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Modernising HIV Outpatient Care: the Contribution that Specialist Nurses make to Managing Patients with Non-Complex Health and Social Care Needs

Project team:
Enrique Castro Sanchez, Elizabeth Kirkpatrick, Dr Kevin Miles, Dr Simon Edwards, Dr Paul Benn, Dr Erica Allason-Jones, Nikki Penny, Gary Brough

Location:
Camden Primary Care Trust, Mortimer Market Centre, London

Contact details:
enrique.castro-sanchez@camdenpct.nhs.uk

Background
The number of people living with the human immunodefficiency virus (HIV) in the UK is rising each year due to increased new diagnoses and decreasing deaths resulting from the effective use of antiretroviral therapy (ARV). At the end of 2004 there were an estimated 58,300 adults aged over 15 living with HIV in the UK (Health Protection Agency, 2005), placing increasing demands on health and social care services.

The Mortimer Market Centre (MMBC), a genitourinary clinic which provides care for the prevention and treatment of sexually transmitted infections, has seen an increase of 225% in the number of patients served since 1992, with no evidence to suggest a reduction on this trend. The current cohort (2005 data) is in excess of 2500 individuals and it is projected to reach almost 4000 patients under current conditions by 2010.

Not only the number of patients has increased, but their profile has also evolved. An in-house review of the characteristics of the population in MMBC suggested that in 2005, 55% of individuals either had a CD4 count above 350 with undetectable viral load or were not taking antiretroviral therapy, thus identifying a core group of 'well' patients unlikely to develop opportunistic infections or suffer from mortality in the medium term, and who could be followed up by specialist nurses, thus providing an opportunity for more experienced professionals to deal with more complex individuals, matching needs to expertise.

Additionally, new treatments have highlighted the need for expanded access. The introduction of post-exposure prophylaxis (PEP) in accident and emergency departments and sexual health clinics impacted on the walk-in service provided by the MMBC, therefore increasing the waiting time for existing HIV patients. Moreover, the extensive waiting list (2 years) for treatment of facial lipoatrophy (a consequence of certain ARVs with dramatic psychosocial morbidity) with dermal fillers led the service to adopt new nursing roles that safely increased the access opportunities for patients.

These new roles would interest professionals and encourage them to stay in the specialty, whilst also conforming to the visions of modernisation embraced in the NHS Plan (Department of Health, 2000), the National Strategy for Sexual Health and HIV (Department of Health, 2001), the Chief Nursing Officer's 10 key roles for nurses (Department of Health, 2002) and more recently Modernising Nursing Careers (Department of Health, 2006).
There is increasing evidence from randomised controlled trials (RCTs) about the efficacy, safety and cost-effectiveness of nurses delivering care previously provided by doctors (Kinnersley et al., 2000; Shum et al., 2000; Miles et al., 2002). Moreover, although a new role in the UK, advanced registered nurse practitioners (NP) in the USA have been providing routine HIV primary care since the early 1990s, and recent evidence suggests comparable levels of competence in several areas when compared with physicians (Wilson et al., 2005).

Although HIV care delivered by NPs is a new concept for the UK, the MMBC is experienced in developing advanced practice roles for nurses in the sexual health setting, and has evaluated nurse-led sexual health clinics using RCT design, providing recommendations for future practice, policy and research (Miles et al., 2002) which have benefited this evaluation in the HIV outpatient setting.

Furthermore, a team of researchers from the Centre for Sexual Health and HIV Research carried out a formative evaluation aiming to define and guide this initiative (Griffiths et al., 2006) involving a wide range of stakeholders including patients, doctors, nurses and managers, and these specialist nurse posts aimed to satisfy the requirements raised by both service users and practitioners.

Aims of project
The team sought to introduce the role of specialist HIV nurse (SpN) in order to manage a cohort of HIV-positive individuals with non-complex health and social care needs, via traditional (clinic visit) and innovative (phone consultation) follow up methods, and pioneering a new direction in HIV outpatient care, reflecting the shift towards a chronic disease model of care and making best use of nurses' skills to encompass clinical, social, psychological and public health domains whilst helping to re-distribute workload so that patients needs are better matched with professional expertise.

Implementation
The introduction of the 2 SpN posts in April 2005 was followed by an intensive induction period of two months where active observation of consultations carried out by the doctors in the clinic took place. Each SpN was also linked with a consultant physician mentor who supervised consultations, patient management and clinical documentation, and supported continuing educational opportunities.

SpN clinics were available for patients from June 2005, following active marketing with leaflets, emails and meetings with clinic staff and service users. Transfer of suitable patients from medical cohorts to the SpN cohort was encouraged, targetting the group of individuals with relatively efficient immune function (CD4 count above 350 cells/mm^3), either naïve or on therapy, without major other co-morbidities (tuberculosis, cancer, etc.).

The evidence base underpinning the project ensured that users and clinicians embraced the initiative and reduced anxiety regarding the introduction of a novel approach. Regular meetings with the HIV service user forum have ensured ongoing user

feedback and input into the intervention, whilst medical consultant support has continued through weekly clinical supervision meetings, and nurse consultant support has enabled SpN clinical leadership skills to be continually enhanced. The main barriers for the full development of the posts have been logistical. Room availability has impacted on clinic schedules. However, this has been resolved with the introduction of an electronic calendar available to all staff to signpost their availability. For example, this has allowed the increase in treatment capacity for facial lipoatrophy from 4 patients to 15 patients for each treatment session.

The SpN's roles include:

- Follow-up of HIV care, with review of results, phlebotomy and issuing of prescriptions
- Treatment support for individuals starting or switching therapy
- Autonomous provision of restorative treatment with facial fillers for facial lipoatrophy
- Sexual health (including contraception and cervical cytology) consultations
- Post-exposure prophylaxis (PEP)

Evaluation

An analysis of all clinical episodes managed by SpNs demonstrated that 95% of consultations were resolved without doctor input, thus freeing medical staff to deal with more complex cases (Castro Sanchez et al., 2006). Moreover, the radical approach to patient care using a 'one-stop shop' model has reduced the number of times that every patient is required to attend, producing a more linear and coherent visit. A further analysis of a subset of patients followed-up by the nurses suggested that these individuals were no more likely to experience virological failure (Benn et al., 2007).

SpN appointments to screen asymptomatic individuals for sexually transmitted infections (STIs) have relieved pressure on the traditional walk-in STI screening service, which can now devote further resources to symptomatic individuals, improving not only the users' experience in terms of waiting times but also staff ability to engage in wider public health activities (e.g. education, health promotion, partner notification). Interestingly, around 50% of the asymptomatic individuals were found to have a STI, potentially enhancing HIV transmission.

The service has virtually eliminated the waiting list for lipoatrophy treatment, improving enormously the quality of life of these individuals. A retrospective practice evaluation (Kirkpatrick et al., 2007) has demonstrated no difference in the complication rates on patients treated by SpNs compared with plastic surgeons.

In terms of post-exposure prophylaxis, increased appointments for follow-up have benefited the service by allowing the emergency doctor to focus on clinic patients attending with acute HIV-related problems, reducing all patients' waiting time, and ensuring continuity of care by specialist rather than by junior staff. In 2006 an audit carried out in the clinic suggested that completion rates and screening for sexually transmitted diseases was above recommended national standards, with an increased yield of opportunistic screenings for sexually transmitted infections.

Conclusion

The conception of the HIV SpN model of care began more than four years ago and results of the formative evaluation have been widely disseminated to stimulate wide ranging debate on this novel approach to HIV outpatient care.

High level exposure within Camden PCT, the North Central Strategic Health Authority and with the Chief Nursing Officer has also ensured that this intervention is recognized as a significant contribution towards meeting a range of objectives set out in local delivery plans, national, regional and local nursing, recruitment and retention and life-long learning strategies.

The SpNs involved in the project have gained not only clinical skills, but also experience in developing cutting-edge services that maximize existing skills. This position has also allowed them to intervene in the development of national policies that will support the dissemination of the model nationally and internationally.

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Developing a Nutritional Screening and Assessment Tool within Older Adult Mental Health Services

Project team:
Jane McKeown – Practice Development Nurse, Lorena Cain – Clinical Nurse Manager, Jill Thompson – Clinical Audit Assistant, Elizabeth Barnett – Speech and Language Therapist

Location:
Sheffield Care Trust and Sheffield Primary Care Trust

Contact details:
Jane.McKeown@sct.nhs.uk

Background
The importance of nutrition in relation to health and wellbeing with older people has been emerging over the past decade. Malnutrition is both a cause and consequence of ill health (NICE, 2006); yet the failure of hospital services to adequately assess for nutritional needs and provide adequate management of malnutrition is well documented (McWhirter and Pennington, 1994; ACHC, 1997; Age Concern, 2006).

Our service began to take a planned approach to improving nutrition following the publication of Essence of Care (Department of Health, 2001). Despite many small nurse led improvements in practice linked to nutrition, it became apparent that these had not impacted on the following nutritional benchmarks:

- Screening and assessment to identify patients' nutritional needs
- Planning, implementation and evaluation of care for those patients who require a nutritional assessment

Aim of project
The overall aim of the project was to develop and implement a nutritional screening tool across older adult mental health services. This would enable people at risk of under-nutrition to be identified, facilitate appropriate action to be taken and improve documentation of nutritional information.

Development of the nutritional screening and assessment tool
A multi-professional steering group was convened to develop a nutritional screening and assessment tool. The group reviewed the comprehensive literature reviews of nutritional screening and assessment tools used by nurses (Green and Watson, 2005; 2006) and a range of existing national and local tools (Vellas et al., 1999; BAPEN, 2003). This process identified that the existing validated tools did not meet the specific requirements for our service for the following reasons:

- The screening questions and assessment guidance did not take into consideration specific issues for older people with mental health needs including the impact of mental health, behavioural and perceptual factors on nutritional risk
- The emphasis of tools appears to be on physical health
- Mental health nurses are not specialists in physical care and therefore may require more in depth assessment guidance and protocols for interventions when nutritional need was identified

The most relevant tool assessed and recommended nationally for use in hospital, community and care home setting is the Malnutrition Universal Screening Tool (MUST) (BAPEN, 2003). The 3 key trigger questions included in this tool were therefore used to form the basis of the new screening tool and because of the potential difficulties of obtaining an accurate body mass index (BMI), alternative more subjective measures were used (BAPEN, 2003).

The tool comprises:

- A nutritional screening tool which is completed for all service users on admission. This gives a score indicating any further action required
- A nutritional assessment form which is used if a person scores 3 or more upon screening. This tick box assessment asks questions about needs across the categories of: social situation; problems handling food; chewing and swallowing; mouth-care and teeth; poor appetite; behaviour and perception; physical and medical
- Pathway information which guides staff on interventions when needs are identified in each of the categories and which assist staff in developing care plans

Piloting the tool
Two in-patient areas providing a cross section of mental health needs were identified as pilot sites. Training in the use of the tool and raising awareness of issues relating to nutritional need was provided for all nurses, support workers, therapy, catering and housekeeping staff before the pilot commenced.

The pilot took place from June - September 2004; during this time the practice development nurse visited the wards to support staff with the implementation process. This involved answering queries about the use of the tool, advising and encouraging staff to complete it correctly and noting any difficulties important for evaluating its use.

Pre and post implementation audit
Alongside the development of the tool an audit was developed with support from the clinical effectiveness department. This audit was conducted before the pilot implementation and again following the 3 month pilot to assess the impact of the tool on practice. The standards used in both audits were identical and were drawn from the Essence of Care benchmarking tool, clinical knowledge and expertise and from discussions between the nutritional screening tool steering group. Table 1 summarises the results of these audits.

Table 1. Results of pre and post implementation audits

Standard	2004 % Yes	2005 % Yes
1. The patients' weight is documented in he care notes on admission	57	91
2. There is documentation regarding the patients' physical appearance on admission	25	91
3. Within the care notes, there is evidence that the patient/carer has been asked about changes in the patients' weight prior to admission	37	86
4. Reference is made to the patients' individual dietary needs and preferences within the care notes	57	52
5. Reference is made to the patients' food and fluid intake in the care notes	77	93
6. If a concern about a patients' food and fluid intake is raised it is monitored and recorded	97	96
7. If continued cause for concern is documented in the patients' notes they are referred to an appropriate specialist	79	75

Semi-structured interviews

Semi-structured interviews were carried out with 8 registered nurses; the interview schedule was designed to elicit nurses experiences of using the tool in practice. The interviews were taped and transcribed and then analysed by generating themes. The themes were negotiated and refined by the practice development nurse and clinical effectiveness facilitator:

- Flexibility/timescales – some practical difficulties in gathering all information on admission were identified e.g. service users/carers were not always sure if the person had recently lost weight. Some staff wanted more flexibility for completing the tool; others appreciated that re-screening could take place when more information was available
- Subjectivity – some staff expressed concern that question relating to physical appearance could be subjective although they agreed that completing BMI had its difficulties
- Training and education – the pre pilot training was assessed as having been informative and sufficient to prepare staff for the use of the tool
- Obesity – concerns were raised that the tool did not assess obesity
- Practice issues – the tool was described as straightforward, simple and easy to use and staff thought it had value and should be implemented within the service. Staff described how it had impacted in a positive way on awareness of nutrition and on care planning, however the pathway information was not widely used. The deputy ward managers discussed some difficulties in encouraging staff to correctly use the tool; motivation and remembering to re-screen when necessary were cited as problems
- Resource issues – these included access and affordability of appropriate weighing scales; the absence of access to a dietician; limited access to speech and language therapy and the difficulty of always offering food preferences

Adaptations

Based on the results of the audit and the interviews the tool was adapted in the following ways:

- A prompt to ask about dietary needs and preferences and space to record these was added
- "Information not known" was given a score to prompt staff to re-screen and weigh a person seven days when information was unavailable on admission
- The value of the pathway information is to be highlighted in future training and ways of making it more accessible to staff have been discussed
- Work is taking place to assess the usefulness of an obesity care pathway within another part of the service

Conclusions

The development and pilot of this nutritional screening and assessment tool is a step towards meeting the requirements of Essence of Care (Department of Health, 2001) and the NICE Guidelines on Nutrition (NICE, 2006).

Overall the tool appears to be effective in encouraging staff to ask important questions essential to identifying nutritional need. There have been improvements in nurses asking and documenting these key questions and documenting baseline weight. It is seen as simple to use and staff understand and value its implementation. The use of audit combined with staff interviews has provided a systematic way of assessing the use of the tool and has informed development of the tool. The data from the staff interviews helped to explain some of the less satisfactory audit findings and have given advice on how to overcome them. This model will be repeated with the continued development work.

Challenges relating to developing and changing practice were also identified and the group acknowledge that implementing a tool is not easy. A number of barriers have been identified within this project for example, staff not always completing the tool correctly or not using all the resources, equipment being inadequate to weight people and gaps in specialist service provision. However this is a reflection of the 'real world' of practice development and once barriers have been identified steps can be taken to overcome them.

Opportunities to involve service users and carers fully in this project were missed as assumptions were made that as a clinical tool they would not be interested in becoming involved. Service users and carers will be involved in further evaluations and adaptations and lessons have been learned in this respect to take to other projects.

The team acknowledge that the tool has not been formally validated and it is difficult to prove nutritional status has improved. This is just one step on a longer journey to improving nutritional care within this service user group and more work will need to be undertaken in this area. The tool is now being fully implemented within ward areas with full support of management with a view to extending its use to community settings and there are discussions of whether a bid should be made to get the tool formally validated.

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Reducing Healthcare Associated Infections using the Take Five Initiative – Evaluating the Impact of an Infection Control Initiative

Project leader:
Angela Thompson, Head of Standards

Location:
Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's Hospital, Cambridge

Contact details:
angela.thompson@addenbrookes.nhs.uk

Background
Following the introduction in 2004 of the MRSA bacteraemia target which requires a 20% year on year reduction for MRSA bacteraemia it was agreed at board level that the trust would implement a strategic programme with the primary aims of raising awareness of best practice in infection control and of reducing health care associated infections. Work was undertaken with the senior clinical nurses (modern matrons) and the infection control team to agree a plan of audits which would address these aims and also take into account issues which were important to our patients and users, as identified by patient stories, complaints analysis and the results of the National Inpatient Survey. This work was named the Take Five infection control initiative.

Aims of the initiative
The primary aims of the initiative were to:
- Raise awareness of infection control issues in order to improve practice and the quality of the patient experience
- Engage staff at all levels throughout the organisation including at senior manager and director level in reducing healthcare associated infections
- Address areas of concern to patients and users as identified by the results of patient stories undertaken in 2003/4, results of the National Inpatient Survey (Picker, 2004) and by complaints analysis

Developing and implementing the Take Five infection control initiative
The initiative was developed during 2005/06. It involved wide consultation with key stakeholders within the trust; consideration of national drivers e.g. Department of Health (2004) National Standards, Local Actions and the Clinical Negligence Scheme for Trusts (2004); additional evidence from the trust's Picker Institute National Patient Survey report (2004) and other sources e.g. National Patients Safety Authority (2004) clean**your**hands Campaign.

Five key standards were identified. These related to:
- Hand hygiene compliance
- Personal protective equipment use
- Uniform/dress code
- Bed/locker space
- Bathrooms, showers and toilets

Relevant infection control policies were reviewed and updated to ensure they reflected evidence-based best practice. Audit tools were then developed to measure practice for all staff groups against these five standards. The trust's communications department were also involved in developing posters and information leaflets detailing the five standards and the wards were provided with a Take Five resource folder which provided a summary of the evidence supporting the standards as well as the audit tools and supporting information such as relevant policies and procedures.

The tools were successfully piloted in March 2005 and the audits were then undertaken quarterly throughout 2005/06 by trained ward auditors. Hand hygiene compliance was audited monthly using the NPSA clean**your**hands campaign audit tool. Fifty three service delivery units across the organisation participated in the audits.

It was agreed that where any audits scored less than 50%, a re-audit would be undertaken within two weeks and the ward manager and infection control link nurse would be supported by a member of the infection control team to develop an action plan for improvement. In all cases where an audit scored less than 80% ward managers were asked to develop an action plan for improvement.

A report detailing the audit results by ward was prepared quarterly for each of the four directorates to allow for discussion and benchmarking at directorate meetings. A progress report detailing analysis at trust and directorate level was provided to the trust board on a quarterly basis.

Evaluating the Take Five initiative
At the end of the first year, a full evaluation of the initiative was undertaken. The aims of this evaluation were to determine if:
- The audit tools were robust and that relevant information was being collected and acted upon
- The initiative was being effective and having an impact on practice
- Staff and users of the service could identify if there had been any improvement in service delivery or could identify any further areas for improvement
- The Take Five audits needed adapting to take into account new guidance/evidence

Evaluation methods
The evaluation utilised the audit results already obtained throughout the first year of the programme in addition to questionnaires for identified staff groups and patients and visitors.

The questionnaire for staff was developed in collaboration with the audit department. It was semi-structured and based on some of the items in the audit tools and the aims of the evaluation. The questionnaires were similar for all staff groups and were piloted prior to finalisation and distribution. Questionnaires were sent to all directors and associate directors of operations, all senior clinical nurses and ward managers. Ward managers were then asked to distribute an agreed number of questionnaires to a random selection of their ward team, to include a ward clerk, health care assistants, junior medical staff groups as well as nursing staff.

The patient and visitor questionnaires were agreed with the audit department and also with the local ethics department. Although this was not a research project all patient questionnaires used in our hospital require approval by the ethics department. The questionnaires were then distributed by a team of hospital volunteers.

It is acknowledged that the use of questionnaires is not always the most appropriate evaluation method, due to the difficulties associated with response rate and the validity of results. However, as this was an evaluation of a trust wide initiative rather than a research project it was felt that this was the most pragmatic approach.
In general the response rates for each staff group were good (33-43%) however, the highest response rate came from

patients and visitors (58%) which confirms that the value of patient and user involvement when undertaking service delivery improvements.

A variety of methods were used to try and ensure validity with the evaluation results. Therefore as well as the questionnaire the evaluation also incorporated the audit data collected throughout the year and also the incidence of MRSA bacteraemias, MRSA first isolates and Clostridium *difficile*.

Findings and discussion

The trust wide results showed that the greatest improvement was in hand hygiene compliance, with a baseline of 60% compliance during the pilot rising to 76% compliance for all staff groups across the trust at the end of the first year. The National Patient Safety Agency also reported a compliance rate of 76% at the evaluation of the clean**your**hands campaign. Despite such improvement it was agreed that there was no room for complacency, particularly as further analyses by staff group indicated that certain staff groups had lower levels of compliance than others, with doctors and support staff showing lower levels of compliance than nurses and allied health professionals. However, it was felt that the campaign had contributed to improvements in hand hygiene and could be considered successful, particularly considering that Pittet et al (2000) report an improvement to 66% compliance over 3 years.

The questionnaire results highlighted a number of issues, in summary:

- 60% of staff felt that there was sufficient training in infection control
- On average it takes between 1-3 hours to complete the Take Five audits on a quarterly basis
- 83% of the directors stated that they had an action plan for infection control but only 41% of ward managers said they had an action plan, this has highlighted the need for multi-disciplinary collaboration when tackling infection control issues
- 50% of directors stated that there was a designated lead for infection control within their directorates compared to 79% of ward managers. The trust has since identified a consultant lead for every service delivery unit and a nurse lead, these roles now have documented roles and responsibilities
- 83% of directors felt that sufficient feedback was provided on the Take Five audit results
- 65% of staff felt that patients would say that cleanliness and hand hygiene had improved within the last twelve months

Overall, staff suggested that there had been an improvement in hand hygiene compliance and the use of alcohol gel (which was supported by increased ordering); an increased awareness about infection control issues and practices and a greater compliance with uniform policy. Staff felt that ward tidiness and cleanliness had improved and that there was greater willingness to challenge colleagues.

The patient/visitor questionnaire results showed that:

- 87% reported that the ward was always tidy
- 83% reported the ward was always clean
- 82% reported the bed area was always tidy
- 68% reported that spillages were always dealt with straight away (a further 16% said they had not seen any spillages)
- 68% reported that the toilets were always clean
- 77% reported that the washing facilities were always clean
- 39% reported that any concerns were acted on immediately (a further 50% had not experienced the need to raise any concerns)

When considering what improvements could be made, it is interesting to note that both staff and patients/visitors would like to see increased frequency of cleaning of toilets and bathrooms. The hospital adhere to the minimum cleaning frequencies of three cleans per day. If there are spillages/cleaning issues in between the set schedule then nursing staff should deal with these directly. With the implementation of a new cleaning contract these practices are being reviewed.

The overall response from staff was that although the audits did take time to complete that they had achieved the initial aims, including improved staff awareness of infection control issues and should therefore continue.

The result of infection control surveillance throughout this time period also supported the continuation of the initiative. In 2005 the trust's *Clostridium Difficile* rate reduced by 28%. The number of new MRSA positive patients identified fell by 9% compared to 2004 and the number of MRSA bacteraemias reduced by 9% in 2005/06 compared to 2004/05. Although the trust did not achieve the 20% reduction set by the Department of Health, it was felt that this was a significant improvement. Although it is acknowledged that the reasons for these reductions were multi-factorial and cannot be attributed solely to the Take Five initiative, the evaluation would suggest that it has had an impact.

Conclusion

The Take Five initiative has contributed to raising awareness of infection control issues, which in turn has led to service improvements. The initiative has engaged staff at all levels throughout the organisation and has continued support at board level. Users of the service were keen to participate in the evaluation and were able to provide suggestions for service improvement as well as evidence that ward cleanliness has improved over a two to three year time frame. Throughout the time period the initiative has been running, the trust has seen a further 28% reduction in MRSA bacteraemia. Although multiple approaches have contributed to these reductions, the trust believe that the Take Five initiative has played an important role.

The initiative has continued to develop and the audit tools have been updated to include some of the High Impact Interventions contained within Saving Lives (Department of Health, 2005) as well as new evidence from EPIC2 (2006), particularly relating to intravascular line care.

A second year evaluation is planned for April/May 2007.

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Young People's Unit

Project leaders:
Sara Hamill – Paediatric Sister, Mel Gannon – Educational Support Nurse

Location:
The James Cook University Hospital, Middlesbrough

Contact details:
melanie.gannon@stees.nhs.uk
sarah.hamill@stees.nhs.uk

Background
The Royal College of Paediatrics and Child Health (2003) argue that young people should be nursed separately from babies, small children and older adults. Young people should also have access to services that meet their holistic needs.

The idea for an innovative service improvement initially started in 1999 after a staff nurse attended a conference where teenage issues were discussed. On her return she motivated and inspired a small group of nursing staff to improve the facilities for young people within the children's unit at South Tees NHS Trust. In 2000, the staff nurse along with one of the paediatricians organised a three-day Teenage Health Conference to help share and spread excellence across the region. Following the conference a multi-disciplinary steering group was formed involving the key people caring for young people whilst in hospital, including young people who regularly used the service. An audit was carried out over one year to highlight how many people were admitted to the hospital and where they were nursed. The audit showed that 2144 patients aged 11-16 years were admitted to South Tees NHS Trust across the three different hospitals and of these only 1353 were admitted to children's wards. This audit further highlighted the need to improve the admission process and young people's facilities within the hospital. The Royal College of Paediatrics and Child Health (2003) have stated that young people make up 13-15% of the population, and they account for one third of paediatric practice.

The National Service Framework reflects the aims and objectives of this service improvement (Getting the right start: National Service Framework for Children Standard for Hospital Services, 2003). It highlights the need for participation of young people in designing NHS services that are readily accessible, respectful, empowering and provide effective response to their needs.

Aims of project
This project aimed to:
- Provide high quality care for young people in an environment designed specifically to meet their needs
- Promote a service that enables a working together approach with family and social care, mental health and education, to meet the holistic needs of the young person

Developing the unit
In 2000, over a period of one month the views of all in-patients patients aged over 11 years were sought using questionnaires and one-one discussions. Questionnaires were also sent out to regular long-term patients. Approximately 100 questionnaires were sent out in total with an 80% response rate. Many of the young people involved in this consultation process expressed that did not want to be nursed with small babies and children. Instead they wanted to be together in a separate space designed for their age group. In response, the multi-disciplinary steering group worked with the young people on the children's ward to design and develop the young people's unit.

In 2003, three hospitals amalgamated into one and an area was identified for a young people's unit, consisting of two four-bedded bays, one for girls, one for boys and three cubicles. Funds were not available within the Trust therefore the steering group took part in fundraising events kick started by a staff charity night which raised £1600 and some money was donated by other organisations. This money was used to pay for the design of the unit and leisure facilities aimed at reducing the young person's anxiety whilst in hospital. A chill out room was also designed in conjunction with the young people who regularly used the service.

The young people wanted to have some rules to ensure the unit was a welcoming and friendly environment. To achieve this, a group of young people and nurses got together and a working together policy and a young person's charter were established which are displayed throughout the unit. The Royal College of Nursing (2002) state that a young people's charter is essential in determining how young people's holistic needs will be met whilst in hospital. The Middlesbrough youth parliament and young mayor were also involved in the early stages. The youth parliament produced and sold a music CD and the profits were used to enhance the environment. Age appropriate leisure activities, including arts and crafts materials, game consoles and DVDs were also bought for the unit following consultation with the young people.

Reviewing progress
In 2005, a year after the introduction of the adolescent area the staff in the young people's unit designed a satisfaction survey which was available in every room within the unit. The young people and parents were informed of the survey on admission and asked to place the completed survey in a marked box. This survey also helped evaluate the unit's effectiveness highlighting several advantages, disadvantages and future challenges. Approximately twenty five patients responded over a three month period and the results are overwhelmingly positive. The majority said that the changes have been a vast improvement and that they were happy with the unit and the staff working within it. The main findings showed that patients and their families were provided with age appropriate facilities and health promotion advice and information, including a charter for young people and a working together policy both of which are displayed throughout the unit. During a one-to-one discussion, one patient with chronic health problems who used the unit regularly said that:

> *Being in hospital is a lot better since the young people's unit opened especially the chill out room, as this is a space just for young people with comfy sofas and a DVD player and x-box. It's great to be able to talk to other people the same age. It's a massive improvement on what was here before. They did not have anything for us to do and you could hear all the babies crying. The staff that work within the unit are all fantastic and it is like a second home to me.*

Another patient who used the unit said that:

> *You cannot improve on what you do because you do the best already.*

Staff development

Ongoing staff development has been key to ensuring that care is provided which meets the holistic needs of young people. To enable this to be achieved members of the steering group have successfully organised and held three National Teenage Health Conferences. The fourth is arranged for November 2007. Local young people have spoken at these conferences highlighting their own experiences of living with chronic illnesses, and the health and social challenges they face. The delegates have been charged a fee for attending and this money has been used to fund education and training opportunities for the staff working within the young people's unit.

Staff have also been proactive in identifying areas of care where they would like to develop more knowledge and skills. For example, discussing sexual health issues with young people was an area of care where staff felt that they lacked confidence. To overcome this barrier the group enlisted the help of local sexual health experts and a study day was arranged for the steering group. Following this event, links were established with these teams to enable young people to access gynaecological and sexual health clinics enabling holistic care to be delivered.

Similarly, the staff working within the unit have highlighted that they are lacking in the specialist knowledge and skills required to meet the mental health needs of the young people. Therefore they are currently utilising the excellent links that have been established within the local organisations. With the help of money raised from the Teenage Health Conference and from this award they will be attending training events and courses in this specialist area.

Conclusion

This service improvement started with a nurse who had a vision of how paediatrics could provide better facilities for young people. The creation of a young people's unit within paediatrics proves that nurse led initiatives can be successful. However, persistence and determination are required particularly maintaining the momentum and enthusiasm of the team involved and also the wider organisation. Perhaps one of the most important lessons that have been learnt is that changes that seem impossible due to financial constraints are not insurmountable and a great deal can be achieved without extra cost to the organisation. Although Sara Hamill took on the leadership role, the whole group including the young people have had equal input into the development of ideas and the implementation of change.

The steering group's philosophy is that young people are entitled to the same rights as children and adults. They deserve to be nursed in a dedicated area designed to meet their holistic needs. The health promotion information has been produced in conjunction with an external youth group who have also fundraised for the unit to enable these leaflets to be published and to provide leisure facilities for the unit.

One of the initial barriers to overcome was the lack of interest locally and nationally in designing facilities specifically for young people within district general hospitals. To be able to raise their profile, the promotion of young people's needs was vital throughout all levels of the organisation. Young people have brilliant ideas and they are often different to what we expect. It is therefore imperative that their views and opinions are sought and utilised fully if current and future services are to meet their needs. The Teenage Health Conferences helped to raise the profile of teenage issues in general, enabled the sharing of good practice nationwide and proved an excellent way of establishing networks. Since the young people's unit opened several other hospitals nationally have shown interest in setting up similar units and have contacted the steering group to ascertain details of how the change came about.

A research project will be carried out later on this year comparing services for young people across other district general hospitals without specifically designed facilities for young people. Part of this process will involve formal evaluation of the young people's unit.

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