



Critical Care Operational Delivery Networks
England, Wales & Northern Ireland

Collaborative Regional Benchmarking Group - the impact of benchmarking across three critical care networks

Presented by Alison Richmond, Quality Improvement
Lead Nurse, WYCCODN on behalf of....

Purpose



To develop a consistent approach to comparing the quality of clinical practice across the North East and Yorkshire Critical Care Units

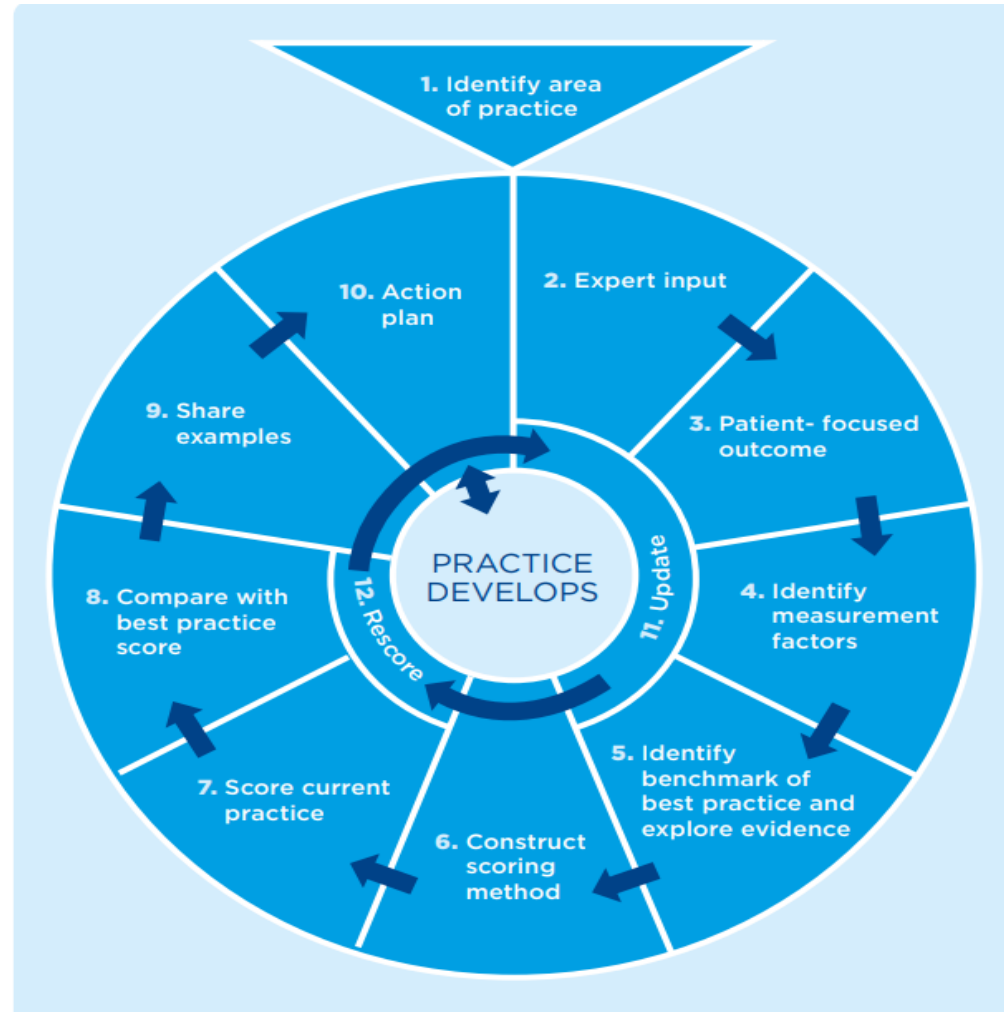


Significance

Clinical benchmarking is a “systematic process in which current practice and care are compared to, and amended to attain, best practice and care” (DH, 2010).

Units should work with other units within their network, and nationally, to share learning, disseminate best practice, quality improvement and for benchmarking (GPICS 2022)

Whilst individual units perform best practice audits, the ability to compare beyond individual units and highlight performance in relation to others can be useful to drive improvements (NHSE 2022), facilitate sharing of best practice, reduce variation, and improve patient outcome

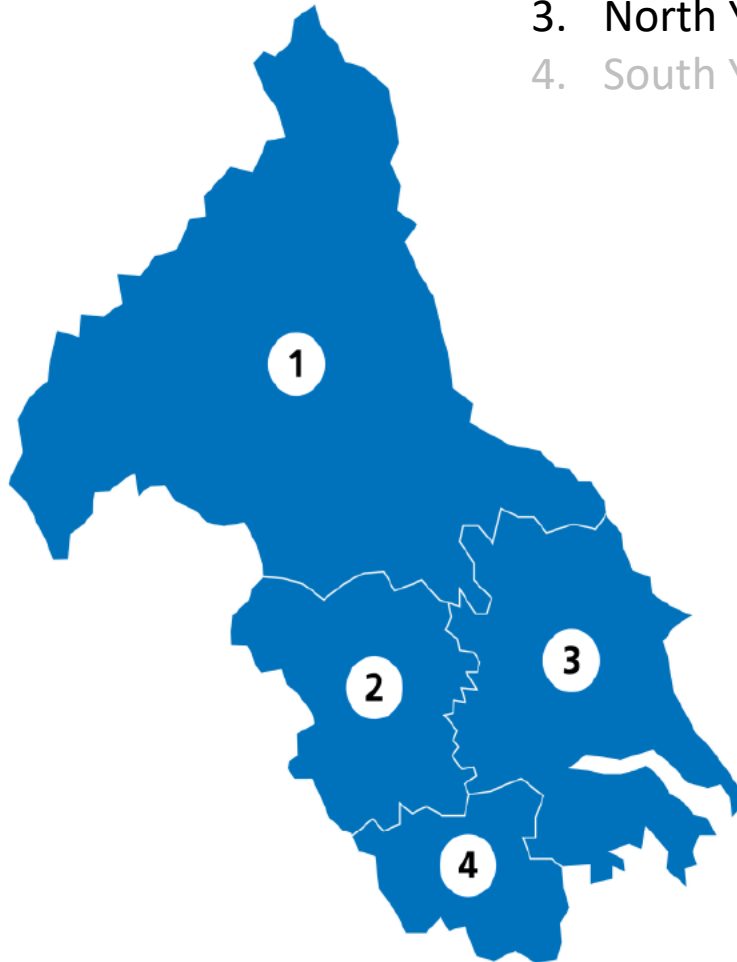


The Benchmarking Wheel (RCN, 2017)



Established benchmarking forum with representation from all units

1. North of England Critical Care ODN
2. West Yorkshire Critical Care ODN
3. North Yorkshire & Humberside Critical Care ODN
4. South Yorkshire & Bassetlaw Critical Care ODN



North of England Critical Care Network

- City Hospitals Sunderland NHS Foundation Trust
- County Durham & Darlington NHS Foundation Trust
- Gateshead Healthcare NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- North Tees & Hartlepool NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- South Tyneside NHS Foundation Trust

West Yorkshire Critical Care Network

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale & Huddersfield NHS Foundation Trust
- Harrogate & District NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Nuffield Health Hospital Leeds

North Yorkshire & Humber Critical Care Network

- Hull & East Yorkshire NHS Trust
- York Teaching Hospital NHS Foundation Trust
- North Lincolnshire & Goole NHS Foundation Trust



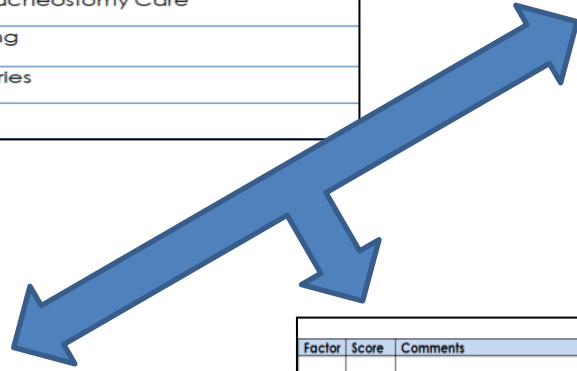
Method

- Develop annual audit programme incorporating benchmarking tool, statement of best practice and scoring matrix to achieve consistency
- Collect and submit data to central point, following validation with clinical leadership team
- Comparative data presented at regional benchmarking meeting, where members:
 - Share best practice/resources
 - Identify common deficits
 - Generate ideas for improvement
- Shared learning taken back to practice to further improve patient care
- Action plans developed, addressing factors that are considered not fully compliant

Date	Benchmark
January	Pain /Sedation/Delirium
February	End of Life
March	Oral Care/Eye Care
April	Nutrition/Bowel Care
May	CVC Management / Arterial Line Management
June	Transfer
July	Pressure Ulcers
August	Renal Replacement Therapy
September	ET Tube Management & Tracheostomy Care
October	Oxygen Therapy/ Suctioning
November	Rehabilitation - Patient Diaries
December	Prone

Develop annual audit programme incorporating benchmarking tool, statement of best practice and scoring matrix to achieve consistency

Benchmarking Audit Tool					
Network:					
Trust:					
Year:					
Month:					
Person completing:					
	Patient / Staff				
Factor 1 - Guideline	1	2	3	4	5
Is there an evidence based guideline available? (reviewed within 3 years)					
When asked can staff locate the guidelines?					
Can staff describe their practice based on the guideline?					
Is compliance to the guideline audited?					
Factor 2 - Education & Training	1	2	3	4	5
Does the unit have relevant training to underpin the guideline?					
Is there documented evidence staff have been trained?					
Is there evidence that 70% of staff have received training?					
Is there a key trainer/champion identified to deliver equipment / practice training for this area of practice?					
Factor 3 - Assessment	1	2	3	4	5
Is there documented evidence of patient assessment?					
Factor 4 - Planning	1	2	3	4	5
Is there document evidence that care planning has taken place?					
Factor 5 - Care Delivery	1	2	3	4	5
Is there documented evidence care has been delivered according to the care plan?					
Factor 6 - Evaluation	1	2	3	4	5
Is there documented evidence that the planned care has been evaluated and reassessed?					
Factor 7 - Equipment	1	2	3	4	5
Is the necessary equipment always available and in working order?					



Eye Care - STATEMENT OF BEST PRACTICE									
All patients will receive adequate and appropriate eye care according to their individual needs, optimising comfort and minimising adverse effects.									
Factor 1 - Guidelines									
Guidelines are available		Guidelines are available but they are not used			Guidelines are available, up-to-date but not used by everyone			Guidelines up-to-date, and used by everyone	
0	1	2	3	4	5	6	7	8	10
Factor 2 - Education:									
Training is not given		Some training is given at the bedside			Formal training is given but staff are not assessed as competent.			All staff caring for patients with eye care needs are formally trained and assessed as competent in this practice.	
0	1	2	3	4	5	6	7	8	10
Factor 3 - Assessment:									
No assessment of patients eye care needs are carried out		Some assessment is carried out.			Risk Assessment tools:			Documentation of assessment	
0	1	2	3	4	5	6	7	8	10
Factor 4 - Planning:									
No eye care is planned		Some patients have their eye care needs planned.			Documentation			Guidelines	
0	1	2	3	4	5	6	7	8	10
Factor 5 - Care Delivery									
No eye care is delivered		Eye care is delivered by an untrained practitioner.			Eye care is delivered by a trained and competent practitioner but not according to their individual needs.			All patients have their eye care needs delivered by a trained and competent practitioner according to their individualised care plan	
0	1	2	3	4	5	6	7	8	10
Factor 6 - Evaluation and Reassessment									
No evaluation of eye care is carried out.		Some evaluation takes place.			Care plan			Evidence of continuous assessment	
0	1	2	3	4	5	6	7	8	10
Factor 7 - Equipment / resources									
No equipment is available		Specialist eye care equipment or resources are not readily available			Stock control			Specialist eye care equipment or resources are available but not used when appropriate	
0	1	2	3	4	5	6	7	8	10

Score Sheet		
Factor	Score	Comments
1		
2		
3		
4		
5		
6		
7		



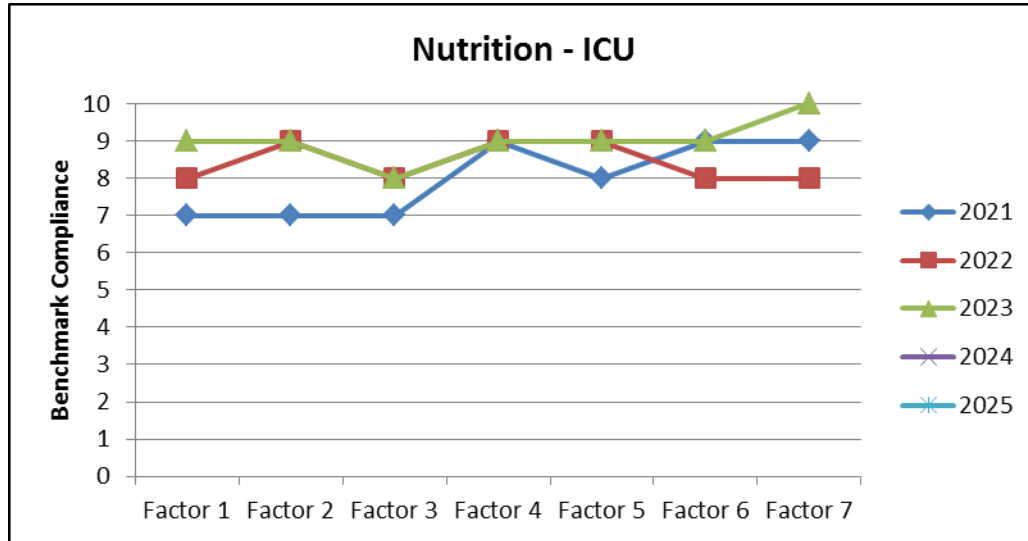
Completed by Date		ACTION PLAN		
Factor	Action	Person Responsible	Time scale	Date completed
1				
2				
3				
4				
5				
6				
7				

Collect and submit data to central point, following validation with clinical leadership team

Data Presentation at Regional Meetings



Network	Nutrition						
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
ICU 1	10	10	10	10	10	10	10
ICU 2	8	5	5	5	5	10	10
ICU 3	5	8	8	8	8	8	8
ICU 4	10	10	10	8	8	7	10
ICU 5	9	10	10	6	9	10	10
ICU 6	10	8	9	8	8	8	10



Results

- Majority of units engage with benchmarking
- Improvement of benchmark scores year on year, indicating improvement in practice
- Common deficits addressed at regional level, e.g. guideline development, reducing regional variation and repetition of effort
- Pockets of innovative practice are not wasted
- Educational resources produced, supporting training and education
- Provides a forum for open and shared learning and avenue for change
- Being practitioner led, provides a sense of ownership



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Patient Diary Guidelines

For Use In Critical Care

Collaborative Regional Benchmarking Group

Best Practice Guidance – Endo Tracheal Tube Care (Adults in Critical Care)

These recommendations are based on the current evidence and best practice at the time of writing and so will be subject to change as further developments are made in this field. Evidence can occur for a substance for clinical judgement to individual cases.

Statement of Best Practice
All patients with an endotracheal tube in situ will have care delivered competently, optimising their comfort and minimising adverse effects.

Scope
All patients in adult critical care who have an endotracheal tube in situ.

Introduction
It is a common practice for critical care patients to require mechanical ventilation which is usually achieved via the insertion of an endotracheal tube (ETT), which contraindicates oral care. As a consequence endo tracheal intubation is one of the most commonly performed procedures undertaken in critical care.¹

The main indications for patient intubation in the critical care are:

- To secure or maintain a clear airway
- To prevent aspiration of gastrointestinal tract contents
- To enable adequate tracheal suctioning
- To apply mechanical ventilatory support

A key component of the management of any patient receiving mechanical ventilation is appropriate care and monitoring of the endo tracheal tube.

It is essential that the position of the ETT remains stable for a number of reasons:

- The ETT is fulfilling the function of the patient's airway
- To ensure access for optimal ventilation
- ETT movement within the trachea may cause local trauma and as such is a source of significant discomfort to patients.

Potential Risks

Migration of ETT
Migration of the ETT can occur in either direction up and down within the trachea and usually occurs during direct care activities when a patient is being moved. When the ETT moves distally (from the larynx) it can migrate into the right main bronchus as a result. This can result in a low lung and pressure wastage of the non-ventilated lung.² The main risk of ETT slipping up the trachea is unplanned extubation.

Unplanned extubation

¹ Miller, J., Sang, A., Chingwaru, G. Textbook of Intensive Care and Emergency Medicine, 2008, Vol. 2008, pp12-202.
² Miller, J., Sang, A., Chingwaru, G. Textbook of Intensive Care and Emergency Medicine, 2008, Vol. 2008, pp12-202.

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Pressure Area Management in Critical Care

Aims: To provide guidance on Pressure Area Management for patients in Critical Care
Scope: All adult patients in Critical Care

Pressure V's Moisture Associated Skin Damage (MASD)

- Pressure damage will normally be over a bony prominence or occluded by a device
- Pressure damage will have more well-defined edges and it likely to be a more regular shape
- MASD will be effuse, with irregular edges (spread across bony prominences)
- Blistered shaped damage to the skin distal one normally to be moisture
- Pressure damage will be non-healing
- MASD can be covered by incontinence, oedema, wetting wounds/trauma sites.
- MASD will increase the susceptibility to pressure damage

Assess medical device sites 2 hourly and consider repositioning
Including ET tubes, ECG wires, sialivation probes, NG tubes, CI, masks, drains, catheters.

STANDARD CARE

- 1 Undertake full skin assessment and document within 6 hours of admission to the unit using a risk assessment tool such as PURPOSE¹ or Waterlow.
- 2 Document skin assessment on SSkin Bundle/repositioning care plan every shift.
- 3 Reposition patient and all devices in line with units guidance, with full skin check 4 to 6 hourly.
- 4 Update risk assessment tool and plan of care if there are any changes to skin condition, when a patient's clinical condition changes or at least every 7 days.
- 5 If unable to reposition patient as per plan of care document rationale behind this decision.

If pressure damage/MASD is present

- Discuss with your nurse in charge and/or Tissue Viability Unit nurse
- Increase repositioning schedule
- Consider use of a heel protector
- Consider using additional pressure relieving equipment e.g. mattresses, cushions, boots
- Follow local guidance on reporting pressure damage/MASD (NICE, RICK, Stop the Fall)
- Consider medical photography

Consider referrals to other members of the MDT

- Tissue Viability for advice and treatment plans
- Dietician for high calorie/protein diet that will be required for wound healing
- Consider commencing oral supplements
- Physiotherapy to assist patient and staff in mobilisation/management
- Diabetic and vascular teams for advice

Refer to local guidelines for more information

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Eye Care in Critical Care

Aims: To provide guidance on nursing care for the eyes of patients in Critical Care
Scope: All adult patients in Critical Care

PATIENT AWAKE & ABLE TO BLINK

- Allow patient to perform own eye care (or with assistance when required) by cleaning eyes as part of the patient facial wash or at patients request
- If eyes become itchy or annoyed use sterile gauze and sterile water

ASSESS EYES / PATIENT

- Within 2 hours of admission
- At least 12 hourly thereafter

Seek senior medical / ophthalmology advice for patients with eye disease, infection or injury, including post-op surgery and chemo/radiotherapy related red eye.

Standard Eye Care

- 1 Clean eyes with sterile water soaked gauze, cleaning from inner aspect of lids of the nose and sweep across the lids to outer aspect. This prevents the spread of infection or debris being introduced into the lacrimal system.
- 2 Clean along both sets of lashes; do not drag debris across the surface of the eye.
- 3 Use new gauze swab for each sweep and for each eye.
- 4 Apply prescribed ocular lubricant.

Sedated Patient (Difficultly Blinking)

- Standard eye care 4 hourly
- Consider taping eyelids closed, especially during interventions e.g. proning, transfers and procedures.

Reddened & Tarry (not Visible to Risk)

- Standard eye care 2 hourly
- Consider taping eyelids closed, especially during interventions e.g. proning, transfers and procedures.

HIGH RISK OF EYE INJURY

Please see your units full guidelines for more information

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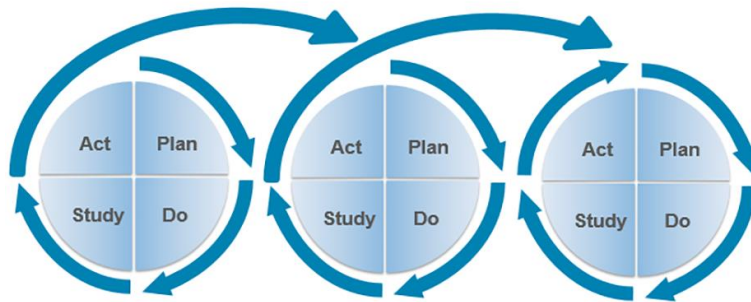
Conclusion



- Clinical benchmarking is now embedded across 3 networks.
- Findings corroborate reliable benchmarking developed a culture of continual quality improvement, stimulates healthy competition, allows sharing of good practice, and reassures everyone that they are doing their best to improve the quality of care.

Moving Forward.....

- South Yorkshire & Bassetlaw ODN
- Undertaking a review of the benchmarking tools to remove subjectivity and promote evidence based care
- Developed Best Practice Principles
- Patient focused audit



References

- Department of Health (2010) Essence of Care 2010. London: DH
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- RCN (2017) Understanding Benchmarking: <https://www.rcn.org.uk/Professional-Development/publications/pub-006333>



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