

*Emergency Induction for
non-critical care staff
working in Critical Care to
support the escalation
process in times of surge.*

Non-Critical Care Staff in Critical Care

Emergency Induction



03/2020

Introduction

This guidance originally created by the North of England Critical Care Network has been shared, edited and endorsed by CC3N and the ICS. It is designed to be used to enable non-critical care staff to augment the staffing in Critical Care in extreme surge scenarios to support local escalation processes.

General Principles

All non-critical care staff;

- Have a structured orientation to the area, including general information pack.
- Easily identifiable (colour scrubs /uniform)
- Are allocated a buddy who they work alongside who can support them.
- Should not be expected to work outside their scope of practice.
- Are not expected to look after L3 patients independently.
- Are not expected to administer Critical Care specific medication, this includes a minimum:
 - Inotropes
 - Vasopressors
- Are not expected to operate critical care specific equipment, including but not limited to:
 - Ventilators
 - Renal replacement systems
 - Volumetric syringes and pumps
- Only deliver care activities that they have been deemed competent in.

Delegated Care

Delegation is the process by which a Registered Nurse can allocate work to someone who is deemed competent to undertake that task. As a registered nurse you are accountable for your actions and should not work outside your scope of practice. ^{1,2}

Within the pack there are a number of skills that can be achieved to enable the non-critical care nurse to deliver delegated care under the supervision of the Critical Care nurse.

¹ NMC The Code 2018

² Available at: www.nmc.org.uk/news/coronavirus/how-we-will-regulate Accessed 14/03/2020

Appendices

Appendix 1 – General information for the non-critical care staff member

Appendix 2 – Orientation Checklist

Appendix 3 – Non-critical care staff skills

Appendix 1

General Information about Adult Critical Care

Levels of Care ³

Level 0

Ordinary ward based care.

Level 1

Ward based care and a bit more observation

Level 2

High Dependency, patients are sicker and need a higher ratio of nurses

(1 Nurses to 2 Patients 1:2)

Level 3

Intensive Care, patient's sickest in the hospital and need 1 nurse to each patient (1:1)

Initial information to be thinking about

Patients on critical care are, by the nature of being on the unit at higher risk of adverse events. Our care and practices are aimed at reducing and/or preventing these events.

Policies, Guidelines and SOP's

Additional education resources such as clinical contact details, clinical guidelines and education packages should be easily available and readily accessible across the hospital.

Safety

Paramount in Critical Care – things for you to think about:

- Safety for patient – cot sides up, ID bands on and never leave a patient unobserved
- Safety for staff – needle free devices, visors, working as a team.

Infection Prevention & Control

We cannot overstate the importance of hand hygiene- if in doubt wash or gel your hands.

For specific advice on managing a patient in isolation please see Appendix 3

Documentation

This is rather different to the wards and may be in paper or electronic format but required to ensure care is assessed, planned, given and evaluated. You will be guided as to completion.

Death and Dying

Always difficult but can be exacerbated on Critical Care where family may not have had time to cope with their loved one being critically ill. Within Adult Critical Care, we have a close working relationship with a specialist team of nurses who are links between the transplant team and the donor (SNOD).

³ ICS Levels of Critical Care for Adult Patients 2002

Much of what we do within Critical Care is very different to on the ward due to the high tech nature of the care but care delivered is still care and we still hold hands, talk to patients and ensure they are clean and comfortable.

Common Treatments.

You will not be expected to care for a patient alone; you are there to assist and must not take on responsibilities outside your scope of practice especially the things detailed below.

Invasive ventilation

Invasive positive pressure ventilation requires that the patient be intubated by placing an endotracheal (ET) tube to provide direct ventilation to the lungs. It's indicated for patients who aren't breathing (apnoeic) or breathing ineffectively, causing ventilation problems. Intubation is necessary for any patient with impending or current respiratory failure.

Non-invasive ventilation

Sometime patients don't need to be intubated but need breathing support. When respiratory failure is pending, the healthcare team will often take the least aggressive method of providing appropriate ventilation. Non-invasive ventilation can be an effective alternative to intubation. There are two different methods of non-invasive ventilation that can be used in this situation: BIPAP and continuous positive airway pressure (CPAP). Both use a mask that's placed over the nose or face delivering positive airway pressure and oxygen to help assist breathing. These methods are to be used only for a patient who's breathing spontaneously.

Inotropes and Vasopressors

Inotropes and vasopressors have excitatory and inhibitory actions on the heart and vascular smooth muscle, as well as important metabolic, central nervous system and presynaptic autonomic nervous system effects. They are powerful drugs that are used in Critical Care to regulate a patient's heart rate, blood pressure and the force of contraction of the heart. They do this by working on specific receptors throughout the body⁴. Inotropes and vasopressors are seen as high risk drugs due to their rapid effect on the cardiovascular system and their short duration of action both of which could have serious consequences if the drugs are administered incorrectly. Continuous infusions of these drugs are necessary to ensure a constant plasma drug concentration and **MUST NOT** be stopped and any alarms dealt with immediately. A replacement syringe should be prepared well in advance of the old syringe needing to be replaced; alarms should be dealt with immediately and the need for replacement should be swiftly brought to the attention of the nurse in charge before it is empty.⁵.

⁴ Overguard & Vladimir **Inotropes and vasopressors: review of physiology and clinical use in cardiovascular disease.** Circulation. 2008 Sep 2;118(10):1047-56

⁵ Crisp (2002) **Minimising the risks: safe administration of inotropic drug infusions in intensive care.** Nursing in Critical Care 7(6) :283-289

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Appendix 2

Orientation Checklist

Name		Designation	
Discuss	Specific Criteria	√	Completed
Environment	Layout of the ward /check access		Initials Date
	Visitors reception/facilities		
	Sluice		
	Linen Store		
	Stores		
	Staff Facilities		
Staff Uniform & Roles	Doctors		Initials Date
	Registered Nurses		
	Healthcare Assistants		
	Physiotherapists		
	Pharmacists		
	Dietician		
Ward Clerks			
Fire Policy/Procedure	Location of fire panels		Initials Date
	Location of break glass points		
	Fire exists		
	Hoses and Fire Extinguishers		
	Evacuation Procedure		
	• <i>equipment</i>		
	• <i>evacuation area</i>		
Fire Alarm Tests			
Resuscitation Equipment	Location of Resuscitation Trolleys		Initials Date
	Content of trolley		
	Location of airway trolleys		
	Content of trolley		
	Checking Procedure		
	Restocking procedure		
Other Emergency Equipment	Location of portable oxygen		Initials Date
	Checking/Ordering O ₂ cylinders		
	Location of transfer equipment		
	Emergency procedure trays/trolleys		
Emergency Procedures	Emergency call bell		Initials Date
	Equipment Alarms to be aware of		
	• <i>Ventilator</i>		
	• <i>CRRT</i>		
	• <i>Infusion pump (inotropes)</i>		
Emergency Bleep System			
Storage Areas	Equipment		Initials Date
	CSSD procedures		
	Documentation & Stationary		
Visitors	Visiting Hours		Initials Date
	Number of visitors to bed		
	Visitor information leaflets		
<i>Person who is doing the Induction</i>			
Name	Signature	NMC Number	Date
<i>New Staff member</i>			
Name	Signature	NMC Number	Date

**The checklist must be completed fully and signed by both yourself and the person doing the orientation.
A copy must be given to the Unit Manager to be kept in your personal file.**

Appendix 3

Non-Critical Care Staff Skills Checklist

New Staff member

Name	Signature	NMC Number	Date
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Patient Bed Areas

Discuss	v	Initials /Date
1 Operation and functions of bed area pendant systems <ul style="list-style-type: none"> Safety aspects Medical Gases Maintaining privacy and dignity for patients 		
2 Equipment and stock required to set up a bed area for admission for a patient. <ul style="list-style-type: none"> Preparation for Critical Care Bed 		
3 Maintaining a safe environment in the bed area <ul style="list-style-type: none"> General safety checks Daily checks Reporting faults / broken equipment 		
4 Infection control procedure in the bed space <ul style="list-style-type: none"> Correct use of PPE Daily cleaning Cleaning of equipment Mattress cleaning Cleaning of non-disposable kit 		
5 Waste disposal policy <ul style="list-style-type: none"> Clinical waste Non clinical waste 		

Demonstrate an understanding of the principals involved in prevention of cross infection

Discuss and/or Demonstrate	v	Initials /Date
1 Demonstrate correct hand washing technique		
2 Demonstrate the use of personal protective equipment including "donning and doffing"		
3 Demonstrate the nursing management of patients with an infection		
4 Demonstrate the correct disposal of all types of waste from the clinical area		
5 Demonstrate the precautions that relatives need to take to prevent cross infection		

It is anticipated that the non-critical care nurse will work under the supervision of a critical care nurse and support the delivery of following care:

Demonstrate an understanding of the safe practice required when caring for a ventilated patient

Discuss	v	Initials /Date
1 Discuss and understands the safety factors that need to be considered when caring for a ventilated patient		

**The checklist must be completed fully and signed by both yourself and the person doing the orientation.
A copy must be given to the Unit Manager to be kept in your personal file.**

	<ul style="list-style-type: none"> cot sides raised and secured observation of patient ET tube secured – tubing not pulling 		
2	Monitoring of a patient in critical care <ul style="list-style-type: none"> Attach the ECG monitor leads in the correct manner. Understands common alarms and actions 		
3	Discuss understanding of critical care patient observation charts <ul style="list-style-type: none"> What information is recorded Correct completion understands escalation procedure if observations outside expected parameters 		
4	Discuss care of Central and Arterial Line. <ul style="list-style-type: none"> Transducer Position Flush bag 		
5	Discuss the importance of recording accurate fluid balance in critically ill patients <ul style="list-style-type: none"> Fluid balance chart - completion Hourly urine measurements 		
6	Medicines Management <ul style="list-style-type: none"> Patients only medications at the bedside IV's not to be drawn up more than an hour in advance Importance of Inotrope/vasopressor infusions - actions Controlled Drugs as per Trust policy 		

Discuss a holistic approach to patient's hygiene

Discuss and/or Demonstrate		√	Initials /Date
1	Demonstrate the nursing interventions required to promote effective eye care.		
2	Demonstrate the nursing interventions required to maintain healthy oral mucosa		
3	Demonstrate the nursing interventions required to maintain skin integrity		

Any Comments / Concerns

<i>Person who is doing the Induction</i>			
<i>Name</i>	<i>Signature</i>	<i>NMC Number</i>	<i>Date</i>
<i>New Staff member</i>			
<i>Name</i>	<i>Signature</i>	<i>NMC Number</i>	<i>Date</i>

**The checklist must be completed fully and signed by both yourself and the person doing the orientation.
A copy must be given to the Unit Manager to be kept in your personal file.**