norm” and therefore miss subtle changes in the patient’s condition.

In Mr Brown’s case, his blood pressure would have been considered normal. However, for him, this pressure constituted hypotension; it contributed to his poor urine output and accelerated his clinical deterioration.

There are no quick and easy solutions to this problem. Track and trigger tools, by definition, are broad and not patient specific. Solutions need to be trust wide and could include “acceptable heart rate or blood pressure” parameters on observation charts. Patients would then not trigger above or below this rate. This has the potential to cut false triggering, which causes desensitisation to the tool. However, decisions to accept vital signs outside normally accepted limits are unwise.

**BOX 1. CASE STUDY 1**

Tom Brown*, aged 68, was admitted to the intensive care unit following successful resuscitation for a pulseless electrical activity arrest. His past medical history included hypertension and atrial fibrillation controlled with digoxin. He had been admitted to an acute medical ward five days earlier with a lower respiratory tract infection and started on intravenous antibiotics and chest physiotherapy. His observations had been recorded six hourly, as per ward protocol, since admission. Although these triggered an alert on the early warning score system, the results had been added up incorrectly. A review of his observation charts revealed that in the two days before his arrest:

- His respiratory rate was slowly increasing;
- His blood pressure was falling from his baseline of 165/80 to 110/65;
- His heart rate had risen from 96 and irregular on admission to 130;
- The fluid balance chart showed increasing oliguria and poor oral intake secondary to nausea and vomiting;
- His early warning score had been incorrectly calculated and repeated.

*The patient’s name has been changed.
parameters need to be reviewed carefully. A consultant or senior registrar would be best placed to make this judgement based on a thorough review of the patient and clear documentation in the medical notes. Clear guidance and training for this would be vital. It is a method used successfully in some trusts with the requisite safety systems in place for specifying who, what, grade, and in which circumstances it should and – importantly – should not be used.

In this case, Mr Brown’s condition was detected and reported eventually, but it was reported to a junior doctor who may not have the skills or experience to make an appropriate judgement. The National Institute for Health and Clinical Excellence (2007) suggested the response to a trigger should be a doctor with sufficient experience to manage the patient in question.

Not all patients at risk will be moved to a higher care area. Recognition and awareness of those at risk in the clinical area can be a significant challenge in rapidly changing ward cultures. Consider using the patient location/ward whiteboard to provide an instant visual reminder of the location of those at risk, not only for all nursing staff but also for medical/allied health professionals. The Royal Devon and Exeter Foundation Trust uses an alarm icon on the physical and electronic patient administration system to denote patients at risk, which:

- Provides a visual trigger of those at risk;
- Allows the nurse in charge to ask questions about clinical management plans, providing clinical leadership and support for more junior team members;
- Prompts discussion about placing patients at risk together to facilitate nursing and appropriate observation;
- Allows a trust wide view of acuity, which is important for staff allocation.

**COMMENTARY ON CASE STUDY 2**

An increasing respiratory rate and greater effort by patients to breathe are recognised as robust indicators for physiological decline. Although this applies to all patients, staff often appear to be more concerned about the percentage of oxygen saturation.

The second case study further illustrates the dangers of assuming that a parameter is normal. In this situation being tachypnoeic was “normal” for Mrs Armitage; what was abnormal, and a clinical indicator of deterioration, was the steady increase of her respiratory rate.

Issues surrounding desensitisation to parameters and early warning scores are always a risk in busy clinical areas. The solutions are not always clear so leadership has an important part to play:

- Consider short patient safety briefings at one or two points during the shift. These need only take a few minutes, with staff members reviewing early warning scores and areas of concern. This provides a defined forum for nurses to challenge all scores and triggers, allowing clinical support for escalation and a review of the trend of patients’ progress;
- Review handover processes. Try to put patient safety at the centre of the handover with early warning scores handed over as part of patient details;
- Ensure escalation is appropriately documented and that all staff caring for specific patients are clear about the next steps that should be taken;
- Improve communication. Hand over all patients using a communication tool such as SBAR (situation-background-assessment-recommendation, see Changing practice, page 13) or RSVP (reason-story-vital-signs-plan) (Featherstone et al, 2008). This enables all staff to become familiar with the process; in addition, it gives confidence to more junior staff and helps them to coordinate their thoughts and the escalation of patients appropriately.

In summary, observations that are often perceived as basic and routine are a vital part of the information gained to ensure safer patient care and the early recognition of deterioration. Patient safety can and should be influenced at ward level on a daily basis. Without the active involvement of all nurses, it will not be seen as a priority. Patient safety is everyone’s responsibility and should be at the forefront in everyday practice.

The Patient Safety First website, www.patientsafetyfirst.nhs.uk, features a “how to guide”, which gives details on reducing harm from deterioration, provides access to a network of trusts taking similar steps to achieve safer healthcare and offers further practical advice on taking good care of patients whose condition is deteriorating.

**REFERENCES**


---

Nursing Times 1 December 2009 Vol 105 No 47 www.nursingtimes.net

**NURSING**

Do you have a burning question on a practice issue? Is there something you and your colleagues have always wanted to check with an expert? Send your queries and dilemmas on nursing practice to NT@emap.com, putting ‘Practice question’ in the subject box.

---

**BOX 2. CASE STUDY 2**

Jenny Armitage*, aged 76, had long standing chronic obstructive pulmonary disease, and was admitted to a respiratory ward with an infective exacerbation. Mrs Armitage has chronic respiratory problems that limit both her exercise tolerance and activity. She normally has a respiratory rate of 30. On admission she had a respiratory rate of 32 which was thought to be normal for her. Observations continued on a six hourly basis, which was the norm for that ward. Two days after admission her oxygen saturations were noted to be 78% on a 28% Venturi mask. On closer examination, Mrs Armitage had a respiratory rate that had been slowly increasing to a rate of 44 since admission. She was using all her accessory muscles and was both peripherally and centrally cyanosed. She was tachycardic at 110bpm regular and hypertensive at 168/95mmHg. Her early warning score had been recorded over the last few days but no score had been entered for respiratory rate as she is normally tachypnoeic.

* The patient’s name has been changed.
Using a communication framework at handover to boost patient outcomes

A trust introduced a structure for presenting critical information at handover. This has aided communication between team members and benefited care.

INTRODUCTION
It is well recognised that the increased acuity and complexity of patients’ needs in a busy surgical or medical ward presents challenges to both nursing and medical staff. The National Patient Safety Agency (2007) suggested that effective communication is an important factor in improving clinical practice and patient outcome. Some of the main comments in this report from both nursing and medical staff on the difficulties with communication were:

- Unclear documentation;
- Nurses not communicating clearly;
- If nurses are not confident and articulate on the telephone, they do not get the response they need;
- Doctors finding it difficult to prioritise because of inadequate verbal handovers from nursing staff;
- Doctors not always telling other staff about changes to patient management.

NICE (2007) supported these findings and recommended that both nursing and medical staff should use a formal structured handover supported by a written plan. Unfortunately, these recommendations are not always followed in training. In our experience, nurse education has not prepared practitioners in the art of effective verbal communication. This is usually developed through observing peers and reflective clinical practice.

EXPERIENCE IN SOUTH DEVON
In 2006, the South Devon Healthcare Foundation Trust joined phase two of the Safer Patients Initiative (SPI), which is supported by The Health Foundation. The main outcomes of this national initiative were:

- A 15% reduction in hospital mortality;
- A 30% reduction in adverse events;
- A 30% reduction in cardiac arrests;
- A 50% reduction in MRSA bacteraemias.

<table>
<thead>
<tr>
<th>TABLE 1. USING THE SBAR STRUCTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
</tr>
<tr>
<td>Where you are telephoning from</td>
</tr>
<tr>
<td>What is the main problem? This is the most important aspect as you must attract the other person’s attention immediately</td>
</tr>
<tr>
<td><strong>Background</strong></td>
</tr>
<tr>
<td>Relevant past medical history and treatment to date – it is imperative that this is brief, succinct and relevant</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>Be specific about your request and the time frame</td>
</tr>
<tr>
<td>Ask if there is anything you can do before the other staff member arrives</td>
</tr>
<tr>
<td>Document the call including date, time and who you spoke to</td>
</tr>
<tr>
<td>If you are worried and do not receive the response you need, you may need to escalate to a more senior clinician</td>
</tr>
</tbody>
</table>
SBAR was advocated as the structure for communication for the project. Published by the Institute for Healthcare Improvement (2004), this tool can be used at any part of the patient journey and it lends itself particularly well when used to hand over critical information. SBAR stands for:
- Situation;
- Background;
- Assessment;
- Recommendation.

HOW TO USE SBAR

The key to effective communication is preparation. Before picking up the telephone, nurses should gather the necessary information. Then they should use the structure in Table 1 to present the information gathered.

The benefits of using a communication tool such as SBAR are that it encourages and promotes:
- Active listening.
- Effective decision making and prioritisation.
- Adequate time management;
- Improved time management;
- Better decision making by medical staff;
- Appropriate prioritisation of patients;
- Credibility of nursing handover;
- Sharing of accurate and relevant information;
- Patient experience;
- Timely handovers;
- Information for effective decision making and prioritisation;
- Active listening.

TABLE 2. COMMUNICATION STRUCTURES

<table>
<thead>
<tr>
<th>Structure 1</th>
<th>Structure 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor: Hi, this is Matt, the surgical F1, you are bleeding me. Nurse: Hello, this is staff nurse on Rose Ward. Can you come and review a patient of mine please? Doctor: What is the problem? Nurse: His blood pressure is low. Doctor: What is it? Nurse: 80/45. Doctor: What was it before? Nurse: Not sure, let me go and get his charts. It was 135/70. Doctor: What did the patient come in with? Nurse: Hold on, let me get my handover sheet – he had a small bowel resection three days ago. Doctor: What are his other vital signs? Nurse: Hold on, I will just have a look – his temperature is 38.8ºC, pulse is 122/min, respirations 26/min, SpO2 93% on air. Doctor: What is his urine output? Nurse: Not sure, let me go and get his fluid balance charts. Sorry, can’t find it. Doctor: What medications is he on? Nurse: Let me go and get his prescription chart. Doctor: Don’t worry, I will wander up later and review him.</td>
<td>Doctor: Hi, this is Matt, the surgical F1, you are bleeding me. Nurse: Situation: Hi, this is Sue, staff nurse on Rose Ward. I am contacting you regarding a Mr Smith who has suddenly become hypotensive. BP is 88/45. Background: He had a small bowel resection three days ago and is receiving IV fluids at 125ml/hr. This man is normally fit and well with no relevant past medical history. Assessment: His airway is patent, respirations 26/min. SpO2 93% on air. I have started him on 6l oxygen and his SpO2 has come up to 98%. Pulse is regular, rate 120/min, BP was 135/70 earlier, now 90/40. He is cool peripherally with a capillary refill of four seconds. His urine output has also dropped, over the past three hours 35ml, 20ml, 10ml. At the moment, he is alert and complaining of abdominal pain. He has also been vomiting. Temperature is 38.7ºC. I think he is septic, possibly abdominal. Recommendation: I need you to come and see this patient now. Doctor: OK, I am on my way. Nurse: Is there anything I can do before you get here? Doctor: Can you give stat bolus of 500ml normal saline (trust patient group directive 1013) and organise an ECG? Nurse: OK, see you in a minute.</td>
</tr>
</tbody>
</table>

PDSA CYCLE METHODOLOGY

The cycle consists of four phases that are continuous and is usually illustrated as shown in Fig 1. This approach to change and improvement should be a continuous cycle until optimal performance is achieved.

A PDSA CYCLE FOR INTRODUCING A COMMUNICATION TOOL

Plan

Main considerations:
- Acceptance that communication was an issue within the organisation;
- Acknowledgement that a communication tool was needed;
- Key questions:
  - Who is best placed to roll it out?
  - How can we roll this out multiprofessionally?
  - What teaching methods and aids might be suitable?
  - How might we audit the change and ensure it is embedded?
  - How can we ensure the change is positive?
- When and where shall we start?
- Regular evaluation by the project team.

Do

At the trust, the SBAR tool was rolled out to one ward first with the aid of well placed posters, stickers on telephones (compliant with infection control policy), supported with 10-15 minute teaching sessions at ward level and simulated scenarios. Clinical staff were actively encouraged to cascade the tool to their peers, which required active monitoring by ward managers and the project team.

The tool was then rolled out to all ward areas and multiprofessional teams. As mentioned above, the SBAR communication tool can be used at any stage of the patient journey. Communication between wards was formalised by using specific handover sheets and receiver sheets using SBAR.

This format has also been used to structure trust meetings, with positive results. Formal education was delivered at trust clinical induction and all other appropriate forums.

Study

Auditing this change proved challenging for the project team as, initially, it was unclear which was the most effective audit tool. One of the measurements that worked well was for nurses receiving a patient transfer to document the information received and comment on the handover sheet if the information was robust. This data was then
It appeared that, before SBAR was approximately 45 minutes to seven minutes. This showed clearly that, at each handover, the identification of the ward and the individual nurse handing over the patient. This data was collated and fed back to wards that were doing well. Tests of change were performed regularly and new ideas on improvement readily put into practice where appropriate. These planned changes to the process were informed by issues identified at the fortnightly project team meetings.

CONCLUSION

The use of a communication tool such as SBAR addresses the main concerns identified by the NPSA and NICE. Introducing it to South Devon ensures that, as a trust, we comply with NICE guidance and, more importantly, it helps to ensure a positive patient experience/outcome.

SBAR has also helped the trust to meet Safer Patients Initiative requirements. By July 2009, we had achieved:

- An 11% reduction in hospital mortality;
- A 65% reduction in adverse events;
- An 8% reduction in cardiac arrests;
- An 83% reduction in MRSA bacteraemias.

Results showed clear time management improvements, as time was freed up to complete other nursing duties.

A main component in the project’s success was the support of the trust executive team, as well as strong ownership by ward staff.

Nursing staff were initially concerned that using the SBAR tool would lead to a delay in escalation and response during an emergency; however, this has not been the case. In emergency situations, such as when the cardiac arrest team has to be called, staff follow local policies.

One of the main lessons for the organisation was to ensure that a core group of trainers from all disciplines was identified.

For sustained action, the concept should be part of continued education and championed by clinical staff throughout the organisation.

Box 1 has details for more information for trusts wishing to implement SBAR.

For further information, please contact hazel.robinson1@nhs.net

REFERENCES


tinyurl.com/respond-deteriorate


FIG 1. MODEL FOR IMPROVEMENT

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will we know that a change is an improvement?</td>
</tr>
<tr>
<td>What changes can we make that will result in improvement?</td>
</tr>
</tbody>
</table>

Implementing the Patient Safety First intervention to reduce harm from deterioration

George Eliot Hospital Trust dramatically cut the number of in-hospital deaths after it brought in an intervention for deteriorating patients. This is how they did it.

Back in 2005, George Eliot Hospital Trust had one of the worst patient safety records in England. Since then, it has been changing the way staff of all levels work and has greatly reduced the number of adverse events. As part of its efforts, in 2008, the trust signed up to Patient Safety First, which consists of five interventions – four clinical and one on leadership.

While the trust signed up to implementing all five, it paid particular attention to the intervention on reducing harm from deterioration. This aims to reduce in-hospital cardiac arrest and mortality rates through earlier recognition and treatment of deteriorating patients.

To help reduce in-hospital mortality rates, the trust’s associate medical director now monitors all cardiac arrest calls to establish any links between them. This is then fed back to the patient safety committee, and the board when required. The committee discusses the results and, as a multidisciplinary team, agrees actions to be taken. The whole team takes ownership to monitor and make sure this happens.

**REDDUCING HARM FROM DETERIORATION**

This intervention involves six main areas:
- Physiological observations should be recorded for all adult patients in acute hospital settings;
- These observations should be recorded and acted on by staff trained to undertake these procedures and understand their clinical relevance;
- Physiological track and trigger systems should be used;
- There should be a graded response strategy;
- An escalation protocol should be in place;
- A communication tool should be used.

**Improved observations**

One main recommendation from Patient Safety First is to improve observations. For this, the trust began to monitor initial observations on a much more reliable basis.

We used the modified early warning scores (MEWS) track and trigger system. Such systems must be acted on promptly and appropriately. However, it is important to note that by definition, a standardised track and trigger system is not patient specific, so an individual’s condition must be taken into account to ensure clinicians do not miss subtle changes, especially in those with atrial fibrillation and hypertension.

At George Eliot, the MEWS system helps staff remain aware of patients’ needs by providing a visual reminder for the nurse and doctor on duty so they know when they need to act. A colour code is used on patient forms to reflect their health:
- Red – abnormal;
- Yellow – leaving normal range;
- Green – normal range.

This helps reduce levels of deterioration as staff are more alert to patient changes.

**New communication tool**

To ensure that information on deteriorating patients reaches staff quickly, the trust implemented the situation-background-assessment-recommendation (SBAR) tool in a number of wards.

All staff are trained using acute life-threatening events recognition and treatment (ALERT) courses so they can use the tool correctly. Practitioners are taught to recognise early signs or indications of deterioration and identify whether action needs to be taken quickly. Nurses can therefore fill in the relevant observation information or call a doctor or an outreach team if required.

**The hospital 24/7 team**

Another main component was the introduction of the hospital 24/7 team. This consists of experienced nurses who are competent in critical care and are able to attend deteriorating patients to prevent a further worsening of their condition. This outreach team also audits patients’ care when they arrive in a clinical area so they can monitor whether the correct interventions were undertaken or if there were other ways in which staff could have helped to prevent patient deterioration.

**Nurses’ role**

Nurses are responsible for completing observations and MEWS forms, using the SBAR communication tool and encouraging others to get involved.

**OUTCOMES**

Since its poor hospital standardised mortality ratio (HSMR) was revealed in 2005-06, George Eliot Hospital Trust has managed to reduce the number of in-hospital deaths from 126 in March 2006 to 76 in May 2009. Interestingly, 93% of staff employed by the trust in 2007 – when steps were first made to improve patient safety – are still employed today (this does not include doctors who have joined since). This shows the effectiveness of engaging staff.

Since improving the recording of observations, the number of correctly calculated MEWS scores has risen from 55% in October 2006 to 80% in May 2009.

For more information on Patient Safety First, see www.patientsafetyfirst.nhs.uk

AUTHORS Sharon Beamish, BA, is chief executive; Dawn Wardell, MBA, RGN, is deputy director of nursing; both at George Eliot Hospital Trust, Warwickshire

FURTHER READING


George Eliot Hospital Trust won the patient safety category in the Nursing Times Awards 2009
Collaborative working empowers staff to cut the number of cardiac arrests

A Breakthrough Series collaborative was used to engage staff to change their clinical area, which has resulted in cardiac arrests being viewed as never events.

INTRODUCTION

Engaging and empowering frontline staff are known to be influential ways of generating long term improvement, and are promoted by Patient Safety First. This national campaign encourages change to happen in small steps, following a “plan, do, study, act” (PDSA) cycle (see Changing practice, page 13). This method minimises the risks associated with system change and allows weaknesses in a new system to be acknowledged and redesigned before widespread implementation. The aim is to reduce unintended harm and improve the reliability of the systems in which staff work. Salford Royal Foundation Trust has used this method successfully, reducing the number of cardiac arrests in its patients. Salford Royal is one of the 96% of acute trusts that has voluntarily signed up to Patient Safety First. It is using the reducing harm from deterioration intervention tools to support its work under way in this area.

At the trust, 179 patients suffered a cardiac arrest in the year March 2007-April 2008. Medical evidence indicates that many patients show signs of deterioration during the 24 hours before cardiac arrest (Hillman et al, 2001), with various factors contributing to suboptimal care (Box 1). With this in mind, the trust sought to improve the situation by focusing on these factors. The Department of Health (2000) report Comprehensive Critical Care addressed the recognition and management of acutely unwell patients. The report recommended establishing outreach teams whose remit would include avoiding critical care admissions by “identifying patients who are deteriorating and either helping to prevent admission or ensuring that admission to a critical care bed happens in a timely manner to ensure best outcome” (DH, 2000).

This has resulted in the widespread implementation of rapid response teams, critical care outreach teams and medical emergency teams in many organisations. The literature suggests that this approach can result in a 25-30% reduction in cardiac arrests (for example, Goldhill et al, 1999).

However, Salford Royal approached the issue of improving recognition and management of deterioration in a different way. The acutely unwell adults (AUA) faculty decided to undertake organisational change before considering a specialist rapid response team. This approach makes the care of deteriorating patients everyone’s responsibility rather than devolving it to a specialist group of staff. This collaborative working and innovation has been successful in reducing cardiac arrests and, to date, Salford Royal does not have a specialist rapid response team.

The trust’s quality improvement strategy aims to reduce harm and save lives. The clinical area of care for acutely unwell adults was identified as a key area of work that would support this strategic vision. A faculty team, consisting of doctors, nurses, allied health professionals, a project manager and an improvement adviser, was set up in 2008. Together, they set a target of reducing cardiac arrests on wards by 50%.

DESIGN

The trust ran a Breakthrough Series collaborative (Institute for Healthcare Improvement, 2003), using a model in which teams were able to learn both from each other and from local experts around a focused set of objectives (Fig 1, page 19).
 Internationally, this collaborative approach has been used successfully in decreasing Caesarean section rates (Flamm et al, 1998), and in improving diabetes and heart failure care (Glasgow et al, 2002).

The trust then identified the wards that had the highest numbers of cardiac arrests and invited them to participate in the collaborative. Eleven wards took part in the first phase. Representatives attended learning sessions and went on to coordinate ward improvement efforts. Teams were multiprofessional, and included junior and senior nurses as well as healthcare support workers, physiotherapists, doctors and nurse practitioners.

As well as involving staff at many levels, the project was sponsored by the executive director of nursing, who attended the learning sessions to provide senior support and encouragement. Frontline staff were formally “liberated” to change systems in the pursuit of improved patient care and safety.

The first learning session focused on the theory and practice of improvement, and gave background information on the project aims and the local situation, including arrest data for individual wards as well as supporting evidence on best practice. Teams were introduced to the Model for Improvement (Langley et al, 1996). This is a simple, powerful tool for accelerating improvement and is the method advocated by Patient Safety First.

Using the Breakthrough Series collaborative approach, the trust set out to answer three questions for acutely unwell adult patients. These were:

- What is the aim? To reduce cardiac arrests by 50% in one year;
- How will you know a change is an improvement? The trust will undertake measurement to ensure that change is an improvement (see below);
- What can be changed? To find out how the trust could change, participating wards were asked: “What can be done in your area to improve care for this group of patients?”

When wards identified an idea for system change they were then encouraged to test this idea on a small scale using multiple PDSA cycles. This technique allows an idea to be tested for efficacy before it is implemented more widely.

Further learning sessions took place, interspersed with action periods. During these periods, teams tested the changes and had the opportunity to communicate with project directors, an improvement adviser and each other. Teams were able to meet once a week for a half hour discussion to share their learning and develop new tests. This helped to maintain the pace of change, with teams undertaking several small tests every week.

In the second and third learning sessions, the trust followed an “all teach, all learn” philosophy, where each team reported on their methods and results, and discussed the lessons learnt. Teams discussed each others’ developments, suggested modifications and then decided whether the test had been successful. Tests were then adopted, adapted or abandoned.

Assessing improvement

To determine whether a change could be classified as an improvement, regular monthly measures were undertaken:

- Outcome measures: the measure of the aim’s success by cardiac arrest rate per 1,000 admissions (both by ward and for the organisation);
- Process measures: the processes involved in achieving the aim – these measures included completing the early warning score (a sample of charts was submitted);
- Balancing measures: looking at other factors that may be influenced unintentionally, for example, the percentage of intensive care unit admissions coming from individual wards.

FACTORS THAT PROMOTE STAFF ENGAGEMENT

Ownership

Ward teams develop all changes and the expert group or senior sponsors have not mandated changes: this is vital to the success of the collaborative. Ward teams made changes they felt would be useful in their individual areas. Teams from other areas then tested successful changes and adapted them if necessary. The process prevented the imposition of a one size fits all solution to a problem that involves multiple factors.

Each ward receives monthly cardiac arrest data to direct and motivate improvement efforts: data has proven to be extremely useful in driving improvement. Before this collaborative, the trust did not formally collect data on the overall arrest rate and individual wards were not aware of their contribution. Each ward now receives monthly updates and takes pride in the sustained reductions achieved. There is tangible evidence that the work that staff undertake is making a difference to patient care and this is crucial to maintaining enthusiasm on the frontline.

Celebration

Each ward publicly displays “days between” cardiac arrest certificates and takes pride in these achievements: this is a way of using data to celebrate success and boost staff morale. Wards that previously had at least one cardiac arrest a month are now celebrating more than 100 days between arrests. Ward staff also report that patients like to see staff taking pride in achieving this as a measure and feel reassured that staff are constantly striving to improve care.

Ward teams present their work to each other and to senior leadership at learning sessions, where their hard work is formally recognised: senior leadership is a key factor in success. At the first learning session, the executive sponsor “liberates” staff to make changes. In a system with numerous committees and forms to complete, this is essential to ensure teams have the confidence to move forward. Presenting changes to ward teams and senior leadership provides an opportunity for staff to see the impact of the improvements they have made. This is a powerful justification of the opportunity they were given as part of the collaborative.

Regular newsletters celebrate the project achievements across the organisation:

BOX 1. FACTORS LEADING TO SUBOPTIMAL CARE

- Chaotic systems
- Lack of knowledge/experience
- Inadequate supervision
- Failure to recognise the severity of a situation
- Reluctance to seek help

Source: Hillman et al (2001)
internal support from other collaborative teams is important; however, a wider appreciation from the organisation is essential to sustain momentum. As part of this sustainability, a further 11 wards were invited to participate in phase two of the project, which started in January 2009. The aims and achievements of the project had become known throughout the trust and other wards wanted to be part of it and make their contribution.

Public acknowledgement
Teams have been encouraged to present their tests of change at conferences and submit articles for publication: there has been a great deal of pride in realising that the changes frontline teams have developed are of wider interest and can be presented to an interested audience. Teams are encouraged to attend conferences to present their own work and to take credit for their success.

This approach to reducing cardiac arrests has been presented to other trusts as part of Patient Safety First: the campaign is important nationally and teams are proud that other hospitals want to learn from their approach to improvement.

Denying the status quo
Each learning session starts with a patient story, to focus attention on the impact of deterioration on real patients: this is perhaps the most important part of the learning session. Staff no longer view cardiac arrests as unavoidable events but as tragedies that befall real people. This has enabled a patient focused approach to be maintained at all times and to keep the collaborative on track.

Cardiac arrests are now viewed as never events with each arrest reviewed at clinical governance for learning: as a result of this collaborative’s success, cardiac arrests are now rare occurrences at the trust and are classified as never events. When a cardiac arrest does occur, it generates an adverse incident report. The AUA faculty reviews the event and a formal root cause analysis is undertaken by the multidisciplinary ward team. Adverse incident reports on cardiac arrests are presented at the divisional governance meetings to ensure learning is shared across the organisation.

Potential limitations
A number of quality improvement programmes are being developed at Salford Royal, such as Productive Ward, which began six months after the collaborative in the AUA faculty. All this work has the potential to improve the quality of patient care. However, the baseline data collected by the quality improvement directorate before Productive Ward began did show a significant fall in cardiac arrest calls over the duration of the AUA quality improvement programme, which was already under way. This change in cardiac arrest calls had not previously been seen before the AUA Breakthrough collaborative began, suggesting this had made a clear impact.

One other potential limitation is that there may have been some crossover between the collaborative and non collaborative sites. As non collaborative wards noticed improvements made by their colleagues, they adopted the changes before they officially became part of the programme. This results in additional improvement in some non collaborative wards and dilutes evidence showing the power of a collaborative approach.

This programme of work did not require any additional funding other than the time that staff invested in the collaborative.

CONCLUSION
Preliminary data suggests positive outcomes for patients although evaluations are ongoing and a full research report is due to be published at a later date. The experience so far at Salford Royal would suggest that this method of empowering and engaging with staff, to develop and make changes in their areas, is both powerful and effective.

REFERENCES
Prompt and aggressive management of sepsis gives patients the best chance of survival

Poor knowledge can result in a missed or delayed diagnosis of septic shock or severe sepsis, as well as inappropriate or delayed patient management.

INTRODUCTION

The management of patients has become more complex in general as they are becoming older, sicker and more dependent. This places an increased pressure on healthcare staff (Smith, 2003).

Evidence suggests that nurses’ knowledge about the signs of acute illness and their response to these signs are poor (Robson et al, 2007). Gaps in knowledge can result in a missed or delayed diagnosis of septic shock or severe sepsis and lead to inappropriate or delayed management; prompt treatment is crucial to survival.

There is evidence that up to 50% of patients admitted to intensive care units received suboptimal care before referral because of a failure to identify signs of deterioration and lack of skills in responding to acute deterioration (National Patient Safety Agency, 2007).

Doctors also appear to have poor knowledge. Poeze et al (2004) interviewed 1,058 doctors and found that only 17% agreed on a definition of sepsis, but 83% agreed it was frequently missed.

Lack of clarity about the definition of sepsis may contribute to delays in diagnosis and early treatment and increase the risk of patient deterioration and mortality (Ziglam et al, 2006).

It is estimated that patients with sepsis take up 45% of intensive care bed days and 33% of hospital bed days in the UK (Padkin et al, 2003). Forty per cent of intensive care budgets are spent managing sepsis and the average cost of treating a patient admitted to hospital is £10,000 (Dellinger et al, 2004).

Nurses have a key role in identifying patients with sepsis or septic shock and providing appropriate treatment. As such, they need to be knowledgeable about sepsis and nursing guidelines that provide a format for systematic assessment and management.

SURVIVING SEPSIS CAMPAIGN

Worldwide, sepsis kills more people than lung cancer, and more people than bowel and breast cancer combined. Its incidence is rising at a rate of 1.5% per year (Daniels, 2009). Concern about these figures led to the launch of Surviving Sepsis in 2004 – an international campaign to improve survival. Although now officially concluded, the campaign demonstrated that it was possible to change clinical practice and improve patient outcomes using evidence based guidelines.

The campaign’s main aims were to improve the management, diagnosis and treatment of sepsis. These aims were met by:

● Increasing awareness, understanding and knowledge;
● Changing perceptions and behaviour;
● Influencing public policy;
● Defining standards of care (Dellinger et al, 2004).

The campaign concluded that the greatest improvement to patient outcomes had been made through education and changing the process of care for patients with sepsis.

DEFINING SEPSIS

Sepsis typically starts with systemic inflammatory response syndrome (SIRS). This is the cascade of inflammatory events that are part of the body’s response to an insult in an attempt to maintain homeostasis (Lever and Mackenzie, 2007).

SIRS is defined by the presence of two or more of the following symptoms:

● Temperature >38°C or <36°C;
● Heart rate >90 beats per minute;
● Respiratory rate >20 breaths per minute;
● White blood count >12,000 or <4,000 per ml (Levy et al, 2003).

Sepsis is defined as a known or suspected infection accompanied by evidence of two or more of the SIRS criteria (Robson and Daniels, 2008). It is a continuum from a...
Severe sepsis
Severe sepsis is the presence of sepsis with organ dysfunction, hypotension or poor perfusion (Peel, 2008). All organs, including the cardiovascular system, lungs, liver, kidneys and brain, can be affected.

Signs include:
- **Hypotension**: a systolic blood pressure of <90mmHg or a mean arterial pressure of <60mmHg. Changes in blood pressure may be a late indicator of deterioration as the body has compensatory mechanisms to maintain it. Fluid resuscitation must be given with the aim of improving blood pressure and cardiac output (Dellinger et al, 2004);
- **Altered mental state**: the AVPU system (A – alert; V – responsive to voice; P – responsive to pain; U – unresponsive) or the Glasgow Coma Scale (GCS) can be used to assess patients’ neurological status rapidly. Consciousness levels may be decreased due to hypoxaemia, hypoglycaemia or cerebral hypoperfusion due to shock or medications such as sedatives or analgesics;
- **Hyperglycaemia in the absence of diabetes**: this results from the metabolic and hormonal changes that are part of the stress response (Ruffell, 2004). It occurs in critically ill patients and insulin treatment may be required to maintain normoglycaemia;
- **Hypoxaemia**: oxygen saturations <93% or PaO₂ <9kPa on an arterial blood gas analysis. Pulse oximetry must only be used as a guide as the saturation recording may not be a true reflection of gaseous activity; British Thoracic Society (2008) guidelines recommend that arterial blood gases should be checked in all critically ill patients;
- **Acute oliguria**: urine output of <0.5ml/kg/hr. Poor urine output is an early sign that a patient’s condition may be deteriorating. Urine output is a sensitive measure of blood flow to the kidneys and other organs. It is essential that patients have an adequate circulating blood volume; the presence of hypotension, tachycardia and cool peripheries may indicate that extra fluid is required (Smith, 2003);
- **Coagulopathy**: International normalised ratio (INR) >1.5 or platelets <100. The combination of hypotension, slow blood flow, hypoxaemia and metabolic acidosis will interfere with normal clotting mechanisms. Microthrombi form in small vessels, interfering with blood flow to the tissues and the organs, which, combined with hypotension and hypovolaemia, can cause organ failure (Robson and Newell, 2005);
- **Raised serum lactate**: >2mmol/L. Raised lactate is a sign of severe sepsis and indicates that tissues are not receiving enough oxygen and have to rely on anaerobic metabolism, producing lactic acid.

**SEPTIC SHOCK**

Septic shock is defined as severe sepsis with hypotension that does not respond to intravenous fluid resuscitation of 500-2,000ml given rapidly (Dellinger et al, 2004). Hypotension is not always a reliable indicator of shock, as some patients may maintain a systolic blood pressure above 90mmHg, so further signs and symptoms need to be considered before a diagnosis of septic shock can be made. These include:
- A positive fluid balance;
- An unexplained metabolic acidosis;
- Decreased capillary refill time >2 seconds (Lever and Mackenzie, 2007). This indicates poor perfusion.

**EARLY IDENTIFICATION OF SIGNS AND SYMPTOMS**

Early identification and treatment within the “golden hour” is the key to reducing mortality (Dellinger et al, 2004). The first six hours after diagnosis present a small window of opportunity in which to reverse tissue hypoxia and prevent established organ failure.

The Surviving Sepsis campaign produced a six hour resuscitation bundle (Dellinger et al, 2004); aspects of patient care that can be carried out at ward level are known as the “sepsis six” (Box 1).

**NURSES’ ROLE**

By increasing their own knowledge and awareness of sepsis, nurses are in an ideal position to ensure patients are reviewed, thereby preventing deterioration into severe sepsis or septic shock. For every hour’s delay in beginning treatment, a patient’s risk of death increases by 7.6% (Kumar et al, 2006).

The process of increasing awareness of sepsis needs a proactive, multidisciplinary approach. Educational programmes have the potential to increase awareness as well as identify advocates, such as link nurses, to champion sepsis awareness.

The critical care outreach team has a pivotal role in supporting nurses to identify and manage sepsis, and in facilitating escalation of care (Carter, 2007).
By developing and using a sepsis screening tool (Fig 2), nurses can use patient observations to identify whether patients have sepsis, severe sepsis or septic shock. Using the “sepsis six” (Box 1) will empower nurses to take action and ensure patients are promptly reviewed and management is initiated.

CONCLUSION
Introducing the concepts of sepsis pathophysiology and treatment using an evidence based approach increases awareness of sepsis, leading to reductions in mortality, length of stay and cost. It creates a sense of responsibility so that the problem is addressed through early identification and treatment.

Increasing nurses’ knowledge and awareness of sepsis will help to improve recognition and prompt aggressive management, ensuring that patients are given the best possible chance of survival.

FIG 2. NURSING MANAGEMENT OF SEPTIC PATIENTS

<table>
<thead>
<tr>
<th>Are any two of the following present and new to the patient? (Systemic inflammatory response syndrome (SIRS) criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature &gt;38ºC or &lt;36ºC</td>
</tr>
<tr>
<td>Heart rate &gt;90bpm</td>
</tr>
<tr>
<td>Respiratory rate &gt;20bpm</td>
</tr>
<tr>
<td>White blood count &gt;12,000 or &lt;4,000/m</td>
</tr>
</tbody>
</table>

If yes, this is the systemic inflammatory response syndrome, which can be caused by any major insult to the body.

Is the history suggestive of a suspected or known infection? If yes, and two of the above SIRS criteria are present, the patient has sepsis.

Are any of the following present and new to the patient?
- Blood pressure <90mmHg
- Altered mental state
- Hyperglycaemia in the absence of diabetes
- Saturations <93% or <9kPa on ABG
- Urine output <0.5mg/kg/hr
- INR >1.5 or platelets <100
- Serum lactate >2mmol/L
- Capillary refill time >2 seconds

If yes, the patient has severe sepsis.

Does the patient have any of the following?
- Blood pressure <90mmHg despite fluid resuscitation
- A positive fluid balance
- Unexplained metabolic acidosis
- pCO2 <3.5, bicarbonate <20mmol, base deficit >-2.5mmol

If yes, the patient has septic shock.

<table>
<thead>
<tr>
<th>Treatment of sepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate ABCDE assessment</td>
</tr>
<tr>
<td>Refer to junior doctor for review</td>
</tr>
<tr>
<td>Consider supplemental oxygen</td>
</tr>
<tr>
<td>Give fluid challenge as per PGD</td>
</tr>
<tr>
<td>Give IV antibiotics as prescribed</td>
</tr>
<tr>
<td>Hourly observations</td>
</tr>
<tr>
<td>Reassess for severe sepsis hourly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment of severe sepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate ABCDE assessment</td>
</tr>
<tr>
<td>Refer to senior doctor for review</td>
</tr>
<tr>
<td>Commence ‘sepsis six’:</td>
</tr>
<tr>
<td>High flow oxygen as per PGD</td>
</tr>
<tr>
<td>Take blood cultures (two sets)</td>
</tr>
<tr>
<td>Give IV antibiotics as prescribed within one hour</td>
</tr>
<tr>
<td>Give fluid challenge as per PGD</td>
</tr>
<tr>
<td>Catheterise and monitor hourly</td>
</tr>
<tr>
<td>Measure lactate and haemoglobin</td>
</tr>
<tr>
<td>Call critical care outreach team</td>
</tr>
</tbody>
</table>

| Measure lactate and haemoglobin |
| Call critical care outreach team |

REFERENCES
Degrees confer a higher status – but at what cost?

A shift in perspective, created by a rise in status, effectively distances the nurse from her patients.

Students used to make beds while talking with patients, and undertook basic observations. Subtle learning happened under the guidance of experienced nurses. The adoption of a low status position (in terms of activities such as bed making) allowed students to develop skills of perception necessary to become exemplary practitioners with intuitive knowledge based on experience.

As a result of Project 2000, student nurses went into higher education and were suddenly absent from the hospital workforce.

Nurse education moved away from a focus on developing individuals who can deliver care to one that produces nurses who understand the context in which they are practising, but are not necessarily competent to practise nursing skills on qualifying.

The textbook model and definitions of the competencies of the registered nurse are often far removed from the day to day reality of nurses’ work.

The qualities required of the nurse role are not those usually associated with high status; the caring role is not traditionally valued or rewarded by developed societies.

Close contact with the injured, diseased, sick and dying may come as an unwelcome shock to those who have had little contact with the realities of the nursing profession in their years of preparation as student nurses.

Sarah Thelwall, RGN
Devon

“Why do student nurses reject essential care?” was on the cover of Nursing Times (3 November).

I then learn that nursing is going to be an all degree profession. But don’t get too excited – these degrees are only from old polytechnics, few of which are as much as half way up The Independent’s list of best universities. An embittered and jealous RGN? Well, certainly an RGN, but, given that I have a first class arts BA from Durham – one of our best universities – I have no reason to feel inferior.

‘Competencies for registration are far removed from the day to day reality of nurses’ work’

I have done nursing courses at one of the best former polytechnics. There were very particular instructions on how to write essays. However, on giving in an essay to a tutor, I said that had I handed in such an essay to a Durham lecturer, I would have been told to rewrite it.

By all means get your degrees. But go and get your gloves dirty – and don’t forget to wash your hands after taking them off.

Veronica M Burton
Wheatley, Oxford

We are not using HCAs to down grade nurse roles

I was sorry to see that you referred to East Kent Hospitals University Foundation Trust without approaching us (“Hospitals to replace nurses with lower paid assistants”, news, page 1, 27 October).

The trust has invested £2.1m in ward staffing to increase numbers of nurses and improve the skill mix ratio of nurses to HCAs.

Different configurations of professionals and support staff will be required in the future.

The development of a ward based role for associate practitioners is an extension of our work with Canterbury Christ Church University to devise a career framework for our support staff. The aim is to provide development opportunities to enable us to retain our most experienced and skilled HCAs.

The ward role will be piloted in elective, ambulatory and rehabilitation wards and will be implemented within a framework of education, supervision and assessment.

Areas where the associate practitioner role has been a success nationally include mental health, GP practices, critical care, emergency care, radiology, breast screening and pathology. Preparation for the role is based on a foundation degree, work based learning and assessment of competence.

The associate practitioner role at East Kent has had a positive impact in occupational therapy, theatre, radiology and audiology services. The trust has trainees in outpatients, the plaster service and oncology.

We are confident that this role will contribute to providing us with a stable workforce with a defined skill set to deliver safe and reliable care.

Evaluation of the impact of these roles is significant for staffing and skill mix planning, particularly in the light of the move to an all degree workforce and the evolving nurse role.

Julie Pearce
Director of nursing, midwifery and quality, East Kent Hospitals University Foundation Trust

I am a retired nurse and in my early nursing days, because of an increase in technology, some nurses were educated particularly in intensive care units. However, such nurses were, it must be said, sadly lacking in practical skills such as laying up trolleys and what are now called “people skills”.

Over the years, there has been a gradual diminishing of the role of a traditional nurse to that of a technician, with the introduction of equipment such as handheld computers, finger clips to take temperatures, and so on.

The nurse’s role is becoming reduced to recording technical details of a patient’s condition. Now, healthcare assistants are taking on traditional nursing duties, a move which should raise concerns about patient safety.

HCAs do not come under the Nursing and Midwifery Council and therefore have no professional accountability. But the nurse who may be in charge does, and could be held liable for any failings on the HCA’s part.

Some hospitals are planning to fill nursing posts with advanced HCAs to cut costs.

Florence Nightingale put it well when she said: “Doctors doctor. Nurses nurse.”

And that is how it should remain.

T Gailligan, RMN, ODN, RGN
Newbury, Berkshire

Lack of care funds leaves patients stuck in hospital

I constantly hear of people who require continuing care remaining in hospital. The latest example is an acquaintance who revealed that his father has been in hospital for 18 weeks for no other reason but funding.

Budget management must be difficult when medically fit people have to remain in hospital because funding is being denied for continuing nursing care.

What’s happening, please?

Jo Sims
Senior staff nurse, Rossington, Yorkshire
We need to talk about relationship counselling

We visited our allotment yesterday to find that our fish are missing. We had four of them in a little pond and, frankly, we haven’t seen them for a while. I rather hoped they had grown legs and wandered off towards the library but my daughter said this was a silly thing to hope for because, if they had, the foxes would have got them and anyway the library is shut. Then my wife found a dead rat and insisted I “do something with it”.


But I’ll be honest, I don’t know what to do with a dead rat. I feel I should. I feel a “proper” man would know. And he’d know where the fish were.

Anyway we argued about what to do with dead rats and I buried it quite near the artichokes. I thought it was better than her suggestion which amounted to grating it and sprinkling it on the dahlias. Of course the argument continued. She said I lost the fish. I said she killed a rat. Words were said, artichokes were thrown. But it’s OK – we probably won’t need counselling. Which is good because if we did we might be able to waste NHS resources to get it.

In a speech last week health secretary Andy Burnham said, “When couples hit a rocky patch, a bit of help and support can stop it spiralling out of control – that is why I want couple therapy to be more widely available on the NHS."

Indeed, Andy, and why stop with married people? My friend’s 14 year old daughter had an argument with a boy recently about the colour blue. I’m wondering, is there a number she can call?

The idea of making therapy more widely available is part of the increasing access to psychological therapies initiative introduced two years ago to provide treatment to people who are ill. It is a good initiative that will save money on unnecessary prescribing and provide appropriate treatment for a range of problems. But these are health problems, not treatments for dissatisfaction. There’s a difference between recognising the usefulness of some therapies for people who may have a mental health problem and imagining that every activity of life – from falling out to being sad – must be pathologised and treated by a smug bloke in an expensive chair.

If we cannot afford cancer drugs we cannot afford relationship counselling. There may be someone somewhere suggesting that saving marriages makes some kind of weird economic sense but they are probably a therapist looking for work. If we want to maintain a health service – one that attends to the needs of people with cancer, depression or dementia – we need to protect it from the vagaries of therapy culture and political guesswork. The NHS treats ill health not unhappiness and it already has plenty to spend its money on.●

Want to read more of Mark Radcliffe’s opinions? Just log on to nursingtimes.net and click on Forums, Blogs, Ideas, Debate

Comments from NURSINGtimes.net

Here is what you had to say on the story “Young people ‘put off’ nursing”

● The writers don’t realise how important and fragile the perception of the NHS is. The hospital environment is alien to some people, so their perceptions are built on TV programmes.
Anonymous (18 November)

● It may be good that future nurses see another side of nursing other than that in daytime soap operas, where nurses sit and wait to be asked out by Dr Lookingood.
Dennis Emerson (18 November)

● If potential students are so immature that they are put off by silly dramas then perhaps we don’t need them in the profession.
Anonymous (18 November)

● The people who write the dramas should spend time in the NHS and find out what really goes on in accident and emergency or on the ward.
Anonymous (18 November)

● These are called dramas for a reason. They would hardly be entertaining if they just showed the day to day lives of nurses.
Anonymous (24 November)

● I don’t think TV programmes are the problem. I imagine the salary is the real turn-off.
Anonymous (24 November)
Cruise ship nurses are paid to see the world

It is well known that a nursing qualification brings opportunities to work overseas. Many nurses use them to fund backpacking trips, while others take longer contracts in single overseas destinations.

However, fewer people realise that experienced nurses can work on the high seas, providing healthcare to passengers and crew aboard cruise ships. This is a real opportunity to be paid to see the world. It also enables nurses to develop skills that will stand them in good stead in many other areas of nursing practice.

Jennifer Willett is a registered nurse working for Royal Caribbean Cruises Ltd, the world’s second largest cruise holiday company. She is currently working a six month contract on Equinox, a ship owned by Celebrity Cruises, which is part of Royal Caribbean Cruises. The ship, which carries 1,400 crew and 2,900 guests, was launched in the summer of 2009 and her inaugural cruise left Southampton for the Norwegian fjords on 31 July.

Jennifer has been on Equinox since its launch, and is delighted to be a member of its crew.

"Being a nurse on a cruise ship is an opportunity to meet new people and see new places," she says. “The crew is very multicultural – we have people from the Philippines, Colombia, Nicaragua, Thailand, South Africa, the UK and lots of other countries, which is really great." The ship has a team of three nurses and two doctors on board, supported by a medical secretary. Together they run daily clinics and provide 24 hour cover for crew and guests, using a rotating shift system that gives the nurses every third day off. When the ship is in port on their day off they are free to go ashore as they please.

"That is a real perk," says Jennifer. “I’ve been to the pyramids, where I rode a camel, and I’ve swum in the Dead Sea – and I was being paid! You work hard but you have a lot of fun.”

The ship’s healthcare team work closely together, which Jennifer appreciates. “Everyone seems to fit in well and we support each other, so if things get really busy, we will help whoever is on duty at the time," she says.

A large proportion of the healthcare provided on cruise ships is similar to that offered in a GP practice – crew and guests visit the clinic for problems such as coughs, colds and abdominal pains. The nurses take on a similar role to practice nurses, assessing patients, undertaking procedures or assisting doctors in doing so, dispensing medication and educating patients.

However, the team also sees some emergencies, from accidental injuries to heart attacks, so the nurses need to be able to deal with any situation they encounter. They also need to have a cool head in a crisis. For this reason Royal Caribbean, in common with other cruise operators, requires its healthcare team to have a minimum of three years’ experience in areas such as A&E and critical care, or experience of working in remote areas. They also need basic and advanced life support qualifications and other skills such as the ability to apply plaster casts.

“You can be the first on the scene of an emergency, and you never quite know what you’ll see, so it’s vital that you have that experience,” explains Jennifer, who has worked in A&E or high dependency care for most of her career. “You really get to develop your skills. Working on the ship has made me realise that I can think on my feet.” In a major emergency, if the ship is close enough to land, seriously ill patients may be evacuated by helicopter, but this is not always possible.

“If we’re in the middle of the Atlantic, for example, we can’t get patients off the ship, so we have to stabilise them until we can get them ashore,” says Jennifer. “We have a range of equipment such as ventilators and defibrillators, and a stock of medications you would find in the UK or US, so we can stabilise quite seriously ill people, such as after a heart attack or an accident.”

The ship also has a laboratory where blood and other samples can be analysed, X-ray facilities and cardiac monitoring equipment, and the nurses are able to take X-rays, do ECGs and insert intravenous cannulas.

Jennifer has always been a keen traveller. After gaining post-qualification experience in A&E she spent 18 months backpacking round Australia, where she worked in A&E, high dependency and in an aboriginal health facility. On returning to the UK she contacted a consultant who had spent time working on cruise ships, and had encouraged her to do the same. He forwarded her CV to Royal Caribbean Cruises, and after an interview she was offered a job.

While the opportunity to travel was a major factor in her decision to work on a cruise ship, Jennifer enjoys the work itself, and appreciates the team oriented environment. “In fact I sign off from Equinox in December but I have already put in a request to go on another ship in March, working with the same team,” she says.

For anyone wanting to use their nursing skills as a means to travel the world, Jennifer’s experience demonstrates that cruise ships can offer a real alternative to backpacking.

---

**Benefits of Cruise Ship Nursing**

- Opportunities to travel to exotic locations;
- Tax-free salary;
- Free accommodation and meals;
- The chance to develop a range of skills that will benefit future career;
- Opportunities to progress to chief nurse rank.
CAREERS IN NURSING

ROYAL CARIBBEAN CRUISES
CRUISE SHIP NURSES

Royal Caribbean, Celebrity & Azamara Cruise Lines are seeking highly motivated nurses with a minimum of three years A&E or ICU experience to work 6 month contracts. As members of the medical team, you will work onboard offering immediate and primary nursing care to our crew and guests in our well equipped shipboard medical facility. We offer an attractive salary and working conditions, and the opportunity to travel to exotic destinations.

Round trip travel, food, accommodation, malpractice and health insurance provided.

Meet with our U.S. based team in London on 11, & 12 January 2010 to interview and learn more about positions for 2010 and onwards.

Kindly email your resume (CV) and request for interview to kadair@rccl.com

Doctors with 3 years post graduate training in areas that include A&E and GP may also apply.

N47403FEA

REGISTERED MANAGER CHILDRENS HOME
SOLIHULL – WEST MIDLANDS Excellent Salary and Benefits

Our client is expanding its care provision and is now looking to recruit a Manager to manage a new small children’s home in Solihull. Candidates must have at least 3 years experience in a senior role working with children in care and have a relevant social care or management qualification.

An excellent salary and benefits package is on offer commensurate with this key position within their highly regarded and expanding organisation.

For full details please contact the medical team on: 012127 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3521

N47605AP

Live In Nurses

Qualified Nurses (RNA/RN1) with experience in Intensive care and End-of-Life care required to provide 1:1 nursing care for clients wanting to remain at home. Placements usually last 7-21 days.

Must be flexible, confident and compassionate with 3 years varied post-registration experience. Fluent English required, drivers preferred, no work permits.

A commitment to work a minimum of 12 weeks per year in return for a competitive remuneration package.

Call a nurse consultant on: 01732 771924/770403
Email: nursing@consultuscare.com
Website: www.consultuscare.com

N47614AP

DIRECTOR OF NURSING (CHILDRENS)

Band 9 £75,383 - £95,333 – Ref: MCH-0250

Following the recent opening of our state-of-the-art Children’s hospital, there has never been a more exciting time to join us. We are a progressive and innovative organisation, totally committed to achieving the highest quality of care for our patients.

We are looking to appoint an exceptional nurse leader with experience at director or deputy director level; with a proven track record for managing change and improving patient care. Reporting to the Chief Nurse, you will be responsible for the delivery of the professional nursing agenda throughout Children's services across the Trust and will directly manage the safeguarding team.

The portfolio for this position has been carefully considered to ensure that you can contribute to the national and international nursing agenda through education, research and practice development. With a national reputation for research and innovation and links to international children’s hospitals, this role provides a unique opportunity to shape services for children in Manchester and beyond.

First and foremost we want you to be a champion for the children and families of Manchester, helping us to build on our successes and grow our reputation for providing a world class service.

A RSCN/RN (Child)RGN, you will have a post-registration nursing qualification and a graduate or Masters level qualification in a health-related subject. Additionally, you will have an extensive clinical track record as a practitioner/senior nurse within an acute setting, together with extensive experience of safeguarding legislation, guidance and requirements.

For an informal discussion, please contact Cheryl Lenney on 0161 276 8662 or Gill Heaton on 0161 276 4738. Alternatively, please e-mail a full CV to John Harwood at john.harwood@cmft.nhs.uk

Closing date: 17th December 2009. Interviews will be held on the 12th and 13th January 2010.

We are an equal opportunities employer.
Staff Nurses, Speech & Occupational Therapists & Nurse Educator Positions

Hamad Medical Corporation (HMC) provides health services for the State of Qatar in the beautiful Arabian Gulf. We are now recruiting the following roles:

**Staff Nurses**
Applicants will possess a Diploma / Degree in Nursing with 3 years experience in a clinical related specialty.

**Speech Therapists & Occupational Therapists**
Applicants will possess a Diploma / Degree in either Speech or Occupational Therapy with a minimum of 3 years of clinical experience or specialist experience.

**Nurse Educator (Clinical Instructor)**
Applicants will possess a Degree in Nursing. 3 years experience of nursing in an acute care setting & at least 3 years experience in classroom and/or clinical teaching. Working knowledge of Performance Improvement Process and International standards is also required.

Experience New Territories in Healthcare

You will have excellent communication skills, be aware of the diversity of cultural issues. These posts offer an alternative health career outside of the UK with the opportunity to be at the forefront of a new and exciting initiative.

**GENEROUS TAX-FREE SALARY**
+ Excellent Benefits including Free Housing, Annual Flights, Generous Annual Leave, End of Contract Bonus & 365 Days of Sunshine

**HAMAD MEDICAL CORPORATION**
**DOHA, QATAR.**

To apply forward your CV to:
Mr. Daniel Morris
WPRS Limited
Email: daniel@wprslimited.com

HAMAD MEDICAL CORPORATION
DOHA, QATAR.

To apply forward your CV to:
Mr. Daniel Morris
WPRS Limited
Email: daniel@wprslimited.com
We’re a people business at heart.

BMI is the leading provider of independent healthcare in the UK. We believe that healthcare is a people business at heart, which is why we empower our staff to achieve great results – and value their effort when they do. Today, our BMI Alexandra Hospital in Cheadle is expanding fast. We’re now searching for a variety of experienced, dynamic and enthusiastic people to join the cardiology department.

**CHARGE NURSE/SISTER**
£29,000 – £39,000
Providing all aspects of invasive cardiology, you’ll enjoy supporting and leading a multidisciplinary team within the cardiac catheter lab. As an excellent team player, you’ll promote and deliver the highest standards of service.

**ARRHYTHMIA SPECIALIST NURSE**
£29,000 – £39,000
Coordinating and managing arrhythmia-based services, you’ll be responsible for our electrophysiology and pacing service. Working closely with a multi-disciplinary team, you’ll ensure an appropriate pathway for our patients.

To discover more about our careers, the amazing benefits available, or to apply, visit www.bmihealthcare.co.uk

---

**ROYAL NAVY: CRITICAL CARE NURSE**
**TO US IT’S JUST AN EVERYDAY AMBULANCE**

As a Critical Care Nurse in the Royal Navy, you will do everything that a civilian nurse might do, but the circumstances and the places can be extraordinary.

You will need to be educated to degree level and hold 200 UCAS points. Critical Care Nurses must also have two years’ experience in intensive care or be qualified in intensive care nursing.

If you want more than just a job, join the Royal Navy and live a life without limits.

£20,000 JOINING BONUS*
SALARY FROM £28,113
6 WEEKS’ PAID HOLIDAY
FREE MEDICAL & DENTAL CARE
CIVILIAN-ACCREDITED TRAINING
HIGHLY COMPETITIVE PENSION

Contact: Lieutenant Alison Embleton
RN Nursing, Medical and Dental Recruiter
T: 02392 727 745
E: FLEET-CNROPSMMDSG3@mod.uk
or visit royalnavy.mod.uk/careers

* Taxable bonus

---

**Clinical Nurse Tutor**

Working closely with the team at the Clinical Education Centre, we are looking for an inspirational individual who is committed to promoting best practice within the clinical setting. The primary focus of the role is to promote work based learning and develop the clinical skills of our new recruits on the Specialist Graduate Programme as well as our existing staff.

You should be a registered nurse with proven experience of teaching and assessing nurses and students. The ability to work effectively as part of a team is essential as are effective organisational, time management, interpersonal and communication skills.

Evidence of personal and professional development is required.

Benefits include excellent salary and ‘lifestyle’ package which comprises private medical insurance, critical illness cover and other optional benefits.

To apply please visit www.HCARecruitment.com quoting reference 009/9045/CNT2. For further information and an informal visit, please contact Maria Lynch, Graduate Unit Lead on 020 7563 4278 or 07545 101 075.

Closing date: 15 December 2009.

This post is exempt from the Rehabilitation of Offenders Act 1974 and the successful candidate will therefore be required to apply for a standard or enhanced disclosure. HCA is committed to equal opportunities in employment.
So many futures will be in your hands

Great Ormond Street Hospital for Children NHS Trust (GOSH) is an international centre of excellence in the provision of specialist children’s healthcare. Our mission is to provide world-class clinical care and training, pioneering new research and treatments. This is a senior role for an ambitious nursing professional, one that will be key in helping to shape the future of so many lives.

**Director of Nursing**

A strategic focus and ability to lead, challenge and direct the patient experience agenda will be essential to this role. You will possess the skills and charisma to represent the Trust on a national scale, as well as take on an international role in working with partners abroad, furthering the work of GOSH. Patient safety will be your highest priority – it will be for you to ensure that patients receive high quality and safe care that reflects their expectations and values the opportunity to learn from their experiences. The role will include overseeing the safeguarding functions, including ensuring that all teams are trained and competent in child protection issues.

Exceptional management skills will be key to this role. You will bring resilience, positivity and the foresight to handle difficult situations. Educated to post-graduate degree level, you will have a thorough understanding of safeguarding and child protection issues, which will be central to everything you do.

For an informal discussion, please contact Dr Jane Collins, Chief Executive on 020 7813 8330 or email jane.collins@gosh.nhs.uk

To apply, please visit www.gosh.nhs.uk/jobs quoting reference number 271-AML831DA.

Closing date: 21 December 2009.

---

**Medical jobs have never been 9 to 5. Until now.**

**Clinical Assessor**

£23,000 + benefits • 7-month contracts • Eastleigh

As an experienced medical professional you’re used to dealing with difficult, emotive issues that have a real impact on people’s lives. Join Aviva as a Clinical Assessor and we promise you the same level of professional satisfaction, but in a different environment. Working 9 to 5, Monday to Friday you’ll assess insurance claims, review claimants’ medical notes, handle appeals, and discuss issues with GPs and consultants – all over the phone from our relaxed and attractive contact centre. Whether you’re a qualified nurse or you’ve worked elsewhere in healthcare, you’ll need great relationship-building skills, team spirit and real initiative. To apply, please visit www.aviva.co.uk/careers and search the current vacancies within the Customer Services business area.
**CENTRE MANAGER**

**circa £38k per annum**

An exciting opportunity has arisen to commission the Centre having the operational and strategic responsibility for the Centre. We require a Registered Nurse or an Allied Healthcare Professional with experience of healthcare and preferably brain injury and/or rehabilitation management, excellent knowledge of clinical governance and audit. A strong commercial awareness coupled with knowledge of the legislation pertaining to this sector is central to this role. You will possess:

- A proven track record of managing multidisciplinary/professional team.
- Sound knowledge of statutory and employment legislation and well developed business skills.
- An understanding of government initiatives within the healthcare arena.
- Enthusiasm, drive and initiative, with excellent interpersonal skills to work in a complex and challenging environment.

It is desirable that you have experience of this client group and the independent sector.

Offers subject to eligibility to work in the UK, satisfactory CRB disclosure and pre-employment health screening.

For an application pack, please contact Patricia Green, on 01628 607412 or email patricia.green@fshc.co.uk. Informal enquiries welcome or visit www.huntercombe.com

Closing date for applications: 16th December 2009.

---

**REGISTERED NURSES (Full and Part-time) HIGH WYCOMBE, BUCKS and FARHAM, SURREY**

Our client is a family owned and operated company, based in the south of England. They have been running Residential Nursing and Care Homes for over 20 years. Their motivation is to provide the highest level of care. Their High Wycombe home was founded in 1991 and is situated in a quiet, secluded grounds and benefit from being a short walk from the village of Bourne End, which lies on the banks of the River Thames running along the border between Berkshire and Buckinghamshire. The other is a registered Residential and Nursing Home situated in the rural village of Farnham, situated in a quiet, leafy road, but with very good links to local transport and the motorway network.

Vacancies exist for qualified and experienced Registered Nurses to join their established and professional care teams. Competitive rates of pay and genuine career opportunities are on offer.

For full details please contact the medical team on: 01279 843451, ext. 216.

Closing date: Thursday 17th December 2009

Interview date: Tuesday 5th January 2010

For an application pack please contact Reception on 01279 843451. Alternatively, e-mail reception@stelizabeths.org.uk, or download an application pack from our website www.stelizabeths.org.uk

The above posts are subject to an enhanced CRB check.

---

**HOME MANAGER YELVERTON – SOUTH DEVON**

**EXCELLENT SALARY PLUS ACCOMMODATION**

Our client owns and operates a 31 bedded Nursing Home situated in the rural village of Yelverton. The home is a converted Victorian house on the edge of Dartmoor National Park. The village is within walking distance and has a church, newsagents, post office and bank. There is a bus stop nearby which has routes to Tavistock (4 miles) and Plymouth (10 miles).

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3520
Unit Leaders, Nurses, Newly Qualifieds (RNMH/RNLD)

£22,500 to £35,500 per annum plus relocation, welcome bonus and a range of other benefits - South Wales

Please visit our website to find out more about us and our nursing development framework. We’re breaking new ground in caring for people with Mental Health problems and Learning Difficulties and we are looking for a number of outstanding nurses to help maintain our momentum.

Why join us? We’re offering a salary and benefits package designed to attract the best. We have the support and infrastructure in place to enable you to flourish, and we operate in South Wales, a beautiful part of the world.

Interested? Visit www.lsheathcare.co.uk or call us on 029 2034 8849 and ask to speak to a member of the Recruitment Team or email careers@lsheathcare.co.uk.

If successful, your appointment will be subject to a standard or enhanced CRB disclosure, dependent on the role.

www.lsheathcare.co.uk
Looking for a rewarding career move?

Join Quintiles Drug Research Unit at Guy’s Hospital

NMC Registered Nurses and Nursing Technicians

Quintiles is one of the world’s leading Contract Research Organisations, and our London unit (QLON) specialises in Phase I clinical drug trials. We will soon expand to 105 bed capacity across 2 units. We have over 25 years of experience, currently completing more than 60 projects annually. Maintaining subject safety and data integrity are the fundamental principles on which all our trials are conducted.

Research Nurse: Ref. 0905847 - Competitive Salary + Shift Allowance Payment + Exceptional Benefits

As a Research Nurse, you will assist in the coordination of clinical trials, promoting wellbeing and maintaining safety of trial subjects, ensuring that correct clinical procedures are performed and documented thoroughly.

Bank Research Nurses: Ref. 0905846 - Competitive Hourly Rates

Bank nurses are required to work flexibly around the needs of our unit. This role would mostly suit nurses who are available for shift work on weekdays. Some night, twilight and weekend work also available.

Clinical Research Technician: Ref. 0906078 - Competitive Salary + Shift Allowance Payment + Exceptional Benefits

You will assist nurses with the coordination of clinical trials. This role includes performing clinical procedures such as blood pressures, ECGs, and obtaining blood samples.

Experience in a clinical or laboratory environment would be an advantage. Hours of work for permanent posts are fulltime and flexible around the needs of the clinical studies, including rostered weekend work. Most shifts take place during the day however late evening or occasional night shifts may be required.

A full induction programme and ongoing training are provided for all roles. To apply for these posts, please log onto www.Quintiles.com/careers, select Europe, Middle East and Africa and apply online using the relevant job number.

Closing date: Tuesday 15th December.

Berkshire East NHS Community Health Services

Slough Walk-in Health Centre

A new and exciting model for local healthcare delivery has been established in Slough. We therefore require experienced, motivated and enthusiastic staff to join us.

The Slough Walk-in Health Centre was formed following the merger of an existing GP practice and NHS Walk-in Centre. It will offer scheduled and unscheduled care for registered and unregistered patients from December 2009.

The Centre will open from 8am - 8pm, 7 days a week, 365 days a year and all posts will be required to work shifts covering the hours of service.

Would you like to work as part of a friendly team where your ideas and experience will be highly valued and will help us enhance our service to the local community?

Opportunities are available for the following posts:

Nurse Manager
Ref: BE789
Band 7 £29,789 - £39,273 – 37.5 hours per week

We are looking for a highly skilled and motivated Nurse Manager to work with the Nurse Practitioners/Practice Nurses and to support the Centre Manager to ensure delivery and the success of the new Walk-in Health Centre.

Nurse Practitioners/Practice Nurses
Ref: BE785
Band 6 £24,831 - £33,436 – 37.5 hours per week

We are seeking experienced Nurse Practitioners/Practice Nurses to provide cover for our scheduled and unscheduled patients.

Bank Nurse Practitioners/Practice Nurses
Ref: BE786
Band 6 £24,831 - £33,436

In addition, we are also seeking experienced Nurse Practitioners/Practice Nurses to join our bank.

All roles offer excellent training and development opportunities as well as excellent staff benefits.

For an informal chat about any of the posts please contact Sam Jones, Project Manager on 01753 635252.

A disabled applicant who meets the minimum criteria will be interviewed.

HOW TO APPLY

www.jobs.nhs.uk

0118 982 2912 (24 hour answerphone)

Please quote the above/appropriate reference number.

For all other enquiries contact the Recruitment Department on 0118 982 2759.

Closing date: 1st December 2009.

We are an equal opportunities employer committed to safeguarding children and vulnerable adults.

Nursing Times

For the avoidance of all possible doubt EMAP Communications Ltd asserts copyright in the classified advertisements section of this edition. If any party is found to have infringed the rights of EMAP Communications Ltd by copying, duplicating, repeating, or reproducing in any manner, style, format or design any of the advertisements featured in the Nursing Times legal action may be taken against them.
NHS South of Tyne & Wear

Putting patient care in the spotlight

District Nurses
Band 6, £24,831 - £33,436 pa pro rata, various hours available
Ref no: 735-SOTW09-P322

NHS South of Tyne and Wear are dedicated to providing better health care and an excellent patient experience. As part of the current District Nurse Modernisation, we are introducing a 'single point of contact' service model, which requires a positive leadership approach to motivating and developing staff.

You must be a registered nurse, nurse prescriber with a relevant district nursing qualification who is able to demonstrate the ability to organise the provision of care to patients/carers in an inclusive way. Experience of delivering teaching and evaluating learner development within your clinical area, whilst having knowledge of current legislation is also essential.

NHS South of Tyne and Wear is an Equal Opportunities Employer and operates No Smoking and Flexible Working Policies. Applicants wishing to job share will be considered unless otherwise stated. Applicants with a disability who meet the essential criteria for the post will be guaranteed an interview.

For more information visit www.bridgeshealthcare.co.uk

NURSES & HCAs REQUIRED

We seek exceptional Nurses & HCAs to join our team. We are looking for caring, motivated and professional individuals who are reliable and conscientious in their working practice. Competitive salaries with shift premiums paid for night, weekend and bank holiday work. We offer a career, not simply a job. Apply by CV to sclements@bridgeshealthcare.co.uk or call Sarah Clements on 020 8468 7888

Nurse Coordinator Alton - Hants
Salary Negotiable + Comprehensve Benefits Package

Our client, part of Alliance Boots, provides specialist clinical homecare services (including drug therapies and equipment) directly to patients at home. They currently have a position available for an officer-based qualified nurse to work within a friendly team providing professional advice and support across a wide range of therapy areas to patients, their families and the NHS. This is an exciting opportunity to become involved in the rapidly growing area of community-based high-tech homecare. The position will allow you to maintain your nursing registration and would provide full support for mandatory training and PREP requirements.

Positions also exist in and around the London area for Bank Nurses who can provide patient training and education, typically sub-cutaneous injection techniques, across many therapy areas. Excellent rates of pay are available

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3522

REF: 272N/09
School Nurse Team Leader

£34,045 to £43,529 p.a. pro rata inclusive
From 30 hours per week all year round Ref: 128W

Are you looking for a challenge?
Are you looking to work in a friendly and innovative School Nursing team?
Then this could be for you!

Our teams are committed to improving health outcomes for children and young people within the Public Health Agenda, and to work in partnership with the local authority

In this post you will:
- Lead a team of School Nurses, Nursery Nurses and School Nurse Support Workers to meet the Every Child Matters Agenda and the Sutton and Merton Community Services Targets.
- Provide leadership, supervision and day to day management for the team
- Provide Child protection supervision to the team.
- Manage a small clinical case load.

You must have a School Nursing or equivalent diploma or degree. You must have demonstrable experience working as a School Nurse and experience in operational leadership and management.

You must be a car driver and have own vehicle for business use.

For further information, please contact Belinda Shear, Clinical Lead on 0208 544 6148 or Gwen Grant, School Nurse Team Leader on 0208 687 4669.

To apply and for further details please go to www.jobs.nhs.uk

Closing date: 8th December 2009.
Interview date: 21st December 2009.

Sutton and Merton Community Services reserve the right to close this post early if there is an overwhelming response.

Sutton and Merton Community Services is committed to equality of opportunity in employment and to the principle of work life balance for its staff.

Benefits include a family friendly working environment, child care advice, a final salary pension scheme and season ticket loans.

The healthiest life possible for the people of Ayrshire & Arran

Arran War Memorial Hospital
Staff Nurse (2 posts)

Band 5: £20,710 - £26,839 pa

The Isle of Arran, often described as ‘Scotland in miniature’ is an island some 20 miles long by 10 across, separated from mainland Ayrshire by an hour long ferry crossing from Ardrossan to Brodick, and in summer, by a shorter ferry from the Mull of Kintyre to Lochranza. Arran’s stable population of just over 5,000 increases approximately 3 fold during the summer months. Arran War Memorial Hospital is a 19 bed hospital providing care to a diverse patient population on an inpatient and outpatient basis, including Accident and Emergency services, day surgery and outpatient clinics. Patient care services are provided by a wide range of clinicians from both Primary and Secondary care settings.

We require first level registered nurses who will be able to provide evidence of work experience in a variety of care settings, to join our team of staff providing care to clients within the hospital and outpatient setting. Ref: N/588/09

Hours: 37.5 per week. Staff will be required to work on all shift patterns and provide care in all general areas within the hospital. Informal enquiries to Mrs Ailsa Weir, Senior Charge Nurse or Mrs Andrea Bond, Charge Nurse, Tel: 01770 600777.

For an application form please contact the Department of O&HRD, 63A Lister Street, Crosshouse Hospital, Kilmarnock, KA2 0BE, Tel: 01563 826725 or email recruitment@aaah.scot.nhs.uk

Closing date: 11 December 2009.

To find out more about NHS Ayrshire and Arran and services visit www.nhsayrshireandarran.com

REGISTERED NURSES - YELVERTON, DEVON

EXCELLENT RATES

Our Client owns and operates a 33 bedded nursing and residential home. It is a fully refurbished Edwardian House set in picturesque Dartmoor and situated in the heart of the beautiful village of Yelverton.

They are looking for two part time Registered Nurses and flexibility exists with regard to shifts and days available. The home is rated as 3 Star by CQC and an excellent rate of pay is on offer, commensurate with this well regarded home.

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3430

Please mention Nursing Times when replying to these advertisements
with a membership now approaching 400,000, the RCN is the largest professional association and union of nursing staff and students in the UK. With an influential voice at home and abroad, the RCN promotes nursing interests, represents and campaigns on behalf of its members and the people they care for, and is a leading player in the development of nursing policy and practice, and standards of care.

International Projects Adviser

£36,321 p.a. pro rata inc. LW
Fixed term until 30 June 2010
Part-time 17.5 hours per week

This exciting role will see you work with members to develop a service that contributes to global health while enabling nursing staff to broaden their experience. Managing our new member networks on international issues and supporting the work of our International Committee, you’ll oversee our advice service to members looking to work abroad - building relationships with other organisations to enhance it.

To meet the challenges, you must add a sound understanding of UK and international nursing to experience of collaborating with a wide range of partners. An influential communicator, you should also add strong project planning skills to the ability manage teams effectively.

For further details and how to apply, please visit www.rcn.org.uk/aboutus/jobs and complete the online application. Alternatively, email recruitment@rcn.org.uk or telephone 020 7647 3549 to request an application pack, quoting reference N50022-1109.


All confirmed appointments will be subject to a six month probationary period.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies. The RCN includes within it two registered charities. The RCN aims to be a world-class champion of diversity, equality and human rights within the health and social care sector.

Care Principles provides specialist person-centred assessment, treatment and rehabilitation services for adults with learning disabilities, personality disorders and autistic spectrum disorders, including those with a forensic background and varying degrees of challenging behaviour.

CAREER PATHWAYS FOR CLINICAL NURSES (RNLD/RMN/RNMH)

Salary £23,126 - £30,000 pa (depending on experience)

We have opportunities for experienced and newly qualified NMC registered nurses in secure and non-secure services.

Locations: Norfolk, Suffolk, Staffordshire, East Yorkshire, Kent, Derby, Nottingham, Birmingham, Exeter and Peterborough.

Clinical Nurses will provide professional and high quality nursing input and care for patients on their designated ward and across the unit and will provide nursing support and advice based on sound evidence and best practice to all staff within the multi-disciplinary team.

Candidates must have a sound clinical knowledge base in their area of specialism, including understanding of the Mental Health Act (1983) person centred planning and CPA process, good leadership skills and the ability to work effectively within a multi-disciplinary team.

To find out more please call our recruitment line on 0845 070 1914 or e-mail: recruitment@careprinciples.com quoting ref: NFT/11/09.

Closing date: 15th December 2009.

Appointments subject to an acceptable, enhanced Criminal Records Bureau Disclosure. We are an equal opportunity employer committed to developing our staff.
The Pennine Acute Hospitals NHS Trust

**MAINE OUTPATIENT DEPARTMENTS**

We are looking to recruit senior personnel to join our team of staff who provide clinical support to the wide range of outpatient clinics across specialties which include Specialist Surgery, General Surgery, Specialist Medicine, General Medicine, Trauma and Orthopaedics, Infectious Diseases and many others.

These areas require senior staff who can demonstrate their ability to lead and develop large staff teams, communicate effectively with other senior personnel on complex matters, be motivated to achieve high standards of service delivery and have determination to succeed. In order to assist the delivery of the 18 week targets these are complex management roles involving a high level of knowledge and skills in planning, scheduling, monitoring, coordinating and communication.

The posts also manage the Phlebotomy Service on each of the sites, with the Phlebotomy team providing services for the acute wards and clinics.

Your role will be to manage the nursing and technical staff to provide support to the senior Nurse in site operational management and to ensure high quality services are delivered and maintained within the resources available to you.

Working with colleagues from other sites and the senior Nurse you will contribute to the development and implementation of new services in response to divisional and corporate plans, performance targets and financial management.

**NORTH MANCHESTER GENERAL HOSPITAL**

**SENIOR SISTER/ DEPARTMENT MANAGER**

- **BAND 7 £29,789 - £39,273**
- **REF: 352-SRN-SR-OUT-09-N279**

Educated to first level degree desirable, or equivalent level of experience with operational management, this is a senior nursing position with you being responsible for the 50+ nursing staff who support the wide range of specialty clinics held within five different areas you will also be responsible for managing the Phlebotomy Service and its associated 18+ staff who provide their service to the acute wards, clinics, direct access and PCT clinics.

Effective management of the staffing resource and department budget requires a determined individual willing to rise to daily challenges. Negotiation and diplomacy skills are the key to success in this complex management role. This demanding role requires an individual with a portfolio that demonstrates a successful track record of clinical leadership, motivating a team and of managing change.

Previous applicants need not apply.

For further details about these posts, please contact Lesley Brimelow, Senior Nurse - Main Outpatient Departments, Phlebotomy Services, Nurse Led Anticoagulant Services - Division of Diagnostics & Clinical Support Services on 0161 778 2880.

For Application Form and further details please contact: The Recruitment Office, Trust HQ’s, North Manchester General Hospital, Central Drive, Crumpsall, Manchester M8 SRL. Ansaphone available on 0161 918 4041.

If you wish to apply please apply online www.jobs.nhs.uk

For more information regarding vacancies visit our website: www.pat.nhs.uk

Closing date for both posts: 10 December 2009.

We are an equal opportunities employer.

We are committed to flexible working.

---

**THE ROYAL OLDHAM HOSPITAL AND ROCHDALE INFIRMARY**

**SISTER/CHARGE NURSE**

- **BAND 6 £24,831 - £33,436 • REF: 352-SR-OUT-09-OL114**

The opportunity has arisen for an enthusiastic, motivated and organised nurse with excellent management and leadership skills to join the team. You must have substantial experience at Band 5 and hold a recognised mentorship qualification. Demonstration of proven leadership and team player skills are essential as you will be required to assist the Band 7 with the management of the department. You will be expected to provide supervision and team motivation to drive forward the changes around reconfiguration of services across Pennine Acute.

You should be able to demonstrate evidence that you are working to the full post outline at Band 5 or have equivalent transferable skills. You should have the ability to work under pressure, to deadlines, and to undertake significant additional management responsibility.

Service provision is expanding to include evening and weekend clinics so you should have this in mind when making your applications. At The Royal Oldham Hospital only, this is a second Band 6 post and therefore consideration would be given to applicants willing to work 30 hours or above.

---

The Pennine Acute Hospitals NHS Trust

Surrey

**SURREY**

**SENIOR STAFF NURSES**

**DAY CARE – PRE ADMISSION - WARDS**

You will have several years post registration experience working in a relevant acute environment within a UK hospital. Clinically focused and exceptionally competent nurses who have strong communication skills, are patient focused and conscientious team players are required. Further qualifications which support your development are ideal and day or night duties are available. Our Client is able to offer excellent training and development opportunities.

Please call Sophie Bell or Kristie Smith on 01303 840 882

Tel: 01303 840 882  Fax: 01303 840 969

enquiries@sophiebellandassociates.co.uk

www.sophiebellandassociates.co.uk

Hampshire

**HAMPSTEAD**

**CARDIAC HDU NURSES – BAND 5**

This 20 bedded Unit is due to have an additional six bed expansion in the New Year and it cares for patients with a wide range of cardiac surgical and cardiology conditions. You will need to be enthusiastic, motivated and a good team player with a strong patient focus and a genuine interest in Cardiothoracic Nursing. A minimum of one-year post registration experience which includes at least six months Critical Care/High Dependency experience is essential. There are full time or part time hours available.

Please call Sophie Bell or Kristie Smith on 01303 840 882

Tel: 01303 840 882  Fax: 01303 840 969

enquiries@sophiebellandassociates.co.uk

www.sophiebellandassociates.co.uk

Please mention Nursing Times when replying to advertisements you have seen on these pages
School of Medical Education
Clinical Skills Resource Centre
Clinical Skills Tutor (0.6 FTE)
£30,594 - £35,469 pa (pro rata) (under review)
The Clinical Skills Resource Centre is a facility for undergraduate and postgraduate medical and allied professionals. You will join a team undertaking the teaching activities of the centre, the assessment of students and in course development and evaluation. There are also opportunities for educational research and inter-professional educational initiatives.
The post would suit a Registered General Nurse or other allied health professional with educational and administrative experience. Candidates should have a recognised teaching qualification, teaching experience and a relevant degree. The post is available for 3 years initially.
Job Ref: A-571264/NT Closing Date: 5 January 2010

School of Cancer Studies
Clinical Research Nurse Practitioner
£25,623 - £29,704 pa (under review)
You will be responsible for co-ordinating phase I/II clinical trials. Duties will include assisting in the completion of forms for Trusts/Ethics approval; identifying patients through multidisciplinary teams/screening notes; collecting data; interviewing; supporting and monitoring patients and data entry.
You should have NMC Level I Registration or other professional qualification, experience within oncology/haematology nursing or experience in research and phlebotomy skills. The post, based primarily at the Royal Liverpool University Hospital is available for 1 year.
Job Ref: S-570506/NT Closing Date: 11 December 2009

For full details, or to request an application pack, visit www.liv.ac.uk/working/job_vacancies/ or e-mail jobs@liv.ac.uk
Tel 0151 794 2210 (24 hr answerphone)
please quote job ref in all enquiries.
COMMITTED TO DIVERSITY AND EQUALITY
OF OPPORTUNITY

RICHMOND COURT NURSING HOME
Richmond Court Nursing Home is a 42 bedded home for Dementia and Learning Disability Residents.
Vacancies exists for a full time RGN Level 1, RMN or RNLD to be responsible for the ordering and safe storage of drugs. To take charge of shift and supervise other staff members.
Previous experience in a care home environment would be preferred.
Up to £22,400 plus night allowance if appropriate
To apply please visit www.rbkc.gov.uk/jobs

For further details or to apply call Mr D Guest on 0121 558 8509 or email bearwood@btconnect.com

THAMESBROOK RESIDENTIAL HOME
We are looking for people with experience of caring for older people to join our dedicated team working at Thamesbrook which has a 3 star ‘excellent’ rating. Join us and you’ll provide high quality person centred care to our residents, some of whom have dementia.

DEPUTY MANAGER (NURSING)
Up to £41,300 plus PRP
Assisting our Manager, your practical understanding of quality care and good practice in this area should be combined with knowledge of relevant legislation, particularly the Care Standards Act 2000. (Job Ref: HA519)

REGISTERED NURSE – DAY/NIGHTS
Up to £28,700 plus night allowance if appropriate
With your experience we’ll expect you to have proven knowledge of the care needs of older people, and post qualification experience gained in a supervised clinical environment. (Job Ref: HA520)

CARE ASSISTANT
Up to £22,400 plus night allowance if appropriate
Providing high quality person centred care to our residents in all you do, you’ll help encourage and maximise independence. (Job Ref: HA521)

INNOVATIVE

NHS
One Medicare, a leading provider of primary care services, is looking for Nurse Practitioners for its Quayside Open Access Centre, 76b Cleethorpe Road, Grimsby. Sheffield City GP Health Centre, Rothingham House, 75 Broad Lane, Sheffield and Derby Open Access Centre, Lister House, 207 St Thomas Road, Derby. All centres are open from 8.00 am to 8.00 pm, seven days a week, 365 days a year.

Primary Care Nurse Practitioners
Grimsby – Sheffield – Derby
Salary scale up to £35,000 - £38,000 pa + NHS pension
We require enthusiastic and suitably qualified nurses who have the following attributes:
• self motivated, flexible and adaptable team players
• independent/Supplementary nurse prescribers
• experience in primary care or first contact nursing and minor illnesses
• vision and commitment to help us deliver excellent services in this new environment

In return we offer: a competitive salary (shift premiums paid for weekend and Bank Holiday working), NHS Pension and a stimulating, supportive environment, with lots of opportunity for personal development.

Apply to: Dorothy Ternent, One Medicare Limited, The Business Centre, Bank Top Farm, Blackhill Road, Leeds, LS21 1PY or via the website where full job descriptions are available - www.onemedicare.co.uk
Closing date for applications: 11th December 2009

RICHMOND COURT NURSING HOME
Richmond Court Nursing Home is a 42 bedded home for Dementia and Learning Disability Residents.
Vacancies exists for a full time RGN Level 1, RMN or RNLD to be capable of delivering person centred care to old frail residents.
Other duties include, to be responsible for the ordering and safe storage of drugs. To take charge of shift and supervise other staff members.
Previous experience in a care home environment would be preferred.

For further details or to apply call Mr D Guest on 0121 558 8509 or email bearwood@btconnect.com

Southern Cross Healthcare
Swiss Cottage Nursing Home, Leighton Buzzard
Unit Manager (RMN) Full Time Days
Leadership qualities, 1st level Nurse. Experience of working with dementia.

RGN’S Full Time Days
For further information call the Home Manager
01525 377922
Closing date: 18 December 2009
Subject to disclosure. We are an equal opportunity employer

Nursing Times 1 December 2009 Vol 105 No 47 www.nursingtimes.net
**Research Nurse**

**AFC Band 6**

**Full-time, 1 year contract in the first instance**

This is an exciting opportunity for an experienced Haematology nurse, to join the Haematology Department and Clinical Research Facility within St Georges. The Research Nurse, under the guidance of the Senior Research Nurse, will be responsible for the set-up, management, co-ordination and facilitation of a portfolio of research studies within the speciality.

They will also be expected to cross cover for other projects as required and where appropriate.

The successful candidate will be highly motivated and enthusiastic and possess excellent communication and clinical skills. Previous clinical experience in Haematology is essential and previous clinical research experience is desired, however training will be given. Knowledge of Chemotherapeutic agents is essential and administration of chemotherapeutic agents, phlebotomy and cannulation skills are desired.

You must be adaptable, self motivated and a reliable team player. The salary is on the AFC Band 6 with a range up to £39,516 per annum inclusive of High-Cost Area Supplement dependant upon experience.

For further information, about this position, and to apply, visit [http://jobs.sgul.ac.uk](http://jobs.sgul.ac.uk). General enquiries can be made to the Recruitment Team on 020 8725 5020 (24-hour answerphone) or jobs@sgul.ac.uk. Please quote reference: 431-09

Closing date: 15 December 2009.

St George’s is an Equal Opportunities Employer

---

**East Midlands Children and Young People's Integrated Cancer Service**

**Lead Nurse**

**Band 8A**

A rare and exciting opportunity – are you prepared to take it?

The East Midlands Children’s and Young People’s Integrated Cancer Service will deliver a centre of excellence that will provide quality care for children and young people with cancer in the East Midlands. In collaboration with the Clinical Service Directors, the Lead Nurse has a key role in the development and co-ordination of children’s cancer services in the East Midlands. You will lead the nursing contribution in the strategic development of these services and provide clinical leadership in cancer related issues to children’s nurses within the East Midlands. You will be based at the Nottingham Children’s Hospital.

If you have strong leadership skills, vision and commitment, please contact us for further information and/or informal visit. Please call Angela Horsey, Clinical Lead on 0115 924 9924 ext 62458, Professor Richard Grundy on 0115 823 0620 or Dr Johann Visser on 0116 258 5309.

For a job description and application form for this post please visit [www.nuh.nhs.uk/working](http://www.nuh.nhs.uk/working). Reference: 958/09

Closing date: 16 December 2009.

We are an Equal Opportunities Employer.

---

**Nursing Times**

1 December 2009  Vol 105 No 47  www.nursingtimes.net

---

**Central Manchester University Hospitals NHS Foundation Trust**

**ALLERGY SPECIALIST NURSE – COMMUNITY OUTREACH (ADULTS)**

**Immunology, Specialist Medicine**

**Manchester Royal Infirmary**

**Band 7 £29,789 - £39,273 – Ref: MED-0165 Permanent**

A recent regional initiative aims to improve and enhance allergy services for the community by helping patients receive treatment in primary care settings. Our vision is to ensure healthcare practitioners and GPs are sufficiently trained to treat patients, and clinical colleagues are fully knowledgeable about local availability and referral criteria. You will be dedicated to helping us deliver this initiative, working with primary and secondary care settings, triage referrals and nurse-led clinics to deliver high quality care and educational programmes to patients, carers and other professionals.

You will have strong communications and leadership skills together with the ability to communicate to service developments and advise others. Immunology experience is not essential as we will provide training as part of your induction and ongoing development.

For an informal chat, please contact Alex Farragher (Immunology, Specialist Nurse) on 07929 593486, e-mail alex.farragher@cmft.nhs.uk or Dr Matthew Helbert (Consultant Immunologist) on 0161 276 6466, or Pauline Anderson on 0161 276 4503 or e-mail pauline.anderson@cmft.nhs.uk.

Apply online at [www.carers.cmft.nhs.uk](http://www.carers.cmft.nhs.uk)

Closing date: 9th December 2009.

We are an equal opportunities employer.

---

**Nottingham University Hospitals NHS Trust**

**EAST MIDLANDS CHILDREN AND YOUNG PEOPLE’S INTEGRATED CANCER SERVICE**

**Lead Nurse**

**Band 8A**

A rare and exciting opportunity – are you prepared to take it?

The East Midlands Children’s and Young People’s Integrated Cancer Service will deliver a centre of excellence that will provide quality care for children and young people with cancer in the East Midlands. In collaboration with the Clinical Service Directors, the Lead Nurse has a key role in the development and co-ordination of children’s cancer services in the East Midlands. You will lead the nursing contribution in the strategic development of these services and provide clinical leadership in cancer related issues to children’s nurses within the East Midlands. You will be based at the Nottingham Children’s Hospital.

If you have strong leadership skills, vision and commitment, please contact us for further information and/or informal visit. Please call Angela Horsey, Clinical Lead on 0115 924 9924 ext 62458, Professor Richard Grundy on 0115 823 0620 or Dr Johann Visser on 0116 258 5309.

For a job description and application form for this post please visit [www.nuh.nhs.uk/working](http://www.nuh.nhs.uk/working)

Reference: 958/09.

Closing date: 16 December 2009.

We are an Equal Opportunities Employer.
CRITICAL CARE NURSES PRIVATE HOSPITAL LONDON W1

Excellent Salary and Benefits

Our client is a private independent acute Hospital located in Central London. It is registered with the Care Quality Commission and recognised by investors in People and offers the highest standards of medical and surgical excellence, the most modern equipment and facilities combined with impeccable standards of care. 

Vacancies currently exist for senior staff nurses to work in a well established Critical Care Unit which is planned to undergo a major refurbishment next year. The successful candidate will be a competent critical care nurse who has successfully completed a recognised ITU course. An ALS/ILS certificate is desirable. The post holder will be required to undertake activities on the unit on a regular basis ensuring that effective communication is maintained at all times. They must also be willing to be involved in working parties/groups and also to participate in audits and training activities. A generous salary and benefits package is on offer which includes subsidised accommodation, free meals whilst on duty, together with genuine career development opportunities.

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3423

REGISTERED NURSE - Dursley, Gloucestershire

Excellent rates of pay

Our client is a support community comprising a purpose-built Care Home and superior assisted-living apartments, designed to offer retirement living and professional care within a secure and friendly environment. This community is situated in the rolling Cotswold Hills on the edge of the thriving Cotswold town of Dursley, which combines traditional charm and excellent modern amenities. From its elevated position, The Care centre commands delightful views over the surrounding valley and Gloucestershire countryside.

A vacancy currently exists for a Registered Nurse with excellent clinical skills to join their established and professional care team. An excellent rate of pay and comprehensive training are on offer commensurate with this key position within their highly regarded care centre.

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3422

Please mention Nursing Times when replying to advertisements you have seen on these pages

For more jobs online click www.stockport.nhs.uk

We welcome applications made on a job share or part time basis.

For an application pack, please contact our 24 hour jobline 0161 419 5642 or email: recruitment@stockport.nhs.uk Alternatively, apply on-line at www.stockport.nhs.uk

Closing date: 30 December 2009.

For an application pack, please contact our 24 hour jobline 0161 419 5642 or email: recruitment@stockport.nhs.uk Alternatively, apply on-line at www.stockport.nhs.uk

Nursing Times 1 December 2009 Vol 105 No 47 www.nursingtimes.net

Boost your job search with job alerts
Visit www.nursingtimesjobs.com/alerts
PORTLAND DISTRICT HEALTH

Sponsorship Opportunities for Midwives to work in Australia

Are you looking for a change of scene and fancy working in Australia? Portland District Health in Victoria is currently seeking UK midwives interested in spending time on the South West corner of the east coast of Australia. We are a small rural hospital providing all aspects of maternity care to our local community. Midwives employed at Portland District Health have the benefit of being involved in the whole patient journey – ante-natal, birth and post-natal care.

We are interested in UK midwives who would like to spend a few years on a working visa or those who wish to make Australia their home permanently. In exchange, we offer a competitive salary, relocation assistance, visa assistance and sponsorship for the right candidate. We currently have a number of nurses from the UK working here and have a support network set up to help you settle into your new life down under.

Informal enquiries or applications can be made to Ann Silver, Executive Assistant to the Director of Nursing
asilver.pdh@swarh.vic.gov.au

Please provide your telephone number in the email and we will call you at a suitable time to discuss your opportunities here.

This friendly acute hospital, treats patients across all specialties. We have an ongoing education programme delivered by our Clinical Tutor and are committed to giving the highest quality nursing care based on current research.

Sister – Outpatients
37.5 hours per week

If you are committed and care passionately about the care patients receive, why not join our team. You must have the ability to lead the Outpatient Nursing team and deputise for the Outpatient Manager in their absence and supervise students and their placements. Experience within outpatients and possession of an assessor’s qualification is essential together with effective communication and leadership skills.

Senior Registered & Registered Nurses - Wards
37.5 hours per week

To apply for the senior posts you should possess significant experience as a Junior Staff Nurse and have excellent organisational and communication skills as well as a broad clinical knowledge base. After appropriate training you will be required to take charge of the ward during your shift. For the junior posts you should possess registration experience although a newly qualified nurse would be considered.

Lead Anaesthetic Practitioner - Theatres
37.5 hours per week

To assist the Theatre Manager in developing the services offered by the operating department, in order to achieve desired levels of profitability and growth.

Registered Nurses – Theatres (Scrub and Recovery)

The workload includes all surgical specialties, including cardiothoracic.

For a job description and application form, please contact Human Resources on 020 8936 1207/1258 (internal ext. 4335/4326). Closing date: Monday, 7th December 2009. Any appointed candidate will be subject to a Criminal Records Bureau (CRB) disclosure.

REGISTERED NURSES NUNEATON – E WARWICKSHIRE

Excellent rates of pay

Our client is situated on the A5 in between the towns of Hinckley and Nuneaton. The home provides the highest standards of nursing care for up to 22 elderly residents. Accommodation is provided on two floors, access to the first floor is by stair lift for those who are unable to manage stairs. The home has garden areas to the front and rear of the building.

Vacancies currently exist for Registered Nurses with good clinical experience to join a professional and established team. A competitive rate of pay is on offer within a wonderful caring environment at this well regarded home.

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk Ref: MH 3523

TRAINING

Have you considered Foothealth as a Career?
Then train with us to become a fully qualified Foot Health Practitioner.

The only FHP course which is credit rated by a leading university.
A rewarding profession caring for people who suffer with common foot and nail disorders. Continue working whilst you learn in your spare time. The practical element is then carried out at our extensive clinic in Maidenhead. Full professional support and indemnity insurance during training and upon qualifying.

FREE prospectus available from: Enrolment Advisor, NT, The New Hall, 149 Bath Rd, Maidenhead, Berks SL6 4LA
01628 621100 (24 hrs) info@smaeinstitute.co.uk

www.smaeinstitute.co.uk

Please mention Nursing Times when replying to these advertisements
IN NEXT WEEK’S NURSING TIMES

NURSING PRACTICE

Changing Practice
Looking after staff for the benefit of patients
Where staff experience is good, patients’ experiences are more likely to follow suit. The King’s Fund Point of Care programme offers practical tips for trusts to support employees

In depth
Menopausal effects on the pelvic floor
Providing good care for women with pelvic floor dysfunction can impact positively on quality of life

Guided learning
Depression in long term conditions
The first part of this two part unit examines NICE guidance on identifying and managing depression in adults with long term conditions

Research
Risks associated with consumer advice on complementary therapies
A review of 15 popular consumer magazines analyses the quality of advice given on the use of complementary therapies and the potential for adverse outcomes

Guidance in brief
Increasing immunisation uptake
New NICE guidance aims to reduce variations in immunisation rates and maximise uptake

Encouraging innovation
There is fierce pressure for nurses to work smarter and transform old ways of working. Rosemary Cook, director of the Queen’s Nursing Institute, explains why creativity and inventiveness must be encouraged to meet the profession’s challenges
THE NEW NURSING TIMES. SUBSCRIBE NOW.

BE THE BEST NURSE YOU CAN BE
Refreshed with a brand new look and even more essential content, the new Nursing Times equips you with the latest unbiased information and best practice, so you can be the best nurse you can be, now and in the future.

SUBSCRIBE TODAY.
GET 8 ISSUES FREE*
Subscribe today to make a huge saving of 20% off the cover price, meaning that you receive 8 issues FREE!*

* Offer ends 31/12/09. Offer only available to new subscribers.

Go to:  www.subscription.co.uk/nurstimessnuiw or call 0844 848 8859 and quote priority code NUIW

* Offer ends 31/12/09. Offer only available to new subscribers.