Royal College of Nursing

RCN International Centenary Conference

Book of abstracts

22 and 23 November 2016
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Main hall chair biographies

Cecilia Anim, RCN President

Cecilia Anim was elected President of the RCN in 2015, having been a member for over 30 years, elected deputy President in 2010 and re-elected to the role in 2012. She was also an RCN steward for 19 years and a health and safety representative for 17 years. She is also a member of the RCN's Council Executive Team, Membership and Representation Committee, International Committee, Ethics Committee and Awards Panel.

She has worked tirelessly supporting members in three central London NHS trusts.

Cecilia was also the staff-side secretary working in partnership with other unions, and secretary of her local RCN branch for 10 years. She then chaired the new branch and served on the London board before taking up the position of deputy president.

In addition to these responsibilities, Cecilia previously served on the Ethics Forum Steering Committee and was also a member on the RCN Menopause Nurses Steering Group. Cecilia still coordinates the Network Group in London. In recognition of Cecilia's contribution, she and was awarded the RCN Certificate of Merit for outstanding service to members.

Cecilia works as a clinical nurse specialist in sexual and reproductive health at the Margaret Pyke Centre in London and received a long service award for over 30 year's commitment to the NHS. Cecilia specialises in family planning and aspects of women's health and has a particular interest in menopause and public health issues.

Cecilia was awarded the Bevan award for Health and Wellbeing in 2013 and the Wise Woman of the Year Award in 2014.

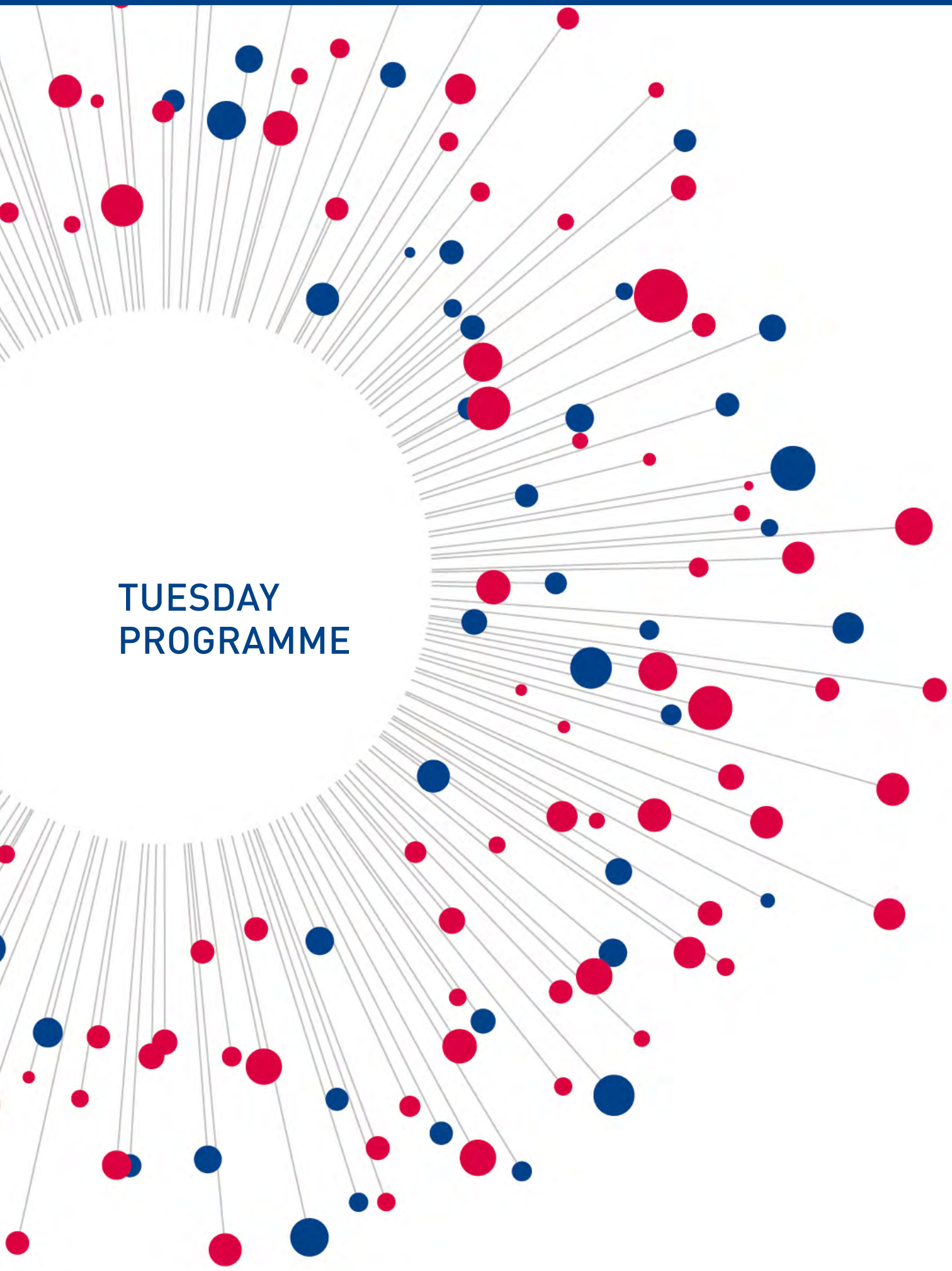
In 2015 Cecilia had the great honour of being receiving the United Nations African Women of Excellence award. This award celebrates and recognises the contribution of African Women or women of African descent have made to political, social and economic independence.

Cecilia originally trained as a midwife in Ghana, where she worked before moving to the UK and qualifying as a nurse in 1977.

Cecilia is also actively involved in the activities of her local church, where she is a member of the PCC and also arranges flowers. Furthermore, she is also Chair of Governors of her local primary school.

Christine Hancock, Director, C3 Collaborating for Health, UK

Christine Hancock is the founder of C3 Collaborating for Health, a global charity working to prevent chronic disease. She is an experienced nurse and NHS manager. She was CEO/general secretary of the Royal College of Nursing and then president of the International Council of Nurses, visiting nurses in 50 countries. She has been a governor of De Montfort University and is a trustee of a charity for homeless people. Christine has recently become a member of the NHS Healthy Workforce Advisory Board, helping to create a step change in the health of the 1.2 million NHS workforce.



TUESDAY PROGRAMME

Tuesday 22 November 2016

Keynote lectures

9.45 – 10.30am

Keynote lecture 1: Title to follow

Room Churchill Auditorium (main hall)

Speaker James Campbell, Director, Health Workforce, World Health Organization, UK

Biography

Jim Campbell is the Director of the Health Workforce Department at the World Health Organization (WHO) and the Executive Director of the Global Health Workforce Alliance (GHWA). Prior to taking on this role in July 2014, Mr Campbell was the Director of the Instituto de Cooperación Social Integrare (ICS Integrare), a not-for-profit research institute in Barcelona, Spain where he worked for eight years.

He has worked as a specialist researcher/adviser on Human Resources for Health for governments, UN agencies and philanthropic foundations, including WHO, GHWA, UNFPA, World Bank, UK DFID, Norad and BMGF. Examples of this work include the Global Code of Practice on the International Recruitment of Health Personnel (2010), WHO policy recommendations on *Increasing access to health workers in remote and rural areas through improved retention* (2010), *A Universal Truth: No Health Without a Workforce* published at the Third Global Forum on HRH in Recife, Brazil (2013) and the State of the World's Midwifery 2014 report.

11.15am – 12noon

Keynote lecture 2: An exciting future for nurses and nursing

Room Churchill Auditorium (main hall)

Speaker Maureen Bisognano, President Emerita and Senior Fellow, Institute for Healthcare Improvement, USA

Summary

Innovation and improvement will be the tools for change for today's nurses. In this session we will look to domestic and international examples of nurses leading health care transformations, and look to the next decades of change.

Abstract

In today's quickly changing and evolving health and health care environment, front line teams, often led by nurses, play a crucial role in delivering the best possible care. In this presentation we will address recent nurse-driven changes in care, as well as future methods of change, and areas that should be explored. Special emphasis will be put on leading multigenerational, multi-professional, and multi-ethnic teams, as well as addressing the changing expectations of patients, especially those of the younger generations.

Intended learning outcomes

- Describe the role nurses have played in transforming health care.
- Identify ways nurses will improve health and care in the future.
- Describe the key roles in leading multi-professional, multigenerational, and multi-ethnic teams.

Reading list

Bisognano M, Schummers D. Flipping healthcare. BMJ. 2014 Oct 3:349

Bisognano M, Kenney C. Pursuing the Triple Aim, Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs. San Francisco: Jossey-Bass A Wiley Imprint; 2012

Biography

Maureen Bisognano, President Emerita and Senior Fellow, Institute for Healthcare Improvement (IHI), previously served as IHI's President and CEO for five years, after serving as Executive Vice President and COO for 15 years. Ms Bisognano advises health care leaders around the world, is a frequent speaker at major health care conferences on quality improvement, and is a tireless advocate for change.

She is also an Instructor of Medicine at Harvard Medical School and serves on the boards of the Commonwealth Fund, Cincinnati Children's Hospital Medical Center, and ThedaCare Center for Healthcare Value.

12noon – 12.45pm

Keynote lecture 3: Education and eliminating violence against women

Room Churchill Auditorium (main hall)

Speaker Khetsiwe Dlamini, Chief of Staff, UN Women, USA

Biography

Khetsiwe has more than 20 years of experience in the development sector, working with public and private stakeholders. In March 2015, she joined UN Women as Chief of Staff from the World Bank Group - International Finance Corporation (IFC) in Washington D.C, where she has been working as a Principal Operations Officer and Fragile and Conflict Affected-Situations (FCS) Advisor. She was also a Senior Advisor for the IFC Gender Secretariat. Prior to this, Khetsiwe was the Principal Operations Officer of the World Bank's South Sudan Country Office.

Between 1999-2012, Khetsiwe held various managerial and leadership roles in the World Bank Group's Private Sector Advisory Services such as Corporate Business Process Head, Women's Entrepreneurship Program Manager (Middle East, North Africa and Sub-Saharan Africa) and Africa Regional Manager a.i.

Khetsiwe is the Joint founder of the Africa Women in IFC Network (AWIN) and was a member of the World Bank's Margaret Mcnamara Memorial Fund's (MMMF), Overseas Scholarship project in Africa selection committee from 2007 – 2013. Khetsiwe also supervises MBA dissertations when her schedule allows.

Born and bred in Swaziland, Khetsiwe received her first degree from the University of Natal, her MBA degree in Gender and Entrepreneurship from the University of Wales in Cardiff and her Doctorate in Business Leadership from the University of South Africa.

Tuesday 22 November 2016

Concurrent session 1

Theme: Society, communities, relationships

2 – 2.30pm

1.1.1 Embodied practice: rediscovering the 'heart' of nursing

Room Rutherford Room

Chair Paula Hancock

Presenter Jan Draper, Professor of Nursing, The Open University, UK

Aim

This paper explores the importance of embodiment in nursing. It examines different sources of authoritative knowledge concerning the body and embodiment. It argues that dominant scientific and medical ways of knowing of the body have displaced and marginalised embodied ways of knowing, creating only a partial understanding of the embodied experiences of our patients and our own embodiment as nurses.

Abstract

Over the last twenty years there has been a rapid expansion of theoretical literature concerning the body and embodiment, spanning a range of disciplines including sociology, anthropology, psychology, feminism and human geography. As a predominantly 'body-based' profession, nursing serves to benefit significantly from these theoretical insights. However, with a few notable exceptions, theoretical and empirical investigation of the body and embodiment in nursing has remained largely neglected. So, although the body is so obvious in the work of nurses – the body of the person 'to-be-healed' (the patient) and also the body of 'the healer' (the nurse) – its presence is strangely absent. At a significant juncture in nursing's history when there is greater international focus on higher standards of care, this paper calls for a repositioning of the place of embodiment in nursing. It examines how such a repositioning is important for contemporary person-centred practice and for the rediscovery of the 'heart' of nursing.

The paper explores the meanings of 'the body' and 'embodiment' prior to examining different sources of authoritative knowledge concerning the body and embodiment. It argues that dominant scientific and medical epistemologies of the body have displaced and marginalised embodied epistemologies and thereby created only a partial understanding of the embodied experiences of our patients and our own embodiment as nurses. The paper proposes a corporeal (re)turn to nursing practice, one that recognises the lived embodied experience of the patient and the embodied skill and knowledge of the nurse. It examines how such a corporeal (re)turn is important for contemporary person-centred practice, research and education, and for the rediscovery of the 'heart' of nursing.

Reading list

Lawler J (1991) *Behind the Screens. Nursing, Somology and the Problem of the Body* Melbourne: Churchill Livingstone

Ray S (2006) Embodiment and Embodied Engagement: Central Concerns for the Nursing Care of Contemporary Peacekeepers Suffering from Psychological Trauma, *Perspectives in Psychiatric Care* 42(2), pp.106-13.

Sakalys JA (2006) Bringing Bodies Back In: Embodiment and Caring Science, *International Journal for Human Caring* 10(3), pp.17-21.

Biography

Following a clinical background in adult nursing, Jan moved into higher education in the late 1980s. Over the last fifteen years this has been predominantly in the field of distance learning, firstly with the RCN Institute and then The Open University. She has led the development of high quality, flexible, work-based learning for the nursing/health care workforce, including a unique, UK-wide, part-time pre-registration nursing programme by distance learning. Central to her approach is a desire that all education should, in some way, make an impact on practice and her education and research activity is predicated on this one, central aim.

2.30 – 3pm

1.1.2 WIN. The healthy weight initiative for nurses

Room Rutherford Room

Chair Paula Hancock

Presenter Michaela Nuttall, Associate – Nursing, C3 Collaborating for Health, UK

Abstract
The Healthy Weight Initiative for Nurses, (WIN.) is a collaboration between C3 Collaborating for Health, London South Bank University, the Royal College of Nursing, the Royal College of Nursing Foundation and the Burdett Trust for Nursing. Its aim is to work with nurses who are obese to design initiatives that they think might help nurses to maintain a healthy weight.

Previous work by C3 and LSBU highlighted there is a strong expectation that nurses should be role models for healthy behaviours but workplace 'offers' to make that easier should be desirable, acceptable and feasible. Alongside this, nurses mostly don't attend healthy workplace initiatives, perhaps this is because often these are designed for non-shift workers?

There are many personal and professional reasons why it's important for nurses to maintain a healthy weight. However, this is a sensitive subject with many complicating factors.

The aim of this project is to co-design and evaluate interventions with nurses who are obese to help them reach and maintain a healthy weight and to promote healthier lifestyles. Understanding the characteristics and behavioural drivers of, as well as awareness and uptake of interventions by, nurses who are obese will help to inform future workforce development strategies.

So far views of nurses have been gathered through surveys and focus groups along with prevalence study and literature review of workplace health. This gives invaluable insight into the next stage of the initiative of co-design of intervention by nurses for nurses.

Biography
A cardiovascular nurse specialist with a research background, with unique and varied spectrum of experience across the NHS and beyond. Her passion is prevention and improving the care that other give. Having recently left the NHS after 27 years she is currently the Clinical Director at Smart Health Solutions and recently become an Associate with C3 Collaborating for Health

Other current activities include Global Cardiovascular Nursing Leadership Forum, Health Care Committee of Heart UK, Guidelines and Information working party of the British Hypertension Society, editorial board of the Primary Care Cardiovascular Journal, the British Journal Primary Care Nursing and an international reviewer. 2013 saw her winning the Nutrition and Health Nurse of the Year Award. Previously set-up and chaired the Cardiovascular Nurse Leader forum, Health Director for HeartAge, Trustee for Mytime Active, Cardiac & Vascular Strategic Clinical Leadership Group, founding chairman of the Prevention Group at the South East London Cardiac Network and twice elected to the British Association for Nursing in Cardiac Care.

Intended learning outcomes:
1 Know the rates of obesity in nurses

2 Able to describe the impact nurses felt their weight had on prevention messages for patients

3 Able to explain why often healthy work place initiatives do not work for nurses

Recommended reading list
KELLY M., WILLS J., JESTER R. & SPELLER V. (2016) Should nurses be role models for healthy lifestyles? Results from a modified Delphi study. Journal of Advanced Nursing 00(0), 000–000. doi: 10.1111/jan.13173

R.G. Kyle et al., 'Prevalence of overweight and obesity among nurses in Scotland: A cross-sectional study using the Scottish Health Survey' (2016) International Journal of Nursing Studies 53: 126-33.

3 – 3.30pm

1.1.3 Medical justice: seeking better care for pregnant detainees

Room Rutherford Room

Chair Paula Hancock

Presenter Morag Forbes, Volunteer Midwife, Medical Justice, UK

Co-author Phoebe Pallotti, RM, BA, MA Anthropology (Cantab) BSc Midwifery (KCL)

Aim
This abstract summarises the work of volunteer midwives Phoebe Pallotti and Morag Forbes, on behalf of the charity, Medical Justice. The abstract advertises a concurrent session where delegates can learn about:

- Medical Justice's work
- detainee health in general and specifically how detention affects pregnant women
- how nurses and midwives can work to improve detainee health.

Abstract
Medical Justice is a small charity that exposes and challenges inadequate health care provision to immigration detainees. Medical Justice deals with approximately 1,000 individual detainees' cases a year; a small number of these are pregnant women.

As volunteer midwives with Medical Justice, we work to end medical mistreatment of pregnant detainees and the damaging effects of immigration detention on their health. We visit pregnant women in immigration detention at Yarl's Wood Immigration Removal Centre. There, we assess the women's health and the quality of care they are receiving. Our assessments inform medico-legal reports (MLRs). Medical Justice then helps detainees to access competent lawyers who properly harness the strength of the medical evidence we generate.

Migrant women have poorer maternity outcomes than the general population. Medical Justice's 2013 report, *Expecting Change*, found that many pregnant detainees were survivors of rape, torture and trafficking. However, there appeared to be no appreciation by Yarl's Wood health care staff that even without health complications, this is a group of vulnerable women who need to be managed as complex cases.

Since 2013, our ongoing work has confirmed these findings. Sixteen out of 21 women we reviewed had pregnancy complications that would have led to consultant management in a tertiary referral centre and/or referral to specialist perinatal mental health services. The women we support are often physically and mentally traumatised by the experiences that led them to seek asylum and by the asylum process itself. These are among the most vulnerable women we have ever cared for and they often struggle to obtain the relevant basic care.

This year, the health care of immigration detainees at Yarl's Wood has come under increased public scrutiny. HM Chief Inspector of Prisons described Yarl's Wood as "a place of national concern", adding that health care in the centre had deteriorated significantly.

We hope this presentation will raise delegates' awareness Medical Justice's work. We aim to convey detainees' key health challenges, and specifically how these impact on pregnant detainees. We also hope to spark debate regarding how nurses and midwives can work to ensure basic rights for these most vulnerable of clients.

Reading list

Tsangarides N and Grant J (2013) *Expecting Change: the case for ending the immigration detention of pregnant women.* Medical Justice, London. Available at: www.medicaljustice.org.uk/wp-content/uploads/2016/03/expectingchange.pdf (accessed 25/10/16) (Web).

HM Chief Inspector of Prisons (2015) *Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre.* HMIP, London. Available at: www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/08/Yarls-Wood-web-2015.pdf (accessed 25/10/16) (Web).

Biography

Morag Forbes is a registered midwife and currently works full time in the NHS as a family nurse. She is passionate about ensuring vulnerable women have access to safe, respectful and appropriate care.

In 2013, Morag started volunteering as an independent midwife for Medical Justice in her spare time. Morag visits pregnant women detained at Yarl's Wood Immigration Removal Centre to assess their health and care. Her assessments form the basis for medico-legal reports, which often become integral to the women's legal cases. Morag has also appeared on BBC Radio 4 to raise public awareness of pregnant detainees' care.

Phoebe Pallotti is a practicing midwife, and a Lecturer in Maternal Care at the University of Leeds. Her professional interests are in health inequalities, feminism, global maternal health for safe motherhood and midwifery education. She is an advocate and campaigner for safe and dignified maternity care during migration and diaspora with Medical Justice. Phoebe is vocal about the need to improve the access to and quality of care that detained women receive. She has discussed the issues they face both in the press, and in professional fora such as Virtual International Day of the Midwife.

3.30 – 4pm

1.1.4 The Macmillan nurse: yesterday, today and in the future

Room	Rutherford Room
Chair	Paula Hancock
Presenters	Gráinne Kavanagh, MBA DMS, Head of Professional Engagement, Macmillan Cancer Support and Adrienne Betteley, Interim Head of Health and Social Care, Macmillan Cancer Support

Aim

- To tell the story of the role of the Macmillan nurse and how it has evolved since the first Macmillan Nurse in 1975.
- To tell how the Macmillan Clinical Nurse Specialist Model has been replicated in other conditions.
- To share our thinking of how the future Macmillan nurse will be part of a much broader skill mix cancer care team.

Abstract

Since Douglas Macmillan founded our charity in 1911, we have grown to be the UK's leading source of cancer support, reaching more than 5.4 million people affected by cancer in 2014. At the heart of that support is the iconic Macmillan Clinical Nurse Specialist (CNS).

The first Macmillan nurse was established in 1975 and we now have over 4,000 Macmillan nurses across the UK, both in hospitals and the community. Macmillan CNSs are registered nurses, educated to first degree and postgraduate level or working towards postgraduate qualifications. Whilst the first Macmillan nurses supported people with palliative care needs in the community, we soon recognised that many people needed support from the point of diagnosis, so we introduced site-specific nurses (Macmillan Breast CNS), treatment-specific nurses (Macmillan Radiotherapy CNS), population-specific nurses

(Macmillan Teenage and Young Adult CNS) and pathway-specific nurses (Macmillan Living with and Beyond Cancer CNS). The Macmillan CNS role was the first of its kind and as a result of its success the CNS model has been replicated across many other conditions in the UK.

With the average life expectancy now over 10 years, for many people with cancer, it is a long-term condition that requires support and care from teams with increasingly shared responsibility, rather than a continued reliance on individual, predominately hospital-based, CNSs. Unfortunately, there are simply not enough specialist nurses to meet the current demand, let alone future demand. We are currently failing to match today's supply of nurses with the demands of tomorrow's population.

The UK needs a workforce to meet these changing needs as the current 2.5 million people living with cancer, becomes four million by 2030. So enabling more self-management will both empower individuals and help meet the increased demand. We also need to remove barriers between professions, as well as create new roles. These changes will require nurses to learn new skills in activating people with care needs and mobilising the community at large to play their part as carers and volunteers.

It's time to rethink the way we work and create the care teams of the future.

Reading list

Rossi P (2009) *Fighting Cancer With More Than Medicine*, Stroud: The History Press.

Professional Standards Authority (2015) *Rethinking regulation* Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf?sfvrsn=8 (accessed 25/10/16) (Web).

Macmillan Canceer (2014) *Cancer Clincal Nurse Specialists* Available at: www.macmillan.org.uk/Documents/AboutUs/Research/ImpactBriefs/ImpactBriefs-ClinicalNurseSpecialists2014.pdf (accessed 25/10/16) (Web).

Biography

Gráinne leads a team to effectively engage with 8,500 Macmillan professionals based in Macmillan partnership organisations across the UK. Prior to that, she managed the Co-ordinated Centre for NHS Service Delivery and Organisation (SDO) RandD programme and worked at the King's Fund for 15 years during which time she completed her MBA.

Adrienne is seconded to lead a team that deliver four broad programmes: Prevention and Diagnosis; Treatment and Recovery; End of Life Care and Workforce. Adrienne's substantive role is End of Life Care Programme Lead and she spent the last 12 years working in Strategic Health Authorities and Cancer Networks in End of Life Care. Prior to that she spent most of her nursing career working as a DN Sister and she was also a North West Board member for the RCN and remains a registered nurse and RCN member.

Theme: Society, communities, relationships

2 – 2.30pm

1.2.1 Using person-centred KPIs to improve care

Room	Wordsworth Room
Chair	Amanda Cheesley
Presenter	Professor Tanya McCance, Director, Institute of Nursing and Health Research, Ulster University, UK
Co-author	Professor Val Wilson, Australia

Aim

The aim of this abstract is to present key outcomes from an international collaborative study the aim of which was to test and benchmark person-centred KPIs within a range of paediatric wards/hospitals in Europe (six hospitals across four countries) and Australia (six hospitals across three states).

Abstract

Nurses are a critical part of the health care workforce and provide a significant proportion of care. Whilst, some metrics are universally recognised within nursing and widely used across the globe to evidence the quality of care, there is a recognised gap in the evidence-base regarding measuring the impact of care and its contributions to the quality of the patient/family experience. To address this gap a set of eight key performance indicators (KPIs) were developed from primary research led by Ulster University. The KPIs focus on what is viewed as important in delivering or being the recipient of person centred care.

The international collaborative study, which is the focus of this presentation, aimed to test and benchmark the KPIs within a range of paediatric wards/hospitals in Europe (six hospitals across four countries) and Australia (six hospitals across three states). Partnering with consumers is an essential component of this work with patients and their families providing feedback on the care they receive whilst in hospital. The framework developed to measure the eight KPIs comprises three key data sources which are collected, analysed and fed-back to staff within a 10-week timeframe:

- user feedback through survey and stories
- observations of practice; and
- reviewing patient records against identified goals.

Each ward used the Plan Do Study Act (PDSA) cycle to work with the collected KPI data in order to identify, implement and evaluate change aimed at improving practice.

In this presentation we share the outcomes of the first two cycles which have been benchmarked across all 20 paediatric wards, highlighting the similarities and differences and reporting on the practice changes (over 50 to date) that have taken place in order to improve the quality of patient care and family involvement in care.

We will also present our findings in relation to the process of participating in the study, the effectiveness of the different data sources in informing change, and tackle the issue of sustainability. Finally we will share our plans in developing this work across a larger and more diverse landscape.

Reading list

Maben J, Morrow E, Ball J, Robert G and Griffiths P (2012) *High Quality Care Metrics for Nursing.* London, National Nursing Research Unit, Kings College London.

McCance TV, Telford L, Wilson J, MacLeod O and Dowd A (2012) Identifying key performance indicators for nursing and midwifery care using a consensus approach. *Journal of Clinical Nursing*, 21(7 and 8): pp.1145-1154.

McCance T and Wilson V (2015) Using person-centred key performance indicators to improve paediatric services: an international venture *International Practice Development Journal*, Vol 5: article 8. Available at: www.fons.org/library/journal/volume5-person-centredness-suppl/article8 (accessed 25/10/16) (Web).

Biography

Tanya is Director for the Institute of Nursing and Health Research and Head of the Person-centered Practice Research Centre at Ulster University in Northern Ireland. She has an international reputation in the development of person-centered practice through the use of participatory research approaches such as practice development and action research. Tanya currently leads a program of research that is underpinned by the Person-centered Practice Framework, which is practice based and collaborative in nature and is focused on developing person-centered cultures.

2.30 – 3pm

1.2.2 Supportive self-management: roots to results

Room	Wordsworth Room
Chair	Amanda Cheesley
Presenter	Lindsay Welch (Salim), ICOPD Team Lead, Solent NHS Trust, UK

Aim

To describe and discuss clinical evidence and present solutions pertaining to building patient engagement in self-management in long-term conditions.

COPD self-management can decrease unnecessary contacts with acute medical providers, and potentially reduce COPD admissions. Unfortunately lay persons often struggle to manage due to the need to understand the complexity of the condition and its medical drivers. COPD can be isolating and this can lead to low mood and an increasing inability to engage with self-care and self-management. Recognising the symptom burden in COPD and addressing the social support and psychological needs can re-engage patients with self-management.

Abstract

COPD is a life-limited progressive illness punctuated by acute episodes of breathlessness, sputum production and wheeze. It also has a well-recognised burden of disabling physical symptoms, compounded by comorbidity, psychological distress and social isolation. The nature and progression of the disease has regularly called for solutions and methods to employ education and self-management strategies in COPD. COPD self-management can decrease unnecessary contacts with acute medical providers, and potentially reduce COPD admissions.

Unfortunately lay persons often struggle to manage due to the need to understand the complexity of the condition and its medical drivers. This in turn compromises the ability of an individual to recognise symptom deterioration and act appropriately. The action taken when symptoms deteriorate has the potential to be influenced by previous experiences and social networks.

Bourbeau, 2003, has developed and trialled various self-management initiatives in COPD with some success. He concluded that teaching self-management alone is not enough to bring about a behaviour change – such as exercise or smoking cessation. Furthermore, the mobility limitations caused by the disease progression, and fear of episodes of acute breathlessness can often lead to decreased social interaction, and isolation. This is a perpetuating cycle as social interaction in vital to maintain our habitus and wellbeing; thus this isolation leads to low mood and an increasing inability to engage with self-care and self-management.

Engagement in wellbeing and self-management starts with the recognition of the work involved in self-care with a long-term condition. Maintaining wellbeing should include recognition and management of social and psychological needs. Recent evidence suggests that readdressing the focus of care in long-term conditions to value social networks and psychological wellbeing can empower patients to have more control of their condition and feel confident in the day-to-day management of their disease.

Reading list

Taylor et al (2014) A rapid synthesis of the evidence on interventions supporting self-management for people with long term conditions. *Health Services and Delivery Research*, 2(53) pp.1-580. Available at: www.journalslibrary.nihr.ac.uk/hsdr/volume-2/issue-53#abstract (accessed 25/10/16) (Web).

Bourbeau (2003) Disease-specific self management programmes in patients with advanced chronic obstructive pulmonary disease: a comprehensive and critical evaluation. *Disease Management and Health Outcomes*, 11 (5) , pp.311-319. Available at: rd.springer.com/article/10.2165/00115677-200311050-00004 (accessed 25/10/16) (Web).

Rogers A, Vassilev I, Sanders C, Kirk S, Chew-Graham C, Kennedy A et al (2011) Social networks, work and network-based resources for the management of long-term conditions: a framework and study protocol for developing self-care support. *Implementation Science*, 6. Available at: implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-56 (accessed 25/1016) (Web).

Biography
Lindsay began as a practice nurse working with long-term conditions in particular respiratory. Lindsay has alternated between commercial research delivery and positions in respiratory medicine; largely leading commercial research in COPD and then leading the COPD supported discharge team at UHS NHS FT.

Lindsay now leads the Integrated COPD service for Solent and UHS NHS FT providing quality COPD Care to Southampton patients. The service encompasses the COPD patient pathway; primary care education/ diagnosis, acute care, supported discharge, pulmonary rehabilitation. Clinical and academic interests include; non - pharmacological therapies in COPD, and complexities in social aspects of COPD.

Reading list
Mason P and Butler C (2010) *Health Behavior Change* Amsterdam: Elsevier.

Miller W and Rollnick S (2013) *Motivational Interviewing: Helping People Change* (3rd edition) New York: Guilford Press.

Rosengren D (2009) *Building Motivational Interviewing Skills: A Practitioner Workbook*. New York: Guilford Press.

Biography
Pat is a school nurse lecturer at Sheffield Hallam University. She teaches on a range of pre and post registration nursing courses. Pat's interests are in mental health promotion and sexual health. Pat works in practice as a school nurse and sexual health practitioner in young people's services. Pat is a member of the Motivational Interviewing Network of Trainers (MINT) and has developed education programmes in motivational interviewing for health professionals.

3 – 3.30pm

1.2.3 The use of motivational interviewing in community and public health nursing to facilitate behaviour change and improve health across the lifespan

Room Wordsworth Room
Chair Amanda Cheesley
Presenter Patricia Day, Senior Lecturer, Sheffield Hallam University, UK
Co-author Gayle Hazelby, UK

Aim
To discuss the application of motivational interviewing in community and public health nursing settings.

Abstract
Around two thirds of deaths among the under 75s are avoidable – that is around 103,000 deaths per year (DH, 2013, Living Well for Longer). Conversely, with increased longevity and morbidity rates, there are a growing number of people living with chronic disease. Community and public health nurses are often the first point of contact for clients with lifestyle-related health issues. They provide a non-stigmatising service to populations across the lifespan and have the opportunity to promote health at key transition points within a person's life. The principles of motivational interviewing, including empathy and acceptance are ideally suited to working with vulnerable individuals. The evidence base for the use of motivational interviewing with behaviour issues will be examined. Application to practice will be considered in relation to case studies concerning substance misuse, obesity, sexual health, mental health and health improvement for people with chronic diseases, particularly those who are functionally dependent. The education of community and public health nurses in motivational interviewing and its potential to improve health will be discussed.

3.30 – 4pm

1.2.4 Collaborative pathway to reduce unplanned admissions in Multiple Sclerosis

Room Wordsworth Room
Chair Amanda Cheesley
Presenter Debbie Quinn, Head of Professional Development, Northamptonshire Healthcare NHS Foundation Trust, UK

Aim
A multiple sclerosis (MS) nursing team has developed a rapid response service to reduce hospital inpatient stays. This is done through partnership with the local acute hospital and GPs to develop a care pathway for people with MS to prevent unnecessary hospital admissions through accident and emergency, acute admissions unit and the out-of-hours service. This rapid response service is driven by patient choice, bringing care closer to home, reducing costs, increasing earlier diagnosis, enhancing speciality for MS in the community and reducing infection risks due to decreased hospital stays and user support. People with MS who have received this service have found it effective and efficient, and report that it accelerated their recovery and improved the patient journey. Cost savings were also identified that secured the funding of an additional seven hours of MS nursing time to facilitate the project.

Abstract
A community MS nurse service has been for 12 years, it is recognised nationally as a best practice model and has been showcased as an Innovation project by the Royal College of Nursing in their Frontline First Campaign.

This service works with GPs, acute services, allied health professionals, care management and the third sector in order to assist people with MS to manage their condition within their own home. It ensures that locality working is at the core of its delivery and advocates/enables people with MS to be self managers of their condition.

The service can demonstrate cost effectiveness through admission avoidance work with both primary and secondary care in excess of £300,000 cost savings per annum (Quinn 2011).

The service supports people with MS to manage their condition within their own homes, reduce unplanned admissions, accelerate hospital discharges and provide expert advice to GPs and community practitioners. Prevalence within the county for people with MS is estimated to be within the region of 1.2 per 1000. It is demonstrated that provision of such a service can provide cost savings in excess of £300k per annum if provided on a substantive basis.

The service demonstrates how community specialist nursing can deliver cost savings for the health economy, adapt to changing political drivers and highlight areas of business development. It captures how partnership working with primary and secondary care can enhance and improve the patient journey and produces evidence of the value of community-based specialised nurses.

Reading list

Leary, A, Quinn, D and Bowen, A. (2015) Impact of proactive case management by Multiple Sclerosis specialist nurses on use of unscheduled care and emergency presentation in Multiple Sclerosis: A Case Study. *International Journal of MS Care*. 17(4) pp.159-163.

Quinn, D (2011) A Collaborate Care Pathway to reduce Multiple Sclerosis admissions to secondary care. British *Journal of Neuroscience Nursing*. 7: pp.497-499.

Biography

Debbie began working in the NHS in 1985 and has held a variety of roles during this time, including ward sister in surgery and infection control, clinical audit facilitator and district nurse. Debbie commenced working as a community MS specialist nurse in 2004, setting up the service and securing recurrent funds. She continues to champion community specialist nursing and the benefits of providing such a service. She is passionate about the demonstration of the need for MS nurses and has published a number of articles on the cost benefits of her service. One of her greatest achievements was receiving the Queen's Nurse award in 2012 for excellence in patient care and provision. She is an active member of the RCN Neurosciences Forum, a book reviewer for the Nursing Times, article reviewer for the Nursing Standard and presents regularly nationally, regionally and locally. She has attended meetings and represented MS nurses in the Houses of Parliament and House of Lords.

Theme: Technology and innovation

2 – 2.30pm

1.3.1 The next hundred years: what foresight tells us about nursing futures

Room Abbey Room
Chair Steph Aiken
Presenter Robert Madelin, Strategy Consultant, Belgium

Abstract

Strategic resilience depends on adequate attention to emerging, novel futures. E-health and the data century may take nursing in strange directions. Can we be prepared?

Biography

Robert Madelin joined the British Civil Service in 1979 and served in the European Commission from 1993 to 2016: since end-September, his major engagement is as Chief Strategist at Fipra International.

Robert has worked on and thought about health issues since his stint as Director General for Health in Brussels, 2004-2010, and as the lead for HealthTech research and innovation in 2010-2015. He is an Honorary Fellow of the Royal College of Physicians of London, a member of the World Economic Forum's networks on the future of health and health systems, and an adviser to the European Health Forum Gastein.

Robert is the author of 'Opportunity Now: Europe's mission to innovate' (2016).

2.30 – 3pm

1.3.2 Patient-centred strategy to reduce donor blood wastage

Room Abbey Room
Chair Steph Aiken
Presenter Sarah Beuschel, Transfusion Practitioner, Aneurin Bevan University, Health Board, UK

Aim

This was work undertaken initially with the coronary care unit to reduce inappropriate blood component use and wastage of blood components through a patient centred strategy. Additionally education and training in blood transfusion for clinical and non-clinical staff was provided promoting evidence based practice to improve patient outcomes, challenge historic practices and apply the principles of prudent health care within blood transfusion. This resulted in a significant reduction in red blood cell wastage and increase in single unit transfusions as the message was spread across the Health Board.

Abstract
Working with the ABUHB pathology incident team we identified significant inconsistencies in cross-match to transfusion ratios (XM:Tx) in Royal Gwent Hospital and the coronary care unit (CCU) was identified as a target area. Using the current guidelines and research it was identified that a low haemoglobin level in some cardiac conditions does not respond favourably to multiple unit blood transfusion. 2,3-DPG increases oxygen at a cellular level, however, when multiple units of blood are transfused, despite haemoglobin relative values increasing 2,3- DPG levels fall demonstrating no increase in cellular oxygenation compared to single unit transfusion. The research evidence to support such restrictive transfusion include the TRICC study, Serious Hazards of Transfusion report, BCSH guidelines, the Welsh Government's Better Blood transfusion Initiative, the Wales strategic Framework for Blood Transfusion and the Health and Care Standard 2.8.

I met with the cardiology medical and advanced nursing team and pathology laboratory staff, discovering variation in understanding of the scientific evidence supporting restrictive transfusion and noting historic working practices: 'if your cross matching or ordering one unit of blood, you might as well have two'. This potential 'over transfusion' can lead to detrimental patient outcomes including an increase in transfusion related infections, complications and respiratory problems in high-risk CCU patients, as well as wasting of scarce and expensive resources.

This had a profound effect on the use of blood in cardiology including a drop in XM:Tx to 1.1:1 which shows that nearly every unit of blood that was issued was given but also consequently the number of red blood cells issued that year dropped significantly, I then took this presentation to the medical grand round and concurrently the blood bank were able to reduce their stock levels ultimately reducing the numbers of time expired blood. The outcome is an incredible 50% reduction in blood wastage in the Royal Gwent Hospital.

This is an important clinical issue and required working with a broad multidisciplinary team including nursing staff, biomedical scientists and medical staff to promote evidence-based practice, to change historic cultural beliefs and to apply prudent health care principles to blood transfusion practices.

Reading list
Retter A, et al (2012) Guidelines on the management of anaemia and red cell transfusion in adult critically ill patients. *British Journal of Haematology* (Vol 160, Issue 4) Available at: onlinelibrary.wiley.com/doi/10.1111/bjh.12143/full (accessed 25/10/16) (Web).

Goodnough L et al (2014) Restrictive blood transfusion practices are associated with improved patient outcomes *Transfusion* (Vol 54, Issue 10)

Handbook of Transfusion Medicine, 5th ed (2013) Blackwell Available at: www.transfusionguidelines.org.uk/transfusion-handbook (accessed 25/10/16) (Web).

Biography
Sarah has many years experience as a critical care sister and has a Masters in Critical Care. She has developed expertise in teaching and training becoming an instructor in ALS and transfer of critically ill patients. She has a clinical interest and experience of blood transfusion and was one of the first non-medical health care professionals in Wales to successfully complete the Master's level non-medical authorisation of blood transfusion training in 2012. Sarah works for the Welsh Blood Service delivering the Welsh Government's *Better Blood Transfusion Initiatives* (2002), reinforcing her concerns about blood wastage in hospitals.

3 – 3.30pm

1.3.3 The role of an advanced nurse practitioner in today's hospital: from a critical care perspective

Room	Abbey Room
Chair	Steph Aiken
Presenter	Suman Shrestha, Advanced Nurse Practitioner, ICU, Frimley Park Hospital, UK

Aim
The aim of this presentation is to discuss how an advanced nurse practitioner (ANP) role has evolved in critical care, the key benefits the role brings to enhance care for the critically ill patients and how this model can be applied to other specialties.

Abstract
The ANP is one of the new roles in critical care in the UK. It is designed to make a significant contribution to the care and management of critically ill patients while offering structured clinical career progression to experienced critical care nurses. This role crosses the professional boundaries of many functions within critical care, including medicine, nursing, technical, physiotherapy and clinical pharmacology. It delivers elements of advanced practice which has been traditionally performed by medical doctors such as daily clinical review of critical care patients, assessing patients' needs; then developing, prescribing and adjusting treatment plans. It also includes undertaking invasive procedures such as insertion of arterial and central line, ordering investigations (for example, x-rays), patient referral to clinical specialties and prescribing medicine within the scope of practice and competence.

The National Education and Competence Framework for Advanced Critical Care Practitioners (Department of Health, 2008) defined the role, its scope, limitations and process of education, assessment and skills acquisition. Recently, this document has been revised and endorsed by the Faculty of Intensive Care Medicine (organisation that governs the training and education for intensive care medicine) and other leading critical care organisations. Furthermore, the

Guidelines for Provision of Intensive Care Services (2013) which defines core standards for intensive care units states that an ICU resident (junior medical cover) may be a medical trainee or ANP. These recent developments have given this role greater recognition and credibility.

An ANP role provides a number of key benefits to the service such as continuity of care and improved adherence to local policies and practice. It provides a method of closing the knowledge and skills gap likely to result from the reduction in trainee doctor numbers due to their shortened training time. The team also benefits from the wealth of clinical experience that ANPs bring and they can be a valuable source of information, knowledge and support on clinical and managerial matters. There are also growing evidence that suggest the role is safe and effective.

Reading list
www.ficm.ac.uk/advanced-critical-care-practitioners-0

Biography
Suman Shrestha is an ANP in critical care at Frimley Park Hospital (Frimley Health NHS Foundation Trust, Surrey, UK). He has been working in critical care for 14 years and last two years as ANP in critical care. He is also a qualified independent nurse prescriber. He is part of the senior team with additional key responsibilities of managing critical care outreach team and providing leadership around training and education within the critical care services. He leads on number of trust wide projects such as improving sepsis care and tracheostomy. He is also steering committee member of the Royal College of Nursing Critical Care and In-flight Nursing Forum – representing critical care nurses at national level such as Critical Care Leadership Forum, NICE, NCEPOD and NHS England.

3.30 – 4pm

1.3.4 Rethinking and redesigning the academic preparation of nurse administrators and system leaders

Room	Abbey Room
Chair	Steph Aiken
Presenter	Michael Villeneuve, Program Lead and Lecturer, Lawrence S Bloomberg Faculty of Nursing, University of Toronto, Canada
Co-author(s)	Lynn Nagle, Canada; Leslie Vincent, Canada and Margaret Blastorah, Canada

Aim
To describe the development, structure and initial evaluation of an innovative hybrid (online and campus based) Master of Nursing – Health Systems Leadership and Administration program at the Lawrence S Bloomberg Faculty of Nursing, University of Toronto. Key considerations in a primarily online program such as student engagement and community-building, active learning strategies, evaluation methods, and real-world applications of learning will be discussed.

Abstract
In 2011, the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto undertook a comprehensive review of the administrative stream of its Master of Nursing program. The purpose of the review was to determine how to restructure and revise the existing program to best prepare advanced practice nurses to meet the evolving needs of Canadians and their health care system. With an interest in being responsive to the needs of prospective employers and the changing student population, data gathering included an external academic and administrative review, document analysis, a series of interviews and focus groups with a broad range of internal and external stakeholders, and examination of competing programs. The results of this review informed the redesign of both the content and delivery of a new curriculum developed to prepare nurses for formal leadership roles in health care administration, health policy, professional practice leadership, and other leadership roles across Canada and internationally. Based in competencies of the Canadian Nurses Association (Advanced Practice Nursing), the Canadian College of Health Leaders and the American Organization of Nurse Executives, a new Master of Nursing program in Health Systems Leadership and Administration was designed over two years. The new curriculum retains some foundational courses in common with all of the Master of Nursing programs while integrating new and redesigned courses in research interpretation and appraisal, health systems and public policy, leadership and administration. Students progress through the two-year program as a cohort, with curriculum delivered across six consecutive terms. Launched in September 2014, the new program is offered largely in an asynchronous

online platform and includes on-campus residencies and leadership practicum experiences. The design process, key features of the program and our preliminary assessments of effectiveness and results will be shared in the presentation today.

Reading list

American Organization of Nurse Executives (2011) *The AONE nurse executive competencies*. Available at: www.aone.org/resources/nec.pdf (accessed 25/10/16) (Web).

Canadian College of Health Leaders. (nd.) LEADS in a caring environment. Ottawa: Author. See: leads.in1touch.org/uploaded/web/pdf/LEADS_Print_Brochure_EN.pdf

Canadian Nurses Association (2008) *Advanced Nursing Practice: A National Framework*. Available at: cna-aiic.ca/~/media/cna/page-content/pdf-en/anp_national_framework_e.pdf (accessed 25/10/16) (Web).

Biography

Since 1980, Michael has held roles in all domains of nursing practice. He is Program Lead for the Master of Nursing – Health Systems Leadership and Administration at the Lawrence S Bloomberg Faculty of Nursing, University of Toronto. Michael has led numerous national and international health system and nursing initiatives in his roles as executive lead for the National Expert Commission, scholar in residence at the Canadian Nurses Association, visiting consultant with OECD, and senior policy consultant in Canada's federal Office of Nursing Policy. He is author of a forthcoming (2016) text on health policy for Canadian nursing students.

Dr Nagle, Ms Vincent and Dr Blastorah are all based at the Lawrence S Bloomberg Faculty of Nursing, University of Toronto, and all teach in the Health Systems Leadership and Administration program. Each is a co-author; I will present the paper. Dr Nagle is an Assistant Professor and was previous Lead for the Master of Nursing program in Administration. She serves as Editor in Chief, Canadian Journal of Nursing Leadership. Ms Vincent is Adjunct Lecturer and Dr Blastorah is Assistant Professor and Director of Graduate Programs. They may all be contacted through my email.

Theme: Technology and innovation

2 – 2.30pm

1.4.1 Learning resources for nurses in the digital age

Room: Wesley Room

Chair: Janice Smyth

Presenters: Dr Caroline Shuldham, Chair of the Editorial Advisory Board, RCNi, UK and Graham Scott, Editorial Director, RCNi, UK

Aim

To share best practice in the delivery of learning materials for nurses and health care support workers around the world through digital formats. To share best practice in how members of the nursing team can maintain, update and develop their clinical knowledge and skills, and demonstrate that they are doing so.

Abstract

Nursing is focused on patient safety and wellbeing, the effectiveness of care and ensuring the patient has a good experience. There has long been a requirement for nurses to keep up-to-date with developments but with increasingly rapid changes in health care, nursing and patient expectations this requirement is growing. In some countries such as the UK it is formalised through a process of lifelong learning and revalidation of nurses' registration.

A variety of materials can be used to facilitate learning and whereas previously much of this would have been print based, digital technology enables a range of media to be used.

We know from research undertaken by RCNi that nurses want material to be informative, relevant, thought-provoking and show them how to use the information in practice.

Nurses use technology regularly in their working and personal lives, it makes sense to use it for learning.

Building on an existing programme, resources are being developed by RCNi that include online (and print) journals, continuing professional development resources and a linked portfolio accessed through one portal, across all sectors and specialities in health care clinical practice, education, management and research. It is available worldwide.

Development is informed by research to establish what nurses need/want from such resources and by a team of nurses at all stages of their career.

RCNi's aim is to be a lifelong partner for nurses, enabling them to be up to date, informed and in the best possible position to provide excellent patient care wherever they work.

Reading list

Nursing Standard

RCNi Portfolio on rcni.com

Andre K and Heartfield M (2011) *Nursing and Midwifery Portfolios: Evidence of Continuing Competence*, Australia: Churchill Livingstone

Biography

Caroline Shuldham has extensive experience of leadership and management in a complex NHS Foundation Trust, ensuring patients receive high quality, effective and safe care and a positive experience. Operated at Board level in the NHS for more than 20 years and in the past four as a Trustee in the Charity sector. Has a proven track of working in the clinical environment, research, development and teaching. Provided strategic engagement at Board level in an organisation that was subject to regulation, inspection and external scrutiny. Has a record of achievement in her discipline that extends to publications and advisory roles.

2.30 – 3pm

1.4.2 'Building a New Front Door': improving pathways for suspected first seizure patients

Room	Wesley Room
Chair	Janice Smyth
Presenter	Malisa Pierri, Clinical Nurse Specialist in Epilepsy, Alan Richens Unit /Welsh Epilepsy Centre, Cardiff and Vale University Health Board, UK
Co-author(s)	Ms Vicki Myson, UK and Mrs Ruth Jordon, UK

Aim

The abstract will illustrate the background, rationale and outcomes of an nurse led innovation changing the pathway of patients presenting with suspected first seizures. The clinical nurse specialists in epilepsy have improved access to specialist care, improved diagnostic times and positively impacted on the care of patients within the emergency unit at the University Hospital of Wales.

Abstract

Purpose: Waking up in hospital with no memory of what has happened to you, at times with injuries and with those around you often upset and concerned for you wellbeing is a common yet traumatic experience in patients who present in the emergency unit with a suspected first seizure. Suspected first seizures are difficult to triage and as a result a range of clinicians from physiatrists' to cardiologists to neurologists can become involved in their care. Misdiagnosis of this group is common and can be fatal. NICE guidelines 2012 recommend review by a specialist within two weeks but within our service this only occurred 35% of cases. Improvements to services within existing resources were needed.

Method: We established a steering group involving patient representatives and professionals to identify ways in which realistic improvements could be achieved. A new service utilising the skill and experiences of the epilepsy specialist nurses was incorporated. They began assessing patients in the emergency unit at their initial presentation. Weekly meetings with cardiology were formed to allow rapid triage into either cardiology or neurology. This lead to swift assessment with the opportunity to talk to patients about what had happened, and discuss lifestyle issues (particularly driving and bathing) at the front door.

Results: Since implementing the average number of patients reviewed within two weeks has nearly doubled. By cutting out unnecessarily waits time to diagnosis has changed from an average of 111 days to 30 days and patient stories have shown us that patients and families value the new service. As a consequence having specialist epilepsy nursing input into the emergency unit we have also managed to impact on unnecessarily admissions from existing patients with epilepsy saving the UHB over £40,000 inteh first year alone.

Conclusion: Involving a full range of partners both internal and external to evaluate existing services can lead to surprising options. Links with other departments developed during the process now allow for a smooth transition for patients between specialities when required.

Reading list

National Institute for Health and Care Excellence (2012) *Epilepsies: diagnosis and management* Available at: www.nice.org.uk/guidance/cg137 (accessed 25/10/16) (Web).

Epilepsy Service Development Directive, Welsh Assembly Goverment, March 2009

Biography

Malisa Pierri is a CNS in epilepsy. After qualifying in 1998 she started work in neurosurgery at the University Hospital of Wales and following a period of working in Sydney, Australia, returned and took up the post of Neurology Nurse Practitioner. In 2004 she commenced her current post with special interests in epilepsy surgery and management of suspected first seizures. In 2011 she was awarded a Florence Nightingale travel scholarship to look at experiences following first seizures in America and Australia and in 2012 she was awarded the inaugural Betsi Cadwaladar scholarship by the Chief Nursing Officer for Wales.

3 – 3.30pm

1.4.3 mHealth and frontline nurses: the medic mobile experience

Room Wesley Room

Chair Janice Smyth

Presenter Jay Evans, Regional Director Asia, Medic Mobile, Kathmandu, Nepal

Co-presenters Shreya Bhatt, India Country Lead, Medic Mobile, Mumbai, India and Ranju Sharma, Asia Regional Designer, Medic Mobile, Kathmandu, Nepal

Aim

This workshop will discuss the role of technology and innovation, specifically mHealth, in supporting nurses to improve health outcomes in low-resource settings globally. It will share experiences of Medic Mobile, a non-profit technology company that builds mobile and web tools to improve the delivery of health care in underserved communities around the world. The workshop will highlight examples in which mHealth tools have helped nurses in patient tracing, behaviour change, treatment adherence and post-treatment follow-up, as well as the importance of human-centered design in mHealth interventions for frontline nurses.

Abstract

Frontline nurses and health workers form the backbone of effective health systems particularly in low- and middle-income countries (LMICs) which face not only the continued burden of infectious diseases but now also a majority share of the burden of non-communicable diseases (NCDs) (WHO). Frontline nurses and health workers are often the first point of contact for most patients in rural and disconnected communities, providing crucial primary health care to a largely underserved population.

At the same time, there are over six billion mobile phone subscribers worldwide and at least 50% of the population in LMICs owns a cell phone (PEW). The field of 'mHealth' seeks to capitalize on this opportunity to strengthen linkages between nurses, health workers, patients, and care givers with the ultimate goal of improved health outcomes.

MHealth is already being used to improve access, adherence, and quality of care in many LMICs for infectious diseases such as malaria and HIV/AIDS (Tomlinson). There is an opportunity to apply these mHealth tools in the prevention and screening, diagnosis and treatment, and palliative care for NCDs.

This workshop will provide an overview of the mHealth landscape, and examples of evidence-based use cases to support nurses across a range of health care verticals and use cases including patient tracing, behavior change, treatment adherence, and post-treatment follow-up. It will also highlight the importance of human-centered design (HCD) in mHealth interventions to support frontline nurses.

Reading list

PEW Research Center (2014) *Emerging Nations Embrace Internet, Mobile Technology*

Tomlinson M, Rotheram-Borus MJ, Swartz L, Tsai AC (2013) *Scaling Up mHealth: Where Is the Evidence?* PLoS Med 10(2): e1001382. doi:10.1371/journal.pmed.1001382.

Biography

Jay Evans is the Regional Director for Asia at Medic Mobile and a Lecturer at the University of Edinburgh. Jay was previously the Senior Adviser for Global Business Planning at the American Cancer Society. Jay has over 12 years of experience in international development in Asia, Europe, and Latin America in the fields of public health and housing. Education: BA in International Affairs cum laude from George Washington University, MS in Development Economics from The University of Pennsylvania, Department Chairman's award for academic excellence.

3.30 – 4pm

1.4.4 Blended learning for safeguarding training

Room Wesley Room

Chair Janice Smyth

Presenter Zoe Clark, Senior Lecturer Children's Nursing, Kingston University, UK

Co-presenter Cameron Cox, Senior Lecturer Children's Nursing, Kingston University, UK

Aim

To share knowledge and experience of developing a blended learning package for mandatory training

Abstract

The concept of using computer technology is no longer a new idea within higher education and in nurse education today. The past decade has seen a steep rise in the use of these technologies within current nursing curriculums (Ginns and Ellis, 2007). However the incorporation of technology mixed with face-to-face teaching is often adopted. This style of blended learning allows the students to engage in education in different platforms and at their own pace and in their own time. Blended learning can enhance the student experience and is often evaluated well (DiVall, 2013). According to the centre for educational research and innovation blended learning of traditional styles and technology is becoming increasingly the preferred method of teaching (CERI, 2005).

However there remains a gap in knowledge relating to the use of blended learning in teaching safeguarding children and young people across the pre-registration nursing programme for all four fields.

The innovation of blended learning will be discussed included evaluation from nursing students. This process presents challenges for lecturers and students alike and these will be discussed in detail.

Overall this presentation aims to bridge the gap of knowledge on how a blended learning package can be used as an effective way to teach safeguarding children and young people. There is also discussion of how this package can be implemented across professions including education and social work.

References

Centre for Educational Research and Innovation (CERI) (2005) *E-learning in tertiary education: Where do we stand?* Paris: OCDE Publishing

DiVall M et al (2013) Perceptions of Pharmacy Students, Faculty Members and Administrators on the use of Technology in the Class Room. *American Journal of Pharmaceutical Education*, 77 (4), pp.1-7.

Ginns P and Ellis R (2007) Quality in blended learning: exploring the relationships between online and face-to-face teaching and learning. *Internet and Higher Education* 10, pp.53–64.

Reading list

Cooner TS (2010) Creating opportunities for students in large cohorts to reflect in and on practice: lessons learnt from a formative evaluation of students' experiences of a technology-enhanced blended learning design. *British Journal of Educational Technology*, 41(2), pp.271–286.

Hsu L and Hsieh S (2014) Factors affecting metacognition of undergraduate nursing students in a blended learning environment. *International Journal Of Nursing Practice*. 20 (3) pp.233-41.

Biography

Zoe graduated with a first-class degree in nursing and moved straight from qualifying into the accident and emergency department. Here Zoe consolidated her training and found a love for mentoring student nurses. Zoe quickly progressed to doing a mentorship qualification and began the task of improving the student experience across disciplines and professions including nursing, paramedics and doctors.

She then moved on to complete a post-graduate qualification as a specialist public health nurse (health visitor). She enjoyed the challenges of working autonomously and here developed a passion for safeguarding practice.

Currently Zoe is a Senior Lecturer in Children's Nursing and she enjoy this role greatly. Leading on some exciting teaching innovations within the university including development of online safeguarding training, implementation of breastfeeding training and field trips to support learning. Zoe is a passionate and enthusiastic educator.

Theme: Conflicts, disaster and recovery

2 – 2.30pm

1.5.1 Healing in an epidemic of suffering

Room	Victoria Suite
Chair	Anna Crossley
Presenter	Catherine Bedford, Psychiatric Nurse/Family Support Centre Coordinator, Modilon General Hospital, Madang, Papua New Guinea

Aim

Trauma, resilience and recovery have both an intellectual and emotional impact. We often put the healing process in a safe place, somewhere women are no longer at risk, somewhere where you start to mend and learn to live normally again. So what happens when there is no safe haven and when everyone you know, everyone around you continues to suffer? I want to explore how healing happens in a context of extreme violence and want to learn if healing really happens or is it just a thin layer of coping that masks as healing?

Abstract

Papua New Guinea (PNG) has some of the highest rates of violence against women in the world for a country not at war. It has been described as a humanitarian crisis (MSF) and health epidemic (WHO). On average two-thirds of wives have been beaten by their husbands and in some areas 89% of women report surviving sexual violence (Ganster-Breidler, 2010). Violence from family members is common and gang rape often used as initiation.

Huge inequalities between men and women, outdated ideas of masculinity, the western world embedding itself alongside traditional culture and unchallenged dominant patriarchal systems mean that all forms of violence against women have been normalised within PNG culture.

We know the physical, psychological and social impact of violence is huge. Women are almost entirely dependent on the perpetrators, most often their husbands, which makes it difficult for them to seek treatment and/or leave their dangerous situations; so they are often forced to go back to the same environment where the abuse continues.

There is a feeling of unity amongst women here; a silent, unsaid acceptance that violence is part of being of a women. An expectation almost that men can do this, free from question or challenge. Little girls look on as their mothers, sisters and aunties are beaten, tortured, abused and raped; innocently constructing their social world punch by punch.

But one thing you notice when you live amongst the violence here is that women heal; the ones who survive, they mend and they continue to raise children, to work and to live. How do you heal in a society that ignores, tolerates and maintains the violence you have endured? The extreme levels of violence here challenge health professionals

to think about healing differently. We can provide an emergency response that mirrors that of war torn countries or we can learn something from cultures where loss, conflict and healing coexist (Ncazelo, Ncube, 2006).

Or we can listen and learn from what women here do to survive and believe that it is possible to heal within an epidemic of suffering when so many people around you experience the same.

Reading list

Ganster-Breidler M (2010) Gender-Based Violence and the Impact on Women's Health and Well-Being in Papua New Guinea *DWU Research Journal* Volume 13

Chandler J (2014) Violence Against Women in PNG: How men are getting away with murder. Lowry Institute.

Ncazelo, Ncube, 2006, The Tree of Life Project, Dulwich Centre Publications. Available at: www.lowyinterpreter.org/post/2014/08/29/Violence-against-women-in-PNG.aspx (accessed 25/10/16) (Web).

Biography

Catherine's nursing career began on an inpatient unit for teenagers detoxifying from drugs and alcohol; moving into specialist outreach and family services using systemic and behavioural approaches. Seeing people recover from their most vulnerable situations stimulated her interest in trauma, resilience and recovery.

She became Clinical Lead and Manager of a specialist family service in London before becoming a VSO volunteer in Papua New Guinea. Spending the past two and a half years building institutional and individual capacity within a local hospital she has started a Family Support Centre providing medical-psychological interventions for survivors of family and sexual violence.

2.30 – 3.30pm

1.5.2 Symposium 1: This is defence nursing

Room Victoria Suite

Chair Anna Crossley

Authors and affiliation

Chris Carter, Chair, Defence Nursing Forum, Royal College of Nursing, British Army, UK

Bridget Malkin, Senior Lecturer, Faculty of Health, Education and Life Sciences, Birmingham City University, UK

Claire Wilcox-Tolley, Lecturer, Faculty of Health, Education and Life Sciences, Birmingham City University, UK

Flt Lt Laura Hodson, Emergency Nurse, Royal Air Force, 4626 Aeromedical Evacuation Squadron, RAF Brize Norton, UK

Major Nicola Corkish, Regional Occupational Health Advisor, Tidworth, UK,

Major Debra Ritsperis QARANC, Deputy Officer Commanding Nursing, Defence Medical Group South, UK

Abstract

This symposium includes three sessions which aims to raise the profile of Defence Nursing and the RCN Defence Nursing Forum by providing delegates with an: Understand the role of UK Defence Nursing - Explore the transition from civilian practice/student nurse status to Defence Nurses - Introduce professional issues facing defence nurses - Demonstrate the contribution of UK Defence Nurses in the delivery of patient care in the deployed setting from dealing with complex trauma to infectious diseases - Explore a series of ethical issues faced by Defence nurses in the firm base and on deployed operations.

Joining the UK Armed Forces provides nurses with exciting career opportunities. Like with all new roles the transition from civilian practice or student nurse status can be daunting. The Royal College of Nursing, Defence Nursing Forum (DNF) has been working with a team of Nurse Academics to develop a series of resources for nurses joining the UK Armed Forces either as qualified nurses or those who are transitioning from student to qualified roles. This symposium encourages delegates to consider how to support nurses undertaking new roles within Defence and explore a series of professional issues facing defence nursing including the concept of lifelong learning, operational nursing and ethical considerations. The first session provides an overview of the Tactical Aide Memoir for Defence Nurses resource which supports Defence Nurses and includes a model for transition and the key professional themes, nurses need to consider from a 'defence' perspective. This includes lifelong learning, resilience and professional responsibilities. The second session focuses on the realities of providing care in the operational environment. During this presentation a series of vignettes will be presented outlining the care of seriously ill trauma patients and Ebola patients. These vignettes will highlight

to delegates the unique challenges of providing care in each of these environments. They collectively demonstrates how each elements within defence compliments and links together in order to provide the best care in challenging, remote and austere environments. The final session in this symposium focuses on unique situations faced defence nurses. By using theoretical scenarios this interactive session will allow delegates to explore specific challenges faced by defence nurses including dual loyalties, consent and rank. By encouraging debate and reflective practice this session will encourage delegates to consider their professional and military responsibilities in the context of providing patient care in this environment. This symposium will be of interest to those who work with defence nurses, those already serving and those considering joining the UK Armed Forces.

Reading list

Moore C (2006). The transition from student to qualified nurse: a military perspective, *British Journal of Nursing.* 15. 10. pp.540-542.

Davies BC et al (2015) Response to the Ebola crisis in Sierra Leone, *Nursing Standard.* 29. 26. pp37-41.

Kenward LJ and Kenward G. (2015) Experiences of military nurses in Iraq and Afghanistan, *Nursing Standard*. 29. 32. pp.34-39.

3.30 – 4pm

1.5.3 Do military simulation exercises add value to military undergraduate student nurse education?

Room	Victoria Suite
Chair	Anna Crossley
Presenters	Chris Carter, Nursing Officer/Nurse Tutor, Defence School of Healthcare Education/ Department of Healthcare Education, UK and Major Sue Viveash QARANC, Nurse Educator, Defence School of Healthcare Education, Department of Healthcare Education, UK
Co-authors	Lieutenant Colonel Davies MBE, UK and Commanding Officer Major K Jamieson, UK

Aim

This presentation provides delegates with:

- an introduction to student nurse education provided by the Defence Medical Services
- an overview of the role of defence nurse lecturers in supporting and developing the next generation of 'defence nurses'
- explore the use of simulation to support military undergraduate nurse education.

Abstract

The Defence School of Healthcare Education, Department of Healthcare Education (DHE) is tasked with supporting uniformed undergraduate nurse and Allied Health Professional education. In early 2014 DHE introduced military exercises for student nurses; with a focus on developing leadership skills, refreshing and expanding military and clinical skills in order to introduce students to the deployed clinical environment. Exercises are used across all professional groups within the military to prepare, train and assess individuals for operational deployments and their role. DHE conducted their exercises at the Army Medical Services Training Centre (AMSTC) in York. The training facilities include a bespoke simulation field hospital which adapts to the changing needs of UK operations and threats. For example the training facilities have evolved from training clinical teams to deal with complex trauma in Afghanistan to preparing health care personnel to treat Ebola in Sierra Leone. Although simulation is used extensively in undergraduate nurse education programmes and military pre-deployment training, minimal evidence exists on the specific use of simulation in preparing military student nurses for their future roles. Since 2014 over 250 student nurses and AHPs have participated in these bespoke simulation exercises. This presentation explores the use of simulation specifically in military undergraduate health care education, the education theories supporting the training and an overview of the scenarios used and feedback from students This presentation will be of interest to those involved in the delivery of defence health care, those with an interest in simulation and student nurse education.

Reading list

Arora S et al (2009) Large scale, simulation based training in non-technical skills: efficacy of the British Army's HOSPEX simulation exercise, *Journal of the American College of Surgeons*. 209. 3. S108

Beaumont P and Allan HT (2012) Supporting deployed operations: are military nurses gaining the relevant experience from MDHUs to be competent in deployed operations? *Journal of Clinical Nursing*. 23. pp.65-74.

Davies BC et al (2015) Response to the Ebola crisis in Sierra Leone, *Nursing Standard*. 29. 26. Pp.37-41.

Biography

Major Chris Carter was commissioned into Queen Alexandra's Royal Army Nursing Corps in 2008. A qualified intensive care nurse he was initially assigned to the Intensive Care Department at the Ministry of Defence Hospital Unit Frimley Park, before a posting to 16 Medical Regiment in September 2010. Major Carter was then posted to the Defence School of Healthcare Education, Department of Healthcare Education at Birmingham City University as a nurse lecturer. He continues to work in intensive care and teaches on a variety of under and post graduate courses including specialist practice courses in critical care. Prior to joining the Army Major Carter held a variety of nursing positions including intensive care nurse, critical care outreach nurse practitioner and resuscitation officer. Major Carter is currently the Chair of the Royal College of Nursing Defence Nursing Forum and Nursing Representative for the Royal Society of Medicine, Military Medical Section.

Theme: Conflicts, disaster and recovery

2 – 2.30pm

1.6.1 The role of nurses and midwives in the response to Ebola

Room St James Suite

Chair Lisa Gardner

Presenter Dr Hossinatu Kanu, Chief Nursing Officer, Ministry of Health and Sanitation, Sierra Leone

Aim

To highlight the roles of nurses and midwives in containing and preventing Ebola in Sierra Leone.

Abstract

The 2014 Ebola Virus Disease (EVD) affected over 8,700 people and claimed 3,950 lives in Sierra Leone. On March 17, 2016, The World Health Organization (WHO) marked the end of the EVD flare-up in the country.

Sierra Leone lost 6.85% of its health workers to EVD, which translated to an 8% reduction in nurses and midwives in the country. It is important to recognise that the rapid containment of the disease was largely due to the heightened response of health care workers to the situation.

The "Getting to a Resilient Zero" strategy developed by Sierra Leone's National Ebola Response Centre (NERC) in 2015 articulated three main strategies for the containment of Ebola, all of which nurses and midwives were integral to:

- adopt a Systematic Focus on Community Ownership in all Districts
- achieve operational excellence in the delivery of critical interventions in all districts
- ensure Effective EVD Event Management in Active Transmission Districts and Resilient EVD Event Management Preparedness and Response Mechanisms in The Silent Districts.

As expected, nurses and midwives were critical in clinical settings during the crisis by leading Infection Prevention Control (IPC) protocols. Our nurses provided services in community centres, holding units and treatment centres, at a scale never seen before.

However, the difference in approach during the EVD that helped Sierra Leone efficiently utilise this workforce was our recognition of nurses and midwives as a point of convergence for vertically structured EVD interventions. This was done by successfully leveraging on the unique position that nurses occupy across multiple interfaces in the health care delivery value chain.

Our nursing staff functioned in key leadership and management roles at the directorate level during the EVD response. At an operational level, nurses and midwives provided key services in community engagement, sensitisation and awareness building, teaching and training, surveillance and documentation as well as in counselling support for survivors and families. Policy makers also relied heavily on the experiences of nursing staff at the bed-side which proved invaluable at developing strategies that were rooted in on-the-ground realities.

Sierra Leone's EVD response strategy continues to impact nursing service today, as it brought about unique challenges as well as opportunities for organisational improvements and skills development. Psychological effects of a stressful and emotionally challenging working environment where resources, equipment and infrastructure were insufficient, as well as stigma against health care workers, may persist beyond the end of the crisis. At the same time, the crisis also presented an opportunity for team building within the nursing cadre as well as coordination and interaction between nursing staff and other health workers, which has positively impacted the health care ecosystem in the country.

It is now crucial that Sierra Leone focuses on ensuring that these strengthened structures and lessons learned are maintained even in the absence of urgency, in order to maintain preparedness for an epidemic outbreak in the future. Key activities being undertaken with this objective include the formation of the Emergency Operation Centre (EOC), improved collaboration between community health workers and nursing cadres, and programs for strengthened clinical mentoring and supportive supervision.

In summary, Sierra Leone's experience can provide valuable insights to other nations in building preparedness for an epidemic outbreak in the future. Key takeaways from our approach include:

- recognising the multi-dimensional role of the nursing community as health care managers
- strengthen the global nursing workforce with increased clinical and public health training in Infection Prevention and Control (IPC)
- enhanced community engagement led by nursing cadres
- continued focus on training as well as surveillance through nursing infrastructure
- establishment of EOCs to ensure preparedness.

Reading list

National Ebola Response Centre (2015) *Getting To a Resilient Zero* Available at: nerc.sl/sites/default/files/docs/National%20Ebola%20Response%20Centre_Getting%20to%20Zero%20Strategy_240715.pdf (accessed 25/10/16) (Web).

McGillis L and Kashin J (2015) Public understanding of the role of nurses during Ebola, *Journal of Nursing Scholarship.* Available at: onlinelibrary.wiley.com/doi/10.1111/jnu.12182/abstract (accessed 25/10/16) (Web).

Oregon State University (2005) *Providing Care and Facing Death: Nursing During Ebola Outbreaks in Central Africa.* Available at: www.ncbi.nlm.nih.gov/pubmed/16160191 (accessed 25/10/16) (Web).

Biography

Education

- Studied at the National School of Nursing in Freetown, Sierra Leone (1984-1987), and earned a registered nursing certificate.

- Studied at the National Midwifery School (1991-1993) and earned a State Certified Midwifery Certificate (SCM).
- Studied at the University of Ghana Legon 1999-2001and earned Midwifery Tutors diploma.
- Studied at college of Medicine and Allied Sciences (2003-2007) and a BSc (Hons) in Nursing.
- Studied at Njala University (2009-2011) and earned MPH.

Professional experience

- Worked for five years in general, surgical and paediatric units
- Worked at the Princess Christian Maternity Hospital (PCMH)
- Taught as a Teaching Assistant at the National School of Midwifery School

2.30 – 3pm

1.6.2 Ebola – the role of the Royal College of Nursing

Room St James Suite

Chair Lisa Gardner

Presenter Rose Gallagher, Head of Standards, Knowledge and Innovation, Royal College of Nursing, UK

Abstract

The Ebola outbreak of 2014-2015 was unprecedented in terms of its size and global impact. The role of nursing in the management, containment and prevention of this infectious disease of high consequence was significant both within West Africa and internationally. This presentation will describe the unique role and support provided by the Royal College of Nursing during and after the outbreak to support nurses in the UK and internationally undertake their roles safely and effectively. It will explore its contribution from both the Professional body and Trade Union perspective and how, as a non-operational organisation, it was able to fulfil its function in an effective and impactful way.

The presentation will specifically address:

- the RCN's key relationship with Public Health England and operational support
- the provision of advice to support the national command and control function
- the RCN's international role and relationships with African nations
- the RCN's role in supporting European partners following the transmission of Ebola to a healthcare worker in Madrid
- lessons identified following the outbreak.

Biography

Rose is the Professional Lead for Infection Prevention and Control (RCN) and also currently interim Head of the Standards, Knowledge and Information Services at the Royal College of Nursing. Based in the Nursing Department, she provides strategic leadership and specialist professional advice to the Royal College, its members and key stakeholders across the UK on infection prevention and antimicrobial resistance (AMR) and the implications for nurses and nursing. She represents the RCN at local, regional, national and international events on both infection prevention and professional nursing issues. Rose is currently a scientific adviser to the European Public Health Alliance on AMR.

Rose is a member of the PHE Rapid Review Panel which evaluates products for use in the NHS on the basis of scientific evidence to support claims of improved efficiency or efficacy of infection prevention and control (IPC) interventions to reduce health care associated infections (HCAIs). Her specific interests include HCAI technology programmes and the development of nursing policy issues. She has recently authored a number of chapters on *Decontamination and the role of the nurse* (Walker J, Ed 2014) and *Clinical skills for nursing* (Delves-Yeates C, Ed 2015).

Rose was recently awarded an MBE in the Queens 90th birthday honours list for services to infection prevention and control in her role at the Royal College of Nursing.

3 – 3.30pm

1.6.3 Life as a nurse with Medecins san Frontieres: Have you got what it takes?

Room St James Suite

Chair Lisa Gardner

Presenter Alison Criado-Perez, Nurse, Medical Team Leader, Medecins san Frontieres

Aim

As a Registered Nurse who has worked for eight years with Medecins sans Frontieres, to introduce nurses to life in the field with MSF: the challenges, responsibilities and role within the team of the nurse

Method:

1. A short introduction to MSF
2. The emergency situations we respond to:
   a. Primary Health Care
   b. Natural Disasters
   c. Armed Conflict
   d. Exclusion from Healthcare
   e. Epidemics
   f. Refugees
3. Specific qualities and qualifications needed to work as a nurse with MSF

The session will illustrate all these situations with examples of my own work in the field with MSF. This will include provision of PHC in Northern Uganda, response to floods in Northern Nigeria, conflict in Libya and Central African Republic, exclusion from healthcare in Colombia, lead poisoning in Northern Nigeria, Ebola in Sierra Leone and refugees including search-and-rescue in the Mediterranean.

3.30 – 4pm

1.6.4 Characteristics and values of a British military nurse

Room St James Suite

Chair Lisa Gardner

Presenter Alan Finnegan, Professor of Nursing and Military Mental Health, Director of the Westminster Centre for Research and Innovation in Veterans Wellbeing, University of Chester, UK

Aim

The study identifies the characteristics and values that are intrinsic to military nurses in undertaking their operational role. This novel insight into defence health care; provides information to inform and change educational programmes and clinical practice, thereby presenting an opportunity to improve operational capability and the quality of deployments for military nurses personnel. A theoretical model is presented that can inform realistic personal development plans that will allow military nurses to build upon their strengths as well as to identify and ameliorate potential areas of weakness. This model is transferable to other armed forces and civilian nurses on an international scale.

Abstract

Background: Between 2001 and 2014, British military nurses served in Afghanistan caring for both Service personnel and local nationals of all ages. However, there have been few research studies assessing the effectiveness of the military nurses' operational role and no papers naming the core values and characteristics. This paper is the only qualitative nursing study completed in this period where data was collected in the War Zone.

Objective: To explore the characteristics and values that are intrinsic to military nurses in undertaking their operational role.

Design: A constructivist grounded theory was utilised. The author designed the interview schedule, then following a pilot study, conducted and transcribed the discussions. Informed consent and UK Ministry of Defence Research Ethical Committee approval was obtained.

Setting: Camp Bastion Hospital, Afghanistan, in 2013.

Method: Semi-structured interviews were conducted with 18 British Armed Forces nurses.

Results: A theoretical model was developed that identifies the intrinsic characteristics and values required to be a military nurse. Nursing care delivered within the operational environment was perceived as outstanding. Nurses consciously detached themselves from any legal processes and treated each casualty as a vulnerable patient, resulting in care, compassion and dignity being provided for all patients, irrespective of their background, beliefs or affiliations.

Conclusion: The study findings provides military nurses with a framework for a realistic personal development plan that will allow them to build upon their strengths as well as to identify and ameliorate potential areas of weakness. Placing nurses first, with a model that focusses on the requirements of a good nurse has the potential to lead to better patient care, and improve the quality of the tour for defence nurses. These findings have international implications and have the potential for transferability to any level of military or civilian nursing practice.

Reading list

Finnegan AP et al (2016) Characteristics and values of a British military nurse. International implications of war zone qualitative research. *Nurse Education Today*.

Finnegan AP et al (2015) Preparing British Military nurses to deliver nursing care on deployment. An Afghanistan Study, *Nurse Education Today*. 35, pp.104-112.

Finnegan AP, (2014) Conducting Qualitative Research in the British Armed Forces. Theoretical, Analytical and Ethical Implications. *Journal of the Royal Army Med Corps*, 160(2), pp.135-140.

Biography

Colonel Alan Finnegan FRCN joined the NHS in 1978 and commissioned into the Army in 1987. His clinical background is in mental health, and he is serving as the first Defence Professor of Nursing. He was pivotal in the establishment of the RCN Defence Forum; serving as chairman from 2004 until 2011 and is a member of the RCN International Committee. Alan is a Visiting Professor at the Universities of Chester, Birmingham City, Central Lancashire and South Florida. He is also Director of Research at the independent College of Military Veterans and Emergency Services.

Theme: Populations, health and economic growth

2 – 2.30pm

1.7.1 The role of the Admiral nurse in the dementia pathway: models for future practice

Room Churchill Auditorium (main hall)
Chair Lara Carmona
Presenter Hilda Hayo, Chief Admiral Nurse and CEO of Dementia UK, UK

Aim

This session will provide information on Admiral nursing (specialist dementia nurses). It will explore the Admiral Nurse's role with families living with the effects of dementia through the trajectory of the condition, from pre diagnosis to grief and bereavement. In addition, the session will explore the effectiveness of Admiral nursing in a range of settings including: local authority, primary care, acute hospitals, community and care homes.

Abstract

The first Admiral nurse service was piloted in Westminster in 1990 and Dementia UK was officially registered as a charity in 1994 to take forward the development of Admiral Nursing.

Admiral nurses deliver specialist dementia care to people with dementia and their families. Traditionally this has been within a person's home environment, but over recent years this has extended to include a variety of settings within social and health services, charities and private care providers. This work is complex and requires Admiral nurses to be highly- killed practitioners functioning within an advanced level of practice, often working autonomously, but at the same time sitting within a multi-professional team or service.

Admiral Nurses have significant clinical experience in working with people affected by dementia before coming into post. On becoming an Admiral nurse they will be expected to continually and systematically develop their knowledge and skills in dementia care, and demonstrate this through use of the Admiral Nurse Competency Framework.

This presentation will provide information on the role of the Admiral nurse in the dementia pathway. It will explore the Admiral nurse's role with families living with the effects of dementia through the trajectory of the condition, from pre diagnosis to grief and bereavement. In addition, the session will explore the effectiveness of Admiral nursing in a range of settings including: local authority, primary care, acute hospitals, community and care homes.

Intended learning outcomes

At the end of this session, participants should be able to:

- demonstrate an understanding of the role of the Admiral nurse in dementia
- identify how Admiral nurses can work alongside families, people living with the diagnosis of dementia, charitable organisations, health and social care colleagues, in order to provide the best quality of care and support
- explore how different models of Admiral nursing can lead to improved outcomes for families and people living with dementia by providing expert advice and support.

Reading list

Evans S, Harrison Dening K, and Read K (2016) Towards the end of life: An in-depth exploration of the role of Admiral Nursing in dementia care (Innovative practice). *Dementia*. Doi: 10.1177/1471301216636485

Rahman S and Harrison Dening K (2016) The need for specialist nurses in dementia care, *Nursing Times.* 112(16): pp.14-17.

Harrison Dening K and Hibberd P (2016) Exploring the role of the community nurse in dementia care: an evidence based approach to family centred-nursing, *British Journal of Community Nursing.*

Biography

Hilda Hayo has been the Chief Admiral Nurse/CEO for Dementia UK since 2013. A dual registered nurse, with over 35 years experience developing and leading dementia specialist teams in clinical services and higher education. She held Principal Lecturer posts at both London South Bank University and University of Northampton specialising in older people's mental health and community care. Hilda is particularly proud of setting up and leading a Younger People with Dementia service in Northamptonshire and still remains clinically involved. She is completing a doctorate into how and why social connectedness changes in families living with behavioural variant frontotemporal dementia.

2.30 – 3pm

1.7.2 Nursing at the heart of delivering improved health nationally and globally

Room Churchill Auditorium (main hall)
Chair Lara Carmona
Presenter Jason Warriner, Clinical Services Director, The Sussex Beacon, UK

Aim

Public Health is at the heart of health and social care across the UK. The RCN have conducted a project over the last year to understand the nursing contribution to public health this has been a joint initiative with the Nursing department and the RCN Public health forum.

- Discuss the findings of this project and the key attributes seen as the value of nursing to public Health.
- Promote the diversity of public health nursing by showcasing a variety of case studies in different areas of practice.

- Consider how to enhance the skills of all nursing staff to embrace their public health contribution and Make Every Contact Count.

Abstract
Improving the public's health is fundamental in terms of the economic drivers facing the NHS. Better housing and sanitation have seen a shift during the 20th century from communicable to non-communicable diseases. As a population life expectancy has increased and yet there are marked inequalities with a 20 year difference between some sectors of the population. Primarily this is attributed to deprivation but there are other factors, education and social norms of behaviour. There are increasing numbers of people living with long term conditions many of which are attributed to lifestyle choices, the main three being; smoking, unhealthy diet and over eating and increased alcohol consumption.

The work of the project has demonstrated that nurses are seen as being in a unique position to address these issues and support their client groups to adopt healthier lifestyles and change behaviour. They are able to develop good relationships and are therefore trusted to support healthy lifestyle messages. They know their populations and the issues that affect them at local levels. They also have enhanced communication skills being able to work with people across the life course and in all sectors of the community.

Reading list
Royal College of Nursing (2012) *Going upstream: nursing's contribution to public health* RCN: London Available at: www2.rcn.org.uk/__data/assets/pdf_file/0007/433699/004203.pdf (accessed 25/10/16) (Web).

Public Health England (2014) *Global Health Strategy 2014 to 2019* Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/354156/Global_Health_Strategy_final_version_for_publication_12_09_14.pdf (accessed 25/10/16) (Web).

Department for Health and Public Health England (2014) A framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals: Caring for populations across the lifecourse. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/377450/Framework_for_personalised_care_and_population_health_for_nurses.pdf (accessed 25/10/16) (Web).

Biography
Jason Warriner is the Clinical Services Director at The Sussex Beacon having previously worked at Marie Stopes International, Terrence Higgins Trust and has held senior nursing posts in the NHS. He is a Trustee for Crisis UK, the national charity for single homeless people and Chair of the RCN Public Health Forum.

3 – 3.30pm

1.7.3 Ageing management and nurses' well-being: a multicentre study in hospitals and nursing homes in Milan

Room	Churchill Auditorium (main hall)
Chair	Lara Carmona
Presenter	Dr Loris Bonetti, Tutor Nurse, Bachelor School of Nursing, Teaching Hospital Luigi Sacco, Milan, Italy
Co-presenter	Anna Castaldo, Lecturer in Geriatric Nursing and Research Methodology in Milan University; Director of Continuing Education Don Orione, Milan; Advisor at the Milan Nursing Council. Expert teacher in geriatric nursing, Italy
Co-author(s)	Miriam Magri, Donatella Camerino, Luca Neri, Andrea Giordano, Maria Chiara Gugiari, Maria Josè Rocco, Giovanni Costa, Paul Maurice Conway and Giovanni Muttillo, Italy

Aim
- Identify strategies in order to manage the nursing staff according to the extension of the retirement age;
- Compare our results with international situations and outcomes;
- Know the working aging management BPGs

Abstract
Aim: Assess and evaluate the state of health and the well-being of nurses in health-care facilities that operate in the Province of Milan according to the aging of the nursing population.

Background: According to the extension of the retirement age, the important theme of aging management among nurses and other health care workers is becoming more and more urgent especially for the future.

Methods: Seven hospitals and seven nursing homes that operate in the Province of Milan have been involved in the project. This multicentre study has been carried out with mix the following methodologies:

- Retrospective study: data collection in the health-care facilities involved in the project in order to define the composition of each nursing staff and the trend of the two main outcomes (i.e. pressure ulcers and falls).
- Cross-sectional study: data on the perception of health and well-being collected through a questionnaire filled in by nurses of the different sampled wards.

Results: In nursing homes, there are fewer people with an open-ended contract and more freelancers than in hospitals. Hospitals have 14.4% of employees with more than 50 years, while the percentage of employees in nursing homes is about 8.6%. Moreover, in nursing homes the rate of pressure ulcers and falls is higher than in hospitals (8.7% vs 1.6% and 1.65% vs 46.2% respectively). Nurses have filled in 551 questionnaires. Working shifts is less

common in employees with more than 50 years. There are no differences in the perception of the work-related stress and of different working ages neither in hospitals nor in nursing homes. The perception of being able to work is better in nursing homes than in hospitals. There is a home/work conflict that can be superimposable in both realities and that proportionally increases with age.

Conclusions: The study stressed the fact that the nursing population is still in good health. Nurses between 35 and 45 years seem to be highly affected by the future negative effects produced by the current situation (that is the extension of the retirement age in a context of economic downturn and reduction in staff)

Key words: Ageing management, Nursing staff, Nursing outcome, Work ability

Reading list

Kooij DTAM et al (2013): Beyond chronological age. Examining perceived future time and subjective health as age-related mediators in relation to work-related motivations and well-being, *Work and Stress: An International Journal of Work, Health and Organisations*, 27:1, pp.88-105.

Bevilacqua L, Dell'Erba A, Privitera G, Sommella L Eventi avversi e conseguenze prevenibili: studio retrospettivo in cinque grandi ospedali italiani. *Epidemiol Prev* 2012; 36 (3-4): pp.151-161.

Biography

Loris Bonetti is a lecturer in nursing research methodology at bachelor school of nursing in Milan University. He is a tutor nurse and has many years experience in teaching evidence-based practice. He also has experience in coordination of research projects.

3.30 – 4pm

1.7.4 Influencing politicians and political agenda: a job for nurses?

Room	Churchill Auditorium (main hall)
Chair	Lara Carmona
Presenter	Baroness Emerton, UK
Co-presenter	Jane Hughes, Deputy Director of Communications & Campaigns, RCN, UK

Abstract

Should nurses take on that responsibility? If so how well equipped should they be? My mind was set from the age of four to be a nurse and, against great opposition from my head teacher, I was offered six London teaching hospital places. I had never shown an interest in politics and my parents were not members of any political party but they encouraged me to read the daily paper which was reiterated as a 'must' in the preliminary training school. I remember the GNC included sessions on the history of nursing and how Florence Nightingale had influenced Government Ministers with the findings of her research on the importance of clean water supplies and means of safe sanitation. We were all encouraged to join the Royal College of Nursing, which I did in 1957 and have been a member since.

My career has been long and varied and my desire to be of value to patients as a nurse has never waned however I never dreamed or wanted to be invited to the House of Lords. In fact I hesitated about accepting as I did not wish to be affiliated to a political party under a whip, but I am about to enter my 20th year as a Cross Bench Independent Peer.

Come and hear what it is like to influence politicians and political agendas.

Theme: Populations, health and economic growth

2 – 2.30pm

1.8.1 Dads, kids and sexuality communication: an unlikely alliance with populations, health and growth?

Room	Albert Suite
Chair	Alison Davies
Presenter	Clare Bennett, Research Fellow, University of Worcester, UK
Co-authors	Dr Jane Harden, UK and Dr Sally Anstey, UK

Aim

To present data from an interpretative phenomenological analysis of eight fathers' experiences of talking to their children about puberty, relationships and reproduction. The aim is to link the micro family context to the macro level, encompassing the potential impact of adult-child sexuality communication on populations, their health and their economic growth.

Abstract

Young people internationally are engaging in sexual intercourse at a younger age and have more concurrent partners than previous generations. Consequently, 16-24 year olds are experiencing higher rates of sexually transmitted infections (STIs) and unintended pregnancies than any other section of society. Whilst the physical and psycho-social ramifications of STIs for the individual are well recognised, their impacts at the economic level are frequently overlooked. However, the potential complications of STIs such as cancers, infertility, ectopic pregnancy, miscarriage, neurologic damage and comorbidities represent a significant economic burden to all populations.

Epidemiological data and systematic reviews have questioned the efficacy of traditional approaches to young people's sexual health promotion and practices have moved towards models which focus on the development of young

people's confidence and resilience. Internationally, the primacy of parents in influencing their adolescents' sexual decision making is being emphasised but there is a paucity of research concerning parents', and particularly fathers', experiences of communicating with pre-adolescent children about relationships, reproduction and their changing bodies.

This presentation will report on the findings of an interpretative phenomenological analysis of eight fathers' experiences of talking to their children about puberty, relationships and reproduction. Interpretations will be presented that link prevailing neoliberalist values and the widely held childhood innocence ideal with the fathers' experiences which were largely characterised by avoidance behaviours. In keeping with neoliberalist values, the fathers wished to minimise risk which they managed, paradoxically, by suppressing sexuality dialogue. However, it will be argued that by continuing the silence fathers are potentially rendering their children more vulnerable both now and in the future.

Whilst it is acknowledged that father-child sexuality communication needs to be part of a much broader sexual health strategy which aims to enhance the health and, hence, economic growth of populations, it will be argued that the childhood innocence ideal should be challenged by nurses and health care professionals and fathers should be supported in talking to their children about sexuality in its broadest sense. The presentation will conclude with a resumé of the applications of this research to nursing practice nationally and internationally and its potential impact.

Reading list

Bennett C and Harden J (2014) An exploration of mothers' attitudes towards their daughters' menarche. *Sex Education.* 14 (4) pp.457-470.

Bennett C, Farquharson N and Preece E (2015) Sexual abstinence and young people: A subject worthy of consideration? *British Journal of School Nursing*. 10 (4) pp.176-180.

Stone N, Ingham R and Gibbins K (2013) Where do babies come from? Barriers to early sexuality communication between parents and young children. *Sex Education*. 13 (2) pp.228-240.

Biography

Clare Bennett is a registered nurse with a special interest in sexual health. Clare is a Research Fellow and a Senior Lecturer at the University of Worcester. Dr Jane Harden and Dr Sally Anstey are registered nurses and Senior Lecturers at Cardiff University.

2.30 – 3pm

1.8.2 Better care in the community

Room	Albert Suite
Chair	Alison Davies
Presenter	Beth Griffiths, Senior Lecturer in Advanced Practice, Swansea University, UK
Co-author	Annette Davies, UK

Aim

This concurrent/poster session aims to demonstrate an innovation that provides 'Better care in the community'. It describes a service where a small team working in a Welsh Valley provide a rapid assessment service to patients in their local community.

This service has been successful in reducing workload in secondary care, as well as providing a very high level of patient and carer satisfaction.

Abstract

Prudent health care requires that we create innovative services, which will deliver better care to achieve better outcomes for service users. The fragmentation of specialities, technological advances and the increasing number of older people are creating demands for services that are not realistic within our current structures or budgets.

There are many different community models under development in the UK with the Aim of delivering better care. The difference in the service design is primarily influenced by the existing services, which makes it difficult to benchmark these services and their impact.

Setting the Direction (Welsh Assembly Government 2010) has set the agenda for Wales and aspires to deliver 'world class integrated health care in Wales.

This acute clinical team works as part of the multidisciplinary community resource team in a Welsh Valley. It is an advanced nurse practitioner led service that is supported by a consultant physician/geriatrician. They provide rapid assessments and clinical interventions in the person's place of residence (private home or care home).

A comprehensive geriatric assessment is carried out with every patient. The most common problems encountered re: dehydration, respiratory infections, falls, anaemia, cellulitis, urinary tract infection, exacerbation of heart failure, acute kidney injury, fast atrial fibrillation and general frailty.

Referrals are taken from general practitioners, other community teams and secondary care services, the number of referrals continues to increase year on year.

During the six-month period January 2015 to June 2015, there were 618 patients looked after by the team; 85% of the problems treated, either improved or completely resolved whilst under the care of the team. Of the patients referred to the service the majority are treated successfully in their

normal place of residence. During the six-month period only 3% of referrals were admitted to hospital after 48 hours of referral. 9% of referrals were admitted within 48 hours of referral and this is often at the point of initial assessment.

The impact of this service is positive for patients and service. We would welcome the opportunity to share the knowledge we have gained regarding the improvement of care in our community.

Reading list

Welsh Assembly Government (2010) Setting: *the Direction, Primary and Community Services Strategic Delivery Programme.* Available at: gov.wales/docs/dhss/publications/100727settingthedirection.pdf (accessed 25/10/16) (Web).

Aylward M, Phillips C, Howson H (2013) *Simply Prudent Healthcare – achieving better care and value for money in Wales – discussion paper.* Available at:

www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Bevan%20Commission%20Simply%20Prudent%20Healthcare%20v1%2004122013.pdf (accessed 25/10/16) (Web).

Biography

Beth Griffiths works as a Senior Lecturer in Advanced Practice in Swansea University. She started her training in 1981 and worked for a short while in Singleton Hospital before becoming a midwife. Having worked for a few years as a midwife she took up a post in general practice. Whilst working in general practice she undertook her BSc in Nursing/Nurse Practitioner, MSc in Public Health/Partnerships in care. She worked in general practice as an advanced nurse practitioner/non-medical prescriber 2009, when she left to set up an early response team in Bridgend and worked there until joining the University in 2015.

3 – 3.30pm

1.8.3 Climate change and health - what are the implications for nursing practice?

Room Albert Suite

Chair Alison Davies

Presenter Rebecca Gibbs, Sustainable Specialities Programme Manager and Nursing Lead, The Centre for Sustainable Healthcare

Aim

This session will examine the threats to human health from climate change, discuss the implications this has for nursing practice and outline the resources and support available for taking action.

Abstract

This session will cover the following:

- evidence on the health impacts of climate change both in the UK and further afield
- the carbon load of the NHS and why nurses are critical to making progress
- actions already underway in the nursing profession
- an interactive section on the implications for nursing practice
- resources and sources of support

Biography

Rebecca is a trained nurse with an MSc in social policy from the London School of Economics. She has Whitehall and parliamentary policy experience in sustainable development, including time as a sustainability policy advisor in the Department of Health. Before working in policy, Rebecca spent time as a social researcher and has lived in two eco communities in Dorset and Southern Spain.

Intended learning outcomes

- Describe how climate change will impact human health
- Identify actions that can be taken in their own clinical settings
- Identify tools and sources of support

Reading list

Managing the health effects of climate change: Lancet and University College London Institute for Global Health Commission, Anthony Costello et al, The Lancet, Vol. 373, No. 9676, p1693–1733

NHS could save £1bn by adopting green strategies used in kidney units, Limb M, BMJ 2013;346:f588

Nurse Educ Today. 2012 Oct;32(7):765-71. doi: 10.1016/j.nedt.2012.05.012. Epub 2012 Jun 7. The health effects of climate change: what does a nurse need to know? Barna S1, Goodman B, Mortimer F.

3.30 – 4pm

1.8.4 Salford Dadz: Improving the wellbeing of children facing disadvantage through improving the wellbeing of their fathers

Presenter Heather Henry, Independent Public Health Nurse, Co-Chair New NHS Alliance, UK

Abstract
This is the story of a town on the outskirts of Salford that suffers serious and multiple disadvantage, which is passed down the generations. In this matriarchal community, fathers are often ignored and judged as guilty until proved innocent and regularly end up marginalised by their own families. Yet local children said they wanted their fathers in their lives.

Unlimited Potential, a Salford based social enterprise, was commissioned to use an innovative asset based community development approach, led by a Queen's Nurse called Heather Henry, called 'positive deviance' .

Using an action learning approach, Unlimited Potential found that fathers' pride and shame prevented them for seeking help.The fathers demonstrated maladaptive coping behaviours leading to negative spirals of drink, drugs, crime and violence They discovered fathers (Salford Dadz) who were emotionally open (the 'positive deviants') who then helped others discover that they were not alone.

As the fathers' wellbeing improved, so did the children's.

A social return on investment analysis concluded that the wellbeing value created by the fathers is between £13 and £20 for every £1 invested. The financial return on investment is £3 for every £1. Unlimited Potential is now undertaking proof of concept in 2 further communities in Greater Manchester.

Biography
Heather Henry is an independent public health nurse and Queen's Nurse. She specialises in social innovation to address health inequality and works in some of the most divided and disadvantaged communities in the UK. She is currently working with a social enterprise called Unlimited Potential which is a partner site for NHS England's Realising the Value programme: Heather is co chair of New NHS Alliance, a national organisation which over the last 18 years has significantly influenced national primary care policy.

Heather is listed in Nursing Times as one of the top 48 most influential nurse leaders in the UK and received the 2016 Open University Business School 'Outstanding Contribution to Society' alumnus award.

Intended learning outcomes
At the end of this session, participants should be able to:

1 Understand what is meant by an asset based approach

2 Understand the link between father and child wellbeing

3 Understand the principles of positive deviance

Reading list

1 A Glass Half Full Improvement and Development Agency, 2014

2 Salford Dadz Year 2 Report, Leeds Beckett University, 2015

3 The Power of Positive Deviance, Pascale, Sternin and Sternin, 2010

2 – 2.30pm

1.9.1 Ethical considerations and complexities for military nurses and ways to overcome them

Room Westminster Suite

Chair Tom Sandford

Presenter Dr Janet Kelly, Lecturer in Healthcare Law and Ethics, University of Hull, UK

Aim
The Aim of the session is to explore ethical considerations and complexities for military nurses and ways to overcome them. In doing so, it examines:

- What makes clinical ethical-decision making difficult and challenging?
- What are the most challenging clinical decisions to make or resolve from an ethical viewpoint when deployed and why?
- How can military nurses prepare for the clinical ethical decisions that they may need to make and be supported to make these decisions effectively?
- How the use of ethical models can assist military in addressing ethical complexities.

Abstract
There are clear ethical challenges and complexities that military nurses' face in hostile, austere and dangerous environments. Caring for the sick and wounded in these environments is detached from traditional support mechanisms. One person can seldom solve an ethical dilemma. Problems can be solved whereas ethical dilemmas cannot. There are no easy answers to solving dilemmas in war and conflict. Despite this, military nurses need the skills and knowledge to help deal with ethical challenges. Challenges that military nurse face include medical eligibility (human factors), mission creep (military objectives becoming subjugated to medical objectives), end-of-life decisions (best care versus local availability influencing decisions), duty of care (treatment is promised and started by a non-medic before medical assessment), complex medical ethical decision making (caring for children changes everything) and a two tier health system with different medical resources and assets. One such way in assisting military nurses to prepare for the clinical ethical decisions that they may need to make and to make these decisions effectively is through education on the use

of ethical models. The four quadrant model is a framework for sorting through specific aspects of clinical ethics cases. It considers, (i) Medical Indications i.e. how can the patient be benefited by medical and nursing care, and how can harm be avoided? (ii) Patient Preference such as respect for patient autonomy and is the patient mentally capable and legally competent of making an informed decision, (iii) Quality of Life; is the patient's present or future condition such that his or her continued life might be judged as undesirable and (iv) Contextual Features; are there family and provider issues that might influence treatment decisions. The paper concludes by suggesting that ethical decision-making is challenging for military nurses but all avenues and options should be considered before making any decision.

Reading list

Gross M (2006) Bioethics and Armed Conflict, Moral Dilemma of Medicine and War, The MIT Press

Gross M and Carrick H (2013) *Military Medicine for the 21st Century.* Ashgate

Biography

Janet is a nurse and midwife and also qualified in law. She lecturers in Healthcare Law and Ethics at the University of Hull. She has 25 years' experience in the military as both a regular and reservist in Queen Alexandra's Royal Army Nursing Corps.

Janet is a registrant panellist on the Nursing Midwifery Council's, Fitness to Practise Conduct and Competence Committee. As a member of the British Army Professoriate affiliated to the Royal College of Nursing, she advises nurses in the army who engage in research and ethics. Her research interests include military medical ethics and contemporary ethics in midwifery.

2.30 – 3pm

1.9.2 How can nurses help gypsies and travellers access the immunisations they want?

Room	Westminster Suite
Chair	Tom Sandford
Presenter	Dr Louise Condon, Associate Professor, Swansea University, UK
Co-author	Dr Cath Jackson, UK

Aim

To share recommendations from a UK NIHR Health Technology Assessment research study on how nurses can facilitate gypsies and travellers' access to child and adult immunisations.

Abstract

Gypsies and travellers are recognised as one of the most disadvantaged minority groups in the UK and globally, with poor health status and access to health services (Parry et al 2007, van Cleemput 2010). Immunisation is an important public health intervention which is predominantly delivered by nurses. There is a lack of reliable data about immunisation within the Travelling community. The UNITING study, funded by the National Institute for Health Research (NIHR), is a multi-site, in-depth qualitative study with six traveller communities in four UK cities. The study aims were to explore the barriers and facilitators to uptake of immunisations in traveller communities, and to identify possible interventions to help travellers access the immunisations they want. From 2013-2015 interviews were carried out with over 200 travellers, and professionals who provide health services for travellers. Findings were mapped across the socio-ecological model which recognises that individuals' behaviour is affected by multiple levels of influence (namely, intrapersonal, interpersonal, institutional, community and policy levels (McLeroy et al 1988). Using this model as a framework this paper presents study findings which relate to the practice of delivering immunisations to the traveller community; it also makes recommendations on how nurses can facilitate gypsies and travellers' access to immunisations.

Reading list

McLeroy K, Bibeau D, Steckler A, and Glanz K (1988) An ecological perspective on health promotion programs. *Health Education and Behavior,* 15(4), pp.351-377.

Parry G et al (2007) Health status of gypsies and travellers in England. *Journal of Epidemiology and Community Health*, 6: pp.198-204.

van Cleemput P (2010) Social exclusion of gypsies and travellers: health impact. *Journal of Research in Nursing.*

Biography

Louise Condon holds a PhD in social policy from Bristol University and is currently an associate professor in the College of Human and Health Sciences, Swansea University. Louise enjoyed a long career in the NHS as a midwife, health visitor and then public health manager, before moving to academia in 2010. Throughout her professional and academic career Louise has carried out research into health inequalities, and has a particular interest in the health of black and minority ethnic groups.

3 – 3.30pm

1.9.3 Examining a nursing quality indicator (NQI) framework in evidencing the quality of nursing care

Room Westminster Suite

Chair Tom Sandford

Presenter Dr Dawn Connolly, Nursing Governance Co-ordinator/Research Project, Southern HSC Trust, UK

Aim

The Aim of this study was to examine the use of a nursing quality indicator (NQI) framework in evidencing the quality of nursing care.

Abstract

The NQI Framework links safe and effective indicators, patient safety outcomes, patient experience and nurse's knowledge of individual patient needs, set within the context of a ward. A mixed methods case study design was used. Data was collected from five patients per week, per ward, over a calendar month. Wards comprised medicine, surgery and older people specialties. The methods for collecting data included documentation review, patient stories, and nurse's knowledge of the patient's needs questionnaire mapped to the patient's care plan. In addition, a stakeholder evaluation workshop was facilitated to assess the usefulness of the information gathered.

A total of 53 patients, 22 nurses and 22 stakeholders participated in the study. The findings indicate that applying the NQI Framework, whereby the determinants of quality were viewed collectively, did provide a more comprehensive and balanced picture of the quality of nursing care, as opposed to considering elements singly or in isolation of each other. Therefore analysis on the 'person's care journey' approach rather than individual element reviews is recommended.

Findings should be interpreted in light of two main limitations. The study took place in one HSC Trust in Northern Ireland and relied on three wards as the data source. The sample was restricted by the number of patients who could speak English and were able to give consent to participate in the study.

This study demonstrates a more person-centred approach to the measurement of nursing care by following the care pathway of individual patients and the nurses who cared for them.

Reading list

Maben J et al (2012) *High quality care metrics for nursing*. National Nursing Research Unit, King's College: London

McCance T et al (2012) Identifying key performance indicators for nursing and midwifery care using a consensus approach. *Journal of Clinical Nursing*, 21 (7and8). pp.1145-1154.

Resar R et al (2012) *Using care bundles to improve health care quality. IHI Innovation Series white paper.* Cambridge, Massachusetts: Institute for Healthcare Improvement Available at: www.IHI.org

Biography

Dawn works as a Nursing Governance Co-ordinator/ Research Project Nurse at the Southern Health and Social Care Trust in Northern Ireland. She has a specific interest in developing an integrated framework to measure the quality of nursing care. Improving practice, the patient experience and patient outcomes is central to the work.

Her PhD tested the link between transformational leadership and the quality of nursing care. Specifically, the aim of the study was to describe the association between the leadership style of the ward sister and the quality of nursing care given by the staff that they manage.

2.30 – 3pm

1.9.4 Taking back control of data; how nurses can use it to influence better care

Room Westminster Suite

Chair Tom Sandford

Presenter Naomi Baldwin, Senior Nurse Patient Safety and Performance, Northern Health and Social Care Trust, UK

Co-presenter MaryJo Maxwell, Ward Sister, Northern Health and Social Care Trust, UK

Aim

This is the story of how a simple new system, when introduced in the Northern Health and Social Care Trust, has made things easy for frontline nurses to collect data for immediate understanding of trends and the cause and effect of key measures and performance indicators. Taking control of data, nursing teams truly own the measures they choose to collect information on. Knowing this information provides an early warning of problems, driving actions for improvement. This new system is empowering nurses to better articulate and evidence the care they provide in order to make the best decisions for patients.

Abstract

In the Northern Health and Social Care Trust we have introduced a simple process of data collection coupled with some innovative technology to empower our nurses to objectively articulate evidence of the care they provide to make the very best decisions for their patients.

The Alamac Nursing Kitbag is simple and easy for frontline nursing staff to use, helping them to collect and collate information to immediately understand performance trends and the cause and effect of key measures and performance indicators.

By comparing operational and staffing pressures against quality performance indicators and outcomes, nurses can see in real time the impact that these measures may have on each other for maintaining patient safety and quality of care. Previous data collection systems have always been complicated and difficult for front line staff to analyse but by introducing this new simple system it has allowed better situational awareness, analysis of cause and effect at ward level and is helping nurses to organise data better. Performance can also easily be measured over time, demonstrating first hand to nursing staff the impact of their interventions and actions, enabling them to act swiftly when risks or failures in care are identified.

By taking back control of their data nursing teams truly own the measures they choose to collect information on. Really knowing this information provides an early warning of problems to manage and drive actions for improvements in real time at ward level and across the organisation.

Intended learning outcomes

- Understand how data can be of benefit to improving patient care.
- Identify how information and data collection can be made simple for nursing staff on the frontline.
- Identify the cause and effect of operational pressures on the quality of patient care that data collection can show us.

Biography

Dr Baldwin qualified as a Registered General Nurse in 1987 at the Royal Victoria Hospital, Belfast. She has worked in the speciality of infection prevention and control for 14 years in acute and community settings, completing a Post Graduate Diploma in Infection Prevention and Control in 2008 at Inverness University. In 2009 Naomi attained a PhD with Queens University, for research into the management of MRSA in nursing homes.

Naomi's current role is Senior Nurse for Patient Safety and Performance in the Northern Health and Social Care Trust and is presently undertaking a Leadership Scholarship with the Florence Nightingale Foundation.

MaryJo Maxwell is a registered general nurse and qualified in 2008 and began working in Antrim Area Hospital.

MaryJo has undertaken a Post graduate Diploma in Diabetes care in 2010 at the University of Ulster, and has completed the short course in Respiratory care in 2013 in Queen's University, Belfast. She has worked in Acute and general care since 2008.

MaryJo has been working as a ward sister in an acute medical ward for the last three years and is currently undertaking her specialist practice in Diabetes.

Theme: Knowledge for change and improvement

2 – 2.40pm

1.10.1 Stress and resilience in executive directors of nursing in England and Wales in the wake of the Francis Inquiry

Room	Henry Moore Room
Chair	Elaine Whitby
Presenter	Professor Daniel Kelly, Chair of Nursing Research, Royal College of Nursing and Cardiff University, UK
Co-authors	Dr Aled Jones, UK and Professor Annette Lankshear, UK

Aim

To address the means by which Executive Nurse Directors cope with the competing demands of protecting standards of care despite political, financial and organizational constraints and sustain their resilience.

Abstract

Background: Executive directors in the UK NHS are working under increasing pressure. In common with health care services throughout the world, the NHS is dealing with a rising and simultaneously aging population and, in this time of austerity, increasing fiscal restraint. There have been, in addition, a number of scandals, most notably, but by no means exclusively, that relating to poor care in Mid Staffordshire NHS Trust that resulted in independent and public enquiries and the publication of two detailed reports containing many recommendations specifically relating to the work of executive directors (Francis, 2010, Francis, 2013). These financial and care quality pressures on the UK NHS have implications for Executive Nurse Directors.

Methods: We conducted semi-structured telephone interviews with 40 Executive Nurse Directors in England and Wales in order to address the means by which they cope with the competing demands of protecting standards of care despite political, financial and organizational constraints and to sustain their resilience.

Results: Stressors were both chronic (workload, lack of corporate responsibility for quality, reductions in quality team staffing, tensions between financial solvency and care quality and personal vulnerability) and acute (dealing with complaints and major incidents). Resilience required the support of fellow executives, peers, family and mentors and could be enhanced by self-discipline, good preparation for the post and ongoing coaching.

Conclusion: Recent austerity and scandals relating to quality of care have increased pressure on executive nurse directors, who need clear strategies to maintain resilience. Executive leadership carries inevitable and necessary levels of stress but excessive and largely pointless demands for data can and should be ameliorated. Engendering

resilience requires appropriate role preparation (preferably in programmes that broaden perspectives beyond nursing) proper resourcing, corporate ownership of the quality function and ongoing opportunities for safe and supportive meetings of peers.

Reading list

Jones CB, Havens DS, Thompson PA (2008) Chief nursing officer retention and turnover: a crisis brewing? Results of a national survey. *Journal of Healthcare Management* 53 (2), 89-105; discussion pp.105-106.

Machell S, Gough P, Steward K (2009) *From ward to board: identifying good practice in the business of caring.* London: The King's Fund.

Thorlby R et al (2014) *The Francis report: one year on.* London: Nuffield Trust.

Biography

Professor Kelly is the RCN Chair of Nursing Research and president of the European Oncology Nursing Society (2015-17). His research interests have focused on the impact and experience of illness as well as the potential of nursing and associated NHS workforce issues.

2.30 – 3pm

1.10.2 What is the quality of end-of-life care for those who die at home? A study to explore the views and experiences of bereaved carers

Room	Henry Moore Room
Chair	Elaine Whitby
Presenter	Dr Carolyn Lees, Senior Lecturer, John Moore's University, UK

Aim

This research was undertaken to explore bereaved carers' experiences of end of life care for those who had died at home using a validated tool in order to influence the redesign of the Trust's End of Life Strategy and Implementation Plan.

Abstract

What is the quality of end of life care for those who die at home? A study to explore the views and experiences of bereaved carers'.

Background: The quality of end of life care has been the focus of much government policy. Collecting data from those who are dying is complex (Mitchell, 2002) but it appears that relatives and carers' views provide a valuable evaluation of the patient's end of life care, synergised with their own unique experiences as carers.

Aim: To explore bereaved carers' experiences of end of life care for those who had died at home using a validated tool.

Methods: A mixed method approach comprised of a self completed questionnaire allowing respondents to provide narrative to support their responses. Two hundred and ninety one patients who had an expected death at home were identified. Narrative data from the questionnaires were analysed using framework analysis identifying prominent words and phrases, expanded to include associated key words or themes (Richie and Spencer, 1994).

Results: Four main themes and associated sub themes emerged from the narrative data. The main themes were coordination and continuity of care, competence, compassion and communication. Quantitative data will not be presented here.

Discussion: The findings from this study reflect that generally good quality care was provided for those who died at home. There were examples of well orchestrated care with services working well together, but there were times when adequate support was not evident.

Conclusions: With the number of deaths globally set to increase there is a need to identify tools which measure the quality of end of life care for those who choose to die at home in order to improve the experiences of patients and carers. The CODE questionnaire represents a user friendly, comprehensive tool to achieve this.

Reading list

Mitchell GK (2002) How Well do General Practitioners Deliver Palliative Care? A Systematic Review, *Palliative Medicine,* 16; pp.457-64.

Richie J and Spencer L (1994) *Qualitative Data Analysis for Applied Policy Research* (Bryman and Burgess, eds) Analysing Qualitative Data: London

Biography

Having worked in the NHS since 1982 Carolyn has undertaken a variety of roles which focus on improving the quality of care for patients and carers with the emphasis on using patient stories and research evidence to shape and influence service redesign and policy development. Currently she is a senior lecturer at Liverpool John Moore's University with an interest in promoting nursing research and the use of different methodologies to change patient services and progress nursing knowledge.

3 – 3.30pm

1.10.3 A service evaluation project to explore patient satisfaction associated with specified clinicians in colorectal two-week wait clinics

Room Henry Moore Room

Chair Elaine Whitby

Presenter Karen Cock, Lead Colorectal Specialist Nurse, Royal Cornwall Hospital Trust, UK

Co-authors Rebecca Collins, UK and Debrah Evans, UK

Aim

To determine if patient satisfaction is affected by the clinician (nurse or doctor) conducting the colorectal two-week wait clinic and, if so, explore how the service locally can be improved.

Abstract

A service evaluation project exploring patient satisfaction associated with specified clinicians in colorectal two-week wait clinics.

Background: The implementation of the colorectal two-week wait (2ww) guideline in 2000 has dramatically increased demand on the service, leading to many hospital trusts throughout the country utilising specialist nurses to increase their capacity and meet this demand. The effects of this movement on patient experience has yet to be explored and with the emphasis that health care is placing on the measurement of patient satisfaction this study was undertaken to explore the impact.

Aim: To determine if patient satisfaction is affected by the clinician (nurse or doctor) conducting the colorectal 2ww clinic and, if so, explore how the service locally can be improved.

Method: A prospective non-randomised comparative cohort study of 264, consecutive 2ww patients at the local district general hospital (DGH) divided by blind allocation into two different cohorts (nurse-led and doctor-led) and conducted over a three-month period. Patient satisfaction in both cohorts was assessed by an adapted version of a validated questionnaire. The questionnaire was comprised of 10 positively and negatively worded questions (with a five-point Likert scale for responses) and a free text box for any further comments. All negatively worded questions were reverse scored, ensuring that a low score equated to high satisfaction throughout. The questionnaire was piloted first and was found to have high internal reliability (Cronbach's alpha = 0.91).

Results: The study had a response rate of 77% and overall satisfaction scores showed 76% of patients were highly satisfied. Mean satisfaction scores in the two cohorts were compared revealing that the nurse-led cohort achieved a significantly higher satisfaction than the doctor-led cohort (p=0.000).

Further analysis of the responses to each question demonstrated statistical significance when comparing the two cohorts, although in this study gender did not affect patient satisfaction. Inclusion of a free text box added valuable insight into the patients' experience of the colorectal 2ww service with a 27% response rate and 100% of comments being positive. Through thematic analysis six overarching themes were identified. These themes featured frequently in the literature surrounding patient satisfaction. Communication, health professional's conduct and treatment were also shown to directly affect patient satisfaction.

Conclusions: The study offered patients the opportunity to reflect on service delivery and have a direct impact on the care future patients receive, thus enabling a more responsive approach to health care within the colorectal 2ww service. It provides strong evidence that patient satisfaction is affected by the clinician conducting the 2ww clinic and demonstrated that the nurse-led cohort displayed significantly higher patient satisfaction compared to the doctor-led cohort. The findings support the service at the author's DGH and highlight possible implications for increasing and developing the use of specialist nurses further, within colorectal and other specialties across the Trust.

Reading list

Grogan S et al (2000) Validation of a questionnaire measuring patient satisfaction with general practitioner services, *Quality in Health Care*, 9(4), pp.210–5.

Aljarabah MM et al (2009) Referral letters for 2-week wait suspected colorectal cancer do not allow a "straight-to-test" pathway, *Annals of the Royal College of Surgeons of England*, 91(2), pp.106–9.

BBC News (2002) *Do you prefer doctors or nurses?* Available at: news.bbc.co.uk/1/hi/talking_point/1912767.stm (accessed 25/10/16) (Web).

Biography

After obtaining her registration from Southbank University in 2009, Karen worked for 12 months in Oldchurch hospital (Essex) on a general surgical ward before moving back to Cornwall and starting work at the Royal Cornwall Hospital in the Accident and Emergency department.

In 2001 she transfered over to work on the GI surgical ward and progressed through out the ranks to eventually manage the ward.In 2010 Karen was appointed as the colorectal specialist nurse and then in August 2015 became the lead for the other colorectal specialist nurses and stoma department.

3.30 – 4pm

1.10.4 Partnerships, policy and safe nursing frameworks making safe staffing a commissioning priority

Room	Henry Moore Room
Chair	Elaine Whitby
Presenter	Siobhan McIntyre, Regional Lead Nurse Consultant, Public Health Agency Northern Ireland, UK
Co-author	Rita Devlin, RCN Northern Ireland

Aim

To share the overarching Aim of the project which is to develop a HSC Regional Framework for Safe Nurse Staffing levels to support high quality patient-centred care across hospital and community settings.

- To share the background, context policy drivers, methodology construct and implementation framework of the Northern Ireland regional project 'Delivering Care'.
- To demonstrate the key success achieved through integrated partnership working across a range of health and social care organisations to embedd this project as ministerial Regional Policy Framework for Safe Nurse Staffing levels in Northern Ireland.

Abstract

'Delivering Care' nurse staffing in Northern Ireland is the result of a commission undertaken by the Executive Director of Nursing in The Northern Ireland Public Health Agency from the DHSSPS Chief Nursing Officer and has been approved as DHSSPS NI Policy by the Minister of Health Northern Ireland in 2014.

Aims and Objectives

- To support the provision of quality care which is safe and effective in hospital and community settings by ensuring safe nurse staffing levels are in place.
- To develop a robust framework to determine nurse staffing ranges for the nursing and midwifery workforce in a range of specialities across the nursing and midwifery workforce in Northern Ireland.

Methodology This framework is based on the best evidence available including a range of recognised workforce planning tools, and has been produced in consultation with a wide range of stakeholders including commissioners and service providers, nurse managers, front-line staff personal and public involvement, professional and staff side organisations.

The project is co-ordinating four phases of the framework at present.

Phase 1: General and specialist medical and surgical hospital-based settings (2014)

Phase 2: Emergency departments (2015/16)

Phase 3: District nursing (2015/16)

Phase 4: Health visiting (2015/16)

Future phases are likely to include mental health, learning disability and midwifery care across inpatient and community care settings.

Outcomes: Phase one secured an additional recurrent resource of £10.4 million to meet the recommended nursing requirements for 145 acute medical and surgical wards in N.I. The framework was subsequently endorsed by the Minister for Health as Northern Ireland policy. The process for monitoring and implementing phase one is on-going.

Work is continuing on phases two three and four and it is anticipated that these will be complete by 2016.

The completion of the phases for delivering care will enable the development of definitions and staff ranges for the Northern Ireland nursing and midwifery workforce.

Reading list

Department of Health (2011). *Quality 2020, A 10 Year Strategy to Protect and Improve - Quality in Health and Social Care in Northern Ireland.* Belfast, DHSSPS. Available at: www.health-ni.gov.uk/topics/safety-and-quality-standards/quality-2020 (accessed 25/10/16) (Web).

Francis R (2009) *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009.* London, TSO. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/279109/0375_i.pdf (accessed 25/10/16) (Web).

DHSSPSNI Delivering Care Nurse Staffing in Northern Ireland section 1 and 2 2014 www.dhsspsni.gov.uk

Biography

Siobhan is employed in the Northern Ireland Public Health Agency as the Regional Lead Nurse Consultant with a professional regional portfolio for service improvement and workforce development. She has a lead role in co-ordination of the professional nursing advice to inform commissioning at regional and local level.

Siobhan plays an important role in representing the nursing profession at strategic and local level this work includes working closely with HSCB staff, HSCTs, GPs and primary care representatives and professional bodies. She has established close working relationships with the RCN and nursing colleagues in terms of engaging with frontline staff.

Theme: Knowledge for change and improvement

2 – 4pm

1.11.1 Symposium 2: Research and innovation in the RCN: building the evidence base, building relationships

Room Henry Moore Room

Chair Dave O'Carroll

This symposium will present examples of work produced by the Research and Innovation (Evidence) team as a result of research projects commissioned by internal and external stakeholders. The team is fairly new and has expertise across a range of qualitative and quantitative social science research skills. The projects include systematic rapid evidence reviews and primary research. They all were intended to add to the body of evidence required to support a range of nursing practice and policy problems and were delivered under challenging timelines and high expectations. The focus will be on learning and development; this is brought to life by an early career researcher explaining what it is like to work in social science and nursing.

Reading list

Staniszewska S et al (2014) The Warwick Patient Experiences Framework: patient-based evidence in clinical guidelines. *International Journal for Quality in Health Care* Available at: intqhc.oxfordjournals.org/content/26/2/151 (accessed 25/10/16) (Web).

Paper 1: Rapid evidence review of infusion therapy: a case of informed standards development

Authors and affiliation

Anda Bayliss, Research and Innovation (Evidence) Manager, Royal College of Nursing, UK

Abstract

The RCN Research and Innovation (Evidence) Team was commissioned to design and undertake a rapid evidence review to support the updating of the RCN Standards for Infusion Therapy, last published in 2010. The review aimed to (1) identify the areas with robust/promising/no evidence and evidence identifying harmful practice and (2) identify any gaps in the evidence and agree on where professional consensus is required.

Following agreement by an expert group on the content of the Standards, a four-fold classification scheme was developed to structure the evidence needs: (a) nursing-specific practice where no guidelines exist and/or primary evidence was required; (b) nursing-specific practice where guidelines exist; (c) non nursing-specific practice where guidelines exist from other professions and (d) contextual factors. A mixed collaborative model was adopted and search and review were developed according to this classification. This presentation will report the activity that addressed area (a) above. Specifically the focus was on management, decisions and practices made by health care workers relating to infusion therapy that may affect nursing practice. The outcomes of interest were effectiveness of interventions and safety.

The extensive search strategy was developed and systematic searches and first sift were conducted in-house. Final inclusion, text extraction, quality appraisal and synthesis were both contracted out (for the higher level of evidence to include RCTs and systematic reviews) and in house for the remaining designs.

Overall the level of evidence was medium and gaps were identified in research dealing with safety, non-acute settings and patient perspective. Implications for developing the standards will be discussed.

Paper 2: Rapid evidence review: aspects of clinical practice in infusion therapy

Authors and affiliation

Toni McIntosh, Research Assistant, Royal College of Nursing, UK

Abstract

After a systematic literature search, the results were initially sifted to include only high level evidence (RCTs and SRs). However, while it is widely understood that RCTs provide the gold standard of evidence to inform practice, in nursing research it is often impractical or unethical to conduct RCTs. Therefore by including this review of well-designed non-RCT / SR studies, valuable evidence was uncovered which added to the evidence base and allowed for a more inclusive approach to the Standards development.

The overall volume of studies included in the review was generally low with bloodstream infections receiving most attention and arterial catheters and subcutaneous infusions having no studies included. The overall quality of the studies as assessed within the confines of this review was medium.

Due to the heterogeneity of the studies included, it was not possible to draw any robust conclusions about any single intervention or practice. However when assessed in the context of the evidence review as a whole, the results of this review add to the evidence base and provide useful knowledge for the development of the updated Standards.

Paper 3: Rapid evidence review: the patients' perspectives of infusion therapy

Authors and affiliation
Lynne Currie, Research and Innovation Analyst, Royal College of Nursing, UK

Abstract
Following recognition of the need to update and revise the RCN Standards for Infusion Therapy, last published in 2010, the RCN Research and Innovation (Evidence) Team undertook a rapid evidence review to underpin the process, with the aim of producing evidence-informed guidance to support the delivery of safe infusion therapy across different settings whilst also meeting patients' needs. In addition to looking specifically into clinical nursing practice, a systematic approach was taken to search, identify, map, quality assure and synthesise research evidence to answer the following research question: What are the facilitators and barriers identified from examining and including the patient perspective in the delivery of a range of infusion therapies?

There was particular emphasis in seeking literature for infusion therapy delivered in settings other than acute hospitals. Three databases were searched (CINAHL, Medline and BNI) and an extensive search strategy was developed to include primary studies and reviews published from 2010 onwards, concerning adults and adolescents and located in OECD countries. The initial searches produced 466 papers, which were further sifted for relevance resulting in 22 studies for inclusion (15 qualitative and 7 mixed methods). Quality assessment was conducted using the CASP tool for qualitative research and an in-house tool (based on existing published tools) for the mixed methods studies. Mapping the evidence was informed by the Warwick Patient Experiences Framework and indicated the volume and quality of evidence, context, service setting and whether impact was reported. The evidence was synthesised with a view to providing information to enable the author of the Standards to produce statements of good practice.

Paper 4: How do you do it? Getting started in nursing research

Authors and affiliation
Lynne Currie and Toni McIntosh, Royal College of Nursing, UK

Abstract
Through the medium of dramatized interview this session will offer the opportunity for the audience to hear first-hand of a recent nursing graduate's journey into exploring and experiencing research. Tips, lessons learned, ideas and expectations from academia, professional organisations and employers will be shared.

Paper 5: Enriching policy and practice with research: a tale of collaboration

Authors and affiliation
Julian Russell, Research and Innovation Analyst, Royal College of Nursing, UK

Abstract
The RCN were required to respond to consultations from the Department of Health on proposed changes to Nurse Education Funding, as well as a proposal to introduce a new Nursing Associate role. Scoping meetings were held with a range of internal stakeholders to identify any gaps in our existing evidence, and to understand where policy positions may need to be developed in more detail. Research activities were agreed to investigate these areas, with the Evidence team co-ordinating the subsequent activity. Findings were reported to high-level audiences and incorporated in the RCN's response to each consultation, with the result being a positive response from Government and a commitment to work closely with us when making changes in the key areas identified.

The Clinical Services Accreditation Alliance (the Alliance) is a collection of colleges, professional bodies, patients, regulators and other health bodies created to improve and standardise clinical services accreditation (CSA) to support quality improvement in health settings. The Evidence team undertook a research project on behalf of the Alliance in order to explore the experiences and expectations of potential and current CSA users. The analysis of the data collected informed the strategic thinking of the Alliance. This example of working with external stakeholder was a developmental experience for the team in understanding the client brief and focusing on the core of the request and communication of the feasibility of options.

Tuesday 22 November 2016

Concurrent session 2

Theme: Society, communities, relationships

4.30 – 5pm

2.1.1 Women's experiences of mental and physical health issues in accessing and receiving care

Room	Albert Suite
Chair	Steph Aiken
Presenter	Dr Nicky Lambert, Associate Professor, Middlesex University, UK
Co-author	National Service User Network (NSUN), West Hampstead Women's Centre (WHWC)

Aim

The study explores how women understand their mental and physical health concerns. Women are demographically more likely to experience complex need and they are likely to have that need exacerbated by socio-political constraints like poverty, sexism and violence. If an insight can be gained into ways of better supporting women with complex health needs it is possible to establish good practice guidelines. This co-produced study has been undertaken in partnership at all stages, and care has been taken to ensure this subject has been considered ethically, compassionately and with the help of women in working together.

Abstract

Recent research notes the inequality of mental health service users' access to physical health care and the poor outcomes they experience in terms of ill health and early death (Lambert, 2012); however there is little that is gender specific. It is important that teaching and practice are rooted in an evidence base and one aim is to use this work to continue to raise the profile of physical health within mental health services. It is vital to ensure that physical health – a relatively new field of expertise within mental health nursing is practiced holistically and with personalisation in mind.

Women's specific health needs are highlighted by the reviews of service provision that provide a constant backdrop of change within health and social care; and the guidance paper 'I Am More Than One Thing' (2014) from the Women's Health and Equality Consortium observes this challenge. Van Den Tillaart et al (2009) notes the increased medicalisation of social problems such as poverty, crime, and societal marginalisation and that they affect women's health outcomes more severely. This tension is best encapsulated in Keating et al's (2003) work which noted that services fail to meet women's needs by asking 'what's wrong with this woman?' instead of 'what's happened to this woman?'. The experience of illness is a one which can reach into all aspects of a person's life (social, physical and psychological), the nature of health care has changed from addressing single issues to working with long term complexity and there is a need to build an evidence base of effective interventions.

Our response: A workshop in partnership with NSUN was held with a diverse group of women who have experience of both mental and physical ill health. We worked to co-produce guidance for focus groups to explore women's experiences of having multiple care needs. This group designed the focus group topic guide and participant safety guidelines. This work was used to deliver four focus groups in partnership with WHWC.

Our joint presentation will describe how the process of co-production occurred, will outline the findings and disseminate the outcomes of our project.

Reading list

Lambert N (2012) Understanding and Supporting the Physical Health Needs of Clients, *Mental Health Practice* 15 (10) 15-9

Van Den Tillaart S, Kurtz D, and Cash P (2009) Powerlessness, marginalized identity, and silencing of health concerns: Voiced realities of women living with a mental health diagnosis. *International Journal of Mental Health Nursing,* 18(3), pp.153-163.

Women's Health and Equality Consortium (2014) *I am More Than One Thing*

Biography

Nicky is a proud mental health nurse and an Associate Professor for Practice. She is registered as a specialist practitioner with the NMC and is a Teaching Fellow with the HEA. Nicky works with the CQC as a Specialist Advisor and is a Trustee for West Hampstead Women's centre. She also has a professional Twitter feed (@niadla) and is keen that all people with an interest in mental health engage together as a community to support good practice and challenge discrimination. She has research interests in women's health, physical and mental health, social media and health education.

5 – 5.30pm

2.1.2 A celebration of community nursing over the last 100 years

Room Albert Suite

Chair Steph Aiken

Presenter Dr Crystal Oldman, Chief Executive, The Queen's Nursing Institute, UK

Co-presenter Anne Pearson, QNI Director of Programmes, The Queen's Nursing Institute,UK

Aim

To provide an overview and a celebration of the power of community nursing to make a difference to people's lives over the last 100 years. This will include the establishment of the Queen's Nursing Institute (QNI), through to the present day nursing services – and the vast range of ways in which nurses now engage with the communities they serve, through the whole life course – working in specialist roles in clinics, GP surgeries, residential and care homes, in school, in prisons and in people's homes – and serving our most disadvantaged in society, such as people who are homeless.

Abstract

Nurses working with the community are privileged to develop relationships with people, sometimes over many years, touching people's lives in a truly enduring way which impacts positively on health and wellbeing. This presentation will celebrate their trusted position in society and track the development of the nursing profession in the community over the last 100 years.

Community nurses provide a vast array of services that support individuals, families, carers and communities throughout the life course. They provide public health and prevention services as well as nursing interventions for all ages and conditions; they support the birth of children through to end of life care in people's homes – and every other stage of life in between. They have a particular focus too on working with disadvantaged communities and provide care and support to our most vulnerable in society, including people who are homeless.

The presentation will provide a background and overview of the origin of nursing services in the community, the development of the role of the District Nurse and the establishment of the Queen's Nursing Institute. The central role of community nursing in people's lives over the last century will be celebrated with the voice of service users, alongside Queen's Nurses in practice.

The presentation will bring the celebration of community nursing to the present day – with examples of the significant contribution being made to the transformation agenda in community and primary care and the use of telehealth and technology assisted living to support people to live in their own homes.

The presentation will also cover the ways in which the Queen's Nursing Institute has transformed, to deliver its mission to provide the most appropriate support for nurses, to influence health policy and to champion excellence in nursing care both now and into the future.

Reading list

Queen's Nursing Institute (2014) *2020 Vision Five Years on: Reassessing the Future of District Nursing* Available at: www.qni.org.uk/docs/2020_Vision_Five_Years_On_Web1.1.pdf (accessed 25/10/16) (Web).

Queen's Nursing Institute (2012) *Nursing People at Home* Available at: www.qni.org.uk/docs/Nursing_People_at_Home_web.pdf (accessed 25/10/16) (Web).

Queen's Nursing Institute (2015) *Smart New World: using technology to help patients in the home* Available at:

www.qni.org.uk/docs/Smart_New_World_Web_2014.pdf (accessed 25/10/16) (Web).

Biography

Dr Crystal Oldman is Chief Executive of the Queen's Nursing Institute. Crystal started her career in the NHS in 1975 and worked in clinical practice, mostly in London communities, for 18 years. She then spent 18 years in Higher Education, completing her academic career as Dean, where her role included the development of partnerships to promote evidence based practice and the community and primary care nursing workforce.

Crystal is the Governing Body Nurse of Aylesbury CCG, with an interest in quality assurance and the transformation of community services to meet the national agenda of care being delivered closer to home.

5.30 – 6pm

2.1.3 Exploring the use of cultural safety in nurse education

Room Albert Suite

Chair Steph Aiken

Presenter Dr Jim Richardson, Senior Lecturer (Children's Nursing), Faculty of Health, Social Care and Education, Kingston University and St George's, University of London, UK

Co-author Diana De, UK

Aim

- To define the concept of culture.
- To explore how the idea of culture can be used across nurse education to enhance inclusivity and user experiences.
- To establish the relevance of culture in ensuring positive learning and caring environments.

Abstract
Practice environments have traditionally hosted a wide range of service users. Nowadays though, nursing programmes are also seeing a much more culturally diverse mix of learners. Educators therefore need to consider how this influences teaching and how student learning needs can be addressed to meet the populations' ever changing health and social care requirements. In this paper we describe how the idea of "cultural safety" can promote professionally comprehensive and culturally coherent health care education in both academic and clinical situations.

Recognising through reflection that our actions can have a positive or negative impact on other's health care or learning outcomes is a key principle of cultural safety. It can only be possible to appreciate other's differences, when we begin to gain a more detailed understanding of our own cultural identity and sense of belonging.

Only then will strong, trusting therapeutic relationships forge between the academic or mentor and a student nurse, or the service user and a health professional.

This session will go on to summarise ways of clarifying the key concepts of cultural safety and how these might be deployed in practice to enhance effectiveness and satisfaction in productive learning and more considerate service user experiences.

Reading list
De D and Richardson J (2015) Ensuring Cultural Safety in Nurse Education, *Nursing Times* 111 (39) 17-19

De D and Richardson J (2008) Cultural Safety: An Introduction, *Paediatric Nursing* 20 (2) 39-44

Fadiman N (1997) *The Spirit Catches You and You Fall Down*. New York: Farrar, Strauss and Giroux

Biography
Following qualification, Jim worked in neurology, paediatric anaesthetics and paediatric surgery in Finland and Wales for ten years. Following this he commenced his teaching career at the University of Wales College of Medicine where he delivered the four year Bachelor of Nursing (children's) for over nine years. This was then followed by 14 years at the University of Glamorgan where he co-ordinated the provision in children's nursing, child welfare, midwifery, learning disability nursing and diagnostic ultrasound.

Jim is currently a Senior Lecturer (Children's Nursing) at Kingston University, St George's University of London.

Theme: Society, communities, relationships

5 – 5.30pm

2.2.1 Retired nurse volunteers support vulnerable adults in care homes and hospital

Room Wesley Room
Chair Garrett Martin
Presenter Tanya Strange, Divisional Nurse, Aneurin Bevan University Health Board, UK

Abstract
Aim: The Care Home Ask and Talk (C.H.A.aT) Volunteer Service is an innovative service which uses retired NHS nurses and allied health professionals to support older people living in care homes. The volunteers offer a confidential listening 'ear' to gain valuable feedback on patient experience and quality of life. Feedback is used to improve services for all NHS patients living in residential care and to share and celebrate best practice. Patient and relative feedback has led to the development of a 'trip advisor' for care homes to help patients and relatives see real live feedback from people living in a home.

Introduction: Older people 'struggle' to get their voice heard, especially those with dementia. The Operation Jasmine review into significant abuse in local care homes identified that older people/relatives were not afforded the opportunity to speak about their care experiences. Innovative ways to gather patient feedback and protect patients was needed to improve care/services/experience. C.H.A.aT has enabled:

- Older people/relatives to speak in confidence about their care experiences
- Nurses use feedback to improve services for ALL older people
- Celebration/sharing of best practice
- Rapid identification of potential safeguarding issues/ changes needed
- Joint working for the betterment of older people in society including NHS/Social Services/Patients/ Relatives/Age Cymru/Advocates/Voluntary Sector/UK companies/Care Homes etc

Retired nurses bring a wealth of skill and expertise which can be harnessed to improve patient experience.

Training for Volunteers
The Divisional Nurse in Aneurin Bevan manages the volunteer team. Training has included:

- Protection of vulnerable adults/Deprivation of Liberty Safeguards
- Whistleblowing
- Confidentiality
- Lone working

Engaging Patients
Older people/relatives were fully engaged in the service development. A number of focus groups were held to gain their views on the model, what support they felt would benefit them, whether they wanted to be offered 1:1 or group meetings with volunteers etc. Older people informed the patient information leaflet and the communication prompt. CHAaT has given older people/relatives a voice!

Resource Benefits
C.H.A.aT is cost neutral to the NHS. Funded through NHS Charitable Funds C.H.A.aT utilises the skills of retired NHS staff to determine patients experiences of care. There is a wealth of experience in the NHSRF and it is prudent to use them! A first for Wales/UK, the innovative C.H.A.aT service is yielding significant benefits for NHS patients living in care-homes and supporting the safeguarding agenda.

Benefits to Practising Nurses
Supporting revalidation, patient feedback has been used to improve nursing care and target training for registrants. Training has included:

- Advance Care Planning
- Human Rights
- Communication

New Initiatives from Feedback
Feedback has enabled:

- Additional training for the sector
- Development of a Choice of Accommodation policy
- Development of a 'Trip Advisor' for Care Homes (supported by technology monies)
- Hospital C.H.A.aT Transition pilot- volunteers supporting older people/relatives in hospital make an informed choice on care homes
- Development of 'Prescription for Loneliness' initiative
- Improved multi-agency working to protect older people
- Positive change management

Transferability: C.H.AaT has been fundamental to service re-design which is informed by and maximises patient experiences. C.H.A.aT could benefit every older person living in nursing-homes across Wales/UK. Working in partnership with the Royal Voluntary Service means that locally 3,500 older people now have access to a dedicated volunteer. There is untapped/wealth of experience within the NHSRF.

The model could be adapted to support other vulnerable groups in residential care/own homes. The model is being adapted to provide a befriending service to the socially isolated, something we are now embarking on through our 'Prescription for Loneliness' idea.

Recommended reading:
Older Persons Commissioner for Wales Review 'A Place to Call Home'

My Home Life Cymru Standards for Care Home Life

British Geriatric Society (2011) A Quest for Quality in Care Homes

Biography:
Tanya is a registered nurse with a real commitment towards improving patient experience. Her passion for older people and vulnerable groups has led to the establishment of a number of innovative services that have improved access to healthcare and enhanced patient's lives. These services have won national acclaim. Tanya has won a number of awards including:

- RCN Awards
- Patient Experience Networks National Award
- NHS Wales Awards
- Kate Granger Compassionate Care Award
- Equality and Human Rights Award

Tanya firmly believes that nurses are the drivers of compassionate care and nurse innovation must be shared and celebrated.

5.30-6pm

2.2.2 'The art of nursing': compassion and equality in emergency care

Room	Wesley Room
Chair	Garrett Martin
Presenter	Kerry Anne Wykes, Practice Development Nurse, Emergency Department, Whittington Health, London, UK

Aim
The paper evaluates whether an experimental forum theatre project based on patient narratives can assist nurses and Emergency Department Assistants (EDAs) to develop their interpersonal skills, particularly compassion, and lead to greater equality in Emergency Care. A mixed methods approach was utilised and focuses on the experiences of nurse and EDA participants.

Abstract
Described as 'soft' skills, 'human factors' or more recently the 'Six Cs', interpersonal skills have long been seen as essential to nursing practice. In emergency care these skills include: being adaptable and flexible to a changing workload, critical reflection, analysing complex problems, highly developed communication skills for an increasingly diverse workforce/patient group and practising compassion to ones' self and ones' patients. This innovative project was a collaboration between two hospital trusts and Central School of Speech and Drama students, with funding from the Florence Nightingale Foundation. The project involved three scripting workshops on different aspects of equality in emergency nursing. Participants were encouraged to reflect on particular situations at work which had required advanced interpersonal skills, for instance caring for a patient in mental health crisis or assessing a patient who had experienced domestic abuse. In addition to applied theatre students, contributors included other staff members

(medical/admin) patient educators and representatives from community groups. The aim of the workshops was to provide opportunities for debate and to create a 'menu' of pieces for performance at the final event, scripts were woven together from multiple narratives.

Staff, students and patients were invited to the final event. During this event, the audience were given the opportunity to select which three pieces they wished to see performed. Each piece was performed once all the way through once then, during the second performance, the audience as 'spect-actors' had the opportunity to stop the action and intervene to change the path of events and demonstrate interpersonal skills/ provide compassionate care.

The project was evaluated through a mixed methods study including before-after questionnaires, focus groups and observation of participants in practice, with the aim of demonstrating how this type of experimental project can assist in the development of interpersonal skills and improve equality in emergency care.

Reading list

Mardlin P (2014) *Exploring the usefulness of 'Forum Theatre' as a technique for developing communication skills in nurse education.* Available at: medhealth.leeds.ac.uk/info/810/research/1573/past_papers/8 (accessed 25/10/16) (Web).

Kumagai A et al (2007) Use of interative theatre for faculty development in multicultural medical education. *Medical Teacher*. 29:4, pp.335-340.

Wilson J (2013) Let's all play 'Stigma'! Learning together using forum theatre in collaboration with mental health service users and nurse lecturers. Working papers in health sciences. 1:4, 1-5. Available at: eprints.soton.ac.uk/355719/1/Lets%20all%20play%20Stigma.pdf (accessed 25/10/16) (Web).

Biography

Kerry Wykes is Practice Development Nurse for the Emergency Department at the Whittington Hospital, North London. Working with a diverse patient group in one of the most ethnically and socially diverse areas of London, Kerry emphasises the development of interpersonal skills and cultural competence throughout her training programmes for nurses and EDAs. Kerry's particular areas of interest include recognising and responding to domestic abuse in the Emergency Department, cultural competence and LGBT (lesbian, gay, bisexual, transgender) health and wellbeing. She was nominated as one of Health Service Journal's LGBT role models for the NHS in 2014 and has presented at the European Conference for Domestic Violence. She was also the recipient of a Winston Churchill Travel Fellowship which took her to Bangladesh to investigate the issue of domestic abuse. She has a particular passion for using innovative and experimental teaching techniques to foster excellence in care.

Theme: Technology and innovation

4.30 – 5pm

2.3.1 Nursing in a digital world

Room: Wordsworth Room

Chair: Jason Warriner

Presenter: Gerry Bolger, Imperial College Healthcare NHS Trust, St Mary's Hospital, London

Abstract

This session looks at how information has been important for nursing and with technology and digital tools how this is and will impacting over the generations.

Biography

Gerry Bolger is a leading nurse of over 25 years, with vast experience in the NHS, having led a number of national change programmes both in health and central government. He is the clinical lead for Nursing informatics at Imperial College Healthcare NHS Trust in London. He leads the nursing elements for the ICT directorate enabling transformation solution for patient care enabled by information and IT. Previously he led the measurement and quality outcomes agenda for general nursing care as the Programme Director for the Quality in Caring for the Chief Nursing Officer (CNO) at the Department of Health for England.

Intended learning outcomes

1 Understand how nursing has influenced information to influence health care

2 Understand the drivers around digital health and how this is impacting nursing

3 Be able to describe what the future healthcare is and how nursing practice is going to need to adapt.

5 – 5.30pm

2.3.2 Let's get together - Innovation in action: NI hospice specialist nurses spearhead the use of ECHO

Room Wordsworth Room

Chair Jason Warriner

Presenter Susan Foster, Head of Education/Lecturer of Palliative Care, Northern Ireland Hospice, Belfast, UK

Co-authors Barbara Watson, Northern Ireland and Loretta Gribben, Northern Ireland

Aim

The NI Hospice embarked on a collaboration with New Mexico University to explore the use of Project ECHO (Extension for Community Healthcare Outcomes); a model of education and care management that empowers practitioners to provide better care to more people, right where they live. The aim of the project was to:

- pilot the ECHO Model using an educational governance approach
- determine if this method of learning improved the specialist nurses knowledge and skills in palliative and end-of-life care
- explore their experiences and perceived usefulness of the ECHO Model
- make recommendations for future use of Project ECHO NIH.

Abstract

ECHO (Extension for Community Healthcare Outcomes) uses teleconferencing technology to improve access to specialised care through remotely training health care providers in a supportive environment. In order to determine the efficacy of ECHO in Northern Ireland, Northern Ireland Hospice Education and Research Department, in collaboration with the Director of Nursing and Patient Services and the Clinical Services Manager, Community implemented Project ECHO. Northern Ireland strategic direction for palliative care is driving the development of locality-based services in the community, and with an aging population the complexity of patients being cared for by the Community Hospice Specialist Nurses is increasing. Due to the challenges this presents for NI Hospice Community Specialist Nurses a six-month pilot project was initiated and introduced under the banner of tele-mentoring which enabled Hospice Community Specialist Nurses from eight teams across the province to participate in weekly tele-ECHO sessions, which is a combination of case presentations, education (topics chosen by the specialist nurses), reflection on previous learning, question time and mentoring. The ECHO model links specialist teams at an academic 'hub' with practitioners in local communities, the 'spokes' and encourages the sharing of experiences, discussions on the challenges of caring for patients with complex needs in the community. Project ECHO enabled the organisation to explore the use of technology versus the traditional methods of learning to enable practitioners to learn together in a safe and secure environment with access to the multidisciplinary team. Furthermore Project ECHO proposed to increase the knowledge and skills of the Hospice Community Specialist Nurses and to determine if the model could form part of their access to learning and development without travelling to a central hub. The findings from the evaluation were positive and Project ECHO has been implemented and occurs monthly for the NIH Community Specialist Nurses.

Reading list

Aora S et al (2010) Expanding access to hepatitis C virus treatment--Extension for Community Healthcare Outcomes (ECHO) project: disruptive innovation in specialty care. *Hepatology* 52(3)

Aora S et al (2007) Academic Health Center Management of Chronic Diseases through Knowledge Networks: Project ECHO, *Academic Medicine* 82(2)

Biography

Sue Foster is a Lecturer in Palliative Care and Head of Education at Northern Ireland Hospice. She has been in nursing for twenty six years and has gathered experience of palliative care in a variety of settings. The early part of her career was firmly rooted in the clinical setting working as a Hospice Nurse Specialist before her focus switched to education delivery and research. Sue holds a joint post and works in a collaborative role with the University of Ulster. She leads on the Specialist Nursing Practice Palliative Care course at both undergraduate and post graduate levels in addition to the post-graduate diploma and Masters in Palliative Care. She is interested in all aspects of palliative care education and practice development and has a particular interest on the end-of-life care needs of people with dementia.

5.30 – 6pm

2.3.3 Development of an ECG MOOC for health care practitioners

Room Wordsworth Room

Chair Jason Warriner

Presenter Joanne Gregory, Associate Professor, Kingston University and St George's University of London, UK

Aim

To raise awareness of the role and potential benefits of Massive Open Online Courses (MOOCs) in the continuous professional development of nurses and other health care practitioners.

Abstract

MOOCs are free, open access online courses, which attract high numbers of participants and are facilitated by university academics over a defined timeframe. Initially developed in the US in 2008, they have recently grown in popularity amongst UK universities, due to their potential for widening participation and driving recruitment onto more traditional programmes.

Kingston University and St George's University of London, in collaboration with St George's University Hospitals NHS Foundation Trust, has recently developed and delivered a two-week 'Introduction to ECG assessment' MOOC, designed for pre-registration and inexperienced qualified nurses and paramedics, as well as health care support workers. The MOOC provides a step-by-step guide to undertaking and assessing a 12-lead ECG, using a variety of video demonstrations, quiz questions and lecturer facilitated discussion forums. Over 12,000 people from around the world enrolled on the first run of this MOOC, which was delivered in October 2015. The course attracted 1000s of forum posts and was well evaluated, with a large number of participants reporting changing their practice as a result of the learning. Although access is free, participants also had the opportunity to purchase a certificate of participation at the end of the course, which may provide evidence of continuous professional development.

MOOCs can offer a no-cost, or low-cost opportunity for universities to connect with a large number of people in a shared learning experience which can promote reflection and enhance clinical practice.

Reading list

Department for Business Innovation and Skills (2013) *The maturing of the MOOC: literature review of massive open online courses and other forms of online distance learning.* Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/240193/13-1173-maturing-of-the-mooc.pdf (accessed: 30/11/15) (Web).

Biography

Jo is Course Director for a large BSc Healthcare Practice programme for qualified health care practitioners, and also oversees a Foundation Degree for support workers, study days and bespoke courses within Kingston University's Undergraduate Workforce Development portfolio. Jo has a keen interest in online learning and cardiac care.

Theme: Professional development

4.30 – 5pm

2.4.1 Leadership development: the RCN clinical leadership programme

Room	Shelley Room
Chair	Anne Corrin
Presenter	Nicholas Paterson, Project Manager, Royal College of Nursing, UK

Aim

An overview of the revised Clinical Leadership Programme (CLP), including learning outcomes and models of delivery, following the successful pilot during 2016.

The session will also focus on the programme content, including the Service Improvement Project (SIP) with examples in practice, coaching and action learning elements, patient stories, observations of care, exemplar stories and a look through the reflective workbook and toolkit.

Abstract

The RCN Clinical Leadership Programme was revised and refreshed in late 2015. Since then a number of organisations have been successfully delivering the programme to both cohorts of registered nurses and mix specialty teams. This presentation will look at the CLP pilot, the revised content, the models for delivery and how the different complementary components impact in the workplace. These include real-life examples of SIPs delivered in practice, coaching and action learning, patient stories, observations of care and exemplar stories.

The presentation is ideal for anyone who is interested in nurse and health and social care leadership, is interested in either delivering or attending the CLP or commissioners of professional development.

Biography

Nick Paterson is a project manager at the RCN and has worked on the design and development of various professional development offers, including the Clinical Leadership Programme, Political Leadership Programme, Leadership Masterclasses, Credentialing and Accreditation.

5 – 5.30pm

2.4.2 Leadership development: the RCN political leadership programme – a system leadership approach

Room Shelley Room
Chair Anne Corrin
Presenter James Rodaway, Business Manager, Royal College of Nursing, UK

Aim
An overview of the revised Political Leadership Programme. The need an importance of having senior leaders that understand, can navigate, influence and impact the political structures that drive progress.

This session will also focus on the use of digital campaigns used to understand our customers and position our offer for maximum impact.

Abstract
The RCN Political Leadership Programme was revised and refreshed in 2016. The refreshed programme has been piloted in London, Manchester and Edinburgh. The next cohort will be delivered in London in November 2016.

This presentation will look at the PLP development, the revised content, the importance of being able to impact and influence health care systems and the digital campaigns used to drive marketing of this programme.

The presentation is ideal for anyone who is interested in health and social care leadership; potential participants who have seen the programme advertised or commissioners of professional learning and development.

Biography
James Rodaway is a business manager at the RCN. He manages the main programme of RCN professional work. He has a specific remit to develop new professional products and services that the RCN sells through its Consultancy Service. James has worked on the design and development of various professional development offers, including the Clinical Leadership Programme, Political Leadership Programme, Leadership Masterclasses, Credentialing, Clinical Services Accreditation and Invited Service Reviews.

5.30 – 6pm

2.4.3 Leadership development: Authentic Leadership Development

Room Shelley Room
Chair Anne Corrin
Presenter Tony Fusco, Director, 3D Leadership Ltd, UK

Summary of session:
RCN's new Authentic Leadership Development (ALD) programme works with you to understand how your personality, experience and values define and direct your leadership practice. This evidence-based group-coaching approach to Authentic Leadership enables you to achieve a greater clarity, confidence and congruence in your personal leadership. This group approach to ALD also contributes to the Collective Leadership culture that has been identified as crucial in helping the NHS and other Healthcare organisations meet the modern challenges they face today.

Abstract
In 2015 the Kings Fund Report strongly suggested that what was needed to overcome the challenges the NHS now face, was what they termed Collective Leadership. They define Collective Leadership as leadership that is distributed to wherever capability, expertise and motivation sit and that this ultimately results in increased organisational direction, alignment and commitment. However, the report also notes that a Collective Leadership culture requires not just new skills but also new mind-sets which must be developed collectively and strategically. This session introduces RCN's new Authentic Leadership Development (ALD) programme and shows how it might help contribute to the development of a Collective Leadership culture within the NHS and other healthcare organisations. The RCN's group-coaching approach to Authentic Leadership is the first evidence-based approach to ALD in the management field. It's underpinning RandD has been published in various journals of the British Psychological Society along with evidence demonstrating its efficacy in developing integrated and strategic leadership characterised by increased leadership capacity, confidence and clarity. Additional qualities this ALD programme is proven to develop are those embedded within the NHS Leadership Academy Leadership Model including; Self-awareness, self-confidence, self-control, self-knowledge, resilience and determination - qualities the Leadership Academy believe lead to high quality care and service for patients, carers and families. This innovative group-based approach to Authentic Leadership Development may prove one crucial vehicle for developing and embedding the Collective Leadership culture that is considered vital in helping the NHS successfully respond to the unprecedented financial and service pressures it now faces.

Biography
Tony Fusco is a Chartered Psychologist and Associate Fellow of the British Psychological Society. He specialises in leadership development and as part of his Doctorate in Psychology developed the group-coaching approach

to Authentic Leadership Development (ALD). This is an innovative and highly effective form of ALD that uniquely, has a robust evidence-base underpinning it which has been published in the various Coaching Journals of the BPS. The programme has been run with Exec Directors and Senior Managers from various technical and regulated industries including Nuclear and the NHS and is now offered by the Royal College of Nursing.

Intended learning outcomes

1 Understand the format and benefits of RCN'S new Authentic Leadership Development (ALD) programme

2 Understand the empirical evidence base underpinning RCN's group-coaching approach to ALD

3 Understand how the ALD programme can contribute to the development of a Collective Leadership Culture

Reading list

Fusco, T., O'Riordan, S. and Palmer, S. (2016). *Assessing the Efficacy of Authentic Leadership Group-Coaching.* International Coaching Psychology Review. 11, 2. 6-16.

Fusco, T., O'Riordan, S. and Palmer, S. (2016). *Authentic Leadership is not just about Ethical Leadership* it's also about Strategic Leadership. Coaching Psychology International. 9, 1. 4-10.

Eckert, R., West, M., Altman, D., Steward, K., and Pasmore, B. (2014). Delivering a collective leadership strategy for health care. Kings Fund.

Theme: Conflicts, disaster and recovery

4.30 – 6pm

2.5.1 Symposium 3: Nurses' work in conflicts and disasters – the road to recovery from 1914 to 2016

Room Rutherford Room

Chair Teresa Doherty

This presentation of five symposium papers from members of the history of nursing steering group will showcase current research focus related to the broad theme of conflict, disaster and recovery. Overall, the speakers aim is to explore the role which nursing has had during a pivotal time of conflict, since the early part of the 20th century, to the present day.

Initially, Dr Alison O'Donnell will give a brief overview of the Scottish Women's Hospital at Royaumont, France which went to care for the wounded, uniquely with an all women staff, at the start of the First World War. The main part of this presentation utilises rich archival sources and secondary resources from all grades of staff working at Royaumont to demonstrate the caring roles which were experienced by staff in 1914. This first paper will act as a backcloth to the second presenter, Professor Christine Hallett's presentation which will focus on the challenges of nursing on trains during the First World War. Thirdly, Dr Claire Chatterton will then discuss the realities of this conflict and the psychological trauma that thousands of military personnel experienced. She will discuss medical and nursing responses to what was commonly known as 'shell-shock' and how this changed over time during subsequent conflicts. This will then lead onto the penultimate presentation by Dr Jane Brooks, who will consider the humanitarian side of nursing during the Second World War. Finally, Mrs Margaret Graham will consider different conflicts in a contemporary setting related to the 'Troubles' of Northern Ireland, and the way in which nursing and nurses are attempting to recover from these turbulent times.

This presentation of five papers aims to show that the past and the present is intertwined, and that, in the relationships between history and the present, there remain lessons to be learned.

Reading list

Hallett CE (2014) *Veiled Warriors: Allied Nurses of the First World War*. Oxford: Oxford University Press.

McKenna J, Manzoor F, Jones G, (2009) *Candles in the Dark, Medical Ethical issues in Northern Ireland during the Troubles.* London: The Nuffield Trust.

Reid F (2010) *Broken Men. Shell Shock, Treatment and Recovery. 1914-30.* London, Continuum

Paper 1: 'A gathering of strangers': a Scottish women's hospital, the emerging conflict of 1914

Authors and affiliation

Dr Alison O'Donnell, Retired Honorary Lecturer, University of Dundee, UK

Professor Christine Hallett, BN (Dis), BA, PhD (Medicine), PhD (History), RGN, DN, HV Cert, Professor of Nursing History and Director UK Centre History of Nursing, University of Manchester, UK

Dr Claire Chatterton, PhD, RGN, RNM, Staff Tutor, Faculty of Health and Social Care, The Open University, Manchester, UK

Abstract

The Scottish Women's Hospitals [SWHs] organisation was founded by Dr Elsie Inglis in 1914 at the outbreak of the First World War [WW1] (Leneman 1998). In October 1914, having been rejected by the British establishment, Inglis with the funding and backing of the Scottish Federation of Women's Suffrage Societies approached the French and Serbian authorities to offer help to treat the casualties of WW1 (Crofton 2013).

Given the position of women in society at this time, these SWH hospitals and casualty clearing stations were remarkable units as they were funded, organised, managed and staffed entirely by women. All of the nurses, surgeons,

bacteriologists, cooks, engineers, drivers, orderlies and VADs were women working at the front line in during the WW1 conflicts. In December 1914, SWHs established a hospital at the abbey at Royaumont,

L'Abbaye de Royaumont, 20 kilometres north of Paris (Joz-Rolland 2009).

The main part of this presentation utilises rich archival sources and secondary resources from all grades of staff working at Royaumont. These sources, paralleled with a site visit, will explore the role and delivery of care which the nurses of Royaumont experienced.

Having set the scene and context of caring in Royaumont in 1914, this presentation then leads on to the next paper which explores the advanced roles that nurses had to adopt, and adapt to, on ambulance trains.

Reading list

Crofton E (2013) *Angels of Mercy. A Women's Hospital on the Western Front 1914-1918* Edinburgh: Birlinn.

Joz-Rolland I, (2009) *Royaumont ....Si Loin des Landes écossaises*. Roman: Paris.

Leneman L, (1998) *Elsie Inglis.* Edinburgh: NMS.

Paper 2: The high roads of the war: nurses' work on ambulance trains in the First World War

Authors and affiliation

Professor Christine Hallett, BN (Dis), BA, PhD (Medicine), PhD (History), RGN, DN, HV Cert, Professor of Nursing History and Director UK Centre History of Nursing, University of Manchester, UK

Dr Alison O'Donnell, PhD, MSc, BA (Hons), Dip CNT, RNT, RGN, RNLD, Retired Honorary Lecturer, University of Dundee, UK

Dr Claire Chatterton, PhD, RGN, RNM, Staff Tutor, Faculty of Health and Social Care, The Open University, Manchester, UK

Dr Jane Brooks, PhD, MA, BA (Hons), RNL/PE, RN, Lecturer, School of Nursing Midwifery and Social Work, University of Manchester, UK

Margaret Graham, LLM, RGN, RMN, SCM HV Cert, Retired Commisssioning Manager, Belfast, UK

Abstract

Work on an ambulance train was a highly desired posting for British military nurses during the First World War. Transport nurses travelled to railheads within a few miles of the fighting, and performed essential, sometimes life-saving work which was viewed as an integral part of the war-effort. Early in the war, men were entrained with the mud of the battlefield still clinging to their bodies and uniforms, their injuries covered only with first field dressings and their general conditions weakened by lack of food and water. From the winter of 1914-15 onwards, they were taken on from casualty clearing stations (CCSs) where they would have received necessary treatment, including shock therapy, emergency surgery, wound care and feeding. The work of transport nurses therefore changed as the war progressed. The need to improvise and offer emergency care gave way to the requirement to implement some highly sophisticated techniques, including wound irrigation and tube feeding. Nurses were responsible for stabilising and sustaining patients on long, slow journeys from CCS to base. The paper will examine the ways in which they gave meaning to their highly autonomous and responsible roles, in which decisions had to be taken rapidly, sometimes without medical support, and orderlies had to be closely supervised. Drawing upon a range of primary sources, including nurses' letters, diaries and official narratives, the paper considers both the nature of nurses' work and the ways in which they gave meaning to their wartime experiences. Being 'close to the action' was highly valued; but nurses gave the greatest significant to experiences in which they successfully solved 'nursing problems', enabling them to offer expert physical and emotional care in the cramped, crowded and unsteady environment of a train carriage.

Following on from these two papers which considered the physical care of the wounded, the next paper will explore the psychological care of the wounded, which was pivotal to caring and required to be taken into account by nursing staff at this time.

Reading list

Hallett CE (2014) *Veiled Warriors: Allied Nurses of the First World War.* Oxford: Oxford University Press.

Hallett CE (2009) *Containing Trauma: Nursing Work in the First World War.* Manchester: Manchester University Press.

Harrison M (2010) *The Medical War: British Military Medicine in the First World War.* Oxford: Oxford University Press.

Paper 3: From shell-shock to PTSD: nursing care and approaches

Authors and affiliation

Dr Claire Chatterton, PhD, RGN, RNM, Staff Tutor, Faculty of Health and Social Care, The Open University, Manchester, UK

Dr Alison O'Donnell, PhD, MSc, BA (Hons), Dip CNT, RNT, RGN, RNLD, Retired Honorary Lecturer, University of Dundee, UK

Professor Christine Hallett, BN (Dis), BA, PhD (Medicine), PhD (History), RGN, DN, HV Cert, Professor of Nursing History and Director UK Centre History of Nursing, University of Manchester, UK

Abstract

Psychological casualties first became apparent during the First World War in September 1914, during the retreat from Mons, and the numbers of those affected rapidly grew. By the end of the war, it has been estimated that over 80,000 men had received treatment for mental health problems. Popularly known as shell-shock, there were a variety of symptoms that afflicted mentally traumatised men (and some women) and the possible causes, diagnoses and treatment for their distress was to remain contentious.

This paper explores these issues and discusses both the medical and nursing care that these men received. Famous medical men such as Myers, Rivers and Yealland are frequently discussed in accounts of the treatment of mental disorders such as shell-shock during the First World War, but much less is known about the nurses who assisted them and were expected to provide an environment which would promote and aid recovery.

The experiences of the First World War were to impact on the way that psychological trauma was conceptualised and treated in subsequent conflicts and this will also be discussed and explored in the next paper, the fourth in this symposium, in relation one of the horrors of the Second World War.

Paper 4: So stirred - with pity – shame – remorse... also an increased desire to help: humanitarian nursing with the liberated inmates of Bergen-Belsen Concentration Camp, Spring 1945

Authors and affiliation
Dr Jane Brooks, PhD, MA, BA (Hons), RNL/PE, RN, Lecturer, School of Nursing Midwifery and Social Work, University of Manchester, UK

Dr Alison O'Donnell, PhD, MSc, BA (Hons), Dip CNT, RNT, RGN, RNLD, Retired Honorary Lecturer, University of Dundee, UK

Professor Christine Hallett, BN (Dis), BA, PhD (Medicine), PhD (History), RGN, DN, HV Cert, Professor of Nursing History and Director UK Centre History of Nursing, University of Manchester, UK

Dr Claire Chatterton, PhD, RGN, RNM, Staff Tutor, Faculty of Health and Social Care, The Open University, Manchester, UK

Margaret Graham, LLM, RGN, RMN, SCM HV Cert, Retired Commisssioning Manager, Belfast, UK

Abstract
Although during the Second World War, the Allies had known about concentration camps, it has been suggested that the exaggeration of German atrocities from the First World War had made the British public cynical; therefore many of the stories were treated as stories (Brown 2008: 165). Notwithstanding the veracity of this, there is no doubt that the early liberators were shocked. Sister Molly Silva Jones, a British Red Cross registered nurse wrote of the shame and remorse they felt when they saw the inmates of Bergen-Belsen concentration camp.

Following the initial liberation of Bergen-Belsen in April 1945 nurses from the military and international relief agencies worked in the camp trying to save the lives of those who can be saved. The nurses cared for inmates who suffered from a combination of typhus, dysentery, starvation and TB, once they had saved their lives, they had try to return the living to a semblance of humanity (Brooks 2015). It is this aspect that is often ignored, as all too often the focus has been on the critical issue of saving lives. Given the years of degradation that some of the mostly Jewish inmates had experienced under National Socialism, many had forgotten to consider themselves even part of the human race, thus the humanitarian work of the nurses was essential, if any sense was to be made of the work of life saving.

Using Hunt et al. (2012) criteria for understanding the nature and character of humanitarian assistance, this paper explores the challenges the nurses faced in their work and the strategies they employed to create a space in which the liberated inmates could recover physically and emotionally.

This issue of creating a time and space to try and find some reconciliation from settings of conflict, will be illustrated in the final paper to follow, which considers a recent contemporary setting, and the way in which nurses can support themselves and patients, in an endeavor to start on the road to recovery.

Reading list

Brooks J (2015) The nurse stoops down... for me: Nursing the liberated persons at Bergen-Belsen. IN: Brooks J and Hallett CE (eds.) *One Hundred Years of Wartime Nursing Practices*, 1854-1953. Manchester: Manchester University Press.

Brown K (2008) *Fighting Fit: Health, Medicine and War in the Twentieth Century.* Stroud: The History Press.

Hunt MR at al (2012). The ethics of engaged presence: A framework for health professionals in humanitarian assistance and development work, *Developing World Bioethics* 14 (1): pp.47-55.

Paper 5: Nurses' work in Northern Ireland: from the Troubles in 1969 to Recovery in 2016

Authors and affiliation
Margaret Graham, LLM, RGN, RMN, SCM HV Cert, Retired Commisssioning Manager, Belfast, UK

Dr Alison O'Donnell, PhD, MSc, BA (Hons), Dip CNT, RNT, RGN, RNLD, Retired Honorary Lecturer, University of Dundee, UK

Professor Christine Hallett, BN (Dis), BA, PhD (Medicine), PhD (History), RGN, DN, HV Cert, Professor of Nursing History and Director UK Centre History of Nursing, University of Manchester, UK

Abstract
The Aim of this final presentation is to explore the way in which "story telling" can enable individuals to recover from the stress and trauma of living and working with a prolonged period of conflict. For this presentation, the context and setting was the role which nurses experienced during the conflicts of the 1970s in Northern Ireland.

In 2013, the History of Nursing Network in Northern Ireland (HoN NI) supported by the RCN, published a book of narratives, Nurses' Voices from the Northern Ireland Troubles, detailing the written reminiscences from nurses who had worked through three decades of civil unrest 1969-1998, commonly referred to as 'The Troubles'.

To record this history, focus groups were held across the Province; these were attended by 170 participants and from this, subsequently 100 narratives were submitted, all were analysed and authenticated against contemporaneous records of the time.

The main key findings from this qualitative research study were that even after 40 years many nurses still suffer flashbacks and emotional trauma from their experiences. Nurses themselves suffered bereavement and feelings of loss. Positively, for some of those who could write their narrative, it was a cathartic experience. Some nurses wanted to tell their story but still, even with the passage of time, could not, because their memories were still too painful. Nurses preferred to share their experiences of dealing with trauma, with other nursing friends and colleagues who had shared similar experiences. Political discussions were kept out of the workplace, all casualties were seen as 'patients', and thus the work of nurses is central to caring in whatever setting they find themselves working in.

Reading list

Graham M, Orr J (2013). *Nurses Voices from the Northern Ireland Troubles.* London: RCN Publishing Company.

CAIN (Conflict Archive on the Internet) www.cain.ulst.ac.uk

McKenna J, Manzoor F, Jones G, (2009) *Candles in the Dark, Medical Ethical issues in Northern Ireland during the Troubles.* London: The Nuffield Trust.

Theme: Populations, health and economic growth

4.30 – 6pm

2.6.1 Symposium 4: The community nurse research strategy for Wales: developing knowledge for change and improvement

Room St James Suite

Chair Stuart Abrahams

The Aim of this symposium is to demonstrate how the Community Nursing Research Strategy for Wales has been used to coordinate, support and develop knowledge for change and improvement.

Early data following validation shows a significant increase in the numbers of people 'accepting' the course and a decrease in those 'not responding' and 'DNA'. A simple process, working with patients, has improved access and uptake of this education programme.

Reading list

Wales School for Primary Care Research (2013) *A Community Nursing Research Strategy for Wales* (CNRS). Welsh Government. NISCHR

Welsh Assembly Government (2009) *A Community Nursing Strategy for Wales. Consultation Document*

NHS Wales *Health in Wales: structure* Available at: www.wales.nhs.uk/nhswalesaboutus/structure (accessed 25/10/16) (Web).

Paper 1: The role of the community nursing research strategy national (CNRS) coordinator

Authors and affiliation

Dr Carolyn Wallace, Reader Integrated Care, University of South Wales, UK

Abstract

This first paper describes how the role of the National Coordinator has influenced the development of evidence based practice in Wales.

Reading list

PRIME Centre Wales (2015) Community Nursing Research [online] www.primecentre.wales/community-nursing.php

Kolb DA (1984) *Experiential learning: Experience as the source of learning and development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall

Kenkre J et al (2013) Developing and implementing the community nursing research strategy for Wales. *British Journal for Community Nursing* 18(11) pp.561-566.

Paper 2: Creating an opportunity for community nurses to develop an outline study design in north Wales

Authors and affiliation
Dr Carolyn Wallace, Reader, University of South Wales UK/ Clinical Research Fellow, PRIME Centre Wales, Cardiff, Wales, UK

Dr Lynne Grundy, Head of Nursing and Midwifery Education, Research and Professional Practice, Betsi Cadwaladr University Health Board, North Wales, UK

Abstract
This second paper gives an example of how an introductory research master class and consensus workshop can provide nurses with an opportunity to be involved in research for the development of evidence based practice.

Reading list
PRIME Centre Wales (2015) Community Nursing Research [online] www.primecentre.wales/community-nursing.php

Betsi Cadwaladr University Health Board (2015) *About Us* [online] www.wales.nhs.uk/sitesplus/861/page/40836

Kolb DA (1984) *Experiential learning: Experience as the source of learning and development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall.

Paper 3: Working together to develop the family resilience assessment instrument and tool for health visitors

Authors and affiliation
Georgina Jones, Health Visitor, Abertawe Bro Morgannwg, University Health Board, UK

Dr Carolyn Wallace, Reader,PhD, MSc, PGCE, BSc (Hons), RGN, USW UK/ Clinical Research Fellow, PRIME Centre Wales, Cardiff, UK

Prof. David Pontin, Aneurin Bevan Chair of Community Health, USW, UK

Sue Thomas PhD Student and RCBC Fellow, University of South Wales, UK

Michelle Thomas, Senior Lecturer, USW, UK

Liz Wilson, Flying Start, Hywel Dda University Health Board, UK

Fran Dale, Retired Health Visitor Advisor, UK

Abstract

Aim
This third paper will illustrate how developing the Family Resilience Assessment Instrument and Tool (FRAIT) (phase one) has led to health visitors' (HV) conceptual understanding of family resilience and increase their participation in research.

Background: HVs work with a wide range of families; some are more resilient than others in times of crisis and may need support to overcome difficulties. Between December 2014 and November 2015 researchers and HV practitioners developed a study to explain HV conceptual understanding of family resilience. This informed the development of the FRAIT which identifies situations when families may not be able to address life difficulties, which may interfere with child health and development outcomes. This is now included in the Welsh Government 'Healthy Child Programme'.

Method: Group Concept Mapping enabled several stages of instrument development to be addressed, including; theory development, items design, and items selection1. Group Concept Mapping methodology with a web-based interface (Concept Systems Global MAXTM) allowed participants to perform brainstorming, sorting, and rating activities from anywhere in Wales where they had access to a web browser. A total of 62 HVs were invited to brainstorm and complete the single focus prompt, '"When assessing a family's resilience, a specific aspect to look for is....."' The participants were then asked to sort and rate the statements using two scales – essential and importance.

Results: Forty-four (44) respondents generated one hundred and seventeen (117) statements. Following the sorting and rating (essential and importance) these were analysed using multi-dimensional scaling and hierarchical cluster analysis3. The resultant maps demonstrated that the concept of family resilience consisted of five clusters Socioeconomic Factors, Responsive Parenting, Family Support, Family Health and Engagement.

Conclusion: Concept Systems Global MAXTM has been used as a mechanism to engage HVs across Wales in a research study which developed the FRAIT to increase health visitor knowledge and improve practice across Wales.

Reading list
Trochim W and Kane M (2005) Concept Mapping: an introduction to structured conceptualisation in health care. *International Journal for Quality in Health Care* 17, 3, pp.187-191.

Concept Systems Incorporated (2015) Concept Systems Global Max™. Concept Systems Incorporated. Ithaca, NY, USA. Related literature is available for download from www.conceptsystems.com/content/view/the-concept-system.html (accessed 15/11/2015)

Kruskal J and Wish M (1978) Multidimensional Scaling. Sage University Paper series on Quantitative Applications in the Social Sciences 07-011. Sage Publications.

Paper 4: Using Rasch analysis to validate a community-based patient complexity instrument

Authors and affiliation
Sue Thomas, PhD student (RCBC), University South Wales, UK

Dr Paul Jarvis, PhD Computing, BSc Computing Maths, PGCE (Maths), University of South Wales, UK

Dr Ruth Davis, PhD, MPhil, BN, RN, NDN Cert, PGCE, Retired, UK

Abstract
This fourth paper illustrates a PhD student's progression towards a principal investigator role through phase two of her study to validate a patient complexity instrument for use by district nurses. This study and the student's development has been supported by the Community Nursing Research Strategy for Wales.

Reading list
Rasch G (1960 and 1980) *Probabilistic Models for Some Intelligence and Attainment Tests.* University of Chicago Press, Chicago

Tractenberg R (2010) Classical and modern measurement theories, patient reports, and clinical outcomes. *Contemporary Clinical Trials*. Vol. 31(1), 1-4

Andrich D, Sheridan B and Luo G (2008) Rasch Unidimensional Measurement Model (RUMM) 2030 (Computer Software) RUMM Laboratory, Perth, Australia

Paper 5: Managing the knowledge needed to manage medicines

Authors and affiliation
Dr Sue Jordan, Reader, Swansea University, UK

Marie Ellenor Gabe-Walters, College of Human and Health Sciences, Swansea University, UK

Dr Alan Watkins, College of Medicine, Swansea University, Swansea, UK

Ioan Humphreys,College of Human and Health Sciences, Swansea University, UK

Louise Newson,College of Human and Health Sciences, Swansea University, UK

Dr Sherrill Snelgrove, College of Human and Health Sciences, Swansea University, UK

Prof. Michael S Dennis, College of Medicine, Swansea University, Swansea, Wales, UK

Abstract

Aim
Packaging knowledge in formats convenient to busy clinicians may improve delivery and outcomes of care, cf. the WHO Surgical Checklist. This principle can be applied to minimise any adverse effects of medicines, and ensure the best use of medicines. We aimed to pilot nurse-led medicines' monitoring using the West Wales ADR (WWADR) Profile for Mental Health Medicines. This is a paper from one of our well-established Community Nursing Research Strategy network members.

Background: Preventable Adverse Drug Reactions (ADRs) (side-effects) account for: 5-8% UK unplanned hospital admissions, and £1-2.5bn NHS costs annually1. Over-prescribing amongst older adults is rife and linked to hospitalisations. However, adverse consequences of untreated conditions are equally common in primary care. Failure to monitor patients is a greater problem than poor prescribing, and nurse-led monitoring is one option.

Methods: We undertook a pragmatic cohort stepped-wedge cluster randomised controlled trial of nurse-led medicines' monitoring versus usual care in five private sector care homes, involving 41 service users, taking at least one antipsychotic, antidepressant or anti-epileptic medicine. Nurses completed the WWADR Profile with each participant according to trial step.

Information on problems addressed and changes in medicines prescribed was collected from participants' notes before randomisation and after each of five monthly trial steps. The Profile's impact was explored in multivariate analyses, accounting for trial step and site.

Results: Five of 10 sites and 43 of 49 service users approached participated. The intervention increased the mean number of problems addressed from 6.02 [SD 2.92] to 9.86 [4.48], effect size 3.84, 95%CI 2.57-4.11, P <0.001. For example, pain was more likely to be treated (adjusted Odds Ratio [aOR] 3.84, 1.78-8.30), and care plans addressed medicine-related problems. Profile use was associated with reduction in mental health medicines (aOR 4.45, 1.15-17.22).

Conclusions: The WWADR Profile can improve the quality and safety of care, and warrants investigation as a strategy to mitigate known adverse effects of prescribed medicines2.

Intended learning outcomes
At the end of this session, participants should be able to discuss:

- the implications of ADRs for nursing practice
- the implications of ADRs for patients
- strategies to reduce the impact of ADRs on patients.

Reading list
NICE Medicines and Prescribing Centre (2015) *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.* NICE guideline 5. NICE: London. 2015. Available at: www.nice.org.uk/guidance/ng5/evidence/full-guideline-6775454 (accessed 25/10/16) (Web).

Jordan S et al (2015) Nurse-Led Medicines' Monitoring for Patients with Dementia in Care Homes: A Pragmatic Cohort Stepped Wedge Cluster Randomised Trial. Available at: journals.plos.org/plosone/article?id=10.1371/journal.pone.0140203 (accessed 25/10/16) (Web).

Taylor D, Paton C, Kapur S (2015) *The Maudsley Prescribing Guidelines*, 12th Edition, Oxford: Wiley Blackwell.

Theme: Populations, health and economic growth

4.30 – 5pm

2.7.1 All our health – health care professionals: a vital resource for improving the health of individuals

Room	Churchill Auditorium (main hall)
Chair	Irene Gray
Presenter	Professor Viv Bennett, Chief Nurse, Public Health England, UK
Co-authors	Charlotte McArdle, UK; Jean White, UK; Fiona McQueen, UK and Siobhan O'Halloran, UK Republic of Ireland

Aim

To promote the work of the *All our Health* programme, particularly the progress of the Five Nations Network, and enthuse participants to support the ambition to drive a social movement of change to maximise the contribution of nurses, midwives to prevention of illness, health protection and health promotion.

Abstract

The Chief Nurses of the Five Nations (England, Wales, Scotland, Northern Ireland and Republic of Ireland) have led on a commitment to work together to share and learn from each other and develop tools on shared priority areas.

The Five Nations Network, facilitated by Public Health England, has been working to:

- maximise the contribution of nurses, midwives (and where appropriate on country basis allied health professionals and other health care professionals) to prevention of illness, health protection and health promotion
- build the UK and Republic of Ireland as leaders in 'population health nursing and midwifery'
- support the public health nursing and midwifery contribution to WHO Health 2020
- produce products and tools to promote engagement and health promoting practice. The 'Toolkit' that underpins the All our Health programme has been adapted to include a Five Nations approach to obesity (to be published shortly with the next version of the Toolkit). The work aims to prioritise learning disabilities and diabetes in the next phase of work.

The presentation will promote the work of the *All our Health* programme, particularly the progress of the Five Nations Network, and enthuse participants to support the ambition to drive a social movement of change to maximise the contribution of nurses, midwives to prevention of illness, health protection and health promotion.

Reading list

PHE (2014) *Framework for personalised care and population health: Resource to support nurses, midwives, health visitors and AHPs to access best evidence for practice and deliver their public health role.*

WHO (2015) *European strategic directions for strengthening nursing and midwifery towards Health 2020 goals*

WHO (2015) *Nurses and midwives: A vital resource for health. European compendium of good practices in nursing and midwifery towards Health 2020 goals*

Biography

Professor Viv Bennett is Public Health England's Chief Nurse and the principal adviser to the government on public health nursing and midwifery.

Between 2012 and April 2015 she was joint Director of Nursing for the Department of Health and Public Health England and led for Health Visitor and 0-5 transition programmes

Viv is leading on developing the important role that all health care professionals play in protecting and improving the public's health. Within the strategic framework of the *Five Year Forward View* and *From Evidence into Action* Viv is leading the PHE programme *Personalised Care and Population Health* and the related programme for the UK and Republic of Ireland *Nurses and Midwives Caring for the Public's Health.*

5 – 5.30pm

2.7.2 The role of nurses and midwives in prevention and population health

Room	Churchill Auditorium (main hall)
Chair	Irene Gray
Presenter	Joanne Bosanquet MBE, Deputy Director of Nursing, Public Health England, London region, UK
Co-presenter	Professor Viv Bennett, Chief Nurse, Public Health England, UK

Aim

To demonstrate how the role of nursing and midwifery has influences prevention and population health nationally and internationally.

Abstract

The Public Health England (PHE) Chief Nurses Directorate would like to deliver a symposium on the role of nurses and midwives in prevention and population health and in so doing demonstrate how the professions have historically led in many areas of public health and how today are a vital resource to meet the health challenges of 21st century nationally and internationally.

The symposium will be delivers in three sections:

The first part will start with an overview of how all nurses have skills and knowledge in public health and how this has been embedded into practice from the early insights of Florence Nightingale until today and will showcase the 'All Our Health' programme and toolkits for supporting all nurses and midwives in 'Prevent illness Protect health Promote wellbeing'.

The next section will convey an insight into the changing roles and opportunities modern day public health nurse. It will identify the specialist nurse role in the areas such as health protection, health visiting, school nursing, practice nursing and how these evolving roles have influenced health and wellbeing of our current UK populations.

The last section will explore the future, identifying new programmes of work being led by PHE in public health nursing both nationally and internationally.

- Development of the nurse consultant role in public health.
- The work across the UK and RoI 'Five nations nursing midwifery and population health'.
- All OUR Health programme and toolkit.
- Developments with World Health Organisation (WHO).
- UK as leader in public nursing and midwifery.

The symposium will finish with a celebration of the nursing role and the importance of Public Health in the modern day training of nurses

The symposium will be presented by Professor Viv Bennett, Chief Nurse for PHE and Nicky Brown, Senior Nurse, PHE London Region

Reading list

Department for Health and Public Health England (2014) *A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals* Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/377450/Framework_for_personalised_care_and_population_health_for_nurses.pdf (accessed 25/10/16) (Web).

Biography

Joanne Bosanquet has held the position of Deputy Chief Nurse at Public Health England since 2013. Her role is to establish a prolific stakeholder relationship with the Nursing and Midwifery Council and other professional organisations as part of PHE commitment to the Public Health Workforce Strategy, and to build an appropriate skilled multidisciplinary public health workforce. She qualified as a Registered General Nurse in 1992, Joanne's knowledge and experience was applied to great effect working in a deprived London borough, specialising in care for vulnerable groups, including asylum seeking families, and unaccompanied minors. Joanne was then recruited to set up a nurse-led Personal Medical Services pilot in Doncaster in 2002. She later became a Nurse Consultant in Health Protection at the Health Protection Agency, selected as a member of the Health Protection team for the 2012 Olympics. She now holds academic posts at London Metropolitan and Greenwich Universities.

She was appointed as a Queens Nurse and awarded an MBE for her services to nursing and health care in June 2013.

Joanne's passion is person-centred care. She strives for an inclusive health and care system where the individual, community and population are at the centre of decision making.

5.30 – 6pm

2.7.3 Leaders or laggards? Nurse education and employment in Malta over the last few decades

Room	Churchill Auditorium (main hall)
Chair	Irene Gray
Presenters	Dr Maria Cassar, Senior Lecturer, and Maria Navarro, Lecturer, University of Malta, Malta
Co-author	Maria Navarro, University of Malta, Malta

Aim

The Aim is to present and discuss, how and why nurse education and employment has evolved in Malta over the last few decades.

Abstract

As with other countries nurse education and nursing employment in Malta has evolved from a hospital-based, apprentice-type training and non-professional employment status of the 1980s, to the current university-based pre- and post- registration education programmes, and professional warrant employment status at the work place. In this paper, the socio-political influences and outcomes of the period, and the economic implications of the referred development and change in nurse education and training are discussed, against a backdrop of the identified challenges and threats, enhancers and enablers towards such development and change. These include the prevalence of a dominant medical profession,very low percentage of females in the country's overall workforce and heightened demand for accountable and evidence-based care delivery. Reported economic implications are discussed in view of the employment and payment conditions that have changed significantly over the latter third of the century. The level of congruence between economic growth associated with nursing in Malta, as an EU member state in the Mediterrean, and that experienced in other countries, is explored in an attempt to determine Malta's position across a leader – laggard spectrum of development and change, in nurse education and employment, registered globally.

Reading list

Fenech Adami M, Kiger A (2004) A study of continuing nurse education in Malta: the importance of the national context, *Nurse Education Today* 25, pp. 78-84.

European Training Foundation (2000) *An overview of vocational Educational and Training in Malta.* Turin, Italy - www.etf.eu.int/etfweb/nsf/pages/downloadmalta

Fenech Adami M (2002) *The adequacy of the Nurse Education System in Malta* Unpublished PhD dissertation, University of Aberdeen, Scotland

Biography

Dr Maria Cassar trained to become a nurse at the University of Malta in the early 1990s. She later pursued post graduate studies in the UK. Her PhD studies focused on the development of nurse education in Malta in view of the challenges and opportunities defined at the turn of the 21st century. She is currently a senior lecturer at the Department of Nursing at the University of Malta.

Theme: Knowledge for change and improvement

4.30 – 5pm

2.8.1 Children's cancer nursing: past, present and future

Room Abbey Room

Chair Paula Hancock

Presenter Angela Houlston, Matron, The Children's Hospital, Oxford, UK

Aim

This concurrent session will show how the development of children's cancer nursing has contributed to improved outcomes in the treatment and care of children and young people with cancer over the last 50 years. It will demonstrate that nursing has been fundamental to the development of the speciality and the changes which have led to improved service provision. It will outline the key role played by the Paediatric Oncology Forum of the Royal College of Nursing (RCN) in the establishment of the clinical and professional nursing knowledge base, the growth of nursing research, and the use of evidence in practice.

Abstract

In the 1960s, children with cancer and leukaemia in the United Kingdom (UK) were looked after by general paediatricians and children's nurses. Cancer was considered to be fatal, and the focus of nursing care was palliative.

Early advances in treatment were made in the United States of America, and paediatricians from the UK crossed the Atlantic to train and return to the UK to develop treatment, and the multidisciplinary teams, and services required. This new breed of 'paediatric oncologist' recognised the need to share information, work together in the developing speciality, and collaborate on clinical trials. As treatment became centralised, and the speciality began to develop, the importance of nursing skills, knowledge and expertise was increasingly apparent to both doctors and nurses working in the field.

In 1984 a group of nurses working with children with cancer met together under the umbrella of the Royal College of Nursing to establish a network for communication and support in order to improve treatment and care. The Paediatric Oncology Nurses Forum thus became the first paediatric network within the RCN.

Over the last thirty years the forum has driven the development of children's cancer nursing. This presentation will outline the breadth of the clinical and professional nursing knowledge base within the speciality, the growth of research and the use of evidence in practice. It will show how children's cancer nurses have contributed to clinical, professional and health service guidance. It will demonstrate how nurses work closely with multidisciplinary colleagues, third sector partners, alongside children, young people and their families to continue to lead change and improve services and treatment outcomes in the UK.

The presentation will discuss the international work of the Forum, with collaborative partnerships in education and research. Nurses are active in lobbying and advocating for the care of children with cancer across the globe. In the UK today, almost 80% of children will be cured of their disease; in low income countries less than 20% of children with cancer will survive. Nurses are working with international partners to develop standards of nursing provision to help address that disparity.

Reading list

Challinor J et al (2014) Educational Needs and Strategies of Pediatric Oncology Nurses in Low- and Middle-Income Countries. *Cancer Nursing* 37 (4) E36-47

Gibson F et al (2015) Building the Evidence for Nursing Practice; Learning from a Structured Review of SIOP Abstracts 2003 – 2013, *Pediatric Blood and Cancer* Published On Line 14 July 2015 DOI: 10.1002/pbc.25652

Hollis R and Hooker L (2009) Improving Outcomes: Update on Progress, *Paediatric Nursing.* 21 (4) 14-18

Biography

Angela Houlston RGN, RSCN, BSc Hons, MSc was until recently Matron of the Children's Hospital part of Oxford University Hospitals NHS Foundation Trust. This role covered the day-to-day running of the hospital, incorporating a wide range of clinical specialties. She previously worked at the hospital in various roles including Ward Sister and Lead Nurse for Children's Cancer. She was a member of the Steering Committee of the RCN Paediatric Oncology Nurses Forum and on the Editorial Board of the Children's Cancer and Leukaemia Group (CCLG) Parent's magazine.

5 – 5.30pm

2.8.2 A jewel in the crown of the NHS: the evolution of a specialist trophoblastic service in Sheffield

Room	Abbey Room
Chair	Paula Hancock
Presenter	Jane Ireson, Clinical Nurse Specialist, Weston Park Hospital, Sheffield, UK

Aim

The UK Gestational Trophoblastic Disease (GTD) service is one of the National Health Service's (NHS) great success stories. After the service was centralised in 1973, two centres were developed in Sheffield and London to monitor and treat this rare complication of pregnancy, where part of the placenta grows abnormally and can become cancerous. During the last 40 years the service in Sheffield has evolved in line with knowledge highlighting the importance of a holistic person-centred approach within a bio-psychosocial, not a biomedical model of health. The specialist nursing team now co-lead the service and are able to offer exemplary standards of care.

Abstract

Gestational Trophoblastic Disease (GTD) is a rare complication of pregnancy, where part of the placenta grows abnormally and can become cancerous. The United Kingdom's (UK's) GTD service is the envy of the world, as it is the only GTD service that has been centralised allowing each GTD patient in the UK access to a specialist GTD multidisciplinary team (MDT) and a world leading surveillance and treatment programme. There are only two surveillance and treatment centres for GTD in the UK, based in Weston Park Hospital, Sheffield, and Charing Cross Hospital, London. In Sheffield, the nursing team has evolved and is now pivotal to the MDT. The UK GTD service was first centralised in 1973 and in the beginning the GTD service was based on a bio-medical approach to health and there was little psychological care for women and their families as they faced not only the loss of a pregnancy, but also a potentially cancerous, life threatening condition. The knowledge gained on the benefits of a nurse specialist role for cancer patients, combined with research into the psycho social impact of GTD in the 1990s was the trigger for the appointment of the first GTD nurse specialist in 2000. Since this time the role has evolved, where three nurse specialists now work with a high degree of autonomy and minimal medical supervision to provide holistic, person-centred care to all GTD patients. GTD is a very rare, often misunderstood condition even for experienced gynaecologists, and the specialist input we can offer to patients and their local clinicians has had a huge impact on the patients' experience of care. Each nurse specialist is highly skilled to provide clinical and supportive care, and also has a fundamental role in GTD education and research, and the strategic development of the service locally, nationally and internationally. The UK GTD service has the highest cure rates and the lowest use of chemotherapy in the world, and is also able to offer exemplary standards of patient care. It is a service that the NHS can be proud of, and should be celebrated on a national level.

Reading list

Ireson, J., Singh, K., Gillett, S., Hills, A., Everard, J., Winter, M., ... and Hancock, B. W. (2013). Evolution of a specialist gestational trophoblastic disease service with a major nursing component: the Sheffield, United Kingdom, experience. The Journal of reproductive medicine, 59(5-6), 195-198.

Seckl MJ, Sebire NJ and Berkowitz RS (2010) Gestational trophoblastic disease, *The Lancet*, 376(9742), pp.717-729.

Tidy J and Hancock BW (2010) The management of gestational trophoblastic disease. *Green-top Guideline,* (38), 1-11.

Biography

Jane has been a clinical nurse specialist within Sheffield's regional unit for the screening and treatment of Gestational Trophoblastic Disease (GTD) since 2010. With a background in health service research in infectious diseases Jane moved into nursing to get closer to patient care, and

has worked in various posts as an oncology nurse in the Royal Marsden, London and Weston Park, Sheffield. Her current role combines the clinical care of GTD patients with teaching and research, where she is currently incorporating an online assessment into the care of GTD patients during and after chemotherapy.

5.30 – 6pm

2.8.3 Keeping frail and elderly people safely at home

Room Abbey Room

Chair Paula Hancock

Presenter Jenny Jarvis, Clinical Lead Community Treatment Team, Grays Court Community Hospital, Dagenham, UK

Co-authors Lea Agambar, UK; Deb Richmond, UK

Aim

The Community Treatment Team, a NELFT initiative, works in innovative ways to keep frail and elderly people safe in their own homes. Taking referrals at a time of crisis and using team working and collaboration to keep people safely at home preventing acute hospital admission, saving money and promoting independence, ensuring dignity and prioritising people.

Abstract

The Community Treatment Team (CTT), a NELFT NHS Foundation Trust initiative, is made up of nurses, geriatricians, occupational therapists, physiotherapists, social workers, support workers and administrators. The service provides short-term intensive care and support to people experiencing an urgent health care need or social crisis. The service is for adults living in Barking and Dagenham, Havering or Redbridge, and every day between 8am and 10pm.

The team aims to contact patients within two hours and support them to remain at home rather than them going to hospital. The team sees patients that are experiencing pain, difficulty in moving following a fall, difficulty in breathing, infections such as chest, UTI's and skin infections. The team can also administer IV antibiotics for lower limb cellulitis.

The team also works within the Emergency Department at Queens Hospital where therapists assess patients and support them to return home without hospital admission. At discharge the team liaises with the patients' GPs informing them of the team's involvement and the treatment the patient has received.

The nurse paramedic response service was set up in October 2014 following an audit that was carried out in our local emergency department (ED) in October 2013.

The audit found that 34% of conveyances to the ED by the London Ambulance Service were patients over the age of 75; significant proportions of these patients had fallen but interestingly were discharged home the same day with little intervention. Frailty academy provided by HENCEL and UCL Partners facilitated the work we have achieved with this project by providing teaching around quality improvement methodology.

Our aim was to reduce unnecessary conveyance and admission to ED for frail and elderly fallers. This was achieved by setting up a fast response vehicle provided by the LAS with an experienced paramedic and a CTT (NELFT) nurse to attend to low acuity fallers, with the intention of keeping patients at home wherever safe to do so.

The savings are clearly documented on the supporting poster and the monthly feedback is overwhelmingly positive. The service is successful both on a financial front and patient experience.

Reading list

www.england.nhs.uk/wp-content/uploads/2014/10/wint-press-rep-2014.pdf

Kings Fund (2014) *Making our health and care systems fit for an ageing population*

The Keogh Urgent and Emergency Care Review

Kings Fund (2012) Older people and emergency bed use Available at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf (accessed 25/10/16) (Web).

Biography

Jenny Jarvis is the Clinical Lead for the innovative and evolving Community Treatment Team working for NELFT NHS Foundation Trust. Prior to this she was working as a nurse practitioner within the team. She has extensive experience in acute hospital. She worked in Whipps Cross AandE for many years before spending a couple of years at Queens in Romford, which is one of the busiest emergency departments in the country.

Jenny has also worked in the community for a respiratory team. This experience and knowledge has lead to a great interest in developing care for community patients in acute crisis. She is excited by change and innovation and enjoys the challenge of developing new ways of working.

Theme: Knowledge for change and improvement

4.30 – 5pm

2.9.1 ANA's health risk appraisal: insight into RN health, safety, and wellness

Room: Henry Moore Room

Chair: Christian Beaumont

Presenters: Holly Carpenter, Policy Associate, American Nurses Association, USA and Mary Jo Assi, Director, Nursing Practice and Work Environment, American Nurses Association, USA

Aim

Real time data is not readily available detailing nurses' unique health, safety, and wellness risks data. Therefore, American Nurses Association, in collaboration with Pfizer Inc, developed a nurse-specific health risk appraisal (HRA). By examining preliminary findings from the HRA, trends and priorities emerge, assisting registered nurses and nursing students in establishing healthier and safer professional and personal lives.

Abstract

Real time data detailing nurses' unique health, safety, and wellness risks is not readily available, particularly for older age groups and males. In response, the American Nurses Association, in collaboration with Pfizer Inc, developed a nurse-specific health risk appraisal (HRA) and web wellness portal to identify, refine, and assist nurses in identifying and addressing these risks. The HRA is a free, HIPAA-compliant, web-based survey, open to all registered nurses (RNs) as well as students enrolled in a nursing program leading to RN licensure. It complies with the United States' Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted to protect individually identifiable health information. Launched on November 18, 2013, over 9000 participants have taken the HRA to date. Participants complete the HRA which includes questions about their work environment and personal health and wellness. At completion, participants view their confidential results in an interactive stoplight graph. Within the graph, participants can access their results and compare them to the ideal target as well as national averages. Participants can also link to resources and educational materials aimed at improving health for identified risk areas. Survey work environment topics include hazardous exposures, safe patient handling and mobility, and sharps safety. The wellness focus includes nutrition, physical activity, stress reduction, tobacco use cessation, moderation in alcohol consumption, general safety practices, preventive immunizations/screenings, and healthy sleep. The goals of the survey are twofold: first, to help nurses identify their personal and work environment health, safety, and wellness risks, and access tools and resources to address these risks. Second, the HRA gathers nurse-specific data to identify trends and issues that will assist individual nurses and professional organizations in setting priorities to improve the health, safety and wellness of nurses. Preliminary findings from the HRA will be presented.

Intended learning outcomes

- Participants will discuss ANA's HRA development.
- Participants will examine specific overall HRA findings.
- Participants will compare and contrast HRA over various demographic statistics.

Reading list

American Nurses Association. (2015) *Executive Summary: American Nurses Association Health Risk Appraisal (HRA)-Preliminary Findings October 2013 to October 2014.* Available at: www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/HRA-Executive-Summary/ANA-HRA-Executive-Summary.pdf (accessed 25/10/16) (Web).

Biography

Holly Carpenter is the Policy Associate for the American Nurses Association's (ANA) Nursing Practice and Work Environment. Her responsibilities at ANA include HealthyNurse™ initiatives such as the HealthyNurse™ health risk appraisal, resources and continuing education programs, as well as supporting multiple occupational health and work environment issues. Prior to her work with the ANA, she was employed at the Maryland Nurses Association and the State of Maryland's Department of Health and Mental Hygiene. A registered nurse for over 25 years, Holly graduated from Salisbury University with a Bachelor of Science in Nursing.

5 – 5.30pm

2.9.2 Clinical research nursing: innovations in nursing practice

Room: Henry Moore Room

Chair: Christian Beaumont

Presenter: Jennifer Allison, Research Nurse Manager, NIHR Wellcome Trust Clinical Research Facility, Southampton, UK

Aim

To highlight the varied roles undertaken by clinical research nurses.

Clinical Research Nurses balance participant needs with the research study protocol requirements. It is estimated that over 10,000 clinical research nurses (CRNs) work across the UK in a variety of settings – in NHS hospitals, dedicated clinical research facilities/centres/units, universities, and private research units. The unique role of the CRN has been defined and they are key to the NHS Constitution's goal to offer all patients the opportunity for research participation. We will illustrate some of the opportunities available to nurses within the field of clinical research.

Abstract
Central to all research is the participant, whether a patient or healthy volunteer. Their safety, wellbeing and dignity are paramount and. Clinical Research Nurses balance participant needs with the research study protocol requirements. It is estimated that over 10,000 clinical research nurses (CRNs) work across the UK in a variety of settings- in NHS hospitals, dedicated clinical research facilities/centres/units, universities, and private research units. The unique role of the CRN has been defined and they are key to the NHS Constitution's goal to offer all patients the opportunity for research participation. We will illustrate some of the opportunities available to nurses within the field of clinical research.

The first five Millennial Wellcome Trust Clinical Research Facilities (CRFs) opened in 2001. Subsequent new, significant investment by the Department of Health's National Institute for Health Research (NIHR) has enabled the growth of clinical research across the UK. NIHR Clinical Research Networks, Biomedical Research Centres and Units and CRFs fund and employ CRNs in 99% of Trusts on over 4,000 studies in all disease areas. This infrastructure provides structure and support to nurses working from Band 5 through 8. Robust inductions, training and ongoing professional development ensure CRNs are able to meet the demands of their research studies. Areas of work specific to CRN have been described as domains of practice and include:

- protection of participants: advocacy is embedded in the role
- care coordination and continuity: integration of research and clinical activities to meet needs of participant and protocol
- contribution to science: operationalizing research protocols and maintaining the scientific process
- clinical practice: direct nursing care while balancing adherence to research protocol
- study management. Precise, detailed assessment and documentation is required for the study and to identify safety issues or changes to participants condition.

Recognition of this unique contribution has allowed novel posts to evolve allowing CRNs to progress through the infrastructure to senior CRNs and team leaders. This also enables CRNs to undertake academic posts, joint clinical and specialist posts.

Reading list
HSJ (2014) Research Supplement, *HSJ* Available at: www.crn.nihr.ac.uk/wp-content/uploads//Campaigns/HSJ%20Supplement/Clinical%20Research%20Evolved%20-%20HSJ%20supplement.pdf (accessed 25/10/16) (Web).

Castro K, et al (2011) Validating the clinical research nursing domain of practice. *Oncology Nursing Forum*, 38(2) Available at: onf.ons.org/onf/38/2/validating-clinical-research-nursing-domain-practice (accessed 25/10/16) (Web).

Biography
Jennifer Allison is the research nurse manager of National Institute for Health Research funded infrastructure in Southampton UK. This includes the NIHR Wellcome Trust Clinical Research Facility, Biomedical Research Centre and Respiratory Biomedical Research Unit, facilitating collaborations across the Southampton research partnership and managing over 70 research nurses.

A research nurse for over 25 years, she has co-author ed a number of papers, presenting nationally and internationally. She is a founding member of the NIHR UK CRF Network. An early member of the International Association of Research Nurses (IACRN), she was presented with their Distinguished Clinical Research Award in 2011.

5.30 – 6pm

2.9.3 Going the extra mile

Room Henry Moore Room
Chair Christian Beaumont
Presenter Theresa Fyffe, Director, Royal College of Nursing - Scotland, UK

Aim
- Be able to understand the complexities and challenges for older people in many remote and rural areas and how the integration of health and social care services will deliver health services.
- Describe how digital enabling care can make a difference to older people and what is required to ensure these processes and nurses are supported.
- Explain how a whole-system approach is required to support nurses through the shift of resources into the community.

Abstract
Improving access to community health care for older people in remote and rural Scotland.

The way we deliver care for older people in many remote and rural communities is not fit for the future. The remote and rural population is older compared to urban areas and it is ageing. In the future, a great number of older people are likely to be living with multiple and complex health conditions and living alone without family support at home. Advances in technology mean we have the opportunity to develop a more mobile workforce with the ability to make connections to people and services at the click of button, but poor digital infrastructure in remote and rural areas is holding back progress. The current generation of older people, who are most likely to use health services, are also less likely to use the internet. 'Going The Extra Mile' report looked at specific areas within the NHS, areas which have an above average prediction in terms of over 65 years olds and with increasing levels of access deprivation. We talked to staff and through a survey supported by Age Scotland, sought opinions from older people; feedback shaped the report. The report sets out key steps: Ensuring digital

enabling care is delivered to make the difference to those in our care. To provide this refreshed approach we will support our nurses in the shift of resources into the community, take a whole-system approach to recruitment and retention, developing and supporting the advanced nurse practitioner role. Ensuring community nurses are confident users of technology with significant improvement in broadband infrastructure thus bringing services and communities together, in turn supporting older people to live independent and active lives.

Reading list

Age UK Loneliness and isolation Review. www.age.uk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk+tru

Golden J, Conroy RM, Bruce I, et al (2009) Loneliness, social supports, mood and wellbeing in community-dwelling elderly, *International Journal of Geriatric Psychiatry*, 24, pp.694-700.

Cosh, J (2012) Skills on wheels, *Nursing Standard* Bol.26 Issue 21, p23

Biography

Theresa Fyffe trained as a registered nurse in Dublin and later went on to become the Director of Practice Development and Research in Tayside. After joining the Scottish Executive in a wide-ranging role with responsibility for research, quality, safe and effective care, clinical leadership, practice development, and strategy development, she went on to become the Deputy Chief Nursing Officer. Since becoming Director of RCN Scotland Theresa has used her wide experience and influencing skills to bring a strategic focus and direction to the RCN in Scotland on behalf of members in Scotland. One of her key aspirations is to ensure the voice of nursing is heard and that nursing has a visible profile in the media, parliament, with the public and other stakeholders.

Theme: Knowledge for change and improvement

4.30 – 6pm

2.10.1 Symposium 5: Building, assuring, sharing and using knowledge for change and improvement

Room Westminster Suite

Chair Anda Bayliss

In this symposium we will share the Royal College of Nursing's knowledge and innovation plan and locate it within an historical context. In the first paper McMahon and O'Carroll will share the methods we have deployed to engage stakeholders in shaping the current plan, and in previous RCN research strategies. Three papers will follow which will illustrate some of the methods employed by the RCN to implement the plan and the wider impact of building nursing capacity and capability in research and innovation. In the second paper, O'Carroll will outline the methods the RCN has deployed to engage with members and other stakeholders to build and share knowledge and information resources on research and innovation. In the third paper, McMahon and Sin will share methods used to maximize the impact of nurses' innovative capacity, with a specific focus on a pragmatic approach to building nursing capability in economic assessment. In the fourth and final paper Taylor et al will examine the impact of research in nursing within the context of the UK Higher Education Funding Council's assessment of research, the Research Excellence Framework (REF).

Paper 1: RCN Knowledge and Innovation Action Plan 2014-2018

Authors and affiliation

Dave O'Carroll, Programme Manager, Royal College of Nursing, UK and Ann McMahon, Research and Innovation Manager, Royal College of Nursing, UK

Abstract

For more than 50 years the Royal College of Nursing (RCN) has actively engaged in research, recognising its critical relationship with innovation, public health and patient's experiences of care and their health outcomes. High quality nursing research and support to innovate, to use evidence in practice and to evaluate impact, enables nurses and those who work with them to develop new knowledge and nursing practice, and to transform care and services.

The *RCN Knowledge and Innovation Action Plan for 2014-2018* – which builds on previous research strategies (Kitson, McMahon et al. 1997, McMahon and Kitson 1997, McMahon and Kitson 1997) was developed in consultation with over 60 members, staff and partner organisations. It presents a vision that describes what the RCN will do to make it possible for nursing staff to use knowledge to transform

care. The plan also states how we will work with our members and other stakeholders to achieve our vision. It sets a clear direction of travel for over the next five years, states our priorities and, we hope, will act as a catalyst for creating new partnerships and alliances. Working together over the coming years, we are aiming for a fully research-literate nursing workforce, a significant increase in nursing capacity and capability in using and doing research and a robust nursing research evidence to underpin all practice settings.

We want to make it easier for nursing staff to use knowledge in practice and policy making and for nursing staff to feel confident and able to undertake research and to innovate to enhance care. We want the nursing community and other stakeholders to know what knowledge we hold, and how they can access and contribute to it. We want to help grow a dynamic knowledge base for nursing with the coverage, breadth, depth and rigour required for effective decision making and action.

This first presentation sets out the historical context behind the development of the Knowledge and Innovation Action Plan 2014-2018, and will discuss some of the ways in which the RCN will use, build, assure and share knowledge over the next five years.

Reading list

Royal College of Nursing (2015) *RCN Knowledge and Innovation Action Plan 2014–2018: the journey begins.* London: RCN www.rcn.org.uk/knowledge

Royal College of Nursing (2014) *RCN Knowledge and Innovation Action Plan 2014–2018*. London: RCN www.rcn.org.uk/knowledge

Royal College of Nursing (2007). *A strategic direction for research within the RCN.* London: RCN. www.rcn.org.uk/knowledge

McMahon A and Kitson A (1997). Supporting RandD: the role of a professional organisation, Part 1. *Nursing Standard* 12(11): pp.36-38.

McMahon, A. and A. Kitson (1997). Supporting RandD: the role of a professional organisation, Part 2. *Nursing Standard* 12(12): pp.35-39.

Paper 2: Leading, influencing and collaborating with our members and other stakeholders

Authors and affiliation

Dave O'Carroll, Programme Manager, Royal College of Nursing, UK

Abstract

This presentation will look at how the RCN seeks to advance the knowledge base for nursing by promoting and facilitating collaboration and networking amongst all our stakeholders. The RCN recognises that research should not exist in a vacuum. If nurses are going to put research into practice, they need to have access to the right information to support high quality care and drive improvements in practice.

The research and innovation pages of the RCN website have been developed as a one-stop-shop for nursing research and innovation needs, signposting resources that support nurses on their research journey. Mirroring the structure of the RCN Knowledge and Innovation Action Plan 2014 – 2018, we highlight activities that the RCN leads on, collaborates with and influences to help nurses use, build, assure and share knowledge. In this presentation, we will look at specific examples such as the database of Higher Education Institutions in the UK and their special areas of research activity, the ongoing longitudinal survey of the UK nursing and midwifery professoriate, and our work to influence research funding and research priorities through nurse representation on the scientific boards of organisations which fund health research and develop health research priorities.

An electronic bulletin has been produced continuously since 1998. It is currently disseminated to over 3,500 subscribers on a fortnightly basis. Subscription is free and open to anyone throughout the world. The bulletin keeps people up-to-date with the very latest developments in nursing research and innovation. We encourage our subscribers to provide content for the e-bulletin, and have developed clearly defined criteria for what we can and cannot include.

To augment our dissemination strategy and encourage dialogue amongst our stakeholders, RCN staff utilise other social media avenues such as Facebook, and have created Twitter accounts.

Reading list

O'Carroll D (2013) The effectiveness of the Royal College of Nursing (RCN) weekly research e-bulletin in engaging researchers and meeting their information needs. Project report as part of a Research Methods course, University of Salford. Unpublished.

Johnson M and Haigh C (2005) Royal College of Nursing Research and Development Co-ordinating Centre Website Evaluation Report, University of Salford, Salford

McMahon A, O'Carroll D and Caveney J (2003), *Think RCN Think Nursing Knowledge: How to improve the targeted communication of nursing knowledge to RCN members and other key stakeholders*, Royal College of Nursing RandD Coordinating Centre, Manchester

Paper 3: Making an economic case for nurse-led service innovation

Authors and affiliation
Ann McMahon, Research and Innovation Manager, Royal College of Nursing, UK

Dr Chih Hoong Sin, Director, Business Development, OPM, UK

Abstract
In the UK, the National Health Service (NHS) has been undergoing one of the most significant financial challenges in its history. We know that making savings by reducing or not replacing clinical nursing staff impacts on the quality and safety of care that, in turn, have implications not only on patient outcomes but also on the financial costs to the health and social care system. While no one denies the importance of establishing the costs and benefits of different health care interventions, the evidence base relating to the economic contributions of the health care workforce and of specific nurse-led innovations is still poorly developed. In addition, nurses often lack the skills to formulate and put forward arguments about the economic impact of what they do, over and above the clinical outcomes they contribute toward achieving. This can make efficiency drives feel very disempowering to the nursing workforce.

In partnership with the Office for Public Management (OPM) the RCN has worked with innovative nurses to enable them to generate evidence on the economic impact and value of nurse-led innovations. By applying the economic assessment tool (EAT) (Ryrie and Anderson 2011) in practice, through a 6 month programme (McMahon and Sin 2015) of face to face training and one to one coaching, nurses are adopting a whole-system and outcomes focussed approach when looking at costs and benefits (HM Treasury 2002). This paper will include examples of where nurses across the UK, working in a wide range of clinical contexts are demonstrating the value of nurse-led innovation in practice. It will conclude with a discussion of how the RCN is working with these nurses to maximise their impact.

References
HM Treasury (2002) *The Green Book: Appraisals and Evaluations in Central Government*, London: The Stationery Office.

McMahon A Sin C-H (2015) *A Guide to Economic Assessment in Nursing,* RCNi, London UK

Ryrie I and Anderson B (2011) Tool to assess the cost and quality benefits of nursing innovation, *Nursing Management*, vol. 18, no. 4, pp.29-31.

Paper 4: Unpacking impact

Authors and affiliation
Professor Julie Taylor, Professor of Child Protection, University of Birmingham, UK

Professor Daniel Kelly, Chair of Nursing Research, Royal College of Nursing, and Cardiff University, UK

Professor Bridie Kent, Professor in Leadership in Nursing, Plymouth University, UK

Ann McMahon, Research and Innovation Manager, Royal College of Nursing, UK

Professor Michael Traynor, Professor of Nursing Policy, Middlesex University, UK

Abstract
Background: The UK's research excellence framework (REF) 2014 rated the research from 154 universities. For the first time, the impact of research was evaluated in 6975 impact case and nursing was not assessed separately. Unit of Assessment (UoA) 3 covered research in Dentistry, Pharmacy, Allied Health Professions and Nursing, although nursing research was also submitted within other UoAs. Users were central in leading the assessment of impact case studies.

Aims: To analyse REF impact case studies to categorise the range of direct and indirect impact cases that could be traced back to nursing.

Methods*:* 460 entries were retrieved from the REF database. Category 1 indicated research undertaken by a team containing at least one nurse and concerned with the practice of nursing; 2 where the research was on the practice of nursing, but where nurse representation was not obvious; 3 where the impact was either of no relevance to nursing or was relevant to health care generically. All case studies were interrogated by category and coded thematically for topic and type of impact.

Results: 80 diverse impact case studies were submitted by nurses. Submissions were across 11 UoAs, the majority in UoA3 (n = 52). A further 55 revealed relevant impact, but nurses did not have an obvious leadership role. 226 case studies described health care practice impact that could impact significantly on the profession, but were not associated specifically with the discipline.

Discussion: Nursing research has demonstrable impact. There is a significant body of research that could have relevance for nursing but was not presented as such. There are implications for nursing in working with users to capture nursing research impact.

Conclusion: There is a hidden impact of nursing that needs to be illuminated. This study offers unique insights into the current state of nursing research impact.

References
Greenhalgh T and Fahy N (2015) Research impact in the community-based health sciences: an analysis of 162 case studies from the 2014 UK Research Excellence Framework. BMC Medicine 13:232

Higher Education Funding Council for England. 2014 REF: Assessment framework and guidance on submissions. Panel A criteria. London (REF 01/2012): HEFCE; 2012.

Penfield T, Baker MJ, Scoble R, Wykes MC. Assessment, evaluations, and definitions of research impact: a review. Research Evaluation. 2013. rvt021. doi: 10.1093/reseval/rvt021.

Theme: Knowledge for change and improvement

4.30 – 5pm

2.11.1 Evaluation of the *National Infection Prevention and Control Manual (NIPandCM)*

Room Victoria Suite

Chair Donna Kinnair

Presenter Jackie McIntyre, Senior Nurse Infection Control, Health Protection Scotland, UK

Aim

To present the findings of an evaluation of the National Infection Prevention and Control Manual, to summarise the thoughts and experience of our stakeholders in implementing the manual locally and to discuss what can be done to improve the NIPandCM and subsequently, its implementation nationwide.

Abstract

In 2009, the Scottish Government tasked Health Protection Scotland (HPS) with developing a NIPandCM to reduce variation and optimise infection prevention and control (IPandC) practices throughout Scotland. At present it covers Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) and is based on current scientific evidence and expert practice.

The NIPandCM became mandatory in 2012 under the instructions of the Chief Nursing Officer for Scotland, requesting adoption by all NHSScotland Boards.

The consistent implementation of SICPs into national practice is vital. The key recommendations in Chapter 1 of the NIPandCM are used by the Healthcare Environment Inspectorate (HEI) as the basis for their safety and cleanliness inspections of NHSScotland hospitals. However, the consistent implementation of SICPs in everyday care situations remains a challenge. This is reflected in the HEI Annual Reports:

"NHS Boards should ensure that all staff are implementing SICPs. We found 12 hospitals where practice was poor and staff were not consistently implementing SICPs."

The original Aim of the NIPandCM was to:

- support safer care and reductions in harm from HAI
- provide infection control teams (ICTs) with the evidence base with which to effectively inform local decision making to support more effective application at a clinical level across NHS Scotland
- allow more efficient use of ICT time resulting in more efficient delivery of services
- align practice, monitoring, quality improvement and inspection.

Therefore HPS ICT intended to perform an on-line evaluation of the NIPandCM to determine whether NHS Boards have adopted the NIPandCM completely; whether the NIPandCM meets its original aims and to gather intelligence on thoughts and experiences of our stakeholders and to use these to improve the NIPandCM and subsequently, its implementation nationwide.

Reading list

The National Infection Prevention and Control Manual, and associated literature reviews for more in depth reading, are available on the Health Protection Scotland web pages.

Biography

Jackie trained and worked as an Infection Control Nurse within Lanarkshire Primary Care Division from 1996-2004. In 2004 she joined North Glasgow University Hospital Division where she worked in Glasgow Dental Hospital and School as an ICN until taking up a post as a senior infectio control nurse at Health Protection Scotland in July 2006. The main remit of this post is to support the activities of the infection control team within HPS functioning at a national level to assist in the development and support of infection control projects across NHS Scotland.

5 – 6pm

2.11.2 National Institute for Health Research (NIHR) - Sponsored session

Room Victoria Suite

Chair Donna Kinnair

Presenters Kirsty Winkley, Specialist Diabetes Nurse and HEE/NIHR Senior Clinical Research Fellow, UK

Pete Thompson, Assistant Director, NIHR Trainees Coordinating Centre, UK,

Helen Jones, Senior Research Nurse, UK and Chris Oxnard, Senior Research Nurse, UK

The NIHR is the UK's major funder of applied health research. As the research arm of the NHS, more than 25,000 people are engaged in leading, delivering or supporting NIHR research; all of whom work towards improving the health and wealth of the nation through research.

The NIHR is committed to developing the next generation of research leaders and provides clear pathways for healthcare professionals to pursue careers in clinical research.

This interactive session will explore some of the opportunities available for nurses; from the help and support available to clinical research nurses to increase their skills, to the funding available to nurses to lead their own research and pursue a clinical academic career. Attendees will hear from a clinical research nurse and an NIHR-funded active nurse researcher as well as Pete Thompson, Assistant Director at the NIHR Trainee Coordinating Centre.

Theme: Social event presentation

6.30 – 8.30pm

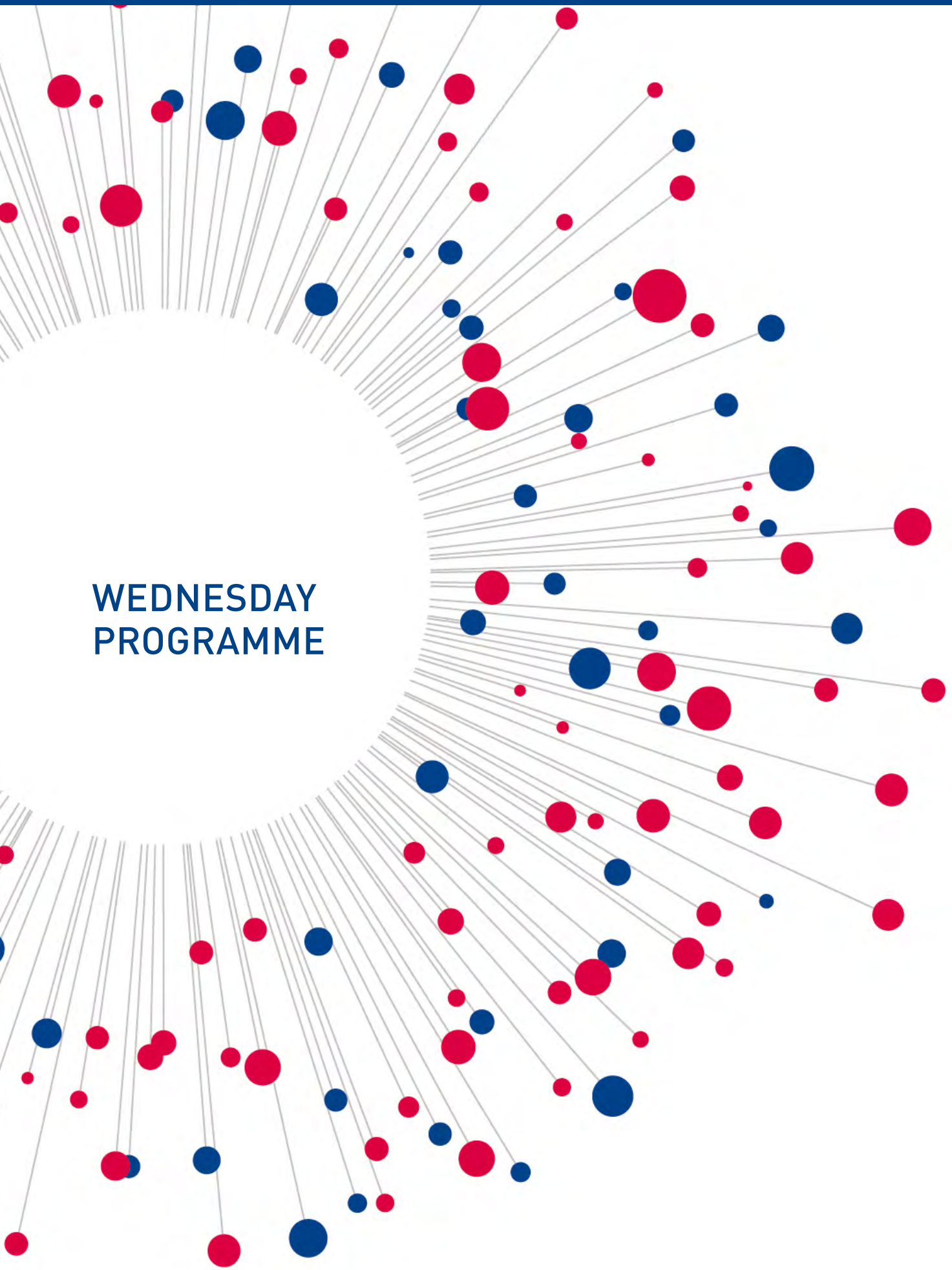
2.12 How the Nurse Staffing Levels (Wales) Act 2016 came into being

Room 101/102, First Floor, Royal College of Nursing, 20 Cavendish Square, London W1G 0RN

Chair Tom Sandford

Presenters Professor Anne Marie Rafferty CBE, FRCN, Professor of Nursing and Dean of the Florence Nightingale School of Nursing and Midwifery, King's College London and Tina Donnelly, Director of RCN Wales, CBE, TD, DL

Abstract
Hear from Professor Anne Marie Rafferty CBE, FRCN, Professor of Nursing and Dean of the Florence Nightingale School of Nursing and Midwifery, King's College London in conversation with Tina Donnelly, Director of RCN Wales, on how they secured the nurse staffing bill into legislation in the Welsh Parliament.



WEDNESDAY PROGRAMME

Wednesday 23 November 2016

Keynote lectures

9.30 – 10.15am

Keynote lecture 4: These shoes were made for walking...

Room Churchill Auditorium (main hall)

Speaker Matt King OBE, Patient advocate, UK

Summary

An interactive journey reflecting upon the experiences – positive, negative and emotion churning – which have taken Matt from lying on a rugby pitch as a 17-year-old boy with a broken neck, through to reading law at university, qualifying as a solicitor, completing the New York Marathon and being the youngest person ever to be awarded an OBE at the age of just 26.

Matt is in the unique position of having lived with the NHS, 24 hours a day, for nine months during the toughest times any one individual can face, and the experiences he reflects upon emphasises how the smallest things make the biggest difference to patients experience.

Abstract

An interactive journey reflecting upon the experiences – positive, negative and emotion churning – which have taken Matt from lying on a rugby pitch as a 17-year-old boy with a broken neck, through to reading law at university, qualifying as a solicitor, completing the New York Marathon and being the youngest person ever to be awarded an OBE at the age of just 26.

Matt is in the unique position of having lived with the NHS, 24 hours day, for nine months during the toughest times any one individual can face, and the experiences he reflects upon emphasises how the smallest things make the biggest difference to patients experience and that anything is possible in life!

Matt emphasises the importance of a positive mind-set, and attributes his remarkable recovery to the ability to see past obstacles and focus on only those factors he can affect. It is by focusing on what he can do, as opposed to the huge number of possibilities closed to him due to disability, which has allowed him to rebuild his life.

It is the smallest things, the 1% differences, which make the biggest difference to what individuals, teams and organisations can achieve.

Matt will show you that impossible does not exist and is the living example of the strength of the human spirit!

Intended learning outcomes

- Appreciate the importance of care and compassion when engaging with patients and their families.
- Understand it is the smallest things which make the biggest difference to patients.
- Understand it is not what is done, but rather how it is done, that makes the biggest difference.

Biography

Matt sustained a broken neck at the age of 17, following which he spent nine months in hospital, during which time he had to learn to come to terms with his disability and strive to rebuild the pieces of his life.

During this time the hospital, and those that cared for him became his home. Matt reflects upon the good, and the not so good, experiences he had with the NHS, and the doctors, nurses and care staff that helped him.

Since his discharge, Matt read Law at university, qualified as a solicitor and is now pursuing a career as a motivational speaker.

10.15 – 11am

Keynote lecture 5: A window on the future

Room Churchill Auditorium (main hall)

Speaker Dr Susan Hamer, Director of Nursing, NIHR Clinical Research Network (NIHR CRN), UK

Summary Nursing sciences contribution to global advances in clinical care.

Abstract

Rapid changes in health and health needs is a global phenomenon. All health systems are being challenged to respond in new and different ways. The demand for better solutions and clearer answers is driving an accelerated need for high-quality clinical research. Nurses are at the forefront of responding to this demand and are developing new and innovative approaches in the clinical research field. This session will use case studies to illustrate the important daily contribution nurses make to clinical research.

Intended learning outcomes

- Identify key global health issues.
- Describe the features of a strong health research system.
- Identify the importance of high-quality data.

Reading list

Nurses 'A force for change 2016 – Improving health systems' resilience' ICN Geneva

Jones H 2015 Clinical research nurse or Nurse researcher? *Nursing Times* 111: 19 12-14

Hallberg I R 'Moving research forward towards a stronger impact on health care practice' Int J Nursing Studies 46 (2009) 407-412

Biography

Dr Susan Hamer is Director of Nursing, Learning and Organisational Development for the NIHR Clinical Research Network (NIHR CRN). The NIHR CRN provides the infrastructure that enables high-quality clinical research to take place in the NHS, so that patients can benefit from new and better treatments.

Susan is passionate about purposeful change and in particular the development of the health care workforce. As lead nurse Susan works with colleagues to ensure that the clinical leadership culture is vibrant and integrated across the large managed network which is the NIHR CRN.

As a committed adult educationalist Susan understands that a positive work environment is key to high performance and leads a team to develop timely, high quality learning opportunities using a range of media. A previous role as national leader in the Department of Health Informatics Directorate persuaded Susan about the possibilities for technology to enhance practice and to support innovation in the development of patient led services. She sees the development of digital confidence and accessible information as crucial to this.

Susan is a regular writer and is the author of *Achieving Evidence-Based Practice* and *Leadership and Management: A Three-Dimensional Approach*. She is a Fellow of the Queens Nursing Institute. In 2012 Susan received the EHI CCIO award for Clinical IT leadership and in 2013 Susan was named one of the HSJ's Inspirational Women. In 2015 she was named on the HSJ top 100 clinical leaders for her contribution to the development of clinical research careers and leadership opportunities for nurses and AHP's. In 2015 she was also included on the Nursing Times' Leaders 2015 list. The Nursing Times Leaders recognises and celebrates nurses and midwives who are pioneers, entrepreneurs and inspirational role models in their profession.

11.45am – 12.30pm

Keynote lecture 6: Looking at our past to better plan our future

Room Churchill Auditorium (main hall)

Speaker Dr Frances Hughes, Chief Executive Officer, International Council of Nurses, Geneva, Switzerland

Abstract

In this keynote presentation celebrating the centenary of the Royal College of Nursing Dr Hughes, Chief Executive Officer of the International Council of Nurses will take a look at how we can learn from nursing history to better inform our work today and in the future. Dr Hughes will specifically look at some of the icons of nursing, including Ethel Gordon Bedford Fenwick, the first President of ICN, who along with Lavinia Dock and Agnes Karll, founded ICN from the roots of the international suffrage movement. Our history sets the scene for what we have become and will become, and by looking through this historic lens we can better prepare for the challenges ahead. Dr Hughes pays tribute to the achievements of the RCN and looks at the path ahead.

Intended learning outcomes

- Understand the importance of nursing history to current issues and challenges.
- Identify key landmarks in the history of ICN and RCN.
- Explore the challenges of the future in light of the past.

Reading list

A history of the International Council of Nurses, 1899-1964: the first sixty-five years, Daisy Caroline Bridges, Lippincott, 1967

ICN – Past and Present, Dame Sheila Quinn, 1989 Scutari Press

Winifred Hector, The Work of Mrs Bedford Fenwick and the Rise of Professional Nursing (University of London, 1970)

Biography

Dr Frances Hughes was appointed as Chief Executive Officer of the International Council of Nurses in February 2016. Immediately prior to this, she held the role of Chief Nursing and Midwifery Officer, Queensland, Australia, and also served as Chief Nurse for New Zealand. From 2005-2011, Dr Hughes worked for the World Health Organisation with 16 countries in the Pacific region, supporting them to develop policy and plans to improve mental health for consumers in the Pacific. Qualified as a general and psychiatric health nurse, Dr Hughes has a Doctor of Nursing degree from the University of Technology, Sydney. She has held senior roles for many years across a range of organisations and served as the Commandant Colonel for Royal New Zealand Nursing Corp. Dr Hughes has an extensive publication record and has received several awards for her work.

Wednesday 23 November 2016

Concurrent session 3

Theme: Society, communities, relationships

12:30 -1pm

3.1.1 'Not wanting to upset': the heart of palliative care nursing in Addis Ababa, Ethiopia

Room	Albert Suite
Chair	Lara Carmona
Presenter	Dr Nicola Ayers, Palliative Care Advisor, Federal Ministry of Health, Addis Ababa, Ethiopia
Co-authors	Dr Vasso Vydelingum, UK and Dr Anne Arber, UK

Aim

The aim of this abstract is to show how palliative care nursing has become a global phenomenon in the last 100 years. It considers the cultural aspects of caring for the dying in Ethiopia, with the advent of palliative care in the country. It shows the importance of emotional care and how the family and hospice staff support the loved one with a life-threatening illness. It demonstrates the essence of having a culturally appropriate palliative care service.

Abstract

When we consider the changes in nursing in the last 100 years globally, one of the most important innovations has been the start of the modern palliative care movement. Cicely Saunders, herself a nurse, realised the importance of caring for patients with life-threatening illnesses in a holistic way and founded St Christopher's Hospice in 1967. Forty seven years on, the World Health Organisation declared that palliative care should be part of each member states' health system.

In Ethiopia, palliative care is in early stages of implementation. This study considers the cultural aspects of caring for the dying in Addis Ababa. Using a focused ethnographic approach, data were gathered using participant observation, interviews and home visits to reveal a picture of the culture of care. The central feature found was how the family takes on the role of relieving the emotional burden of a life-threatening illness from their dying loved one. This is done by not talking openly about cancer and dying in order 'Not to Upset'. This ethic of non-disclosure was a strategy found to be used to emotionally protect the family and the ill family member from deep sadness associated with dying from a life-threatening illness. Hospice staff were found to use various communication strategies to create openness, though ultimately they deferred to the dying person's family. Emotional care was further expressed by family members 'stopping everything' to care for their dying relative. Through physical care, the dying person's emotional equilibrium and comfort were maintained. Hospice staff were found to provide a 'family-style service'. This study gives valuable insight into how families and the emerging Ethiopian palliative care service together provide care for the dying.

Reading list

Glaser BG and Strauss AL (2005) *Awareness of Dying.* New Brunswick, New Jersey: Aldine Transaction.

Hochschild AR (2012) *The Managed Heart Commercialization of Human Feeling.* 1st revised edn. California: University of California Press

Levine DN (1965) *Wax and Gold: Tradition and Innovation in Ethiopian Culture.* Chicago: The University of Chicago Press.

Biography

Dr Nicola Ayers has worked in the Middle East and Ethiopia for many years. Her main focus has been refugee health. From this, the importance of palliative care for vulnerable groups in developing countries became apparent. In 2006, Nicola's Master's thesis considered how Ethiopian and Somali refugees access end of life care in government hospitals in Yemen. In 2014, Nicola completed her PhD, investigating the cultural aspects of caring for the dying in Ethiopia. Nicola currently works as a Palliative Care Advisor for the Federal Ministry of Health and is a Palliative Care Specialist for Hospice Ethiopia, a Non-Governmental Organisation.

1 – 1.30pm

3.1.2 Back to the future: delivering person-centred care in the home

Room	Albert Suite
Chair	Lara Carmona
Presenter	Jean Donaldson, Associate Director of Nursing Long Term Conditions, NHS Lanarkshire, UK
Co-authors	Ms Jenny Butchart, UK; Ms Janette Clow, UK; Ms Sheila Steel, UK and Ms Janette Barrie, UK

Aim

The aim of this paper is to propose a symposium to demonstrate the impact of a range of person centred approaches within the community nursing service of NHS Lanarkshire and the positive impact this has on patient experience.

Abstract

Similar to other communities within the UK, the population of Lanarkshire is ageing and there are particular challenges for people living with multiple long term conditions. There is also a commitment to deliver person centred care within the home environment for a population with increasingly complex health and social care needs.

Patients who are housebound often live alone, they may have memory issues or sensory impairments and may wish their family or a carer to be present when the community nurse calls. Some patients are often quite anxious in case they miss the nurse when she/he attends and will leave doors unlocked for long periods. Others sometimes fail to recognise the early signs that their condition may be changing and rather than seek early advice and support, may wait until there is a crisis, which results in hospital admission.

Within Lanarkshire the community nursing service has identified a number of ways to improve the patient experience, to capture patient preferences and priorities for care, to anticipate potential issues and to proactively follow up patients who may be at risk of hospital admission.

Using a range of contemporary improvement techniques, the community nursing service has implemented these approaches to facilitate the journey back to the fundamental principles of nursing to ensuring person centred care is delivered to every patient, every time.

This symposium will present a few of these approaches and will include:

- integrated community support teams
- integrated care management
- patient preferred timed visits
- anticipatory care planning.

Reading list

Scottish Government (2011) A 2020 Vision: achieving sustainable quality in Scotland's health care, Edinburgh

King's Fund (2012) Integrated Care for patients and populations: Improving Outcomes by working together. London

Scottish Government (2010) Healthcare Quality Strategy for NHS Scotland. Edinburgh

Biography

Currently Associate Director of Nursing for Long Term Conditions within NHS Lanarkshire with responsibilty for the community nursing service, three community hospitals, heath care within the prison environment, out-of-hours nursing serivce and treatment Room serivce. previously senior nurse with the community nursing service and former district nurse.

Theme: Society, communities, relationships

12.30 – 1pm

3.2.1 Developing peer social support in UK prisons

Room Rutherford Room

Chair Annie Norman

Presenters Warren Stewart, Senior Lecturer, University of Brighton, UK and Rachel Lovely, Service Manager, Health Services, HMP Isle of Wight, UK

Aim

The aim of the paper is to describe our action research project to develop peer care amongst serving prisoners and to disseminate good practice guidance to a wider audience.

Abstract

This presentation describes a small training pilot designed to enhance the role of the peer social support in UK prisons. The project is funded by Care UK and builds on previous Department of Health funded work. The training initiative was undertaken with two cohorts of prisoner buddies from HMP Isle of Wight between 2015 and 2016. There are felt to be multiple benefits to both the peer 'buddies' and the wider prison community. A collaborative, action research methodology was used to organize and evaluate the training intervention. The work has developed good practice guidelines for prisoner peer care training and makes recommendations for future training and research in this area.

Reading list

Cloyes K et al (2013) *To be truly alive: motivation among prison inmate hospice volunteers and the transformative process of End of life Peer Care Service.*

Loeb S et al (2013) Evaluating Peer Social Care in Prisons'. Stewart, W. (2011). 3. 'Care and companionship in an isolating environment: Inmates attending to dying prisoners.

Biography

Warren Stewart has worked as a nurse, nurse manager and practice educator in health and justice settings. Between 2004-2010 he undertook a sequence of joint higher education/health and justice appointments, producing mental health awareness materials, health and social care student placement guidance, and the Offender Care Foundation degree. He is presently a senior lecturer at the University of Brighton where he is a part-time student of the Educational Doctorate programme.

1 – 1.30pm

3.2.2 Theoretical basis of partnership in global health nursing practice

Room Rutherford Room

Chair Annie Norman

Presenter Professor Michele Upvall, University of Central Florida, USA

Aim

Relational-cultural theory provides the foundation for constructing the role of global health nursing. This theory, as it relates to global health nursing practice, will be explored in this presentation. The practice of global health nursing must promote moving toward and growing in relationship for transformation of all partners. Outcomes for applying a relational-cultural theory framework include facilitating sustainability of partnership, encouraging shared responsibility among partners, and embracing cultural humility for a transformative approach to global health nursing practice.

Abstract

Global health nursing requires ethical, responsible and just practice. A definition of global health nursing focuses upon the essentials of social determinants of health, cultural humility, deliberate and reflective practice, and full partnership with individuals and/or communities. Developing this practice requires ongoing movement toward interpersonal connection and partnership, bounded by the principle of inclusion where all voices are heard, including those who may feel marginalized and powerless.

Partnerships in global health nursing may vary from coordination of activities, cooperation among programs, or close collaboration for individual and/or population-based improvement of health outcomes. Despite the variation of intensity, all partnerships require a connection with others that results in mutuality and inclusion. Relational-cultural theory asserts the importance of these connections, recognizing that individuals thrive on connections and want to be connected through relationships that nurture personal growth. The central concept of relational-cultural theory include mutuality, relational authenticity, mutual empathy, and relational awareness. Relationship awareness depicts the fluidity of these connections as a partnership moves from a sense of connection to transformation (Comstock, Hammer, Strentzsch, Cannon, Parsons and Salazar, 2008).

Disconnection poses a threat to global health nursing partnerships through all stages of relationship development, but may be mitigated by the concept of cultural humility. Cultural humility is demonstrating respect in relationship, not promoting subservience. It is "learning with" rather than "telling to". In addition, cultural humility as an act of being human, requires attention to issues of power balance in relationships and developing partnerships that are nonpaternalistic and of benefit to all partners.

Connecting, disconnecting, and re-connecting through cultural humility depicts growth in relationship. This ongoing process leads to the development of true partnership required for global health nursing practice. The ultimate goal to be realized within this theoretical foundation is growth of all partners, and sustainable, transformative outcomes.

Reading list

Comstock DL et al (2008) Relational-Cultural Theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling and Development*, 86, 279-287.

Eisler R and Potter TM (2014) *Transforming interprofessional partnerships*. Indianapolis, IN: Sigma Theta Tau International.

Racine, L. and Perron, A. (2012). Unmasking the predicament of cultural voyeurism: A postcolonial analysis of international nursing placements. *Nursing Inquiry,* 19(3), 190-201.

Biography

Dr Upvall has a long history of practice in global health nursing. She has studied the collaborative practices of nursing with indigenous healers in Swaziland and the Navajo Nation in southwestern United States. Other populations she has worked with include Somali refugees, nurses and other health care providers in Cambodia, Botswana, Bhutan, Pakistan, and Vietnam. She has many publications in the area of global health including the book, Global Health Nursing: Building and Sustaining Partnerships. Currently, she is a Professor of Nursing and Coordinator of the Nurse Educator program at the University of Central Florida in Orlando, Florida, USA.

Theme: Society, communities, relationships

12.30 – 1pm

3.3.1 Women's health in Europe – from research to health care delivery

Room Churchill Auditorium (main hall)

Chair Theresa Fyffe

Presenter Peggy McGuire, Director General, European Institute of Women's Health, Ireland

Aim

The session will look at the state of women's health in Europe in the context of a changing political economic, demographic and social environment, the inequalities in health. The session will address the health challenges across the life course and how the interaction of sex and gender affects women's access to resources such as health promotion and disease prevention, treatment and care. The session will look at the European Institute of Women's Health (EIWH) work as one organisation promoting women's health policy and the important role of the health care professionals (nurses) in supporting women's health policy.

Abstract

Attention to sex and gender in biomedical, health and clinical research is an important quality and safety issue. Medicinal products are safer and more effective for everyone when clinical research includes diverse population groups. Historically, women's health issues have focused on reproductive health. Additionally there has been attention devoted to some gender issues, including how societal constructs—such as behaviour, socio-economic factors, culture, and lifestyles—influence biological development and health.

Women and men living in poverty or in vulnerable situations often experience poorer access to health services. Inequalities are usually influenced by the intersection of multiple factors such as biological differences and gender roles, age, socio-economic background, religious orientation and ethnicity. In addition, patient access to and understanding health promotion and disease prevention material can affect timely, affordable, good quality and appropriate treatment and care.

Over the years, scientific knowledge has increasingly demonstrated that some treatments affect men and women differently. However, the proportion of treatments for which men and women respond differently is yet unknown. Many physiological and pathological functions are influenced by sex-based differences in biology. Recent research on cardiovascular disease (CVD), osteoporosis and depression has identified significant differences among women and men with respect to the distribution of certain diseases. Women and men have different sex- and gender-related risks for developing certain conditions and responses to

treatment. For example, biological differences between males and females can affect how a medicine works in the body. Additionally, patterns of gene expression differ between males and females.

These sex and gender differences have important implications for health and health care. Thus, it is imperative to target medicines to these patient population sub-groups by utilising the correlation between sex and the incidence, prevalence, symptoms, age at onset and severity of disease as well as the reaction to medicines.

Since a primary aim of clinical research is to provide scientific evidence leading to improved standard of care, it is important to determine whether the intervention or therapy being studied affects women or men differently.

Intended learning outcomes

- Explain some of the health policy issues relating to women.
- Identify some research issues/gaps.
- Need for supporting women's health policy.

Reading list

Sex and Gender in Medicines Regulation and Education: eurohealth.ie/2015/03/05/31475/

Health Canada. Considerations for Inclusion of Women in Clinical Trials and Analysis of Data by Sex—2013 Guidance Document

European Commission. 2013. Health Inequalities in the EU. ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf

Biography

Director General at the European Institute of Women's Health (EIWH) Peggy is a political scientist and graduate of Trinity College Dublin, Peggy has been working in the health sector at European and national level for over twenty years, highlighting women's health needs andthat gender/sex are important determinants of health.

Peggy has initiated and co-ordinated, many research projects, publications and communications initiatives. As an advocate for a health literate public, Peggy developed Cancom, a cancer communication and information initiative for women and families. In her previous role as Director of Development at the National Maternity Hospital, Holles Street, the largest maternity hospital in Europe, Peggy was responsible for the preparation and implementation of a three year strategic plan for the hospital and initiated the first women's health survey in Ireland: *Women's Health in Ireland –Attitudes and Behaviour*. (A survey of 2000 women between the ages of 18-64 on attitudes to various health issues across the lifespan. Prior to working at the National Maternity Hospital, Peggy worked at the Irish College of General Practitioners (ICGP) as Director of the Research Foundation.)

Peggy has served as a member of many expert groups, including, the EU Commission's External Advisory Group on Ageing and Disability and EU Commission's advisory group on gender in FP6, the WHO Expert Group on gender mainstreaming and currently a member of the EU Commission H2020 Advisory Group on Gender and the WHO Expert group on the WHO Women's Health Strategy for Europe. Peggy was a founding member of the Women's Health Council (Ireland). As a board member of the Institute of Public Administration in Ireland, Peggy was part of the team who successfully negotiated degree status for the Institute's distance education programmes. Peggy is past President and a current board member of the European Public Health Alliance.

3.3.2

What sort of Nurse are you? Research with Looked after Children and care Leavers

Room	Churchill Auditorium (main hall)
Chair	Theresa Fyffe
Presenter	Lin Graham-Ray, Nurse Consultant Looked After Children and Care Leavers, Central London Community Health Care Trust, UK

Abstract

At the heart of this piece of research was the wish to better understand the relationships that form between looked after children and care leavers in the specialist nurses that work with them in social care.

The doctoral research examined the lived experience of a group of looked after children and care leavers in relation to their experiences receiving specialist nursing in a social care setting. The research adopts a psychosocial approach to exploring and understanding looked after children and care leavers. The methodology used was The free Association narrative interpretive method (FANI) supports this model, as developed by Holloway and Jefferson (2002). What emerges from the data is an account of how looked after children and care leavers experienced being cared for by the looked after children's nurses, intertwined with their experiences of being in care and their relationship with their social workers and the local authority as an organisation.

Cutting across the findings is a central theme that relates to the emotional impact and life experiences narrative for this group that give voice to the more subtle nuances of how looked after children and care leavers experience the nurse and nursing with particular emphasis on the emotional connectedness looked after children and care leavers.

Implications for the findings on policy and practice are discussed, highlighting practical and organisational cultural challenges.

Finally the research methodology used and its applicability to research with looked after children and care leavers and also vulnerable groups will be critiqued .Recommendations for future practice and the importance of undertaking further research is also made with particular emphasis on the contribution this research makes to the field of looked after children's nursing in social care and its practical application to practice

Biography

Lin is a paediatric Nurse by background and has held many posts in children's acute and community nursing. In 2000 Lin was first nurse in London to be appointed to work with looked after children, having been a strong campaigner and steering group member locally of the Quality Protects rollout programme. Lin is currently the Nurse Consultant/Designated Nurse for Looked after Children in Hammersmith and Fulham where she currently manages the Nursing team, delivering health assessments and health support to the population of looked after children. Lin is chair of the London LAC nurses forum and appointed steering group committee member of the Children and Young peoples Professional issues Forum of the Royal College of Nursing.

Lin was awarded the Nursing standard Child health award for Innovation and Excellence in the Field of Child Health in May 2009 and went on to win the ultimate accolade of Nurse of the year at the awards ceremony at the Dorchester in London in November 2009. Since then Lin has been at the forefront of developments in the field of looked after Children's health, including radio and television projects, visits to health ministers and the Prime minister and collaborative work with the Who Cares Trust. Lin regularly presents at national and international conferences, most recently at the Florence Nightingale Foundation annual conference where are work was highly commended by an expert panel of judges.

Lin has a strong interest in the subject of inequalities in health and life chances and made this the basis of her MA thesis. Lin obtained her MA in child protection and family support in 2004 following a three year course at the Tavistock centre London, where she also worked as a part time clinical associate. Lin is also an Independent Expert witness and a Professional Doctorate student at the Tavistock and Portman Trust. Lin is also a current Florence Nightingale research scholar and Care Quality Commission Specialist advsier.

Intended learning outcomes

1 Identify the value of qulaitative reseacrh with children and young people

2 Describe the added value of Nursing in a social care setting

3 Explain the benefits of collecting patient expereince

Reading list

1 Carter, B. 2011 Ethical aspects of paedaitric nursing research. In Brykczynska, G and Simons, J (Eds) Ethical and philosophical aspects of Nursing Children (pp281-303). Oxford: Whiley Blackwell

2 Carter , B and Ford K. 2013. Researching Chidlren's Health Experiences: The place for Particpatory, Child-Centered, Art-Based Appraoches. Research in Nursing and Health. 36, 95-107

3 Holloway, W and Jefferson T. 2010. Doing Qualitative Research Differently

2nd Edition. London, Sage

Theme: Technology and innovation

12.30 – 1pm

3.4.1 Increasing reach of HIV screening in the emergency department through a bundled nursing and EMR intervention

Room	Shelley Room
Chair	Rose Gallagher
Presenter	Madeleine Whalen, Registered Clinical Nurse, Johns Hopkins Hospital, USA
Co-authors	Richard Rothman, USA; Danielle Signer, USA; Yu-Hsiang Hsieh, USA; Somiya Haider USA; Margaret Leathers, USA and Mustafa Saheed, USA

Aim

To describe the positive impact of a triage nurse liaison and electronic medical record optimization in reaching emergency department (ED) integrated HIV testing goals.

Abstract

Introduction: Routine HIV screening in the emergency department (ED) is a standard of care recommendation by the Center for Disease Control and Prevention (CDC) in the US. A sustainable HIV screening program requires an integrated approach, aligned with standard emergency care. Task shifting HIV screening to a nurse driven role, has shown potential in our ED and others, yet shortfalls remain.

Objectives: To determine the impact of a focused bundled intervention (introducing a triage nurse liaison and electronic medical record initiated prompts) on overall HIV testing uptake in a large inner-city ED.

Methods:: We logged the number of HIV tests conducted the eight months before and eight months after implementing the first stage of the bundled intervention. At the end of January 2015, a triage registered nurse (RN) partner was added to the HIV testing team (which consisted of a physician champion and several HV testing support staff), followed by EMR optimization.

Results:: Testing increased by 43% post bundled-intervention 914 average per month [CI 576.6, 700.4] from an average of 638 per month [CI 772.7, 1056.3], [p= <.005, df= 14].

Conclusion: EDs implementing universal HIV screening have struggled to meet aggressive CDC targets. Innovative efforts to directly address aspects of routine ED care, such as triage nurses and the EMR, have led to significant improvements in the number of HIV tests performed in the ED. Engaging an RN in the research team has provided the missing link between theoretical implementation and daily practice. EMR changes have addressed workflow challenges with direct impact on HIV testing reach. Nursing involvement and EMR updates in HIV testing program management have had an important impact on this public health initiative.

Reading list
The role of nurses in HIV screening in health care facilities: A systematic review, Leblanc 2015

Biography
Nurse Whalen is a practicing bedside nurse in the adult Emergency Department. She recently earned her MSN/MPH and dedicates her extra time to public health interventions in the department and abroad.

1 – 1.30pm

3.4.2 The challenges and added value of electronic observations on nursing practice

Room	Shelley Room
Chair	Rose Gallagher
Presenter	Dr Alexandra R Lang, Human Factors Research Fellow, University of Nottingham, UK
Co-author	Sue Clarke, UK; Lorrayne Dunn, UK, Dr Mark JR Simmonds, UK; Caron Swinscoe, UK; and Prof Sarah Sharples, UK

Aim
The benefits of technology in acute patient care are increasingly being reported in regard to patient safety. Less has been reported about the impact on nursing practice; the challenges faced and also added value experienced from the deployment and use of technologies for bedside monitoring of patients.

This submission reports the findings of a Human Factors (HF) evaluation of Electronic Observations (EObs) and handheld mobile devices, presenting the findings which have impacted nursing practice.

Abstract
Aims: This submission reports the findings of a Human Factors (HF) evaluation of Electronic Observations (EObs) and handheld mobile devices, presenting the findings which have impacted nursing practice.

Method: The HF evaluation took place in a large teaching hospital in the East Midlands region. Forty hours of observations and interviews with 19 nurses were carried out to investigate the impact of the technology intervention on their working practices and role. The sample population included representation from all nursing grades.

Results: Nurses reported added value in the form of reassurance and reliability in EObs with the potential for reduction in stress, particularly at busy times. Mobile devices were described as their own 'personal tool' for management of workload and improving situation awareness of team capacity. Nursing staff described its value as a communication tool for use with patients and relatives. However as a communication tool with medical staff, nurses experienced difficulties aswell as advantages. Challenges arise in regard to cognitive workload, with nurses experiencing alarm fatigue and information overload. Another challenge is that of clinical skills learning; senior nurses are concerned about ability to recognise a deteriorating patient through clinical assessment if junior nurses become too reliant on the technology.

Discussion: The results of this study indicate that there are numerous opportunities to capitalise on and learn from the use of EObs in nursing practice. Where changes to practice have led to negative experiences, there are possibilities to learn via systems approaches and user research to improve staff and patient experience and working practices. Within this process, the value of pre-established feedback loops between organisation and nursing staff cannot be under overstated. Where the use of EObs and mobile devices have led to unanticipated benefits, this can be communicated widely and proactively to ensure that all users within the nursing community and the wider organisation can realise the benefits.

Conclusions: This submission provides a case study demonstrating the learning that can arise from technology interventions. It demonstrates a case for proactive monitoring of impact and change in practice from technology interventions which can benefit the nursing community as a whole.

Intended learning outcomes
- Communicating unanticipated benefits to nursing accrued from the deployment of an Electronic Observation system.
- Dissemination of the 'lessons learnt' from the roll out of EObs, with particular focus on the future training needs of junior nurses.
- Highlighting the importance of user driven design and evaluation to understand how technology interventions can impact clinical practice.

Reading list
Jones, Steve; Mullally, Miki; Ingleby, Sarah; Buist, Michael; Bailey, Michael and Eddleston, Jane M. Bedside Electronic Capture of Clinical Observations and Automated Clinical Alerts to Improve Compliance with an Early Warning Score Protocol [online]. Critical Care and Resuscitation, Vol. 13, No. 2, June 2011: 83-88.

Patient bedside observations: what could be simpler? Michael Buist, Stella Stevens

BMJ Qual Saf bmjqs-2013-002143Published Online First: 1 June 2013 doi:10.1136/bmjqs-2013-002143

Biography
Alexandra is an experienced Healthcare Human Factors and Ergonomics Researcher, having worked on EPSRC, EU funded and NHS health care projects. She specialises in user-centred design, experience and evaluation of health care and medical technologies and systems. She routinely undertakes participatory research with health care professionals and patients to understand human behaviour and use of technologies in hospital and home settings.

Theme: Knowledge for change and improvement

12.30 – 1.30pm

3.5.1 Symposium 6: A celebration of the last 100 years of nursing education and nurse educators; an exploration of the potential developments for the next 100 years

Room St James Suite
Chair Diane Powles

Authors and affiliation
Dr Anne Corrin, Interim Head of Education, Royal College of Nursing, UK and Pauline Walsh, Head of School Nursing and Midwifery, Keele University, and Chair, Education Forum, Royal College of Nursing, UK

Dr Geraldine Walters, Director of Nursing and Midwifery Education, Standards and Policy, NMC, UK

Aim
Nurse education and the role of nurse educators has changed remarkably over the past 100 years. This session aims to offer a historical perspective of nurse education, a contemporary overview of nurse education and an opportunity to explore future possibilities for nurse education. In order to deliver the session we have drawn on a variety of people, including members of the RCN Education Forum, the UK regulatory body, the Nursing and Midwifery Council, members of the RCN Nursing Practice and Policy Directorate and RCN members. It is hoped that this will be a celebration of the vital role nurse education and nurse educators do and, have always played, in healthcare in the UK.

Abstract
We currently find ourselves in a fast moving and exciting time in terms of nurse education. Nurses, both registered and non-registered, are in short supply at a time when the demand for healthcare in the UK is continually increasing. We know also that an adequate supply of graduate registered nurses is essential for high quality patient and service user healthcare and so the challenge for all nurse educators, the professional body - RCN and the regulatory body – NMC is clear.

During this session we will explore the historical context of nurse education, to celebrate past successes and innovative developments and to ensure so that we do not repeat mistakes from the past. It is also interesting to note that many of the concerns and challenges that faced the nursing profession 100 years ago are still current concerns and challenges, particularly regarding what is the essence of a nurse, regarding how nurses should be educated for their role and what we expect from the registered nurse in today's society.

We will then move on to contemporary nurse education. This will allow us to celebrate some fantastic practice in current nurse education and to explore where the future will take us in terms of innovative teaching and learning strategies. This will be discussed against the very important background of the UK regulatory body, the NMC. The Standards and quality assurance frameworks set by the NMC influence current nurse education and, importantly, will support the necessary changes demanded of nurse education in the future. The future education of pre-registration nurses will be explored and there will be an opportunity for discussion on this topic.

Biography:
Dr. Anne Corrin

Anne believes that excellent nurse education is fundamental to ensuring a high standard of patient care and is, therefore, committed to improving the education and training of all nurses and student nurses. She was delighted to be appointed to the post of Professional Lead - Education (Practice and Policy) in May 2015 and since February 2016, to the post of Interim Head of Education at the RCN. Prior to working at the RCN, Anne worked as an adult nurse, health visitor and latterly as a senior lecturer at the University of Essex, during this time she led curriculum development projects, including a return to nursing practice programme, work-based learning modules and a mentorship preparation programme, and managed the mentorship preparation and pre-registration adult nursing MSc programmes.

Geraldine Walters was appointed as Director of Nursing and Midwifery Education, Standards and Policy in September 2016.

A cardiac nurse by background, Dr Walters brings a wealth of experience to the role, having previously held a number of executive nurse director posts in acute NHS trusts in London.

She has been a Director of Nursing for 19 years in a number of hospitals in London, most recently at King's College Hospital NHS Foundation Trust.

She is a visiting professor at Buckinghamshire New University and at the Florence Nightingale School at King's College London.

Theme: Knowledge for change and improvement

12.30 – 1pm

3.6.1 Professional framework for emergency care nursing

Room Wordsworth Room

Chair Andrew Clarke

Presenter Frances Cannon, Senior Professional Officer, NIPEC, UK

Co-author Roisin Devlin, UK

Aim

This abstract aims to give the reader an overview of the various aspects and background to the development of the project.

The presentation on the day will provide details of the methodologies used to meet the project objectives Discuss the various methods of engagement used throughout the project and provide a demonstration of the Northern Ireland Professional Framework for Emergency Care Nursing

Abstract

In May 2013, the Royal College of Nursing in Northern Ireland hosted a meeting of the Emergency Care Network at which numerous areas of concerns were identified in relation to nurses working in Emergency Departments across the Health and Social Care (HSC) system including the lack of a clear emergency care nursing career pathway.

The Northern Ireland Practice Education Council (NIPEC) was asked by the Chief Nursing Officer to take forward a specific work stream to further the professional development of the Emergency Care Nursing Workforce in Northern Ireland.

One of the objectives of the project was to agree a Professional Framework for Emergency Care Nurses to ensure the optimal use of the nursing contribution within Emergency Departments and support the delivery of person centred safe effective care.

The project was led by NIPEC and chaired by the RCN NI Emergency Care Network chair. The steering group comprises of representatives from the following organisations: RCN Emergency Care Network, the five Northern Ireland Health and Social Care Trusts, Public Health Agency, Royal College of Nursing, Queen's University, University of Ulster and the Clinical Education Centre.

Through extensive engagement with Emergency Care Nursing Colleagues working across the HSC Emergency Departments, and using their knowledge and experience, a Professional Framework for Emergency Care Nursing was developed.

The Framework is unique as it provides for the first time a regional approach to a career pathway for Emergency Care Nurses across Northern Ireland. It is supported by the RCN Emergency Care Association competency framework and allows Emergency Nurses to clearly map their competences and professional development pathway. The Framework for Emergency Care Nurses is hosted on the NIPEC Nursing and Midwifery Careers Pathway, is highly interactive and will be constantly updated by Emergency Care Nurses to demonstrate developments in Emergency Care Nursing Practice. Through the NIPEC website, an Emergency Care Nurse will be able to access links to a range of resources, education, training, and information to support their careers.

This presentation will aim to:

- give a background to the development of the project
- describe the methodology used to meet the project objectives
- discuss the various methods of engagement used throughout the project
- provide a demonstration of the Framework.

Reading list

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley

www.dhsspsni.gov.uk/topics/health-policy/transforming-your-care

Biography

Frances Cannon is a Senior Professional Officer at the Northern Ireland Practice Education Council NIPEC. NIPECs key responsibilities are to promote high standards of practice, education and professional development of nurses and midwives in Northern Ireland. Frances has worked in a variety of roles including clinical, management and education-post graduate - throughout her career.

Frances is the Project Lead for the Professional Framework for Emergency Care Nursing. She also leads on a number of other programmes within NIPEC including: revalidation and learning disabilities nursing.

1 – 1.30pm

3.6.2 Nurse-led Thromboprophylaxis Re-assessment tool to improve the safety of hospitalised patients in a Welsh Health Board

Room Wordsworth Room

Chair Andrew Clarke

Presenter Andrea Croft, Lead Advanced Nurse Practitioner Anticoagulation, Thromboprophylaxis Project Lead, Welsh Nurse Director, Thrombosis UK, Princess of Wales Hospital, Bridgend, UK

Aim

Share the knowledge of this successful innovation.

Abstract

All patients admitted to hospital are at risk of developing a life threatening blood clot, most commonly found in the leg, known as Deep Vein Thrombosis (DVT) or in the lungs, known as a Pulmonary Embolism (PE), collectively these conditions are known as Venous Thrombo Embolism (VTE).

The author's Health Board has adopted the National Institute for Health and Clinical excellence (NICE, 2010) recommendation, a systemic patient assessment at the time of admission for all patients.

This abstract relates to an innovation of the development and implementation of a nurse led Thromboprophylaxis re-assessment tool. The purpose of the tool is to ensure all Hospitalised patients receive a Thromboprophylaxis Risk Assessment by medical staff thus maintaining patient safety.

Robust monthly audit identified poor performance in the uptake of the risk assessment at the point of admission. Part of the author's role is to monitor compliance of the NICE guidance and identify ways to improve the service. In English Hospital Trusts a CQUIN payment had been linked to the uptake of the completion of the Thromboprophylaxis Risk Assessment on all patients when admitted to hospitals in England. This method proved very successful. Unfortunately no such payment existed in Wales therefore a collaborative approach was adopted with key ward based senior nurses as a means to address the issue.

The Thromboprophylaxis Re-assessment innovation was piloted on three wards in one of the Health Boards South Wales Hospitals from March to July 2012. The Improving Quality Together (2013) Model for Improvement was utilised and following the completion of Plan, Do, Study, Act (PDSA) Cycles it remained on the three wards where it was audited and evaluated on a monthly basis until implementation took place throughout the Health Board in spring 2013.

Following the initial pilot phase, the Thromboprophylaxis Re-assessment tool was formally placed on the Welsh Care Metrics which has demonstrated month on month a marked increase in Thromboprophylaxis Risk Assessment and Re-assessment (Table 1 and 2).

The power of collaborative working and support of clinical colleagues is as essential as staff ownership and innovation sustainability.

The introduction of the Thromboprophylaxis re-assessment tool has resulted in an increase in the Thromboprophylaxis RA uptake and the provision of a safer service within ABMUHB.

Cross boundary working between specialties has led to a better understanding of the need to risk assess and re-assess all hospitalized patients and improved communication has resulted in the provision of seamless care.

This innovation clearly demonstrates process and outcome and is underpinned by the principle of Prudent Healthcare, Do No Harm.

The increase in the number of patients risk assessed and re-assessed for Thromboprophylaxis during their hospital admission has improved patient safety.

Collaborating with the multi disciplinary team and involving them in the process of the development of the re-assessment tool and the implementation to their ward areas, gives staff a feeling of ownership which increases the desire to succeed.

Engagement with the Executive team gaining support and approval has been invaluable particularly with regards the cascading of information during the entire process.

In conclusion the increase in the number of patients risk assessed and re-assessed for Thromboprophylaxis during their hospital admission has ultimately improved patient safety and potentially saved costs of treatment. Collaborating with the multi disciplinary team and involving them in the process of the development of the re-assessment tool and the implementation to their ward areas, through the PDSA cycles, gives staff a feeling of ownership which increases the desire to succeed.

Reading list

1000 Lives (2013) The Quality Improvement Guide: A method for improving health care in Wales NHS Wales

National Institute for Health and Clinical Excellence (2010) Venous Thromboembolism: Reducing the Risk, Clinical Guideline 92

House of Commons Health Committee (2005) The Prevention of Venous Thromboembolism in Hospitalised Patients

Biography

Andrea's enthusiasm for anticoagulation has taken her as far afield as Australia. A member of the Welsh Assembly Government Thrombosis Steering Group who regularly attends associated meetings in the House of Commons where her extensive Thromboprophylaxis work was recognised in 2013, she is also Chair of her HB Specialist Nurse and Advanced Practitioner Nurse forum.

Andrea has presented topic-related material both nationally and internationally. She is the HAT Project Lead in ABMUHB and Welsh Nurse Director for Thrombosis UK.

Andrea has been published internationally.

In 2015 Andrea led ABMUHB to gain recognition as a VTE Exemplar Centre.

Theme: Knowledge for change and improvement

12.30 – 1pm

3.7.1 Advanced roles: lessons learnt from U.S. health care 'middle' grade system

Room Westminster Suite
Chair Ann McMahon
Presenter Sara Dalby, Surgical Care Practitioner, Aintree University Hospital, UK

Abstract
The NHS is facing increasing difficulties to deliver services in their current manner. A potential bridge for the clinical shortfall is the use of advanced roles. In response to the national drivers of seven day working, medical restriction through immigration limits and the European working Time Directives, a review of resources and workforce planning has been initiated to overcome the shortfalls. Middle grade system practice was evaluated in the United States. A higher standard and uniformity of "advanced roles" in the U.S. in clinical practice was demonstrated.

This highlighted the need for clinical change in the U.K. advanced role model.

Reading list
Dalby, S. (2014) Advanced Roles: Lessons learnt from U.S Healthcare 'Middle' Grade System in Education and Clinical Practice. Winston Churchill Memorial Trust

Biography
Sara qualified as a Nurse from Edge Hill University in 2003. She has worked within the operating theatres in a number of different specialties. Sara has a BSc in Nursing Studies and MSc in Advanced Nursing Practice from Manchester University. She has taken additional training in Surgical First Assistance and Surgical Care Practice. Sara is a Surgical Care Practitioner (SCP) at Aintree University Hospital and an Associate Lecturer at Edge Hill University. She was part of the Working Party at the RCS who wrote the SCP National Curriculum. In 2014 she became a Winston Churchill Fellow following her travelling fellowship.

1 – 1.30pm

3.7.2 Withdrawn

Theme: Knowledge for change and improvement

12.30 – 1pm

3.8.1 Innovation in education provision and CPD for nurses and midwives in Northern Ireland

Room Victoria Suite
Chair Gill Coverdale
Presenter Maurice Devine, Assistant Head of HSC Clinical Education Centre, Antrim Hospital, UK
Co-presenter Dr Glynis Henry CBE, Head of HSC Clinical Education Centre

Aim
The HSC Clinical Education Centre (CEC) is commissioned by DHSSPSNI (through the office of the Chief Nursing Officer) to provide In-Service Education to Nurses, Midwives and Allied Health Professionals employed in the five Health and Social Care Trusts in Northern Ireland. In addition, the Centre provides consultancy to the voluntary, community and independent sectors. The CEC comprises two units, one for nursing and midwifery and one for Allied Health Professionals.

The overall aim of this abstract is to provide a national and international audience with an overview of this system of education provision that is unique within the United Kingdom.

Abstract
The Berwick report (2013) highlighted the critical impact on patient safety if organisations target the provision of education as a potential for reducing costs or achieving financial efficiency. The report clearly highlights the need for effective, efficient and sustained learning and development for health care professionals:

"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end" (p.9).

This presentation will provide an opportunity for an international audience to hear how Northern Ireland has commissioned and structured the delivery of non-HEI based (or in-service) education for nurses, midwives and allied health professionals who work in all 5 Trusts in Northern Ireland. Such a presentation is timely considering the

demands that the nursing and midwifery professions will face as a consequence of the implementation of revalidation and the demands being increasingly felt as a result of the need for continued financial efficiency. The presentation will provide the audience with an alternative, efficient, effective, innovative and responsive model of education provision that may have the potential to work in other regions or jurisdictions.

The presentation will provide an overview of the education commissioning process in Northern Ireland, with specific emphasis on how this relates to the organisation that is known as the HSC Clinical Education Centre. We believe that this is a unique arrangement and is not replicated anywhere else across the UK and RoI.

The presentation will provide detail of our staff, our structure and how our business model has been developed to achieve equity in education delivery across all Trusts. We will provide details of our quality assurance and accountability arrangements and how we work in partnership to plan our business through effective training needs analysis, locally and regionally. We will also highlight our achievements in supporting the workforce in Northern Ireland, prepare and be ready for new policy, strategy and legislation and we will highlight some of the current and emerging pressures that we are encountering.

Reading list

Berwick. D. (2013) A promise to learn – a commitment to act. Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England.

DHSSPS (2010) A Partnership for Care: A Northern Ireland Strategy for Nursing and Midwifery, 2010 - 2015. DHSSPS.

Biography

Maurice started his training in Learning Disability Nursing, via Muckamore Abbey Hospital in 1981, qualifying as RNLD in 1985.

Following a short spell as a staff nurse in the hospital, Maurice decided to study for RGN, and successfully completed his training via Belfast City Hospital in 1988. Since then, Maurice has held posts in clinical practice, education, management and in policy/strategic development at DHSSPS.

His current post is Assistant Head of the HSC Clinical Education Centre, responsible for the delivery of education to registered nurses and midwives across Northern Ireland

1 – 1.30pm

3.8.2 Midwives and medicines (NI) 2014

Room Victoria Suite

Chair Gill Coverdale

Presenter Verena Wallace, Nursing Officer, Department of Health Northern Ireland, UK

Aim

Once registered, Midwives may supply and/or administer, any of the substances specified under the 'midwives exemptions', during the course of their midwifery practice.

A multidisciplinary working group led by the Northern Ireland Practice and Education Council (NIPEC), developed this interactive toolkit. The aim is to encourage midwives to update their understanding of medicines management and their role and responsibilities around 'Midwives Exemptions'. This interactive toolkit went through small scale improvement programmes with midwives before general rollout. An important part of a midwife's role is an understanding of medicines management, particularly what a midwife can and cannot supply and administer.

Abstract

Midwives will have a better understanding of:

- Safe, effective administration of medicines
- Various methods of supplying and /or administering
- Learning scenarios addressing the implications for practice
- Providing support to student midwives on the administration of medicines by assisting to develop their confidence and competence.

The interactive resource includes short vignettes:

- Community (homebirth) – supply and administration of a controlled drug
- Antenatal – management of routine prophylactic Anti D
- Intranatal – student midwives administration of medication
- Postnatal – calculating the dose of medication for a baby and reporting an incident.

Associated questions test knowledge and understanding of each of the short scenarios with links that take midwives through to an informative list of midwives exemptions, commonly used in NI. The resource concludes with a 'random generation' questionnaire with facility to download 'certificate of completion', providing evidence of learning.

The professional standards expected of nurses and midwives are contained in the Standards for Medicines Management (NMC, 2010). Despite the legislation, there has been confusion around midwives' responsibilities in relation to the supply and administration of medicines, in particular around Midwives Exemptions and PGD's. This resource provides clear messages now and into midwives future practice of their role and responsibilities when supplying and administering medicines.

Prescribing incidents are common due to omissions of therapy, overdose and incomplete medication details; therefore extreme care is required in interpreting prescriptions. It is recognised that midwives could possibly be the last person in the line of protection of the individual receiving the medication.

To raise awareness of the toolkit it was agreed with one of the post education providers to deliver a programme of learning and demonstration of its use. After one year of implementation the impact of the resource is being evaluated - early indication shows (November 2015):-

"This is really an excellent resource. I attended a medicines management workshop in midwifery which had the same information. However I found this on-line resource more effective in helping me to assimilate the information". (Midwife)

This resource could easily be adapted to suit the learning needs of nurses and the wider multi-professional workforce.

Reading list

Project Initiation Document.

On-Line Midwives and Medicines (NI) 2014

Biography

Verena trained as a nurse in Belfast and as a midwife in Bellshill, Lanarkshire. She has worked in Scotland, England and Northern Ireland in a variety of midwifery roles including as a Community Midwife, Project Officer, Consultant Midwife, Deputy Chief Nurse for Women's Services and Head of Midwifery. She was appointed as Local Supervising Authority Midwifery Officer (LSAMO) for Northern Ireland in 2007 and is currently seconded to the Department of Health in NI as Midwifery Officer covering Midwifery and Children's Nursing.

Theme: Knowledge for change and improvement

12.30 – 1pm

3.9.1 Implementation of Meticillin Sensitive Staphylococcus aureus (MSSA) screening pre operatively for elective orthopaedic hip and knee replacement surgery

Room	Abbey Room
Chair	Paula Hancock
Presenter	Sarah Fielder, Nurse Consultant, Maidstone and Tunbridge Wells NHS Trust, UK
Co-author	Pamela Howe, UK

Aim

Mandatory surgical site surveillance of both hip and knee replacement surgery identified an increased incidence of infection during the first three quarters of 2014-15 predominantly associated with superficial MSSA infection.

A multidisciplinary Task and Finish group was convened, comprising of the Orthopaedic Clinical Director, with representatives from the preoperative assessment team, theatres, anaesthetics, ward nurses, the Surgical Site Surveillance (SSS) Nurse and Infection Prevention and Control Lead Nurse , working across site to ensure that each part of the patient's journey was represented, a number of interventions were implemented which included MSSA screening and treatment

Abstract

A Task and Finish Group was set up to review infections, actions and to implement screening for MSSA in the nose of patients undergoing hip or knee replacement surgery, at their pre assessment appointment. An information leaflet was provided to explain the rationale of the screening to the patient. Patients found to be MSSA positive were prescribed topical decolonisation, Chlorhexidine body wash and Mupirocin nasal ointment to be used for five days prior to their surgery.

MSSA positive patients were rescreened on admission as a way of measuring whether decolonisation had successfully reduced the bacterial load prior to surgery. However, patients were not routinely isolated for infection prevention reasons on admission and there were no extra interventions for MSSA positive patients during their surgery in theatres.

In addition all elective patients were given a bottle of Chlorhexidine body wash at pre-assessment for use the night before and the day of surgery, whether the MSSA screen was positive or not.

The SSS Nurse audited all patients undergoing orthopaedic operations, for compliance with the new process. Considering national surveillance data we expected to observe patients with a positive result in between 30% to 40% of those screened, however, locally we found an incidence of around 25% of patients being screened to be positive to MSSA

Microbiology results were reviewed to confirm that an MSSA screen had been undertaken at pre- assessment, to check the result of screen and confirm evidence that a repeat screen had been taken on admission.

A review the patient notes was included to confirm decolonisation had been prescribed for MSSA positive patients or a prescription request had been sent to the GP and body wash supplied at pre- assessment

Alongside a number of other preventative processes, the screening and resulting decolonisation for patients confirmed with MSSA has had a positive reduction on infection rates from 3.5- 0 for hip replacement and 2.9 - 0 for knee replacement surgeries at this Trust. These reduced rates are currently being sustained across the orthopaedic directorate

Reading list

Loveday H., Wilson J.A.,Pratt R.J., Gorsorkhi M.,Tingle A., Bak A.,Browne J., Prieto J., Wilcox M., (2104)epic 3 National evidence based guidelines for preventing health care associated infections in NHS hospitals in England. Journal of Hospital Infection 86 1-70

Biography

Having trained in London and worked in a number trusts, in a variety of specialist areas including; Orthopaedics, ITU and Stroke Rehabilitation, vascular and breast surgery, she decided to specialise in a service that covered all areas of nursing

With previous experience in the Infection Prevention and Control team as Practice Development and Surveillance Nurse, complimenting her surgical experience, she has moved through the ranks, and has now completed fourteen years in Infection Prevention and Control gaining a Bachelor of Nursing in infection control and PGC. She is now Operational Lead Nurse for the Infection Control Team at Maidstone and Tunbridge Wells.

1 – 1.30pm

3.9.2 The development and implementation of the 'Palliative Care Holistic Assessment Aide Memoire'

Room	Abbey Room
Chair	Paula Hancock
Presenter	Fiona Gilmour, Macmillan Palliative Care Service Improvement Lead, Northern Health and Social Care Trust, UK

Aim

Patients who are identified as palliative and end of life care will have their needs holistically assessed (physical, psychological, social and spiritual) using the palliative care aide memoire. This assessment will be carried out a competent community nurse throughout the patients disease trajectory. Therefore ensuring that their care needs are identified and onward referral made to the most appropriate member of the multidisciplinary team and/ or specialist palliative care team.

Abstract

The regional palliative and end of life care strategy for adults in Northern Ireland, Living Matters, Dying Matters (DHSSPSNI, 2010) advocates the need for an ongoing holistic approach for patients with palliative care needs. This can be supported through the use of the assessment tool 'NISAT'. The Trust also considered the Northern Ireland Cancer Network (NICaN) and took the view that an adaption of this would promote a unique focus on palliative care assessment.

A task and finish group was established. Holistic themes were mapped against NISAT, and an 'aide memoire' developed to support palliative needs assessment. The final holistic assessment aide memoire was printed on A5 size.

The group agreed to pilot the aide memoire in community nursing and other specialities.

Before the pilot:

- a baseline audit was undertaken in patients assessed as being in the last year of life, to ascertain if holistic end of life care needs were identified in current documentation prior to introduction of the aide memoire
- key clinical champions were identified and training was delivered at a local level on the aide memoire.

The key champions used the aide memoire for three months. Re-audit occurred to ascertain if the aide memoire helped the clinician with the assessment process and benefited the patient and carer.

A focus group involving identified clinical champions was facilitated to acquire qualitative feedback on the pilot.

Baseline audit: 41 sets of notes were reviewed from acute and community hospitals and the community settings. The results highlighted that nurses were very good at assessing physical health, social circumstances and medicines management. Areas less assessed were mental health, quality of life and spiritual care.

Key staff were advised to use the tool from January to March 2014 inclusive and then a follow up audit was carried out.

Follow up audit: 24 patient notes were reviewed in the same clinical areas. Results showed improvement in all domains except spiritual care where less than 1/3 of patients were assessed.

Focus group: Using practice development methodologies the group (16 staff) engaged in what was good about the aide memoire and improvements needed including issues needed addressed.

Reading list

Living Matters Dying Matters end of life care strategy for adults in Northern Ireland (DHSSPSNI, 2010)

The Northern Ireland Single Assessment Tool (NISAT) Guidance (DHSSSPNI, 2011)

Biography

She qualified as a Registered General Nurse in 1990 and has worked in a variety of care settings, including haematology, oncology and specialist palliative care. More recently she has developed skills in project management and is now working in a Trustwide Macmillan Palliative Care Service Improvement Lead role. This work is very challenging but one which she thoroughly enjoys, as it involves engaging with many professionals from different specialities who have a passion for palliative and end of life care.

Theme: Knowledge for change and improvement

12.30 – 1pm

3.10.1 The validity of the Code of Ethics of Italian nurses for ethical decision-making

Room	Henry Moore Room
Chair	Anda Bayliss
Presenter	Dr Paola Gobbi, Home Nursing Care Coordinator, Local Health Service, Monza Brianza, Italy
Co-presenter	Giovanni Muttillo, RN, President of IPASVI Nurses Council of Milan, Lodi, Monza and Brianza, Director of the journal *Italian Journal of Nursing*, Italy

Aim

- Identify ethical problems in nursing cases.
- Analyze and discuss professional behaviors in the light of professional ethical principles and ethical codes.
- Apply a method for discussion of cases in the field of ethics.

Abstract

Introduction: This project was conducted by the IPASVI Nurses Council of Milan Lodi Monza Brianza in Italy. The Council was invited to analyze the 2008 draft of the new Code of Ethics for Nurses in Italy. The research question addressed by this project was: Is the Council's Code a valid or useful decision-making instrument for nurses when they are faced with ethical problems in their daily clinical practice?

Methods: A series of focus groups were organized to analyze specific ethical problems in the form of eleven case studies. The analysis was conducted by using sections of the Code relevant to the problem being examined; as well as other documents chosen according to the topic being discussed.

Results: Each focus group had a specific theme and nurses participated freely in the discussions according to the clinical competencies they developed through their practice in a specific field.

The answer to the research question posed for this investigation was predominantly affirmative. Many sections of the Code were useful for discussion and identifying possible solutions for the ethical problems presented in the eleven cases.

Conclusion: We conclude from these findings that the Code of Ethics for Nurses in Italy can be a valuable aid in daily practice in most clinical situations that can give rise to ethical problems.

Key words: Ethic code, Italian nursing, decision making.

Reading list

The Nurses' Deontological Code (2009), The Code of Ethics and conduct. Approved the Executive Board of the Federazione Nazionale Collegi IPASVI with the deliberation n. 1/09 of 10.01.2009 and by the National Council of the Federazione Nazionale Collegi IPASVI during the meeting held in Rome on 17.01.09. available on: www.ipasvi.it/static/english/the-nurses-deontological-code-2009.htm

Biography

Paola Gobbi, gained her Nursing diploma in Milan, in 1983. She went on studying with a University course for Master Science in Health Management (University of Milan, 1999) and for master in Science in Nursing (University of Milan, 2006) started to work in Nursing Education. She published her first book on Privacy in health care system and on Bioethics in 2003 and she is still cultivating this passion publishing books and teaching in several University in Italy.

Her nursing career starts in 1983 and mostly takes place in critical care (intensive care and operating theatre, heart surgery intensive care), palliative care (pain management) and psychiatric wards. Now she is home nursing care coordinator.

She is Secretary of the IPASVI Nurses Council of Milan, Lodi Monza and Brianza.

1 – 1.30pm

3.10.2 Making the most of health visiting: mobilising the profession's knowledge for impact

Room	Henry Moore Room
Chair	Anda Bayliss
Presenters	Dr Robert Nettleton, Education Advisor, the Institute of Health Visiting, UK and Sue Hatton, Senior Nursing Policy Manager, Health Education England

Aim

To demonstrate a strategy for mobilising a profession's knowledge for impact on the health of children families and communities

Abstract

In February 2011, the Department of Health published the Health Visitor Implementation Plan 2011-2015: A Call to Action, a four-year transformational programme of recruitment and retention, professional development and improved commissioning linked to public health improvement in England. This was explicitly aimed at a future health visiting service that was universal, energised and fit for long-term growth. In support of this ambition a number of additional interventions broadly aimed at realising the benefits of the expanded health visitor workforce were funded. One of these, 'Making the Most of Health Visiting', was commissioned from the Institute of Health Visiting via Health Education England (HEE) as a project to enhance the post-qualification development and support for health visitors, with transferability across other professional groups. This paper demonstrates how: (a)the project mobilised the profession to utilize evidence to underpin standards for professional development and practice for maximum impact on the health of children, families and communities; and (b)how the process of production and dissemination of project outputs embraced a wide community of practitioners as a social movement across the country with the inclusion of expertise from other disciplines / professions.

Reading list

Department of Health (2011) Health Visitor Implementation Plan 2011-2015: A Call to Action. London: Department of Health. www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015

Bishop, P., Gilroy, V. and Stirling, L. (2015) National framework for Continuing Professional Development-Standards to support professional practice. London: Institute of Health Visiting. www.ihv.org.uk/uploads/iHV_Framework%20Phase%202_AW%20WEB.pdf

Ikioda, F., Kendall, S., Brookes, F. and Reidy, C. (2014) Developing an on-line community of practice to empower health visitors: a pilot study. Journal of Health Visiting. 2: 8: 436-440.

Biography

Robert trained as a nurse and health visitor at the University of Manchester and practised as a health visitor in Stockport for ten years, including four years seconded to the NSPCC where he researched the support and supervision of health visitors dealing with child abuse. Subsequently he worked for 20 years at the University of Bolton focusing on education for professional development in health visiting and more widely. His doctoral research was focussed upon advanced practice roles in health care, including questions of professional identity while working across boundaries. Recently he has focussed on his health visiting roots including teaching community and public health, social and emotional development of children, evidence based parenting programmes and safeguarding supervision. In 2014 he joined the Institute of Health Visiting as Education Advisor. He supported a range of work streams within a major national education project 'Making the Most of Health Visiting' in partnership with Health Education England. He continues to work on educational projects and policy analysis for the iHV.

Wednesday 23 November 2016

Concurrent session 4

Theme: Societies, communities, relationships

2.45 – 4.45pm

4.1.1 Symposium 7: Towards a better understanding of global partnerships for a stronger global nursing workforce

Room St James Suite

Chair Susan Williams

Paper 1: Strengthening ZUNO as the voice of nursing in Zambia: the RCN-ZUNO partnership project

Author and affiliation

Ilona Johnston, Assistant International Adviser (Global Health), Royal College of Nursing, UK

Rita Kalomo, ZUNO Programme Officer, Zambia

Abstract

In 2014 the RCN and ZUNO signed an MoU undertaking to work closely together to develop a strong partnership and to learn from each other. The organisations developed a pilot project which aimed to support the development of nurse leadership in Zambia; to promote good clinical practice to improve patient safety; and to strengthen ZUNO's capacity to shape the health policies that enable good practice.

In April 2015 the two-year THET-funded RCN-ZUNO partnership project began, with the goal that ZUNO can influence nursing policy and improve nursing practice in Zambia as it continues to develop as a professional association. It has a particular focus on theatre nursing, looking at the role that nurses can play in changing team dynamics. This paper outlines the successes and challenges of implementing the project from the perspective of both ZUNO and the RCN, focusing on efforts to build ZUNO's advocacy capacity. It highlights what each organisation has learnt from each other and from the project. For ZUNO this includes learning in areas such as organisational development, nurse leadership and the role of nurses in decision-making and policy making. For the RCN, the project will enable learning about the relative strengths and weaknesses of the RCN's support to nurses in the UK. The RCN has used these lessons to influence the future direction of its international development work, including with regard to the focus of its international partnerships, how they are funded, and how it engages with its members on international work.

Reading list

Public Health Nurs. 2011 Jan-Feb;28(1):91-102. Conceptual model for partnership and sustainability in global health. Leffers J1, Mitchell E

Paper 2: The RCN-ZUNO partnership project: international collaboration to advance the quality of patient care and nursing influence

Author and affiliation

Professor Jane Reid, RCN member and adviser to the Royal College of Nursing, UK

Rita Kalomo, ZUNO Programme Officer, Zambia

Abstract

Globally the need for safer surgery is of increasing concern and is a priority focus for the WHO, World Bank and Health Ministries of individual countries. Demand at the University Teaching Hospital Lusaka operating theatres is ever increasing, and there is an urgent need to ensure that theatre teams can meet it and are following internationally accepted good practices. The WHO Safe Surgery Saves Lives (2009) programme has had variable uptake in Africa. However there is a strong body of opinion and growing evidence that surgical teamwork, patient experience and outcomes can be greatly improved where teams actively engage with and promote the WHO Safe Surgery Checklist (Haynes AB.et al 2009, Reid 2011).

There is also a need to strengthen the nursing voice in Zambia to advocate for and establish nursing standards in clinical practice. The presenters will share their experiences from the RCN-ZUNO partnership project, specifically of adapting and implementing the WHO Safe Surgery Checklist. They will address the question of how surgical safety can be improved by illustrating the impact of partnership, teamwork and peer-to-peer learning for locally owned and delivered improvement.

The partnership between the two nursing associations is committed to raising the profile of the critical role that nurses play in advancing quality care standards for patients. Through strengthening nurse leadership, and advocacy to advance professional standards and practice development,

the work has identified glitches that require the attention of hospital management with regard to procurement, operational efficiencies and safer staffing as well as factors that ZUNO will raise with the Ministry of Health.

At the time of this abstract the project has built the capacity of 80 theatre staff, including surgeons, theatre nurses, anaesthetists, porters and general workers. The training, directed at improving patient safety through enhanced teamwork practices and effective communication, has focused on introducing the value of safety briefings/ debriefings, the WHO checklist and the importance of local adaptation of clinical interventions to address matters of context and culture. An increase in compliance with the use of the briefing and debriefing has been found to be associated with improved patient outcomes (Neily J,2010).

Following the training, adaptation and implementation of the checklist the pilot team staff attested to improved time management, better coordination, improved communication and distinction of roles and a more efficient patient list.

Reading list

Haynes AB, Weiser TG, Berry WR.et al. A surgical safety checklist to reduce morbidity and mortality in a global population. N England J Med. 2009; 360: 491-99

Neily J, Mills P, Young-Xu Y.et al. Association between implementation of a medical team training program and surgical mortality. JAMA – Journal of the American Medical Association. 2010; 304:1693-1700

Reid J, (2011) Surgical Never Events should never happen Journal of Perioperative Practice. Available at: file:///C:/Users/jane/Downloads/JPPNovember2011-SurgicalNeverEvents-Reid.pdf Accessed November 2015

Paper 3: A portfolio approach to international solidarity and development work

Author and affiliations

Anita Robben Asbjornsen, Special Adviser International Affairs, Norwegian Nurses Organisation, Norway

Abstract

The Norwegian Nurses Organisation (NNO) has a long history of international work, beginning in 1988 with HIV/ AIDS projects in Zambia. It now has a portfolio of projects supporting national nursing associations (NNAs) in less developed countries. It has established a solidarity fund to fund some of its projects, and its regulations state that a minimum of 0.03% of the organisation's income will be used on this work. It currently has projects with NNAs focusing on organisational development in Montenegro, Zambia, Malawi, Uganda and Rwanda. It builds partnerships over the long term and its projects in each country change over time to adapt to changes in the country's circumstances.

This paper will draw out some of the key lessons from the NNO's approach to international work, including building mutual support through partnerships and building the capacity of NNAs to be trade unions (through for example establishing an informal network for NNAs in South-Eastern Africa which have trade union status). It will also examine what the long-term impact of its work has been in various countries.

Reading list

As previously listed.

Paper 4: Nursing and health partnerships

Authors and affiliation

Andrew Jones, THET, UK

Meggan Ireland, BA Hons, Grants Programme Manager, THET, UK

Richard Skone-James, BA Hons MSc, Grants Officer, THET, UK

Pippa Williams, BA Hons, Grants Officer, THET, UK

Abstract

To argue that nurses are contributing significantly to improved health in low- and middle-income countries, that Health Partnerships are an effective, responsible way of meeting the increasing training and education needs of these nurses, and that more can and should be done to enable and support this work in future.

In the face of global health worker shortages and changing health contexts, nurses are making increasingly significant contributions to the delivery of health services in low-and middle-income countries (LMICs). Unlike other health workers, their contribution is apparent across all health themes, from non-communicable diseases to palliative care to surgery and anaesthesia, and as such they are indispensable to the delivery of health services. However, while the demands placed on them continue to increase, improved nurse training and education in LMICs is required in order to ensure that nursing services are delivered in an effective way.

At THET, we support the training and education of health workers in LMICs through partnership, in part through managing the Health Partnership Scheme on behalf of DFID. The Scheme supports Health Partnerships between UK and LMIC health institutions through which the reciprocal transfer of knowledge, skills and experience takes place. By supporting partnerships that respond to locally identified needs and that work according to THET's Principles of Partnership, it has enabled over 5,400 nurses to be trained effectively and responsibly across 29 LMICs to date. Examples of nursing partnerships include that between the RCN and the Zambia Union of Nurses Organisation, which is strengthening the organisation's ability to advocate for nurses in the country. All of these partnerships are evidencing improvements to nursing services as a result of their work, which are likely making considerable improvements to the health outcomes of thousands if not millions of patients.

THET argues that the UK should be doing and can do even more to enable and support health partnerships to meet the training and education needs of nurses in LMICs. The UK's nursing community should also continue using the current momentum nationally and globally around the Sustainable Development Goals and other global health discourse for this work.

Reading list

Hasan, N., Curran, S., Jhass, A., Poduval, S. and H. Legido-Quigley (2015) The UK's Contribution to Health Globally: Benefitting the country and the world

All Party Parliamentary Group on Global Health [Online]. Available at:

www.appg-globalhealth.org.uk [Accessed 27th November 2015]

Paper 5: Reflections on the first paediatric nursing course in Zambia: a global health partnership success

Author and affiliation

Alison Taylor, Senior Lecturer in Nursing, School of Health Sciences, University of Brighton, UK

Abstract

Zambia is a low to middle income country with a young population whose health workforce have desired a specialist children's nursing course for many years. This dream became a reality with the launch of Zambia's first paediatric nursing programme in early 2014, following four years of collaborative work within a global health partnership.

The University of Brighton School of Health Sciences and the University Teaching Hospital Schools of Nursing in Lusaka, Zambia, joined forces in 2008 via the Brighton-Lusaka Health Link, a charity which aims to support education and development of health professionals in Zambia.

The innovative post-registration Advanced Diploma in Paediatric Nursing was validated following the introduction of an adult Critical Care nursing course in 2010 under the same partnership. It is wholly delivered by colleagues in-country and endorsed by the Ministry of Health. Financial support for the project was secured from the Tropical Health Education Trust (THET) and British Medical Association, along with generous contributions from private Sussex based donors and the Brighton-Lusaka Health Link itself. The third cohort of students is about to enrol on the year-long, full time programme; by the end of 2016, over 100 paediatric nurses will have registered with the General Nursing Council of Zambia. The Paediatric and Child Health Nurses Association of Zambia has been formed as a result, paving the way for continuous professional development for paediatric nurses. The association is affiliated with the Zambian Union of Nurses Organisation, itself linked to the Royal College of Nursing.

The partnership has relied on openness, flexibility, trust, patience and commitment from a large team of stakeholders at every level to achieve its goals. Valuable learning has been gained on both sides, especially as a result of the many reciprocal visits made by team members over the lifetime of the project. Understanding each other's professional, political and economic challenges as well as appreciating significant cultural differences have been key factors in the project's success.

Sharing the lessons learned, both positive and negative, is central to disseminating good practice in health partnership work and will help support other partnerships wishing to achieve similar outcomes.

Reading list

Crisp, N. 2007. Global Health Partnerships: The UK contribution to health in developing countries [Online]. Available from:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065374

All-Party Parliamentary Group on Global Health 2013. Improving health at home and abroad: How overseas volunteering from the NHS benefits the UK and the world [Online]. Available from: www.appg-globalhealth.org.uk/reports/4556656050

Theme: Societies, communities, relationships

2.45 – 4.45pm

4.2.1 Symposium 8: Health and justice: caring in criminal justice services

Room Abbey Room
Chair Annie Norman

This abstract aims to inform delegates of a symposium highlighting the wide range of nursing roles available in criminal justice nursing

The active and effective involvement of nurses in the criminal justice service has grown significantly in recent years with nurses' roles being developed across a wide range of areas. This includes police custody services, prisons, immigration and removal centres, courts and with probation services in the community.

In this symposium we explore the modern history of nursing in criminal justice services, and hear from five colleagues regarding their experiences of working in nursing services along the whole offender health pathway. Whilst hearing about their experiences, we will also consider the impact of caring for this patient group has on nurses themselves, and consider ways in which extreme levels of emotional labour encountered, can be managed.

Using examples of innovative practice and developments in the care of offenders, we demonstrate how the role of nurses in this area has grown and consider how nurses in these settings can link with colleagues in the wider nursing community, with the aim of providing equivalence and equity of care for people in contact with criminal justice.

Reading list
Norman A and Walsh E (2015) Nursing in Criminal Justice Services, MandK: Cumbria

Paper 1: Caring for prisoners: rewards and challenges

Authors and affiliation
Dr Liz Walsh, Chair, Nursing in Criminal Justice Services Forum, Independent Consultant, UK

Abstract
This paper discusses the broader professional issues facing nurses working with prisoners, in both CJS settings and acute hospitals. We explore and discuss the challenges and rewards in practice.

The 'Six C's of Nursing Care' is part of a widely known and well respected strategy for building a more compassionate culture for nursing in the National Health Service in England. In this paper, the Six 6's of Nursing Care (care, compassion, courage, communication, commitment and competence) are used as a framework to reflect on and identify the key challenges and stresses facing nurses working with prisoners, both in criminal justice and acute health settings, with a view to considering how they can be appropriately managed to ensure high quality care provision without substantial cost to professional wellbeing. Whilst caring for people in prison can be professionally challenging, the rewards from practice in this area will also be explored. Focus on job satisfaction and rewarding practice in this setting will provide a foundation to explore clinical supervision as a framework to learn from and develop practice, as well as being a space for support.

Reading list
Davidson J. 2014. New to Forensic Medicine. NHS Education Scotland.

Paper 2: Collaborative working: police custody health care and emergency department

Authors and affiliation
Jessica Davidson, Senior Clinical Forensic Charge Nurse, South East Scotland Healthcare and Forensic Examination Service, NHS Lothian, UK

Annette Cosgrove, ED Charge Nurse, New Royal Infirmary of Edinburgh, UK

Abstract
Edinburgh is the capital city of Scotland. It is famed for its beauty, its old buildings and traditions , including the world's largest festival of the arts. However, Edinburgh also has a grand medical and nursing tradition, the front door of which is at the Emergency Department at the New Royal Infirmary of Edinburgh.

As in all big cities, there is a darker side. The cost of poverty real and relative translates into crime. There are crimes of desperation and violence, survival crime and crimes that have their roots in the poverty of aspiration.

In 2014-15, the South East Scotland Police Custody Healthcare and Forensic Examination service saw 17,500 patients. These were men, women and children who had come into contact with the Criminal Justice Services due to committing a crime, or being the victim of a crime.

Many of the adults coming into police custody also required treatment from the Emergency Department at NRIE. The development of relationships between departments is often an unsung hero that contributes to the smooth running of the NHS. The quality of relationships can improve response times and quality of treatment for patients and help minimise the impact on stretched public services, in this case, the Police and 2 busy providers within NHS Lothian. In particular, this paper will focus on the work to produce risk management care plans for some of the most marginalized and disenfranchised patients in Edinburgh, and also how we combated the sudden emergence of Novel Psychoactive Substances in the city by joint working.

By highlighting this work and subsequent changes in practice, we are trying to measure success in a positive and quality driven way which will be recognisable by nurses as the daily work of nurses throughout the United Kingdom.

Paper 3: Pulmonary rehabilitation in a prison setting: a feasibility pilot and evaluation

Authors and affiliation
Nina Turner, Clinical Nurse Manager, HM Prison Rochester, UK

Abstract
Pulmonary Rehabilitation (PR) is a grade A evidenced based programme of care which had never been delivered in a prison. Helen Jefford and I set this service up as I noted this was an unmet need causing an inequality. With smoking incidences from 80% in prisons, there are an unknown number of patients with Chronic Obstructive Pulmonary Disease (COPD) with no access to PR in prisons. PR was a service that patients in prison should have been offered as they are entitled to the same access to care as people in the community. A collaborative partnership between prison health care and the local COPD team in the community created screening clinics for prisoners > 35 who smoked and identified those appropriate to attend PR.

Patients were enrolled from Feb to July 2013 and offered twice weekly PR over 7 weeks which was delivered in an allocated gym, in the prison. Standardised outcome measures were used including a 6 minute walk test to measure functional exercise performance. Anxiety and depression were measured by the GAD-7 and PHQ-9 respectively. Health status was measured using the clinical COPD questionnaire (CCQ) and the COPD assessment tool (CAT) and knowledge of COPD via the Bristol COPD Knowledge Questionnaire (BCKQ). Paired t-test (2-tailed) were carried out to determine whether there was a difference in scores pre and post the PR programme. Qualitative feedback data was collected via a questionnaire and analysed thematically. 15 patients completed the programme. Statistically significant improvements were demonstrated in the 6MWT, CCQ and the BCKQ, and although reductions demonstrated in the GAD-7, PHQ-9 and the CAT, they were not found to be significant.

Pulmonary rehabilitation in a prison was found to be effective, safe for patients and staff, and produced equitable outcomes. This included better compliance with medications, prompter treatments for the management of COPD exacerbations and a reduction in out of hours help.

Paper 4: Street triage: collaborative working – mental health nursing and police

Authors and affiliation
Karla Wilson-Palmer, Team Manager, Devon Street Triage Pilot, Devon Partnership NHS Trust, UK

Abstract
Street Triage operates in one form or another across many regions of the UK, but the concept remains essentially the same. Police and mental health services working together to ensure that people encountered by the police, suspected of experiencing mental health crisis, are not unnecessarily detained under Section 136 of the Mental Health Act and receive timely and appropriate support to meet their needs.

In 2013 the Department of Health funded nine police force areas to carry out a 12 month Street triage pilot scheme. The Devon and Cornwall Constabulary was one of the initial national pilot sites. Devon Partnership NHS Trust was successful in a bid to provide the Street Triage service. The model chosen for Devon was to base a mental health professional in the Police Control Room at peak demand times. The pilot design ensured that appropriate incidents were brought to the attention of a mental health professional as soon as possible.

Benefits and outcomes
- Improved care pathway for those experiencing a mental health crisis
- Reduction in S.136 MHA detentions
- Reduction in police time spent dealing with people in mental health crisis
- Shared knowledge and understanding

From the NHS and police data sets analysed over the pilot period, it was evident that the introduction of Street Triage at first point of contact influenced, and positively reduced, the number of S136 detentions made by police officers in Devon. The Control Room -based Street Triage model appears to a cost effective efficient model of operation. One of the key benefits of Street Triage is the cultural shift of police and mental health staff working together promoting mutual understanding of each other's roles and responsibilities resulting in enhanced working relationships and improved outcomes for some of the most vulnerable members of our society.

Reading list
The Bradley Report 2009 www.rcpsych.ac.uk/pdf/Bradley%20Report11.pdf

The Mental Health Crisis Concordat 2014 www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

Paper 5: Mental health nursing and public protection

Authors and affiliation
Mark Warren, Integrated Manager, Cardiff and Vale University Health Board, UK

Abstract
In addition to their caring role Mental Health Nurses have always been charged with ensuring the safety of those in their care and the wider safety of the public at large. In days gone by this took the form of providing care and treatment in large psychiatric hospitals and, as society and its views on mental health have moved forward, now increasingly in the community.

As part of the Nursing in Criminal Justice pathway, Mental Health Nurses are playing an integral part in jointly managing offenders who suffer from mental ill health with the National Probation Service, the Community Rehabilitation Company and taking a lead role for health in the local Multi Agency Public Protection Arrangements known as MAPPA.

This paper will describe to the wider nursing community the role of the mental health Nurse in working across multi agencies with service users who present the highest possible risk to public safety.

It will describe the skills required to survive as an autonomous practitioner in often hostile environments when the mental health nurse will often be the only health professional involved. It will look at the skill set needed to mange high risk offenders with mental ill health in the community especially the development of risk assessment and management skills.

It will also describe the specialist knowledge needed by the practitioners in this field who require clear understanding of the world of Criminal Justice Agencies.

It is intended to propose further ways forward in developing this specialist role which is becoming increasingly enshrined as good practice throughout England and Wales and to reflect on the journey taken by nurses from the institutional care setting to their current place within Multi-agency working

Reading list
Norman, A and Walsh, E. (2014) Nursing in Criminal Justice Services, Glasgow: MandK

Brooker et al (2012) Probation and Mental Illness. Journal of Forensic Psychiatry and Psychology.23 (4), 522-37

Jackson,D., Firtko, A. and Edenborough,M (2007) Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. Journal of Advanced Nursing. 60(1):1-9

Theme: Society, communities, relationships

2.45 – 3.10pm

4.3.1 Influencing Politicians and political agenda: a job for nurses?

Room Churchill Auditorium (main hall)
Chair Ian Hulatt
Presenter Baroness Emerton, UK
Co-presenter Jane Hughes, Deputy Director of Communications & Campaigns, RCN, UK

Abstract
Should nurses take on that responsibility? If so how well equipped should they be?

My mind was set from the age of four to be a nurse and, against great opposition from my Head Teacher, I was offered six London teaching hospital places. I had never shown an interest in politics and my parents were not members of any political party but they encouraged me to read the daily paper which was reiterated as a 'must' in the preliminary training school. I remember the GNC included sessions on the history of nursing and how Florence Nightingale had influenced Government Ministers with the findings of her research on the importance of clean water supplies and means of safe sanitation. We were all encouraged to join the Royal College of Nursing, which I did in 1957 and have been a member since.

My career has been long and varied and my desire to be of value to patients as a nurse has never waned however I NEVER dreamed or wanted to be invited to the House of Lords. In fact I hesitated about accepting as I did not wish to be affiliated to a Political party under a whip, but I am about to enter my 20th year as a Cross Bench Independent Peer. Come hear what it is like to influence politicians and political agendas.

3.15 – 3.45pm

4.3.2 Withdrawn

3.45 – 4.15pm

4.3.3 What next for the RAF reservist nurse?

Room	Churchill Auditorium (main hall)
Chair	Ian Hulatt
Presenter	Jennifer Lewis, IPandC nurse, UHW, Cardiff and IPC Flt, TMW, RAF, UK

Aim

To highlight the many advantages of being a RAF Reservist nurse, with a nod to the personal costs of deployment and the benefits of transferable skills; including leadership, management and clinical skills training.

Abstract

Learning Objective: To discuss and analyse the role, training and deployment of the Reservist nurse within the Royal Air Force and where the future may lie both in peacetime and whilst deployed on operations.

Introduction: RAF Reservist nurses have been working alongside our regular colleagues since World War II – completing Intra War Zone Aeromedical Transfers and Aeromedical Evacuation out of war zones, up to the present day. The author is a member of No 4626 Aeromedical Evacuation Squadron, based at RAF Brize Norton, which trains nurses, doctors, medics and paramedics, most of whom hold civilian jobs in the NHS. However, how much is known by our non-military nursing colleagues regarding this unique and sometimes dangerous role that your NHS nurses are undertaking. This presentation will explore the additional military training achieved and the knowledge required in both military aircraft and aviation medicine that the RAF Reservist nurse has to undertake. It will also look at the cost of training the RAF Reservist Nurse and what benefits there are to the employer that having a Reservist in your Unit can make.

Method: As a Squadron we have had nurses deployed on numerous Operations, completing roles such as tactical and strategic aeromed, forward aeromed, medical emergency response team or working as theatre, ITU, IPC and ED nurses. Their patients have often suffered the most significant trauma, whether that be a gunshot wound or Ebola.

Analysis: The costs and personal time versus exceptional training and experience gained.

Discussion: What next, as we move into a time of contingency? There is a "Whole Force" concept with the numbers of Reservists being increased around the UK on an annual basis. I would also discuss the management, leadership and command training required and the leadership opportunities that are available in projects, training activities and exercises. There is also deliberate transfer of nursing skills from and to the NHS, to constantly improve the patient experience.

Reading list

The 2015 SDSR: a primer

This is defence nursing - An RCN guide for nursing staff

NHS should tap into experience of defence nurses - Nursing Standard, 2013. Vol28(2)page 10

Biography

Jennifer Lewis trained as a General nurse at The Royal London Hospital in Whitechapel, qualifying in 1986. She consequently staffed there and at Guy's Hospital for several years. Having completed the ENB136 course and with no jobs available, she became a Night sister back at The London and then she commissioned as a PMRAFN officer and worked as a Renal nurse at RAF Halton for 4 years. She was then posted to RAF Lyneham and worked on the Aeromedical Evacuation Team for 2 years. Post children, she has worked as a District nurse, a prison nurse and is now a IPandC nurse in UHW. She joined 4626(AE) Squadron in 2010 and sucessfully re-gained her commission in 2012.

4.15 – 4.45pm

4.3.4 Capitalising on opportunities to involve fathers in child health care

Room	Churchill Auditorium (main hall)
Chair	Ian Hulatt
Presenter	Dr Tom Laws, Lecturer, Keele School of Nursing and Midwifery, Keele University, UK

Aim

It is established that working mothers have untenable family and employment workloads and aim to redress this burden by sharing parental responsibilities with the father. The prevalence of childhood illness remains a substantial parental burden. However, opportunities for involving fathers in child health are limited; men are not socially scripted for child health and organisations remain women centred. Fatherhood and illness create stress which may manifest as violence; nurses can play an important role in screening for this impediment to men's caring for mother and child. Contemporary nurses recognise that knowledge of gender is crucial to tailoring support for men.

Abstract

Working mothers frequently amass untenable commitments when combining employment and family responsibilities, this can impact negatively on personal wellbeing and the capacity to promote the child's health; to resolve this state these women seek a more equitable sharing of parental responsibilities with the father. Child health issues represent a substantial proportion of burden of care for

women, yet few men are seen to be capable, competent or willing to share this workload. Burgeoning research shows that fathers do provide care comparable to competent mothers. Nurses have opportunities to socialise and equip new fathers with associated benefits; support for working mothers and a more clearly defined role of contemporary fathers within health systems. Impeding progress are paternal behavioural problems associated with substance abuse, mental health problems and intimate partner violence.

Intended learning outcomes

- Identify the need for involving fathers in child health care.
- Describe the barriers to men participating in providing care for a sick child.
- Explain how an understanding of gender is essential for developing strategies to involve fathers in acquisition of knowledge and skills for the purpose of providing competent paediatric care.

Reading list

Laws TA, (2004) Father's struggling for relevance in the care of their terminally ill child, Contemporary Nurse, 17(4):34-45.

Laws TA (2006) Men's health practices within dual income families. Australasian Digital Thesis, University of Adelaide, digital.library.adelaide.edu.au/dspace/handle/2440/56316

Pelentsov, L. J., Fielder, A. L., Laws, T. A., and Esterman, A. J. (2016). The supportive care needs of parents with a child with a rare disease: results of an online survey. BMC Family Practice, 17(1), 1.

Biography

Dr Tom Laws is an expert in researching fatherhood and its impact on family health. He has authored three men's health books and numerous men's health publications ranging from the development of supportive care pathways for men with cancer to father's care of children with terminal illness /chronic illness. His current focus is the prevention of intimate partner violence in pregnancy. His recent work seeks to establish how men can support mothers in pregnancy and the postnatal period. Dr Laws has a PhD in community medicine and degrees in Economics, public health and education. He is also a midwife.

Theme: Technology and innovation

2.45 – 4.45pm

4.4.1 Symposium 9: Nursing student engagement with health professionals and the public via social media

Room Victoria Suite

Chair Ann McMahon

This symposium will include four papers followed by panel discussion with the audience. The numbers of patients and nurses who use social media to communicate is growing rapidly, therefore it is crucial that nurse academics embrace these changes and help students to become digitally literate professionals.

This symposium describes the introduction of social media, in particular Twitter, into the nursing undergraduate curriculum in two Universities, and how this has enabled nursing students to engage with health professionals and patient groups. We will also look at student involvement with Patient Opinion both via Twitter and its website.

The first two presentations, from academics and students, will describe how Twitter has been implemented using two contrasting methods in Salford University and Plymouth University undergraduate curricula. The third presentation (15 minutes), from @WeNurses with nursing students from Salford and Plymouth, will describe how student nurses have engaged with professionals on one online nursing community, and how nursing students have benefited. The last presentation, from Patient Opinion with student nurses from Plymouth University, examines the interaction between patients and professionals through the 'feedback site' Patient Opinion, and through its Twitter presence, and how students have engaged with patients and patient groups.

Reading list

Online to look at:

@WeNurses, @NursingSUni, amd @punc14 on Twitter
www.PatientOpinion.org.uk

Paper 1: Confidence, curation and professional identity, growing through online presence

Authors and affiliation
Moira McLoughlin, Senior Lecturer/Student Experience Lead, University of Salford, UK

Abstract
As an early adopter of social media in nursing education Salford University nurse academics have developed an on-line presence with students that complements day-to-day work. Some virtual support takes place through the school twitter account (@nursingSUni), co-curated in partnership by academics and students, offering evidence and knowledge exchange. The account has over 5k followers and enables interaction with current and prospective students, health care professionals and the public, providing support beyond traditional workplace hours and with 'conversations' that reach many more.

By becoming involved in social media through the co-curation strategy we argue that students are offered the opportunity and enabled to develop a strong professional work ethic. This embraces traditional nursing approaches with a strong online professional presence congruent with the principles outlined in the Code (NMC 2015). Through promotion of pedagogies and technologies that add value to learning in flexible ways, we are aiming to prepare students more effectively for the rapidly changing workplace.

This digital project therefore aims to be a constantly accessible university department available to all nursing students and the wider public. Students develop the skills to engage professionally online and since inception, we have empowered students to control and curate content for the Twitter account and school Facebook pages, further developing knowledge and networks in their own area of interest. Students are encouraged to post reflective blogs after curation available at www.salforduniversitywordpress.com and these accounts articulate how they have grown in confidence and professional identity. Between January and November 2014 to the present day, there have been over 35 student curators some opting to do it for a second and third time, with blogs produced reflecting on personal growth and development through curation and with tweets that also demonstrate growing professional confidence and ability to support not only peers locally but across the tweeting community.

Reading list

Sinclair, W, McLoughlin M and Warne, T (2015) To Twitter to Woo: Harnessing the power of social media (SoMe) in nurse education to enhance the student's experience. Nurse Education in Practice. In Press. Online June 2015

Wilson,R. Ranse,J Cashin, A and McNamara, P (2014)

Nurses and Twitter: the good the bad and the reluctant

Collegian, 21 , pp. 111–119

Skiba, D. J (2011) Nursing education 2.0: the need for social media policies for schools of nursing Nurs. Educ. Perspect., 32 (2) pp. 126–127

Paper 2: Twitter as an assessed component of digital professionalism for all first-year nursing students

Authors and affiliation
Professor Ray Jones, Professor of Health Informatics, Plymouth University, UK

Abstract
Nursing students need to use social media professionally, avoiding pitfalls but using learning opportunities. Plymouth University introduced Twitter as part of 'Digital Professionalism' as an assessed component representing 10% of an initial module for all first year students in October 2014. We want all students to use webinars, chat Rooms, and social media for their learning, including discussions with professionals and the public.

We piloted Twitter with second and third year students in September 2014, then introduced it as an assessed component for 450 (October 2014), 97 (February 2015), and 498 (October 2015) first year students. Students received a face-to-face lecture, two webinars, used chat Rooms and were asked to set up course Twitter accounts. In the assessment, use of webinars and chat Rooms represents 3/10 and creating Twitter accounts and 'lurking' 3/10. Students do not have to 'Tweet' but can do so for the remaining 4/10 of the assessment or, alternatively, write an essay on the pros and cons of social media in the curriculum.

Few second and third students started optional use of Twitter. Nearly all first years for whom Twitter was part of Digital Professionalism assessment used it. Most students (70.1% first, 88.0% second cohort) thought including Twitter was worthwhile. Changes from first to second cohort included better peer-peer support, more contextualisation in 'Digital Professionalism', and emphasis on nursing communities. More second cohort students learned from Twitter (44.4% Vs 70.8%) and used Twitter recently (43.3% Vs 81.6%). Students gained wider perspectives on nursing, better understanding of social media, 'being student nurses', and topics like health promotion. Students followed nursing communities and patient organisations.

Nursing schools should consider introducing Twitter to first year nursing students, assessed within the context of Digital Professionalism to ensure that all students are aware of social media's potential as well as pitfalls.

Reading list

Online look at @punc14 on Twitter

Paper 3: Students engaging with professionals and others via @ WeNurses

Authors and affiliation

Teresa Chinn, MBE, RN and Social Media Specialist, WeNurses, UK

Megan Betts, 3rd year student, Plymouth University,UK

Debs Cooper, Nursing student Salford University, UK

Abstract

WeNurses was set up in 2012 as a Twitter forum for qualified nurses to share ideas, experiences, resources, best practice and support. The community following has grown rapidly with now over 40 thousand Twitter followers. An average 100 people participate in the twice weekly Tweetchats, with an average of 1000 Tweets being shared with a potential average reach of 6 million people. Many of the participants are students who are able to learn from qualified nurses, other health care professionals and patients and carers, all of whom join in the Tweetchats. Quite a number of the Tweetchats have also been hosted by students. For example: "Student Engagement In Lectures" was hosted by Deborah Cooper from Salford University and "Let's Talk Death" was hosted by Dorcas Lambert from the University of Bradford. In addition to this we have also used webinars with concurrent Tweetchats to engage students for example: "Supporting Student Nurses" With Neuro-Diversity in which Megan Betts from Plymouth University was part of the webinar panel. The student led discussions have not only been valuable to students and nurses but also have provided a valuable experience for the student nurses leading the chats.

WeNurses has been a supportive environment for student nurses as exemplified by numerous 'conversations' This presentation will give examples and share experiences of student nurses who have taken part in Tweetchats, what they have gained from the experience and how Tweetchats have become a valuable resource for student nurses.

Reading list

To Twitter to Woo: Harnessing the power of social media (SoMe) in nurse education to enhance the student's experience - Nurse Education In Practice Wendy Sinclair, Moira McLoughlin, Tony Warne

Paper 4: Engaging with patients via social media including Patient Opinion

Authors and affiliation

Dr James Munro, Chief Executive, Patient Opinion, UK

Nathan Trevena, Julie Woolman, Megan Betts (nursing students) Plymouth, UK

Abstract

Online communication is rapidly becoming mainstream for patients and professionals alike. Social media in particular represents a new form of communication characterised by immediacy, informality and openness, cutting across traditional hierarchical and organisational structures. Increasingly, patients and professionals are connecting with one another via open social media or dedicated platforms such as Patient Opinion (patientopinion.org.uk), creating new possibilities for service improvement, issue resolution, innovation and education.

Patient Opinion began in 2005 and runs as an independent social enterprise, used to some degree by 90% of NHS trusts in England and all health boards in Scotland. Over 130,000 stories are now searchable online, with 5-10% of stories which raise concerns leading to explicit change. Patient Opinion has been used to support professional education in four universities to date (Plymouth, Sheffield Hallam, Edinburgh, Kingston), bringing authentic patient experiences to students in near real-time, and offering new possibilities for health care students to become aware of and interact directly with local and national operational, quality improvement and policy issues.

In Plymouth, students are also engaging directly with patients and patient groups via Twitter. For example Trevena has worked with Epilepsy Action Truro by Facebook, Twitter and in person. The group offers support to its members and raises public awareness of Epilepsy. Woolman met, via Twitter, the founder of the Purple Angel group raising awareness and offering support for people with dementia and has been able to share these posts on Twitter with professionals and students to increase awareness of Lewy Body Dementia. Finally, the use of social media skills developed by students can help address challenges faced by Patient Participation Groups (PPG) in primary care. Betts, in her attachment to a PPG in Falmouth, has helped group members use Twitter and blogging to reach more of their local population.

Reading list

Munro J What I know I owe to patients. BMJ 2014;349:g6734 www.bmj.com/content/349/bmj.g6734.full?ijkey=F95A78Jje5c3h1vandkeytype=ref

Theme: Technology and innovation

2.45 – 3.15pm

4.5.1 Management of implantable cardioverter defibrillators in advanced heart failure

Room Rutherford Room

Chair Ross Scrivener

Presenter Loreena Hill, Heart Failure Nurse and PhD student, Belfast Health and Social Care Trust, Ulster University, UK

Co-authors Prof Sonja McIlfatrick, UK; Prof Brian Taylor, UK and Prof Donna Fitzsimons, UK

Aim

Implantation rates for implantable cardioverter defibrillators (ICD) have risen exponentially across Europe in recent years. Despite expert guidance, clinical practice remains diverse in the management of patients with an ICD at the end-of-life.

This abstract outlines an exploratory study which provided rich qualitative data on patients' and carers' perspective of deactivation. This data was amalgamated with evidence derived from a systematic literature review and current practice, to develop an electronic factorial professional survey. This survey found a number of factors that impacted professionals' decision to discuss ICD deactivation. Results have the potential to improve clinical practice, professional education and international policy, ultimately benefiting the experience of patients with an ICD.

Abstract

Background: The ICD is cornerstone in the treatment of life-threatening arrhythmias, although there is growing concern that dying patients are receiving multiple futile shocks. Expert guideline recommendations regarding ICD deactivation are not implemented in practise and ICD deactivation is rarely discussed. This limits patients' and carers' knowledge and choice at end-of-life.

Aim: To explore perspectives of patients, carers and professionals regarding ICD deactivation and to examine the impact these have on clinical judgements about end-of-life management.

Methods: Sequential exploratory mixed methods design incorporating two phases.

- Phase One: Data from a systematic review of literature, case studies and retrospective case note review were synthesised and used to generate nine independent variables.
- Phase Two: Variables were randomly manipulated and embedded within vignettes of a factorial survey disseminated to UK and Irish professionals.

Results: Phase One data confirmed pre-implantation information on ICD's functionality and possible deactivation was inadequate. Patients' and professionals' held a positive perception of the ICD and were reluctant to discuss deactivation until death was imminent. Most patients wanted involvement in critical discussions, although agreed the decision concerning deactivation should be made by their cardiologist, without burdening family. Carers' were kept uninformed unless the patient became cognitively impaired. Phase Two: 534 vignettes were completed by 89 professionals (22 Cardiologists, 57 Nurses, 10 Clinical Physiologists). Nurses were more likely to favour a pre-implantation discussion than cardiologists, although all groups agreed the subject of deactivation should be broached when death was imminent. Clinical indicators of heart failure severity (NYHA IV) and diagnosis of bowel cancer increased the likelihood of this discussion. All groups felt deactivation was warranted when the patient experienced multiple shocks, however data from Phase One found no evidence of this occurring. Professionals in post for at least six years were most confident in clinical decision-making.

Conclusions: These data highlight missed opportunities to involve patients in shared decision-making, with the majority of professionals reluctant to discuss deactivation. Lack of pre-implantation information compromised patients' knowledge and restricted informed decision-making to last days of life. Professionals' relied on their intuitive judgement rather than evidence-based guidance. Data extends the factorial survey methodology and provides direction to improve end-of-life care for patients with an ICD.

Reading list

Hill, L., McIlfatrick, S., Taylor, B., Dixon, L., Harbinson, M., Fitzsimons, D. (2014) Patients' perception of implantable cardioverter defibrillator deactivation at the end of life . Palliative Medicine, [online]. Available from: pmj.sagepub.com/content/early/2014/09/17/0269216314550374 (Accessed 30th August 2015).

Hill, L., McIlfatrick, S., Taylor, B.J., Dixon, L., Cole, B.R., Moser, D.K., Fitzsimons, D. (2015) Implantable cardioverter defibrillator (ICD) deactivation discussions: Reality versus recommendations. European Journal of Cardiovascular Nursing. DOI: 10.1177/1474515115584248

Padeletti, L., Omar, D.O., Boncinelli, L., Brachman, J., Camm, J.A., Daubert, J.C., Kassam, S., Deliens, L., Glikson, M., Hayes, D., Israel, C., Lampert, R., Lobban, T., Raatikainen, P., Siegal, G., Vardas, P. (2010) EHRA expert consensus statement on the management of cardiovascular implantable electronic devices in patients nearing end of life or requesting withdrawal of therapy. Europace. 12. p. 1480-1489.

Biography

Registered nurse with nearly 20 years' experience in cardiology, for the past 10 years Loreena has worked as a heart failure nurse (HFN) within the Belfast Trust. She completed an MSc 2006 and ISP course in 2007. Her research interest remains the management of end-stage heart failure patients with an ICD. In 2012, she successfully obtained a RandD doctoral fellowship to study this area.

Her thesis was submitted on the 2nd October 2015, and is awaiting viva. Currently she works part time as a HFN as well as completing a post doctoral project funded by the Heart Failure Association of the ESC.

3.15 – 3.45pm

4.5.2 Nursing in a digital world

Room Rutherford Room

Chair Ross Scrivener

Presenter Anne Cooper, Deputy Clinical Director and Chief Nurse, Clinical Services Portfolio, NHS Digital, UK

Summary of session

A broad presentation that explore the current issues in nursing relating to the emergence of technology and outlining the current position in England to illustrate the impact.

Abstract

Exploring the current position with the use of technology and data in nursing practice and looking at practical examples of the application. Aims to explore key challenges for practice.

Biography

Anne Cooper is the Deputy Clinical Director and Chief Nurse at NHS Digital, described by Nursing Times and HSJ as a top social pioneer in health and in the top 50 inspirational women in the NHS for 2014. Anne is a fellow of the Queens Nursing Institute.

A senior nursing leader Anne has a background in nursing, informatics and organisational development she has delivered a change agenda in the integration of clinical informatics leadership with policy and practice.

Intended learning outcomes

1 Identify key challenges facing nursing in relation to the emergence of technology and information

2 Give examples of where technology is being adopted in nursing.

3.45 – 4.45pm

4.5.3 Workshop

Using Twitter as a medium to embed evidence into practice - lessons from evidence based nursing

Room Rutherford Room

Chair Ross Scrivener

Presenter Dr Alison Twycross, Head of Department for Children's Nursing, London South Bank University, UK and Dr Joanna Smith, Lecturer Children's Nursing, University of Leeds, UK

Abstract

This interactive workshop will explore the use of social media as a means of engaging nurses in the challenges of embedding evidence into practice. We will draw on our experience of using Twitter as a strategy to engage with our readers at the journal of Evidence Based Nursing (EBN).

Aims: This interactive workshop will explore the use of social media as a means of engaging nurses in the challenges of embedding evidence into practice. We will draw on our experience of using Twitter as a strategy to engage with our readers at the journal of Evidence Based Nursing (EBN).

Methods: A 2010 readership survey identified that EBN has two distinct groups of readers; those opting for a paper copy and those interacting with the journal online and through social media. The shift in the way nurses interact with the journal corresponds with an increased recognition of the value and possibilities of social platforms such as Twitter to converse, interact, share information and disseminate best practice (Archibald and Clark 2014; West and Verran 2013), The editorial team aimed to enhance reader involvement with the journal content, while at the same time increase the number of people accessing journal content. A social media plan was developed to expand the number of online readers engaging with the journal. A key element of this plan was the introduction of the Twitter platform, in particular Twitter Chats (#ebnjc).

Results: During the workshop we will share our experiences of setting up a Twitter Chat (#ebnjc), the change in focus of our blogs, and reflect on the challenges and successes during our journey. We will demonstrate how a Twitter Chat works through a live Twitter discussion, and use Storify to draw together the themes that transpire from the Twitter chat. There will be opportunity for participants to share their experiences of using social media.

Conclusion: Participants will have an opportunity to debate the challenges and rewards of using Twitter and other forms of social media as a means of keeping updated professionally and disseminating best practice.

Biography
Alison is Head of Department for Children's Nursing and Reader in Children's Pain Management at London South Bank University. She has worked in nurse education for 20 years at five different universities. Alison's research focuses on exploring what happens in practice and identifying strategies for improving children's pain management. Her current research looks at supporting parents to manage their children's pain at home. She has edited three books bringing together the evidence for children's pain management that are used as key texts internationally. She has over 40 papers published in peer-reviewed journals and is editor of Evidence Based Nursing.

Reading list
Archibald, M.M. and Clark, A.M. (2014) Twitter and nursing research: How diffusion of innovation theory can help intake, Journal of Advanced Nursing, Online early.

West, C. and Verran, D. (2013) Something to tweet about: Incorporating social media into your nursing practice, Transplant Journal of Australasia, 22(1): 10-12.

Theme: RCN Session

2.45 – 3.15pm

4.6.1 RCN credentialing advance practice

Room Henry Moore Room
Chair Paula Hancock
Presenter Professor Dame Donna Kinnair, Director of Nursing, Policy and Practice, Royal College of Nursing, UK

Aim
To discuss RCN Plans for credentialing advanced nurse practitioners and its fit with the Royal College function.

Abstract
This presentation seeks to explain the rationale for why the RCN is committed to advancing nursing practice through the introduction of Advanced Nurse Practitioner credentialing. It will offer the definitions of advanced level practice and credentialing and outline how the work has been developed to date and the mechanism for applying for credentialing. It will be set within the context of the wider work and ambitions for our Royal College function.

Reading list
RCN (2010) Advanced Nurse Practitioners, An RCN guide to Advanced Nursing Practice, Advanced nurse Practitioners and Programme Accreditation

NHS Scotland (Accessed 2016) Advanced Practice Toolkit www.advancedpractice.scot.nhs.uk

NLIAH and GIGC/NHSW (2016) framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales

Biography
Professor Dame Donna Kinnair, DBE, RGN, HV, LLB, MA, joined the RCN as Head of Nursing on 1st June 2015, providing leadership to the Nursing department. In January 2016 Dame Donna was promoted to Executive Director leading the Nursing, Policy and Practice department.

Donna held various roles prior to joining the RCN. These included Clinical Director of emergency medicine, Executive Director of Nursing. She was the Strategic Commissioner for Lambeth, Southwark and Lewisham Health Authority's Children's Services. Donna advised the PM's Commission on the future of Nursing and Midwifery in 2010 and served as nurse/child health assessor to the Victoria Climbié Inquiry.

3.15 – 3.45pm

4.6.2 RCN awarding clinical fellowships

Room Henry Moore Room
Chair Paula Hancock
Presenter Gill Coverdale, Professional Lead for Education (Standards and Professional Development), Royal College of Nursing, UK

Aim
This session will share with participants developments in the RCN Fellowship awards and how these fir with the overall professional offer for RCN members.

Abstract
The RCN is expanding their Fellowship offer and this presentation will share with participants the opportunities for applying for an RCN Fellowship or RCN Clinical fellowship award.

Intended learning outcomes
Participants will have an understanding of the

- Fellowship structure in the RCN
- criteria for awards and how they will be able to apply.

Biography
Gill has a wealth of experience in delivering health care in the community and primary care, promoting public health and delivering pre and post registration nurse education and research. She also has a valuable background in UK regulation and has worked with both national and international governments to advise on the delivery of health services and nurse education.

3.45 – 4.15pm

4.6.3 Mentorship: the future of practice-based education

Room Henry Moore Room

Chair Paula Hancock

Presenter Dr Stephanie Aiken, Deputy Director of Nursing, Royal College of Nursing, UK

Aim

In a time of uncertainty and change around investment in, and development of, the current and future nursing workforce, this session will consider the challenges, opportunities and actions required to enhance and develop practice education for nursing.

Abstract

Currently, pre-registration nursing students spend 50% of their education developing and applying leaning in practice settings. The role of the mentor is central in supporting this but the challenges in sustaining the current model of mentorship to support the increasing diversity of the nursing student population, and to meet the needs of a wider variety of health care settings, is becoming increasingly apparent. This session will outline the context which is impacting on practice based education and explore what challenges this presents, together with possible solutions. The recommendations arising from the RCN Mentorship report will be considered, together with the outcomes of the summit on practice-based education, hosted by the RCN in partnership with the Nursing and Midwifery Council and Council of Deans of Health earlier this year.

Intended learning outcomes

To reflect on the current policy and regulatory context impacting practice-based education for pre-registration nursing in the UK.

To identify the key issues which need to be addressed to enable high quality practice learning environments to continue to develop and flourish.

To discuss actual and potential solutions to address the issues identified

Reading list

RCN (2016) RCN Mentorship Project 2015 London: RCN Publication code 005 454

RCN (2015) Nurse mentoring. Rapid evidence review. London: RCN Publication code 005 455

Willis, P.(2015) Raising the Bar. Shape of caring: A review of the future education and training of registered nurses and care assistants. [online] Available from: hee.nhs.uk/wp-content/blogs.dir/321/files/2015/03/2348-Shape-of-caring-review-FINAL.pdf

Biography

Dr Stephanie Aiken is Deputy Director of Nursing at the Royal College of Nursing (RCN). Her remit is to provide leadership to the RCN Nursing Department to shape and support the delivery of its professional work. Stephanie has a background in adult nursing prior to commencing her career in education and undertaking a Masters in Healthcare Ethics. She has extensive experience of working in nursing and health care education and more recent experience in regulation at the Nursing and Midwifery Council. She undertook her doctoral studies at the University of Brighton, exploring the image of nursing and how it is perceived from public, professional and policy perspectives.

4.15 – 4.45pm

4.6.4 Reflections on establishing the 1st UK nurse-led sickle cell screening and counselling services in 1979

Room Henry Moore Room

Chair Paula Hancock

Presenter Professor Elizabeth Nneka Anionwu CB FRCN, Emeritus Professor of Nursing, University of West London, UK

Abstract

Retirement offers a useful opportunity to reflect on one's careers and Elizabeth has also taken the opportunity to write her memoirs Mixed Blessings from a Cambridge Union*. Published in September 2016 and launched in October at the Royal College of Nursing in London, one chapter forms the basis of this presentation.

Entitled 'Why Sickle Cell Disease?' Elizabeth looks back on why she became involved in identifying service gaps in the late 1970s for families affected by sickle cell disease in the north-west London district of Brent. She also sets out the steps taken by herself and a consultant haematologist in order to establish the first ever UK nurse-led screening and genetic counselling and support service for patients with this inherited blood disorder. They were primarily from black and minority ethnic backgrounds and the NHS had never adequately met their needs.

Elizabeth was the first nurse to lead such a service when it was set up in 1979 in Brent in north-west London. She modelled it on those she had visited in the United States of America. It was to offer easily accessible blood tests, rapid results and confidential genetic counselling in a culturally appropriate manner. This pioneering approach then led to over 30 similar centres, also run by nurses, often from similar minority ethnic backgrounds to the users of their services. Nearly 40 years later, is this specialist nursing model still relevant for today's public health agenda? Do the users, many from marginalised communities, value it and is it adequately resourced?

*Available from Amazon as both a paperback and downloadable e-book.

Biography
Before becoming Emeritus Professor of Nursing at the University of West London in 2007, Elizabeth was Dean of their School of Adult Nursing Studies, then Head of the Mary Seacole Centre for Nursing Practice.

In 1979 she had set up the first UK nurse-led sickle cell/ thalassaemia service in Brent and then became senior lecturer in Community Genetic Counselling at London's Institute of Child Health. She has published extensively, see www.uwl.ac.uk/academic-schools/nursing-midwifery/professor-elizabeth-anionwu

Elizabeth was Vice-Chairperson of the successful Mary Seacole Memorial Statue Appeal and is Patron of the Sickle Cell Society. Her memoirs 'Mixed Blessings from a Cambridge Union' published in September 2016, are available via Amazon.

Twitter: @EAnionwu Website: www.elizabethanionwu.co.uk

Intended learning outcomes
At the end of this session, participants should be able to: (E.g., identify, describe, explain...)

- Identify key gaps in service for sickle cell disease (SCD) within the NHS in the 1970s
- Explain why the speaker, a black nurse, became angry about the experiences of local parents of children affected by SCD.
- Describe 3 key features of the nurse-led service that became a model for other parts of the country.

Reading list/references
Politics of Sickle Cell and Thalassaemia. (2001) Anionwu EN and Atkin K. Open University Press

Piloting a new Patient Reported Experience Measure for Sickle Cell Disease: A report of the findings. April 2016. www.pickereurope.org/wp-content/uploads/2016/06/Sickle-Cell-Pilot-Report.pdf

Caring for people with sickle cell disease and thalassaemia syndromes. A framework for nursing staff. 2011 Royal College of Nursing (N.B. Currently being revised.) www2.rcn.org.uk/__data/assets/pdf_file/0004/372991/003874.pdf

Theme: Knowledge for change and improvement

2.45 – 3.15pm

4.7.1 RCN Pain KSF: dissemination and impact

Room Albert Suite
Chair Amanda Cheesley
Presenter Karin Cannons, Nurse Consultant - Pain Management, Frimley Health NHS Foundation Trust, UK
Co-author Sarah Lewis, UK

Aim
To provide an overview of the successful development, dissemination and measurement of the impact of the RCN Pain Knowledge and Skills Framework for the nursing team launched in 2015.

Abstract
Assessing and managing pain are essential components of nursing practice. Pain is often categorised as acute or chronic, but it is a complex physical, psychological and social phenomenon that is uniquely subjective. Although a key fundamental of nursing care patients continue to report unrelieved pain during procedures, after surgery, in the community and in care homes. Pain traverses all clinical settings and the age spectrum yet is often poorly assessed and managed by nurses. This results in short and long-term adverse consequences.

Poorly managed acute pain may result in the development of chronic pain which is known to have a strong association with anxiety, depression, quality of life and the ability to sleep, communicate and work. The key common findings of surveys of chronic pain inform us that one in five people of all ages have moderate to severe chronic pain and one-third of individuals of working age who have chronic pain have lost the ability to perform wage-earning or other work.

Prior to the publication of this document, there were no nationally agreed standards, competencies or frameworks for pain management in the United Kingdom. This RCN funded project focused on developing a knowledge and skill framework (KSF) to improve the understanding and skill set of the wider nursing team - to promote excellence in practice thus improving patient care and outcomes. It is anticipated that this project and publication of this KSF will also help shape health policy by raising the profile of pain by political lobbying.

This KSF aims to provide a framework that supports the development of competence in managing pain for the entire nursing team; from care assistants to nurse consultants. It has been designed to be used alongside local competency documents and illustrates Benner's vision of individual nurse's migration from novice to expert (Benner 1984). There is clear progression in the knowledge, practice and experience of nurses working within the framework. Firstly the career framework (Skills for Health 2010) is mapped

against both Benner's levels of performance (novice, advanced beginner, competent, proficient expert). These two in turn are mapped against levels of education across the spectrum from Care Certificate through to Doctoral studies.

Reading list

RCN (2015) RCN Pain Knowledge and Skills Framework for the Nursing Team. London, RCN

Biography

I qualified as a nurse form The City University and St Bartholomew's Hospital, London in 1987 and spent the early part of my career working a variety of critical care and emergency care units all over the world. Since 1999 I have worked in pain management. I am currently the service lead for 2 Inpatient/Acute and 2 Outpatient/Chronic pain services across a large NHS foundation Trust. I work clinically in all our services leading ward rounds and conducting clinics. I am responsible for service delivery, staff management, educating staff across the Trust and running patient groups. I have been an Independent Non-Medical Prescriber since 2006 and prescribe as part of my daily clinical practice. I am an active member of the RCN and British Pain Society belonging to special interest groups for Acute Pain, Philosophy and Ethics, Developing Countries, Information Technology and Head Pain.

References

RCN (2015) Pain knowledge and skills framework for the nursing team: can be downloaded from the A-Z listing in the publications area of the RCN website at www.rcn.org.uk/publications Publication code: 004 984.

Declaration of interest

I have given clinical advice to/received educational grants and/or payments for speaking from the following companies: Astellas Pharma, Dallas Burston Ashbourne, Grünethal, Janssen-Cilag, Napp Pharmaceuticals, Pfizer, Sandoz, Smith's Medical and White Pharmacy.

3.15 – 3.45pm

4.7.2 Ordem dos Enfermeiros *versus* Portuguese Nurses Emigration – a concern

Room	Albert Suite
Chair	Amanda Cheesley
Presenter	Ana Rita Cavaco, President, Portuguese Nursing Association, Portugal

Summary of session

For the last five years Portugal is facing a serious economical crisis and lack of jobs and we have been watching a huge number of our nurses deciding to emigrate, leaving their homes, their families and friends behind, and taking the excellent knowledge and training they have and the countries, like the UK profit from their competence, being their first choice the United Kingdom.

Abstract

Almost 13,000 nurses (12.859) emigrated in the last 5 years. Most of them went to the United Kingdom.

After Brexit, nurses that chose the United Kingdom to work are a bigger concern to Ordem dos Enfermeiros (OE). So far, there's no knowledge of any complain or anyone thinking on returning to Portugal.

Ordem dos Enfermeiros is following this situation, having regular contacts with NMC and RCN to provide Portuguese Nurses with as many information as possible.

As far as OE knows nothing has changed.

In the last years, for each 100 Portuguese nursing graduates, 47 requested the emission of the declaration for Emigration. For each 100 nurses that emigrated, 40 have been graduated for less than a year. But there's a lack of 30,000 nurses in the Portuguese National Health System.

ODCE Average (2015 data): 9,1 nurses/1.000 inhabitants. Portugal: 6,1/1.000 inhabitants.

A large number of our nurses – less than a year after graduation and registration in OE – decide to emigrate. Portuguese nurses, thanks to their training, are the most equipped in the world. OE is working so that they do not leave the country and also has been working and demanding the reduction of vacancies in Nursing Schools.

Biography

Ana Rita Cavaco was born on April 21st 1976. She was given powers as President of Ordem dos Enfermeiros on January 30th. She graduated in Nursing at Calouste Gulbenkian Nursing School in Lisbon and D. Ana Guedes Nursing School, in Oporto. She´s a specialist and master in Community and Public Health by Lisbon Nursing School and has a post-graduation in Management by the Católica Lisbon School of Business and Economics. With 19 years of professional experience, she began her career in the Emergency Room of Hospital dos Capuchos, in Lisbon. She worked in several health centres where she coordinated teams of continuous care and nursing. She was a Supervisor Nurse at Linha Saúde 24, assumed the position of Advisor of the Health Secretary of State in the XV Constitutional Government and currently works at the Autoridade Antidopagem de Portugal.

3.45 – 4.15pm

4.7.3 Fertility preservation strategies in adolescents diagnosed with haematological cancer

Room Albert Suite

Chair Amanda Cheesley

Presenter Valerie Peddie, ANP – Fertility, University of Aberdeen, UK

Co-author Dr Abha Maheshwari, UK

Aim

To promote awareness of the clinical strategies available to optimise reproductive choices after cancer diagnosis

Abstract

Improvements in long term outcomes of the management of haematological, in particular lymphoma and leukaemia, as well as other malignancies and non-malignant conditions has led to a need to provide clinical services to deal with the sequelae of the illness, its treatment, and subsequent survival of young people diagnosed with cancer. Fertility preservation is thus seen by providers of care as well as service users as a fundamental and integral component of cancer care in young people. For some, one of the most devastating long-term consequences of aggressive, yet life-saving treatment is infertility. The degree of impact on reproductive potential after treatment is influenced by a number of factors including age and gender, the chemotherapeutic agent used and the field and dose of irradiation employed in treatment. Fertility preservation in young men and women diagnosed with cancer is widely accepted and now well established in the context of clinical practice within many fertility clinics in the UK, and its implementation and resource allocation endorsed by the National Institute of Clinical Excellence and Royal College of Obstetricians and Gynaecologists (RCOG), the British Fertility Society (BFS) and the American Society for Reproductive Medicine (ASRM). However, adolescent girls diagnosed with cancer, present a unique challenge to Oncologists and Reproductive Specialist alike. Increasing long-term survival rates, harmonised with advances in reproductive techniques, provide clinicians with greater scope, yet create the potential for ethical discussion. Little is known about the influence of first line cancer therapies and female reproductive potential, therefore good prognosis patients should be afforded the opportunity for discussion in the context of fertility preservation. Through innovative techniques and increasingly supportive and collaborative efforts with reproductive, oncology, haematology (including paediatric), ethics, genetics and legal colleagues, the fertility sector currently proposes a responsive strategy to this unique client group. Word Count 295

Reading list

Fertility Problems: Assessment and Treatment (2013) www.nice.org.uk/guidance/cg156

Fertility preservation in girls and young women. Anderson, A., and Wallace, H.

Clinical Endocrinology (2011) www.ncbi.nlm.nih.gov/pubmed/21575025

Biography

I have been involved in Fertility Nursing since 1993, and Chair of the Royal College of Nursing (RCN) Midwifery and Fertility Nurses Forum from 2008-2011. My clinical role is predominately 'nurse led' and incorporates nurse led clinics, pelvic ultrasound, embryo transfer and IUI. I have always been perceptive to the development of a specialist training and educational framework for fertility nurses that would provide the basis for standardised job titles and role definition. I chaired the project team leading to publication; 'Training and Educational Framework for Fertility Nursing' (RCN, 2013) and Fertility Nurse Competences - and review, (RCN, 2011) whilst supporting the RCN vision for advanced nursing practice.

4.15 – 4.45pm

4.7.4 The UCLH Exemplar Ward Programme: Co-design of a scoring model and formative process evaluation of a ward accreditation scheme

Room Albert Suite

Chair Amanda Cheesley

Presenter Natasha Phillips, Assistant Chief Nurse, University College Hospitals London, UK

Co-presenters Dr Cecilia Vindrola-Padros, Research Associate, the Department of Applied Health Research, UCL, Qualitative Researcher, UCLH Embedded Research Team, UK and Vicky Dunne, Quality Improvement Facilitator, UCLH UK

Aim

Aims and intended learning outcomes

- Demonstrate the role of accreditation in assurance and supporting improvement efforts at local and organisational level
- Describe how multi-criteria decision analysis can be used to support complex judgments about performance
- Demonstrate the relational aspects of organisational change and how the learning from this change might inform future large-scale interventions

Abstract

Background: UCLH will implement a ward accreditation programme in 2015 to assure that the Trust is providing high-quality care, identify areas that need improvement and provide staff with the support they need to improve services. Wards will be assessed against a predefined set of

standards, organised according to five fundamental pillars: efficiency, staff experience, patient experience, quality and safety, and improving. Ward compliance with these standards will be measured using data already collected by Trust staff and through an annual cycle of inspection. A ward's performance over 12 months will culminate in it being classified as "exemplary", "great", "satisfactory", or "receiving support". Research-informed accreditation scheme The UCLH Exemplar Ward development group and UCLH Embedded Research Team (ERT) have co-designed the accreditation model with over 200 stakeholders including: clinical staff, management staff, patient and public representatives, and data analysts. It is underpinned by best available evidence1,2 and the scoring model is based on multi-criteria decision analysis3. In this approach, objectives are weighted by comparing the value of improvements, metrics are fairly scored considering the specific contexts of each ward, and the overall ward performance measure strongly incentivises "fixing" weaknesses, but also rewards striving for excellence. Research-led formative process evaluation In addition to the scoring model, the ERT has designed a process evaluation4 to understand how the programme was developed and document its implementation and impact across UCLH. The ERT has been carrying out observations and interviewing staff about their views of the programme. Feedback has been provided to the staff leading the programme on an on-going basis. This in-depth study of how the programme was designed and implemented at UCLH will help this and other Trusts learn valuable lessons on developing similar programmes to improve services.

Reading list

American Association for Critical Care Nurses (2015). Beacon Award for Excellence Handbook. www.aacn.org/wd/beaconapps/docs/beacon-handbook.pdf, accessed November 2015.

Bliss-Holtz J, Winter N and Scherer EM (2004). An invitation to magnet accreditation. Nursing Management 35(9): 36-42.

Hariharan S, Dey PK, Chen DR, Moseley HS and Kumar AY (2005). Application of analytic hierarchy process for measuring and comparing the global performance of intensive care units. Journal of Critical Care 20(2): 117-124.

Hulscher ME, Laurant MG and Grol RP (2003). Process evaluation on quality improvement interventions. Quality and Safety in Health Care 12(1): 40-46.

Biography

Natasha Phillips is an experienced nurse leader who has a particular interest in clinical leadership and organisational development. She holds a number of posts including Assistant Chief Nurse and Head of Exemplar Ward at UCLH, Visiting Research Fellow at King's College London and editorial board member at the RCN journal Nursing Management. Natasha is also studying part time for a PhD examining frontline clinical leadership in the NHS.

Natasha Phillips is Assistamnt Chief Nurse at UCLH and Head of the Exemplar Ward Programme. Dr Cecilia Vindrola-Padros is a Research Associate in the Department of Applied Health Research at UCL and a Qualitative Researcher in the UCLH Embedded Research Team. Tom Pape is a KTP Associate at University of Surrey and Surrey County Council. Vicky Dunne is a Quality Improvement Facilitator at UCLH working on the Exemplar Ward Programme. Prof Martin Utley is Professor of Operational Research and Director of the Clinical Operational Research Unit at UCL. Prof Naomi Fulop is Professor of Health Care Organisation and Management in the Department of Applied Health Research at UCL.

Theme: Knowledge for change and improvement

2.45 – 3.15pm

4.8.1 Safe staffing in a post-Brexit era

Room Westminster Suite

Chair Rose Gallagher

Presenter Professor Anne-Marie Rafferty, Professor of Nursing Policy, King's College London, UK

Aim

- Understand the dynamics that drive and constrain policy implementation in nursing.
- Identify the 'uses' of evidence in policy making within nursing.
- Reflect upon the contemporary predicament of the profession in education and safe staffing through some historical evidence and examples.

Abstract

This paper considers some of the historical antecedents to contemporary debates in safe staffing and nursing education and explores the role of evidence in policy making and the different policy responses to education and safe staffing across the four countries of the UK as well as the implications for international recruitment and retention policy in Europe and beyond. It highlights the different 'uses' to which evidence has been put drawing on a range of historical and contemporary examples.

Reading list

Dingwall, R, Webster, C and Rafferty, A.M An introduction to the social history of nursing, Routledge, London 1988l

Rafferty, AM, 'The Politics of Nursing Knowledge', Routledge, London 1996

Daves, C, Gender and the Professional Predicament of Nursing, Open University Press, Bucks, 1995

Biography

Anne-Marie is Professor of Nursing Policy and former Dean of the Florence Nightingale Faculty of Nursing and Midwifery at King's College London. She is a graduate of Edinburgh (BSc Nursing Studies) and Nottingham Universities (Surgery) and was the first nurse to gain a doctorate from Oxford University (Modern History). She holds Fellowships from the Royal College of Nursing and American Academy of Nursing. She won the 3M/Nursing

Times Award for Nursing Research; Nursing Times Leadership Award in 2014 and HSJ Top 100 Clinical Leaders Award in 2015. She has worked as a government adviser on nursing and received CBE for services to health care in 2008.

3.15 – 3.45pm

4.8.2 Real time patient diaries

Room Westminster Suite

Chair Rose Gallagher

Presenter Lynda Ockenden-White, Quality Improvement Team, BCUHB, UK

Aim

Real time Patient Diaries: A simple tool that will enhance practice through the development of positive relationships with patients, families and communities. Furthermore; appropriate analysis of the patient feedback will result a deeper understanding of training and development needs on a ward by ward basis. This understanding will assist in influencing the required knowledge necessary for change and improvement. These factors address the most recent recommendations of the Older Peoples Commission. Ultimately, services implementing a real time diary will have clear evidence of a rigorous approach to patient centred care.

Abstract

Nursing, in either an acute or community setting is not without its challenges. A new approach to revalidation places a new, but by no means extra, burden on staff to ensure they achieve compliance. The expectation for nursing staff is clear demonstration of a commitment to ongoing CPD and a capacity to demonstrate person centred care that reflects evidence of communication with patients and their loved ones.

Both the Health and Care Standards (Welsh Gov,2015), and the Older Peoples Commission (OPC.2014) stress the need for front line staff to listen and respond accordingly to the unique voice and needs of each patient. The insight gathered as a result of implementing the real time diary has the potential to influence the development of care plans, pathways and nursing notes that are the direct result of meaningful interactions with patients. The diary is an integral tool in this development process.

The diary provides staff with the information and outcomes necessary to demonstrate their capacity to connect with patients in a meaningful manner. This interaction leads to improved patient satisfaction and, a relationship that has its basis in trust.

In order for the diary to be effective staff must be aware of the strategies and approaches necessary to engage both the patient and their loved ones. Staff will require support and in some cases training to ensure that they have the skills and confidence to engage with patients and support the completion of the diary on a daily basis. With support, both the patient and staff, will come to recognise and appreciate the power of the diary and its influence on all matters relating to the patients stay.

An added bonus of writing a diary is the potential for patients to benefit therapeutically to the process of writing. Diary champions, who are able to promote both practical and therapeutic approaches to the diary, will result in an enhanced approach to patient centred care.

Finally in order to ensure that the diary is used to its full potential staff must be encouraged to analyse and act on the findings to ensure that patients are supported to rewrite their own story and benefit from a service that strives to respond actively to the unique needs of each patient.

References

Older Peoples Commission Wales.2014. Recommendations at a Glance. Cardiff

Welsh Government, (2015). Health and Care Standards. Cardiff

Reading list

Bolton, G. (2008). "Writing is a way of saying things I can't say"--therapeutic creative writing: a qualitative study of its value to people with cancer cared for in cancer and palliative health care. Medical Humanities, 34(1), pp.40-46.

Milligan, C., Bingley, A. and Gatrell, A. (2005). Digging deep: Using diary techniques to explore the place of health and well-being amongst older people. Social Science and Medicine, 61(9), pp.1882-1892.

National Voices UK, (2015). Person Centred Care 2020. Calls and contributions from health and social care charities.

Biography

The mother of nine children, Lynda entered the field of health and social care after being self-employed for many years in the hospitality industry. Starting as a health care support worker, Lynda soon enrolled on a course to become an adult care manager. Whilst studying for her degree, Lynda taught health and social care to both HE and FE students at her local college.

Once qualified Lynda commenced work as a care home manager and worked with both local and national bodies to ensure positive outcomes for all elderly folk in her care. At this time Lynda acquired the required Level 5 qualification to manage nursing and care homes. Lynda also worked to develop a number of tools that provided clear evidence of high quality user-led care.

In December 2013 Lynda commenced working for BCUHB as a health care support worker in the hopes that an opportunity would arise that enabled her to put her skills and knowledge to work in a health rather than social care environment. Currently working.

3.45 – 4.15pm

4.8.3 Nurse leaders: making a difference everyday

Room Westminster Suite
Chair Rose Gallagher
Presenter Dr Clare Price-Dowd, Senior Programme Lead, NHS Leadership Academy, UK

Aim
Development of nurse leaders has often been centred on senior staff. Leadership skills and knowledge are, however, required at all levels. Front line nurses who have been through NHS Leadership Academy programmes are reporting greater personal effectiveness, greater team skills and the ability to lead change in their work areas.

The results of initiatives undertaken by frontline nurses will be shared along with personal learning and development journeys.

Abstract
The importance of developing leadership capability early in career path thus fostering a 'future leadership mind-set' has been identified [NIRH 2014]. Yet within the NHS, provision is frequently targeted at senior leaders - a percentage of which report little preparation for the roles they find themselves in [NHS Leadership Academy 2014]. This session will detail the design, delivery and evaluation findings from over 5000 nurses who have, to date taken part in the first nationally funded, very large scale leadership development programmes – The Frontline Nursing Programme and the Mary Seacole Programme. It describes the curriculum which centres on both service improvement and personal leadership development ensuring that participants are able to demonstrate both by leading a piece of improvement in their workplace to improve care or services. Independent evaluation shows that participants reported:

An Increased awareness of individual working as well as an increased awareness of behavioural styles of others and how to engage with different team members.

Appreciation of a 'new language' with which to talk to senior decision makers enabling them to approach their work in new ways and extend their service improvement impact

A greater ability to step back and consider their actions before acting. This was particularly important for nurses who are used to 'just getting things' done instead of taking the time to engage other stakeholders in the decision making process.

Increased knowledge of service improvement and a greater ability to lead change

The session will share both programme information and case studies from nurses who undertook the programme. It will detail the improvement projects they and the improvements to care, staff engagement or services that have happened as a result. It will also share some of the lessons they would like to pass on to other nurses who would also like to improve their practice.

Reading list
The Kings Fund (2015) Ending the Crisis in Leadership

West M (2014) Collective Leadership fotr Cultural change. The Kings Fund

Biography
Clare has worked in the NHS for 33yrs. She trained as a nurse in Nottingham and spent 13 years as a Health Visitor and practice teacher before moving into management and education. Clare spent 3 years as a Senior Lecturer at the University of Derby before moving to work in a variety of national roles

Clare is currently a senior programme lead within the NHS Leadership Academy. She has been responsible for the launch of the national core programmes and now manages a portfolio of Academy wide activity including evaluation and patient engagement.

4.15 – 4.45pm

4.8.4 The role of European Union standards in building the nursing profession: a post-Brexit perspective

Room Westminster Suite
Chair Rose Gallagher
Presenter Dr Tom Keighley, Freelance Consultant, UK

Aim
The Referendum decision in the UK has been met with utter disbelief by EU Member States, the EU Commission, and the international nursing community. This will impact the development of nursing in the EU in numerous ways. The RCN has been strong supporter both in terms of finance and lobbying of the European Federation of Nurses – the lobbying influence will be dramatically reduced. The Sectoral directives which concern professional practice and education have been heavily influenced by UK nursing and nurses – this will be reduced. Development of nurse education and practice in EU accession countries in particular has been supported by UK nurses and HE institutions – this will need to be renegotiated. This session will provide an opportunity to explore these and other issues arising from Brexit, for nurse standards in the EU

Abstract
Brexit has turned out to be far from a UK only event. It has had dramatic international effect both within the EU and in the wider international arena. The international community is watching not just the fallout from the decision, but also the process by which the subsequent withdrawal will be achieved. This presentation focuses on the nursing implications of this decision for the nursing profession in the EU. The key issue to be addressed is whether or not the UK will continue to adhere to the EU Directives that apply to nursing and with it the free-movement that it underpins.

Secondly, the question of the status of nurses who have utilised this free-movement to come to the UK from the EU to pursue their careers. Thirdly, the free-movement of patients between the UK and the rest of the EU. This will particularly effect countries like Malta and Cyprus which have long, and historic links to the UK.

Alongside all of this is the work that UK nurses have done in those countries that have acceded to the EU since 2001. Currently the focus is primarily on the former Yugoslavia where Montenegro, Macedonia, Serbia, and added recently, Albania. All these countries are recipients of EU support which draws extensively on UK expertise. These countries are now concerned that professional and institutional links may be damaged.

The presentation will address this and associated issues of EU lobbying and networking, professional regulation, and issues of quality and safety, as the UK-EU relationship changes.

Intended learning outcomes

- Identify the post Brexit challenges to nurse education.
- Be aware of decisions to be made about free-movement between the EU and the UK for nursing.
- Recognise the implications of Brexit for other EU countries.

Reading list

EUROPEAN PARLIAMENT AND COUNCIL, T. 2013. amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation') (Text with EEA relevance). Official Journal of the European Communities, L354, 132-170

DE RAEVE, P. 2011. Nurses' Voice in the EU Policy Process, Mechelen, Kluwer

KEIGHLEY, T. 2011. Accession to the European Union 2001-2010: A reflection on some of the ethical issues for nursing. Nurse Ethics, 1-7

Biography

With a professional background in general, psychiatric and community nursing, as well as teaching, research and leadership in the NHS and University sector, the Presenter has been a freelance consultant for over fifteen years. The focus has been on the EU and the development of nursing practice and education as well as involvement in the Americas with STTI and the Bloomberg Faculty of the University of Toronto in particular. Currently working as Norwegian Nursing Organisation (NNO) consultant in Montenegro, as TAIEX expert in several former Yugoslav countries, and as assessor and evaluator for programmes in the EU Horizon 2020 programme focused on innovation in health care. Recognition of the work has been received from the government of Colombia (Gran Cruz), the RCN (FRCN) and the American Organisation of Executive Nurses.

Theme: Knowledge for change and improvement

2.45 – 3.15pm

4.9.1 Nursing-led quality improvement: an international accreditation project in rural Peruvian hospital

Room: Shelley Room

Chair: Elaine Whitby

Presenters: Dr Patrick Palmieri, Presidente, Asociación Peruana de Enfermeria (Peruvian Nursing Association), Peru and Erika Angulo, Assistant Professor, School of Nursing, Universidad Señor de Sipán (Chiclayo, Perú). Research Associate, Institute for Global Nursing (Lima, Perú), Peru

Aim

In developing countries, nurses are clearly the best positioned profession to lead large, yet feasible and affordable, organizational-wide quality improvement (QI) projects. In Peru, nn international health facility accreditation framework was successfully implemented by nursing. Accreditation standards are an important QI tool for nurses as the majority of the standards, about 65%, are focused on nursing practices, 10% on physician work, 10% on pharmacy performance, 5% on other therapies, 5% on management and leadership, and 5% others. However, the process of international accreditation begins with organization leaders recognizing the need for system-wide changes and the willingness to work toward realizing improved outcomes. Nursing leaders at a small private hospital in the provinces of Peru recognized the need for quality improvement and earned hospital leader empowerment to implement a program to achieve accreditation, to improve quality, safety, and financial outcomes.

Abstract

Introduction: Nursing leaders at a small private hospital in the provinces of Peru recognized the need for a significant quality improvement effort, and they began an international accreditation process with an internal, or self-assessment, focused quality improvement projects to address identified deficiencies, and an external review processes, accreditation visit, to assess the outcomes.

Objectives: Through an interactive Plan-Do-Study-Act cycle, guided by a theoretical framework, the specific objectives included nurses to engage in: a) Learning the rationale for each standards of each accreditation chapter, b) Assessing the degree standard compliance within the organization; c) Analyzing the overall chapters assessment for deficiencies; Developing an action plan with discrete projects to

correct the deficiencies; d) Reevaluating the implemented corrections; e) Participating in an organizational wide accreditation evaluation (Pre-evaluation and Formal evaluation).

Method: The quality improvement work was guided by Roger´s diffusion of innovation Theory (changing culture through innovation), King´s Systems Interaction Model (interaction of nursing within organizations), and Donabedian's Quality Improvement Triad (structures + processes = outcomes). With this framework, the nurses developed a committee and specific chapter teams, where each team identified projects and sub-projects ranked from lowest to highest resistance to change for each deficiency, SMART goals were established, an iterative PDSA quality improvement process was implemented, and the results for each subproject and project were evaluated.

Results: The self-evaluation demonstrated 27% compliance with all standards. The sub=projects and projects then resulted in an 86% compliance. Importantly, the standards deemed as "critical standards" were assessed at 100%. Furthermore, the operational balanced scorecard demonstrated improvements in financial outcomes and a decreased number of adverse events with harm. The official accreditation evaluation resulted in no chapter deficiencies and a full three-year accreditation was granted.

Conclusion: Hospitals in developing countries can substantially increase the quality and decrease the cost for health services by fully engaging nurses. Specifically, hospital leaders need to empower nurses to led quality improvement based on accreditation standards. This quality improvement effort results in the diffusion of quality innovation organizational wide. In Peru, the importance of nursing practice in hospitals in Peru is under appreciated and not recognized as a quality improvement strategy. This nursing-led project clearly demonstrates that simple, structured, and affordable projects are FEASIBLE to improve quality in hospitals in developing countries.

Reading list
Nursing-led projects; International accreditation; Developing countries

Biography
Dr Palmieri is the leading Peruvian health system expert with extensive work experience in Latin American clinical operations, insurance risk management, and university education. Dr Palmieri is founded the Asociación Peruana de Enfermeria to advance the nursing profession and discipline in Peru. Notably, Dr Palmieri achieved the first three international health care accreditations in Peruvian history. In addition, he mentored a nursing leader to achieve an international accreditation at a small private hospital in a rural Peruvian province. Committed to developing young professionals, Dr Palmieri developed and directed the first funded nursing fellowship programs in South America. Dr Palmieri is an active health policy expert engaged in promoting reforms and initiating projects to advance quality management, patient safety, and evidence-based practice throughout South America. He has published numerous scientific papers and invited to speak at conferences throughout the Americas.

3.15 – 3.45pm

4.9.2 The role of nurses at the forefront of change

Room Shelley Room
Chair Elaine Whitby
Presenter Dr Julia R A Taylor, Director, Advancing Change and Transformation (ACT) Academy, NHS Improvement, UK

Abstract
The ACT Academy team design and deliver quality assured, action based learning programmes to support the health service undertake the challenge of redesigning services to enable improvements in experience of care and delivery of value for money while simultaneously developing a culture of continuous efficiency and productivity improvement. Primarily, the Academy provides two main suites of programmes: Quality, Service Improvement and Redesign (QSIR) and Transformational Change through System Leadership.

As nurses form the largest part of the health care workforce and are at the forefront of delivering patient care, it is vital that nurses take up their natural role as improvement leaders.

Dr Taylor will present examples of how nurses that have participated in these programmes have gone on to lead improvement and transformational change projects within their own organisations or health systems. She will highlight the inspiring achievements of nurses who have:

- successfully delivered individual service improvement projects
- become associate members of the QSIR teaching faculty within their own organisation and are spreading improvement skills throughout their local organisation – and now further into the STP footprint
- in their role as leaders of change, worked alongside other senior colleagues at the forefront of large scale transformational change programmes.

Dr Taylor will explain how the tools, techniques and methodology that form the basis of the two flagship programmes have enabled nurses to utilise the learning and the resulting benefits.

Biography
Dr Taylor has worked in the health care improvement field at national and international level since 2001. Previously she was the National Programme Director for Building Transformational Change Capability at NHS Improving Quality and before that, Director of Learning and Development at the NHS Institute for Innovation and Improvement. She has held the post of National Programme Director for Ambulance Trusts and has been Director of an NHS trust.

Julia has extensive experience of supporting change management and leadership development in complex environments and building organisational effectiveness. She is a recognised authority on service improvement

and large-scale change approaches to transformation. She has expertise in delivering transformational change across organisational boundaries in complex settings through system leadership. An experienced qualified executive coach, Dr Taylor has studied with the Harvard Kennedy School for Executive Education among other prominent educational centres. She holds a Master's degree with distinction in Leading Innovation and Change and a doctorate in Transformational Change in Healthcare and is an academic consultant for Middlesex University. She was invited to be part of the NEF: Innovation Institute's Innovation Council in 2013.

Dr Taylor has an extensive knowledge and understanding of health and care services gained through both academic study and hands-on management experience of delivering complex change on the ground. She has significant experience in supporting challenged trusts and has designed and delivered national and local developmental capability building programs for senior leaders commissioned by organisations such as the Department of Health, NHS England, and Australian and New Zealand health authorities. For example:

- Organising for Quality and Value (improvement science education programme): Department of Health, Strategic Health Authorities, NHS trusts, New Zealand Department of Health
- NHS Vanguard for Emerging Leaders (leadership development with an innovative design): Department of Health, Leadership Centre, Strategic Health Authorities
- Leading Large-scale Change: senior NHS and Australian health care leaders
- No Delays: developmental programme for Health and Wellbeing Boards, DH 20
- Bespoke master classes (e.g. Authentic Leadership): NHS boards. Dr Taylor has designed and facilitated large group interventions for a range of partners including the Department of Health, the Academy of Medical Royal Colleges and Health Workforce Australia.

Julia has also developed and published detailed guidance on improvement methods and resources as well as other quality improvement focused papers including in peer reviewed journals. For example, Delivering Quality in the NHS, The Handbook of Quality and Improvement Tools, Transforming Access - Clinical Governance an International Journal.

Dr Taylor's work on reducing delays for patients is internationally renowned; she is an international speaker, a contributor to health care publications and sits on a number of forums.

3.45 – 4.15pm

4.9.3 Fall risk assessment in institutionalized elderly longitudinal study - FRAILS

Room	Shelley Room
Chair	Elaine Whitby
Presenter	Dr Anna Castaldo, Director of Continuing Education, Don Orione, Milan, Italy
Co-author	Luigi Maria Bergamaschini, Italy.

Aim

- Disseminate the results of the Italian research on risk factors for fall in nursing homes.
- Knowing the main factors that could direct the assessment of traumatic fall in elderly.
- Learn about the elements that could target the fall prevention inter.

Abstract

Objectives: The aim of the study was to know the risk factors associated with falls, the incidence of falls and traumatic falls in people cared for in nursing home.

Method: A prospective observational study with a 12-month follow up was planned, with a convenience sample of residents in two nursing homes. Using clinical documentation and incident reporting, for each resident was observed demographic and clinical characteristics; number and typology of drugs, and falls occurrence, included consequences. It was used univariate and multivariate logistic regression to estimate the predictive role of clinical variables on people who had fallen. Results were considered significant at a level of p value <0.05 and a confidence interval of 95%, with two-tailed test.

Results: The study was carried out between October 2013-September 2014 in two nursing homes in Milan (Italy). It involved 409 residents, of which 331 in ordinary units, and in 78 specialized units for dementia, predominantly women (82%), with a mean age of 83 years (± 9.4). In the observation period 111/409 (27%) residents fell, of which 54 had a lesion from mild to severe. It was detected an average of 1.26 (± 0.48) falls/resident, with a range from 1 to 10 and a higher percentage (and statistically significant) of falls among males (28/75) compared with women (83/334). Residents with a lower dependence in activities of daily living, compared to those with a total dependence, had a risk more than four times significantly higher (OR: 4.75; 95% CI 2.50 to 9.02 p: 0.000). Previous falls bring a three-fold risk of falling (OR: 3.34; 95% CI 1.5 to 7.44; P 0.003), instead the residents cared for in specialized units presented a two-fold risk (OR: 2.22; 95% CI 1.16 to 4.27; P 0.016).

Reading list

Rubenstein LZ (September 2006) Falls in older people: epidemiology, risk factors and strategies for prevention, Age Ageing 35, (suppl 2): 37-41.

Close JC, Lord SR (2011) Fall assessment in older people. BMJ, Sep 14;343:d5153.

Deandrea S, Bravi F

Biography
PhD, RN, MSc Nursing. Lecturer in geriatric nursing and research methodology in Milan University; Director of continuing education Don Orione, Milan; Advisor at the Milan Nursing Council. Expert teacher in geriatric nursing.

4.15 – 4.45pm

4.9.4 Zika virus: dealing with the present, planning for the future

Room Shelley Room
Chair Elaine Whitby
Presenter Jane Chiodini, Independent Travel Health Specialist Nurse and Director of Education, Faculty of Travel Medicine, Royal College of Physicians and Surgeons of Glasgow, UK

Aim
- Describe the transmission routes of Zika virus.
- Explain methods of prevention of the Zika virus infection.
- Appreciate the range of resources available including the Strategic Plan addressing the impact of Zika virus in the longer term.

Abstract
Zika virus (ZIKV) was first identified in Uganda in 1947 in monkeys and later in humans in 1952 both in Uganda and United Republic of Tanzania. During the 1960s to 1980s human infections have been found across Africa and Asia. Since 2015, an outbreak of Zika virus infection has been occurring in the Caribbean, Central and South America, Oceania and some parts of Asia.

ZIKV is a disease transmitted primarily by the day-biting Aedes mosquito, although there is now known to be a small number of cases of sexual transmission and increasing evidence of transmission from mother to baby via the placenta. While the illness is usually mild, there is scientific consensus that ZIKV is a cause of microcephaly and Guillain-Barré syndrome.

In February 2016 the World Health Organisation declared that the recent cluster of microcephaly cases and other neurological disorders reported in Brazil, following a similar cluster in French Polynesia in 2014, constituted a Public Health Emergency of International Concern. No public health justification for restrictions on travel or trade to prevent the spread of ZIKV were introduced although much concern was expressed and discussed in the media with the event of the Olympic Games being held in Brazil.

More than 60 global and local partners are participating in the Zika Strategic Response Plan which outlines 4 main objectives (detection, prevention, care and support and research) to support national governments and communities in preventing and managing the complications of Zika virus and mitigating the socioeconomic consequences.

This presentation will address these issues and also briefly outline the challenges when advising travellers to endemic areas. Links to key resources from this session will be available at www.janechiodini.co.uk/home/hot-news/

Reading list
Please see www.janechiodini.co.uk/home/hot-news/

Biography
Working in travel medicine since 1990, Jane works part-time in primary care running a travel clinic, but mainly teaches travel medicine. In 2015 she was appointed Director of Education for the Faculty of Travel Medicine, Royal College of Physicians and Surgeons of Glasgow, became a Queen's Nurse and was awarded the First Distinguished Nurse Leadership Award of the International Society of Travel Medicine.

With a passion for sharing information, Jane writes a monthly travel health feature in Practice Nurse Journal, writes and creates e-Learning, publishes on social media @ janechiodini, www.facebook.com/TravelHealthTraining and janechiodini.blogspot.co.uk/ and authors and manages her website at www.janechiodini.co.uk

Theme: Knowledge for change and improvement

2.45 – 4.45pm

4.10.1 Symposium 10: Developing partnership through involving and engaging others

Room Wordsworth Room
Chair Anne Corrin

To demonstrate the progress made within nursing in involving and engaging patients, carers and health care staff in meaningful partnerships that improve both outcomes and the relevance of research undertaken, and to consider future directions

This symposium focuses on developing partnerships with patients, carers and others in order to improve health outcomes. The degree to which patients and families have been involved in decisions about what happens to them individually, locally and nationally has changed significantly overtime. Patients, carers and families have become more involved with shaping services and the research that underpins practice. This symposium presents work that has illuminated nursing activity in this area and shaped where we are going in the future. It is based on research evidence from the RCNRI within its four themes: experiences of health care; patient and public involvement; person reported outcomes; and translating knowledge into practice.

Reading list

National Institute for Health Research (2013) Public and Patient Involvement. Information for researchers. NIHR, Southampton

Involve (2015) www.invo.org.uk/ accessed 17.11.2015 Patient and Public Involvement www.nihr.ac.uk/funding/pgfar-patient-and-public-involvement.htm. Accessed 17.11.2015

Paper 1: Knowing: staff and patient experience

Authors and affiliation

Dr Liz Tutton, Senior Research Fellow, RCN Research Institute, University of Warwick, UK and Dr Stephanie Tierney, Senior Research Fellow, RCN Research Institute, University of Warwick, UK

Abstract

This paper will explore how we come to know and understand others by presenting research that explores: the meaning of compassionate care for staff caring for patients with type two diabetes; and patient experience of open fracture of the lower limb.

Knowing the other is firmly centred within the notions of nurse patient/family relationships. Through listening to others and appropriate questioning, cues about how they feel, what is affecting their health and life are uncovered and provide the basis for care. However what we know and how we know it is influenced by the framework within which care is provided, who we ask and the type of questions we use. This paper will explore these elements and the challenges they present through examining research that explores: the meaning of compassionate care for staff caring for patients with type two diabetes; and patient experience of open fracture of the lower limb.

- The notion of compassionate care is central to health care but is difficult to capture and professionals can struggle to articulate what it means. Providing opportunities to explore the concept through research highlights the complexity of relationships in practice; it emphasises the challenges that working in partnership with patients can bring due to the emotional nature of such work, which occurs alongside a professional intent to improve health within demanding clinical environments.
- Providing time for patients in acute care to tell us what it is like for them using open questions can uncover a wealth of information about their experience that provides the basis for developing practice. An example is the emotional work patients undertake when living with 'being a person with wounds'. Knowing the impact it has on their perceptions of their body, their family and friends and how they manage this work provides essential information to enable nurses to facilitate their recovery.

These research studies highlight how nursing has focused on developing knowledge that underpins practice and focuses on improving health.

Reading list

Tutton, E. Seers, K. Langstaff, D. (2012) Hope in orthopaedic trauma: A qualitative study. International Journal of Nursing Studies. 49(7):872-879

doi:10.1016/j.ijnurstu.2012.01.013

Tierney, S; O'Brien, K; Harman, NL; Madden, C; Sharma, RK and Callery, P. (2015) Otitis Media With Effusion: Experiences of Children With Cleft Palate and Their Parents. Cleft Palate-Craniofacial Journal 52: 23-30.

Paper 2: Involving: how we involve patients and carers

Authors and affiliation
Dr Carole Mockford, Senior Research Fellow, RCN Research Institute, University of Warwick, UK

Professor Kate Seers RN, PhD Director RCNRI, University of Warwick, UK

Dr Sophie Staniszewska PhD Senior Research Fellow University of Warwick, UK

Professor Jan Oyebode PhD Consultant Psychologist, Professor of Dementia Care University of Bradford, UK

Mr Matt Murray MA, Research Engagement Manager Alzheimer's Society, UK

Ms Rosemary Clarke, Lay member and co-applicant, UK

Ms Rashida Suleman Lay member and co-applicant, UK

Patient partner, Retired

Abstract
To understand how we can involve patients and their carers in planning service provision and why we need to involve them

To illustrate this involvement with findings from the SHARED study (Services after Hospital: Action to develop REcommenDations) which has had substantial lay involvement from development of the study through to dissemination of the results.

For many older patients with memory loss the transition from acute hospital to their home can be double edged – a desire to be back in their own environment surrounded by what they know, and a return to daily routines. However they are not always involved in assessments such as whether their home is safe enough, equipment needed, or arrangements for care. The experiences of leaving hospital with memory loss, draws on interviews with carers, patients, and health and social care staff, many conducted by lay co-researchers. The lay co-researchers were past or current carers of people living with memory loss or they had some personal experience. They interviewed study participants who were patients with memory loss who had just left hospital and their carers three times over a 12 week period to investigate their experiences of service provision after hospital discharge. They also interviewed staff involved in hospital discharge about their experiences. The lay researchers were involved with analysing the interview data and facilitated focus groups of study participants who shaped and finalised recommendations.

Service users led the development of recommendations for staff to use at hospital discharge for people with memory loss, and these will be discussed.

Intended learning outcomes
- Participants will understand some of the benefits and challenges of involving carers in the development of service user led recommendations.
- Participants will understand that what is thought to be provided may not be experienced in the expected way.
- Carers and patients should always be involved in decision making around care after discharge to provide an acceptable balance of informal and formal care.
- Changes to existing services may improve outcomes for patients with memory loss and their carers (having a named co-ordinator of services, a written and mutually agreed discharge plan, and improved home care services)

Reading list
Mockford C (2015) A review of family carers' experiences of hospital discharge for people with dementia, and the rational for involving service users in health research. Journal for Healthcare Leadership 2015(7):21-28

Paper 3: Influencing: how we use evidence to influence policy

Authors and affiliation
Dr Sophie Staniszewska, Senior Research Fellow, RCN Research Institute, University of Warwick, UK

Abstract
This symposium aims to demonstrate the progress made within nursing in involving and engaging patients, carers and health care staff in meaningful partnerships that improve both outcomes and the relevance of research undertaken, and to consider future directions. As part of the symposium this paper will focus on influencing, how we use evidence to influence policy and ensure our patients are represented within the health care system. Using patient evidence in formalised ways through frameworks to influence health care systems will be explored.

Involving patients, carers and families in their care has become an increasingly important part of practice. There is a broad spectrum of activity, from individual involvement in the patient's own care, for example with nurse providing information and discussing this with patients, to regional and national activity, with patients shaping service provision in hospitals, or influencing national policy.

In this paper we will explore key aspects of using patient evidence to help inform practice and policy. We will present the Warwick Patient Experience Framework (WaPEF), developed to underpin the NICE Patient Experience Guidance and Quality Standards. WaPEF highlighted the importance of patient experience as a form of evidence underpinning guidance. NHS England has drawn on WaPEF as the best evidence to inform the development of their Patient Experience Narrative, which aims to develop consistency in how key agencies define patient experience in their work.

We will consider how to both embed and report on successful forms of patient and public involvement, drawing on the RAPPORT study and GRIPP2, (Guideline for Reporting the Impact of Patient and Public involvement). We will highlight how nurses can report key information about the way in which they have involved patients in their research.

We have also launched a new journal, Research Involvement and Engagement (RIE), which aims to develop the international evidence base of patient and public involvement, helping to inform effective practice. RIE is co-produced with patients.

Reading list

Stephens R, Staniszewska, S (2015). One small step... Research Involvement and Engagement; 1:1 doi:10.1186/s40900-015-0005-8

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C. and Suleman, R (2014) A systematic review of the impact of patient and public involvement on service users, researchers and communities. The Patient. DOI 10.1007/s40271-014-0065-0

Staniszewska, S, Boardman, F, Gunn, L, Roberts, J, Clay, D, Seers, K, Brett, J, Avital, L, Bullock, I, O'Flynn, N (2014). The Warwick Patient Experiences Framework: patient-based evidence in clinical guidelines. International Journal of Quality in Health Care. DOI:10.1093/intqhc/mzu003

Paper 4: Engaging: how we make sure what matters to patients is measured

Authors and affiliation

Dr Kirstie Haywood, Senior Research Fellow, RCN Research Institute, Warwick Medical School, UK and Dr Sophie Staniszewska. DPhil. BSc. Senior Research Fellow, RCNRI, Warwick Medical School, University of Warwick. Coventry, UK

Abstract

To explore how engagement with patients can influence how the outcomes that matter to patients are assessed alongside other important outcomes. The benefits and challenges of patient engagement in outcomes research will be considered in relation to cardiac arrest research.

The active involvement of patients and members of the public in health service research is increasingly encouraged both within the UK and in other health care systems. Growing evidence highlights the value of active collaboration with patients which values the significant expertise and experience that patients may contribute to every stage of research.

Historically, a clinician determined what were important outcomes. Increasingly views of patients are valued in defining outcomes important to them. Research has highlighted the important differences between how clinicians and patients determine 'a good outcome'. Many traditional assessments fail to consider the outcomes that really matter to patients. High quality assessment should be robust, but relevant and acceptable to the range of stakeholders – including patients, clinicians and health care managers.

For many areas, evidence for how best to assess outcomes is lacking and patient important outcomes may not be included. This paper will explore the benefits and challenges of engaging with patients as both research partners and participants in a study which sought to achieve international consensus between health professionals, researchers, cardiac arrest survivors and their partners, in the development of guidance to inform a more standardised approach to assessment in cardiac arrest research (COSCA: the Core Outcome Set for Cardiac Arrest clinical trials study). This research highlights the importance of active engagement with patients as collaborative members of the research team and as active participants in the research process.

Reading list

Whitehead L, Perkins GD, Clarey A, Haywood KL. (2015) A systematic review of the outcomes reported in cardiac arrest clinical trials: The need for a core outcome set. Resuscitation. Mar;88:150-7. doi: 10.1016/j.resuscitation.2014.11.013. Epub 2014 Dec 9.

Haywood KL, Whitehead L, Perkins GD (2014) The psychosocial outcomes of cardiac arrest: Relevant and robust patient-centred assessment is essential. Resuscitation. 2014 Jun;85(6):718-9. doi: 10.1016/j.resuscitation.2014.03.305. Epub 2014 Apr 4

Paper 5: Changing: how we use the evidence we need to examine and change our practice

Author: Professor Kate Seers, Director, RCN Research Institute, UK

Aim of abstract:

This paper aims to look at changing practice and how we use the evidence we need to examine and change our practice in complex healthcare environments. Understanding what works for whom in what context will be highlighted in relation to guidelines for incontinence.

Abstract

This paper will explore an approach to making changes in practice by working in partnership. It will explore how the Promoting Action on Implementation in Health Services (PARIHS) framework worked in a long term care setting. This framework presents successful implementation as a function of the nature of the evidence being implemented, the context into which it is implemented and the amount of facilitation or help people get with the change. It will draw on a study across four European countries that explored how evidence based recommendations were used in practice, and their effect on outcomes. It particularly examined two different types of facilitation or help and tested these alongside a control group. The role of partnerships through involving and engaging others, including health care professionals and patients was crucial and will be explored in this presentation. Understanding what works for whom in what context will be highlighted in relation to implementing recommendations for incontinence in long term care settings. As part of a rapidly changing healthcare system we need to be skillful in how we understand working in partnership to change practice.

Biography
Professor Kate Seers is Director of the Royal College of Nursing Research Institute, based at Warwick Medical School at the University of Warwick. Kate trained at Charing Cross Hospital and Chelsea College, University of London. Kate has a long track record of high quality publications and successful grant income. Her research interests include translating knowledge into practice, complex interventions and pain management.

Recommended reading:
Seers, K., Cox, K., Crichton, NJ., Tudor-Edwards, R., Eldh, A., Estabrooks, CA., Harvey, G., re Hawkes, C., Kitson, A., Linck, P., McCarthy, G., McCormack, B., Mockford, C., Rycroft-Malone, J., Titchen, A., & Wallin, L., (2012) FIRE (Facilitating Implementation of Research Evidence): a study protocol. Implementation Science 7: 25 doi:10.1186/1748-5908-7-25

Theme: Knowledge for change and improvement

14.45-15.15

4.11.1 Critical care nurses attitudes towards undertaking academic pathways

Room Wesley Room
Chair Bernell Bussue
Presenter Anna McGuinness, Senior Nurse Education Learning and Development, Imperial College Healthcare NHS Trust, UK

Aim
This paper determines the current landscape in which critical care nurses undertake continuing professional development and their attitudes towards incorporating this within an academic award to achieve graduate status. This may have benefit in determining how to facilitate staff to achieve graduate status in future.

Abstract
Graduate trained nurses have been shown to reduce patient mortality (Aiken et al. 2014). The Department of Health recommend that critical care nurses complete a specialist course (worth sixty academic credits at undergraduate level) to work in this speciality. However not all diploma registered critical care nurses go on to incorporate this into an academic career pathway to achieve graduate registration. In order understand and identify common themes which motivate, or prevent staff from undertaking academic career pathways to achieve graduate status a hermeneutical phenomenological study was undertaken. Van Manen's research activities (1990) were used analyse and identify themes from a purposive sample of 7 critical care nurses across 3 critical care units in a central London teaching hospital. Themes from semi-structured interviews were triangulated with data from written questionnaires obtained from senior nurses and educators (n=4) within the units to develop a coherent narrative which incorporated all aspects of the phenomena.

Three themes emerged: relevance to practice, personal factors and career planning. Findings suggested that critical care nurses' motivation to include their specialist Continuing Professional Development (CPD) within an academic career pathway is primarily determined by an enjoyment of academic study at a time in their lives conducive to undertaking this. Secondary motivation is related to career progression. In the current fiscally challenging climate this understanding could possibly be harnessed positively by organisations to:

- achieve a graduate workforce through identifying the need for this within staff Professional Development Reviews
- ensure that CDP is both essential to patient care delivery and strategic service provision as part of a consistent pathway with an identified Higher Education Institutes
- utilise CPD and dissertations to ensure relevance to practice and enhance patient care.

These steps may provide structure to support staff achieve the strategic objective of an all graduate profession through CPD (Willis 2015).

Intended learning outcomes
- The importance of developing a graduate level workforce to deliver care pathways.
- Nurses attitudes towards completing continuing professional development as a part of an academic pathway.
- Possible means of facilitating staff to undertake an academic pathway as a part of continuing professional development.

Reading list
Aiken L.H., Sloane D.M., Bruyneel L., Van den Heede K., Griffiths P., Busse R., Diomidous M., Kinnunen J., Zozka M., Lesaffre E., McHugh M.D., Moreno-Casbas M.T., Rafferty A.M., Schwendimann R., Scott P.A., Tishelman C., Van Achterberg T. and Sermeus W. for the RN4CAST consortium (2014) Nurse staffing and education and hospital mortality in 9 European countries: A retrospective observational study. The Lancet 383 (9931): 1824-1830

Van Manen M. (1990) Researching Lived Experience; Human science for an action sensitive pedagogy. State University of New York Press

Willis P. (2015) Raising the Bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants. Health Education England

Biography
With a background in critical care Anna has worked within education in the NHS for 12 years. She joined Imperial Critical Care education team in 2009 as a clinical educator and became a Lecturer Practitioner in Critical Care with a joint appointment between Imperial and The University of West London. Currently as Senior Nurse for Education Anna has responsibility for the training, development and support of the registered and non-registered nursing workforce in

one of the UK largest NHS Trusts. An interest in facilitating staff to optimise development opportunities influenced the research undertaken during her MSc Education for Healthcare Professionals.

3.15 – 3.45pm

4.11.2 Developing the next generation

Room	Wesley Room
Chair	Bernell Bussue
Presenter	Jacqueline McKenna, Director of Nursing, NHS Improvement, UK
Co-author	Peter Blythin, UK

Aim

The aim of the presentation is to demonstrate the development programme that has been created and implemented by the NHS Trust Development Authority to support nursing leaders at board level.

Abstract

This presentation will highlight what the NHS Trust Development Authority is doing to improve the executive nurse succession pipeline in England. The presentation will give details of the current executive nurse turnover rates, describe the Next Generation Programme it has implemented, highlight results of an evaluation study and describe ongoing support for aspiring and new Nurse Directors. The NHS TDA holds a unique position as a national organisation with responsibility for effective clinical leadership in NHS Trust organisations. The TDA Nurse Director is a member of all Nurse Director interviews in NHS trusts (60 in two years) which gives him a privileged view of executive nursing leadership in this sector.

It was found that Deputy Directors of Nursing understood the nursing and health care agendas well, demonstrated good leadership qualities but lacked the ability to convince CEOs that they could work at board level and it was clear they required support to manage this transition. The TDA worked with the NHS Leadership Academy to create a development programme for aspiring Nurse Directors. The programme includes:

- individual CV assessment
- two-day residential focusing on personal motivation and impact to be a nurse director and an in-depth walk through the nurse director recruitment process
- a mock recruitment process with in-depth feedback.

The first two cohorts of this programme took place in 2014 with eighteen participants, ten of whom are now nurse directors. The programme was well evaluated and the third cohort is planned for November 2015 and the fourth in April 2016.

Results from an evaluation of the programme that was done as part of a Masters dissertation will be presented which demonstrates a high level of support for the programme.

Once appointed first time nurse directors receive one to one support to develop their first 100-day plan, have a mentor and join an action learning set which gives them extra support during the transition to board level working.

This is an important development framework for nursing leaders and could be used for other director positions including medical and finance colleagues.

Reading list

Burdett Trust for Nursing. (2006) Who cares wins. Leadership and the business of caring. London: OPM.

Nath,V.,Steward,K., Machell,S.,Gough,P.,Naylor,D. and Williams,S. (2010) Putting Quality first in the Boardroom, London: King's Fund

Biography

Jacqueline joined the NHS Trust Development Authority in April 2013 having been the Director of Nursing at the Medway NHS Foundation Trust since 2000, and previously been the Director of Nursing at Southmead, Bristol from 1997.

Jacqueline trained as a registered nurse at King's College Hospital and had a successful clinical career in gynaecology. Jacqueline achieved a Masters in Medical Science in Clinical Nursing in 1995.

She implemented the first British model of shared governance which improves staff involvement in 1994, and won the HSJ award for patient safety in 2005 for the development of the Medway Nursing and Midwifery Accountability System – an improvement framework for nursing. Jacqueline received an MBE for services to nursing and health care in the 2010 Queen's birthday honours list. She is currently studying for a PhD at Greenwich University.

3.45 – 4.15pm

4.11.3 Revalidation: a Welsh pilot site experience

Room	Wesley Room
Chair	Bernell Bussue
Presenter	Carolyn Middleton, Senior Nurse, Aneurin Bevan University Health Board, UK

Aim

The aim of revalidation is to provide a mechanism through which nurses and midwives demonstrate continuous career-long evidence of updating. It is designed to underpin safer and more effective practice, thus promoting confidence that registrants have the knowledge and skills required to meet the needs of changing and challenging health care delivery. Aneurin Bevan University Health Board (ABUHB) demonstrated the huge contribution (>38%) made to the revalidation pilot testing and developing materials in preparation of revalidation going live.

Abstract
Nurses and midwives currently maintain their Nursing and Midwifery Council (NMC) professional registration through a self-declaration process. The Francis report, published following the Mid-Staffordshire NHS Foundation Trust public enquiry, recognised the importance of moving away from self-declaration to a revalidation model. The NMC piloted their nursing revalidation model across nineteen organisations within the UK including ABUHB.

A sustainable revalidation engagement programme and action plan was established within the UHB, with exemplary pro-active programme leadership. A memorandum of understanding was agreed by the Board, signed by the Chief Executive and submitted to the NMC. A project team was created, Chaired by the Executive Nurse Director and managed by the Senior Nurse project lead. Membership of the project board was wide-ranging and multi-disciplinary across a number of Divisions including representatives from Workforce and Organisational Development, Planning, Finance, Education and Development, Communications, Information Technology, Human Resources and staff side trade unions, working in partnership.

The action plan and measurable outcomes were wide ranging and reviewed monthly. Outcomes included:

The number of registrants who completed the revalidation process (n=813)

The individual and organisational learning gained from pilot participation

The testing of information and tools provided by the NMC and those developed within the HB

The project team's level of commitment and expertise within created a level of confidence and commitment among registrants that was palpable

The level of staff engagement demonstrated learning and growth visualized through the creation of new resources shared locally and nationally

Creation of efficient and effective communication and staff engagement methods tested across a variety of clinical settings

Reflection in action showed a level of professionalism that will inevitably improve public and patient protection and drive up standards of care

Registrants reported feeling supported in describing their personal development revalidation journeys, specifically through the reflective discussion process

A values and behaviors framework, already widely embedded within the UHB, was built upon through the revalidation pilot processes

The Code was clearly evident at the centre of revalidation and at the heart of everyday nursing and midwifery practice

Reading list
Middleton, C., Ryley, N, Llewellyn, D. (2015) Implications for senior nurses. Nursing Management 22 (6) 31-38

Middleton, C., Ryley, N, Llewellyn, D. (2015)Revalidation: a university health board's learning from pilot partner engagement. Nursing Management 22 (5) 24-30

Biography
Dr Middleton joined the Aneurin Bevan University Health Board Corporate Nursing Team, leading on the revalidation pilot. Following significant success she disseminated learning widely through journal articles and conference presentations.

Carolyn has 37 years nursing experience. Her Doctoral studies focused on opioid medication, as a non-medical prescriber she leads on medicines management, prescribing and advanced practice..

Carolyn was the RCN Wales Chief Nursing Officer award 2015 runner-up, won the RCN Wales Nursing Research award 2013 and the British Journal of Nursing Innovation award 2011. She has published widely in nursing journals and Co-authored and edited a pain management textbook.

4.15 – 4.45pm

4.11.4 New roles in mental health nursing: personal reflection of the role of an approved/responsible clinician

Room	Wesley Room
Chair	Bernell Bussue
Presenter	Carol Molloy, Consultant Nurse, South Staffordshire and Shropshire NHS Foundation Trust, Stafford, UK

Aim
The 2007 revision of the Mental Health Act 1083, saw the introduction of the Approved Mental Health Professional and Approved/Responsible Clinician roles designed to enable experienced nurses, occupational therapists, psychologists and social workers to use their expertise and clinical knowledge within a new and dynamic multi-disciplinary/ legislative framework.

As one of the first non-medical Approved Clinicians in the West Midlands I aim to share my experience, the knowledge and competency framework for the role, provide case studies and service user feedback, an evaluation of the role in line with the strategy for improving the quality, efficiency and delivery of current services.

Abstract
New roles in mental health nursing: personal reflection of the role of an approved/responsible clinician.

Mental health nursing as a profession has been evolving and developing over many years in response to emerging models of health care delivery, increasing knowledge, innovations in technology, political; organisational and clinical needs.

New advanced roles have been introduced to the profession for example Clinical Nurse Specialists, Nurse Consultants and Modern Matron's. Whilst some of these new roles have served to confirm what mental health nurses have traditionally done, others have incorporated advanced tasks and responsibilities traditionally considered to be the remit of Doctors, Psychologists and Social Workers. Examples of this particular type of role evolution include non-medical prescribing (NMP), introduced to mental health nursing in 2003, as well as the extension of the mental health nursing roles in delivering Psychological Therapies.

The Mental Health Act (1983), revised in 2007, introduced two new roles for health care professionals: The Approved Mental Health Professional (AMHP) and the Approved/ Responsible Clinician. These new roles replace traditional roles previously held exclusively by Social Workers (Approved Social Workers) and Responsible Medical Officers/ Consultant Psychiatrists (RMO) and provide opportunities for Nurses and other health care professionals to expand their expertise and knowledge, provide more holistic care, and offer choice for the service user.

However, it is one thing to create new roles and oversee their initial implementation, but another to create an environment where there are the appropriate conditions to allow the roles to become established then developed in line with organisational and professional needs.

I have had the opportunity to act as an approved/responsible clinician for service users who are subject to Community Treatment Orders (Section 17A of the Mental Health act 1983) for the past four and a half years and would like to share my experience of working in this advance role, the professional relationships, the challenge to organisational culture and traditional practice and the impact on clinical service delivery. By using case studies and an evaluation of the role I will explore how new roles are developed, implemented and sustained in a changing NHS.

Reading list

Department of Health 2006 From Values to Action: The Chief Nursing Officer's review of mental health nursing. DH publications London.

Department of Health 2008 Code of Practice Mental Health Act 1983 TSO London

Department of Health 2007 Mental Health: New ways of working for everyone. DH publication London

Department of Health 2007 Mental Health Act 1983 revision 2007. DH publication. London

Biography

Carol Molloy is a Nurse Consultant, Approved/Responsible Clinician and an independent non-medical prescriber. Her area of expertise is severe and enduring mental health, specifically Psychosis and Bipolar disorder.

Carol was one of the first nurses in the West Midlands to be approved to work in the role of approved/responsible clinician in 2011; she has provided specialist care to service users who have complex needs and are subject to Community Treatment Orders (CTOs) in the community. Carol is committed to providing recovery focused individual care that is evidence based, compassionate and person centred.

Posters

Poster number 1

Healthy work environment and Millennium Development Goals' (MDGs) attainment: case study of an organisation

Author Saudat Adeka, Research student, University of Bradford, UK

Theme Populations, health and economic growth

Aim

To explore the impact made by a 'healthy workplace' in attaining MDG (Millennium Development Goal)

Abstract

Background: Workforces make up approximately half the world's population, vital to global socio-economic development and consequently to attaining MDGs. Studies have shown that actions impacting employees' health will also impact performance, productivity, and economic development, whether positively or negatively. The United Nations' MDGs offered avenues to bridge the gap between diverse groups, with the aim of removing or reducing frictions amongst rich and poor; developed and under-developed; gender; racial; and other potential diversities amongst humans. Thus, resulting in member states considering the world as one global village, with common developmental goals, and as partners in progress. Implementing MDGs required effort, yet evaluations have emphasised the impact on health systems and institutions, with little or no consideration for potential contribution of non-healthcare organisations. This research examines the contribution of a corporate, transnational and non-health organisation in preventing and combating the commonly reported health problems among employees.

Methods: Twenty three one-to-one interviews with employees of a Nigerian organisation were thematically analysed, alongside a documentary analysis of occupational health records, service book, and HSE policy.

Results: Using a mixed method design, the initial analysis revealed a positive impact towards MDG6 achievement. With annual reduction in commonly reported health problems among employees and in the prevalence of predisposing factors for chronic health problems. Participant employees gave account of improvements within their workplace, perceiving a positive impact on their health.

Discussion: Various reports exist on progress and contributions towards meeting MDGs. Few examined the contribution of corporate, non-health and transnational organisations. This study demonstrates the positive contribution that such a workplace can make to global development plan in Nigeria.

Reading list

WHO (2010) Health Workplaces: a model for action-For employers, workers, policy-makers and practitioners. Geneva. Switzerland.

Zohrabi, M. (2013) Mixed Method Research: Instrument, Validity, Reliabilty and Reporting findings. Theory and Practice in Language Studies, 3 (2), pp. 254-262.

Zungu, L. I. and Setswe, K. G. (2007) An integrated approach to the Prevention and promotion of health in the workplace: a review from international experience. SA Farm Pract. , 49 (6).

Biography

Earned Bachelor of Nursing science in 1990 and M.Sc. Nursing in 2002 at Obafemi Awolowo University, Nigeria. Commenced employment career as Nursing sister in Nigeria in February 1994. Graduated with Merit from the University of Birmingham in 2005 in Science of Occupational Health, Safety and Environment. Rose to the position of Manager and Head of Occupational Health at the Nigerian Ports Authority Unit in 2008. Currently a doctoral research student in Occupational Health

Poster number 2

Innovation, collaboration and continued professional development

Author Lyndsey Anton, Nursing Practice Educator, Betsi Cadwaladr University Health Board, UK

Theme Technology and innovation

Aim

This abstract aims to show the importance of working together, and how linking with others and building professional relationships will enhance delivery of care ensuring outcomes for all are improved. Nurses are receiving some of the support they need to facilitate change, and to keep up to date in their practice. The aim is to encourage reflection and stimulate further interest in current issues/topics within nursing and provide the resources that will aid this.

Abstract

This abstract describes how the Education Team and Library Services at Betsi Cadwaladr University Health Board through collaborative working have found a way to assist nurses with the constant need to keep updated by providing nurses with a small selection of recently published articles which could support them with their continued professional development and also provide a tool to aid revalidation with the Nursing and Midwifery Council from April 2016

by encouraging reflection on the subject matter either individually or as a professional discussion, or both. Nurses need to balance the demands of working, limited time and other commitments so the education team thought of an idea which could bridge the gap that exists between nurses and library resources. Following a meeting to establish what could be done with the initial idea, a plan of action was formulated. The education team in collaboration with library services and utilisation of available resources devised a workable plan where a small selection of current literature on chosen monthly topics were delivered from the library to nurses at their place of work by email. The education team chose the topics, the library did the searches, 5 open access articles and 5 articles available through NHS Wales license owned content were then chosen by the education team and the library then formats the posters for distribution.

The aim of the initiative is to encourage and support staff in their continued professional development by making it easier for them to access a small selection of information/ articles for professional reflection. The articles provided are not guidelines for practice. The hope of the initiative being that staff will engage with and seek further assistance with their own learning from the now established links with library services.

This innovative idea became known as '5 a month'.

Reading list

Grant M et al (2012) Evidence-bases practice for staff nurses. The Journal of Continuing Education in Nursing: 43: 3, 117-124.

Robb M et al (2014) Strategies for Searching and Managing Evidence-Based Practice Resources. The Journal of Continuing Education in Nursing: Vol 45, No 10, 461-466.

Gard Marshall J et al (2014) Library and information services: impact on patient care quality. International Journal of Health Care Quality Assurance 27.8: 672-83.

Biography

- 1980 aged 18, joined National Westminster Bank, remaining there for 18 years
- 1998 commenced nurse training under 'Project 2000'qualified 2001
- 2001-2005 private sector EMI Nursing Home
- 2005-2010 District nursing and Chronic Conditions ase Management BCUHB – article published in 2006 "Pressure Ulcer Prevention in Older People who Sit for Long Periods, and served on as Trustee on Tissue Viability Council 2005-2008 and 2009-2011
- 2010 6 month secondment to Infection Control Team BCUHB
- 2010-2011 management role IT telecommunications department
- 2011 – present Nurse Education Team BCUHB – article (as outlined'5 a month') accepted for publication November 2015 by Nursing Times

Poster number 3

10,000 voices seeing people behind data and transforming patient experience

Author: Christine Armstrong, Regional Lead, 10,000 Voices Northern Ireland, South Eastern Health and Social Care Trust, UK

Theme: Knowledge for change and improvement

Aim

To demonstrate how nurses in NI are listening and learning from the patients voice and using this information to drive quality improvements in improving outcomes for patients and their families and to influence how services are commissioned. In the past feedback from patients and their families has been focused on the complaints process, adverse incidents and reports in the media; however 10,000 Voices has brought some balance into the arena of patient experience feedback as it asks people to "tell their story" and highlight both positive and negative aspects relating to their care.

Abstract

The 10,000 Voices initiative provides an innovative opportunity for nurses in Northern Ireland (NI) to improve health outcomes for patients and their families by using patient experience information to drive quality improvement across all HSC Trusts. Systems and processes have been established, enabling and supporting 'real time change' and providing assurance that the voices of patients and staff are being heard by those who commission and deliver health and social care services.

Aims

- To improve patient and client outcomes by focusing on experience of health and social care
- To use the information to improve and influence how services are commissioned in NI

The principles of Experience Based Co-Design provide the framework for this inititaive by developing a partnership appraoch, wherby patients, carers and nurses work together to improve patient and client expereince.10,000 Voices blends qualitative and quantitative methodolgies,which enable us to "see the person behind the data", using SenseMaker, a narrative-based research methodology which captures and analyses large quantity of data to understand complex change.

Almost 3000 people have "told us their story" and described their experience of receiving nursing and midwifery care in NI. Many of these stories pay tribute to the care, compassion and professionalism displayed by nurses in all Trusts and demonstrate a high level of respect, appreciation and public confidence in our nurses. Through the information nurses in NI have also been able to to improve outcomes for patients and their families by implementing a number of actions, which include the following:

- Reflection and Learning events for nurses in Trusts and Universities

- Development a person centred training programme and patient experience DVD
- Review of pain pathway for patients in orthopaedic wards
- Training in the care of patients with acute confusion/ dementia

10,000 Voices is making a real difference to outcomes for patients and their families, it ensures that those who commission and deliver services gain an overview of the 'experience' that patients have. In essence 10,000 Voices is:

- Listening to patients,
- Learning from patients
- Improving the quality of services for patients by involving patients and
- Influencing how services are shaped in the future

Reading list

Patient/Client Experience 10,000 Voices Annual Report June 2013 – July 2014 available at www.publichealth.hscni.net

Patient Client Experience standards avaialable at www.nidirect.gov.uk/patientstandards

Biography

Christine began her nursing career in 1983 in general nursing at the Royal Victoria Hospital Belfast and worked in clinical practice for a number of years in medical and haematology nursing. Christine has a keen interest in facilitation of learning and development and in improving person centred practices within healthcare.

Christine is currently the Regional Lead for 10,000 Voices. Her previous roles include Nursing Governance Co-ordinator, Practice Development Facilitator and Ward Sister in Haematology.

Poster number 4

Back to the future: nurses' knowledge for change and improvement

Author Loretta Bellman, Independent Consultant, UK

Co-presenters Sarah Rogers RGN DN and Sue Boase MSt BSc (Hons) RGN

Theme Knowledge for change and improvement

Aim

An oral history research project aims to provide knowledge from past and present nurses, from the 1940s to the present day, for future change and improvement in nursing practice. Analysis of nurses' experience within one NHS Trust in the UK reveals key themes from and across eight decades of nursing education and practice, demonstrating both the wisdom of nurses and their legacy for informing future practice. International delegates will also be able to appreciate that in oral history research, practice and theory are entwined and nurses' memories reflect the clinical context and the socio-political issues of the time, including the present day.

Abstract

How can an oral history research project impact on current nursing practice and contribute to future quality patient experience? The value of this method of inquiry lays with an appreciation that understanding the past can guide us in our decision-making for the future (Miller-Rosser et al 2009). A careful analysis of the nursing profession's history and practice seem appropriate as the nursing profession continues to grow and evolve.

The presentation will outline the oral history research project for current and future nursing practice. An overview of the three year 'nursing through the decades' project will include: participant selection, sample size per decade, the data collection process, and the data analysis process which requires analytical techniques that are peculiarly suited to interpreting its many layers (Abrahams 2010).

Memories from across the decades, from the 1940s to the present day, will include reflections from some of the key themes, in particular: innovative practice; fear and anxiety; fundamental needs of patients, and being compassionate, which cannot be measured, rationed or costed (Bradshaw 2014). This legacy of nurses' wisdom is, at times, extremely challenging and controversial. Yet, when considering the current changing context of healthcare much of the data can provide knowledge and insight to influence both future nursing practice and the patient experience.

Reading list

Abrahams, L. (2010) Oral History Theory. Oxon: Routledge

Bradshaw, A. (2014) Compassion in nursing history: attending to the patient's basic human needs with kindness In Shea S., Wynyard R., and Lionis C (eds) Providing Compassionate Healthcare: Challenges in Policy and Practice. Oxon: Routledge, pp 21-32

Miller-Rosser, K., Robinson-Malt, S., Chapman, Y., and Francis, K. (2009) Analysing oral history: A new approach when linking method to methodology. International Journal of Nursing Practice (2009); 15: 475-480

Biography

Loretta Bellman has held strategic and operational posts in NHS, academic and independent research organisations. Her doctorate in clinical change and development in nursing practice was undertaken whilst working at the RCN Institute. Scholarships awarded by the King's Fund and Smith and Nephew enabled her to further explore nursing innovation in North America and Australia. Past research has led to publications which include surgical nursing and action research books, exploration of nurse leadership, and knowledge transfer and the integration of research, policy and practice for patient benefit. She currently leads this oral history project.

Poster number 5

Young cancer survivors – what happens when the treatment stops

Author Jane Belmore, National CNS for cancer aftercare, Royal Hospital for Children, UK

Theme Society, communities, relationships

Aim

To raise awareness of survivorship in paediatric cancers and to look at the impact of treatment for these children and young people.

Abstract

One of the aims of the Managed Service Network for children and young people with cancer in Scotland, is to develop a robust and integrated national system of follow-up to meet the needs of a growing community of children, teenagers and young adults who have survived cancer.

Following on from a scoping exercise conducted throughout the principle paediatric treatment centres within Scotland, two clinical nurse specialists were appointed by the MSN to take this work forward.

By 2030, young cancer survivors in Scotland will be in the range of 11,000. Two thirds are reported to have at least one physical or psychological problem and one quarter have had a severe or life threatening late complication of treatment. (Right diagnosis, right treatment, right team, right place; The cancer plan for children and young people in Scotland 2016-2018).

Children who survive childhood cancer may be more likely to experience late-effects as a result of intensive multi-modality therapeutic strategies, e.g. surgery, radiotherapy, chemotherapy and combinations of these. These multi-treatment strategies often result in physical and psychosocial effects that have the potential to increase morbidity and mortality amongst this group compared with the overall population. (American acdemy of pediatrics section on hematology/oncology. Long term follow up care for pediatric cancer survivors. Pediatrics 2009; 123: 906-15)

The objective of cancer aftercare is to provided health surveillance, together with psychosocial support and education of survivors to encourage them to develop into independent adults. Traditionally, cancer aftercare hashad a nedical focus but now we want to offer a more holistic and individualised care package.

The concerns of a young person who is at the end of their cancer treatment encompasses many aspects. These include anxiety over recurrence, relationships with their family and peer group, poor body image and low self-esteem, anxieties over returning to work or college, fertility issues and worries about other long term sequelae. (Jones et al. Adolescent cancer survivors: identity paradox and the need to belong. Qual health res. 2011 March 29)

Reading list

George S, Bradbury H. More than my illness. London: CLIC Sargent 2009

Estlin E, Gilbertson R, Wynn R editors. Pediatric hematology and oncology. Oxford: Wiley; 2010

Biography

Jane has worked in paediatric haematology/oncology for over 30 years. She has a wide experience throughout this specialty with a special interest in adolescents and palliative care. However, she has recently changed this focus and is working as a clinical nurse specialist in a new service looking at aftercare, with a national remit over Scotland. She works with the Managed Service Network for children and young people with cancer along with another clinical nurse specialist.

Poster number 6

Journal club as a method to teach evidence based practice: an experience

Author Loris Bonetti, Tutor nurse, Bachelor School of Nursing, Teaching Hospital Luigi Sacco, Italy

Theme Knowledge for change and improvement

Aim

- Share an effective/efficient methodology in order to develop competencies in the Evidence-based Practice;
- Disseminate the Evidence-based Practice culture;
- Compare our personal experience in a more international context.

Abstract

Aim Develop and disseminate the competence in critical analysis of scientific studies as well as disseminate the Evidence-based Practice culture among nurses.

Background: The Evidence-based Practice Journal Club is extremely important for educational and training purposes that are related to clinical problems. In fact, it activates a reflection on the appropriateness of decision-making processes and clinical care pathways. Moreover, it is also an important platform of exchange and discussion where a group of health professionals can develop competencies in critical analysis of scientific studies.

Methods: The Evidence-based Practice Journal Club is a set of continuing education and training courses that were monthly set up by two experts in critical analysis of scientific studies in order to teach nurses how to acquire competences in critical analysis of scientific literature thanks to direct experience in the workplace.

Outcomes: In 2012, the group was made up of nine nurses and between 2013 and 2014 other four participants decided to join the group because of their interest in the project. Between 2012 and 2013, twelve meetings dedicated to the critical reading of an article on hospital falls were

set up regularly in order to implement and level out the participants' competencies. During these meetings, the study methodology, the meaning of statistical tests and the result of their application have been deeply discussed. In 2013, the Journal Club payed also great attention to the assessment of BPGs. According to this, the National Institute for Health and Clinical Excellence's BPG "Nutrition support in adults" (2006) has been assessed and integrated also with an update published in August 2013. Today, the working group has finally created a quick reference of this BPG integrated with decision-making algorithms and is going to disseminate it soon thanks to the Collegio IPASVI's web site.

Conclusions: The compliance and the participation of the majority of the group members have been very constructive. The Journal Club has also promoted the reflection on the application of the best Evidence-based Practice interventions and allowed participants to develop competencies in the critical analysis of scientific studies.

Key words: Journal club, Critical appraisal, Nurses, Education, Lifelong learning

Reading list

Schmidt NA, Brown JM Evidence-Based Practice For Nurses: Appraisal and Application of Research. Jones and Bartlett Learning, 2011

Watson R, McKenna H, Cowman S, Keady J. Nursing research – Designs and Method. Churchill Livingstone Elsevier. 2008.

Biography

Bonetti Loris – PhD, RN, MSc Nursing. He is a Lecturer in nursing research methodology at bachelor school of nursing in Milan University; he is a tutor nurse. He has got a long experience in teaching Evidence based practice.

Poster number 7

Improving care for patients with hip fracture: the UK national hip fracture database

Author Viv Burgon, Project Co-ordinator, Royal College of Physicians, UK

Theme Knowledge for change and improvement

Aim

This abstract demonstrates the effectiveness, of clinically led, clinical audit as a robust structured means of driving up standards of healthcare. Over a number of years a combination of clear, evidence based standards, simple data collection and immediate feedback of performance and outcome has resulted in a transformation in the quality of care for patients with hip fracture in the UK. The authors wish to demonstrate the real benefits to healthcare of measurement and feedback of processes of care, not just in the hip fracture population, but across the whole of the NHS.

Reading list

Royal College of Physicians. National Hip Fracture Database annual report 2015. London: RCP, 2015

National Institute for Health and Care Excellence. The management of hip fracture in adults. Clinical guideline

(CG124). London: NICE, 2011. www.nice.org.uk/guidance/cg124 [Accessed 17 July 2015]

National Institute for Health and Care Excellence. Hip fracture quality standard (QS16). London: NICE, 2012.

www.nice.org.uk/guidance/qs16 [Accessed 17 July 2015]

Poster number 8

Learning disabilities nursing workforce review: Northern Ireland

Author Frances Cannon, Senior Professional Officer, NIPEC, UK

Theme Knowledge for change and improvement

Aim

In order to address the recommendations of Strengthening the Commitment: the Report of the UK Modernising Learning Disabilities Nursing Review (April 2012), the DHSSPS developed the Northern Ireland (NI) Action Plan. A key action within the NI Action plan is centred on strengthening capacity of the Learning Disabilities nursing workforce.

This presentation will focus on the findings and learning from a Northern Ireland, Learning Disabilities nursing workforce review, to include all sectors, which sought to establish the location of employment of LD nurses; line management and professional supervision arrangements; implications of anticipated service developments at local level. The knowledge gained by undertaking this review will be instrumental to informing efforts to strengthen the capacity of the learning disabilities workforce.

Abstract

In order to address the recommendations of Strengthening the Commitment: the Report of the UK Modernising Learning Disabilities Nursing Review (April 2012), the DHSSPS developed the Northern Ireland (NI) Action Plan. This included, at the CNO's request, the establishment of the NI Regional Collaborative) which was tasked with leading and overseeing the implementation of NI Action Plan. The Collaborative is chaired by Dr Glynis Henry and comprises representation from a range of key stakeholders from the statutory, independent, voluntary and education sectors. Recognising that Learning Disabilities nurses have an essential part to play in NI's integrated health and social care system providing care and support to people with learning disabilities and their families the Collaborative has committed itself to the task in hand by providing visible and credible leadership in the delivery of a number of work streams which stem from the NI Action Plan.

A key action within the NI Action plan is centred on strengthening capacity of the Learning Disabilities nursing workforce. In the absence of readily available data the Collaborative initiated work to undertake a review of this workforce, across NI to include all sectors.

This presentation will focus on the findings and learning from the review, which sought to establish the location of employment of LD nurses; line management and professional supervision arrangements; implications of anticipated service developments at local level and educational/development needs.

The findings highlight the changing health care needs of people with learning disabilities and identify the need for new ways of working and development of new roles, skills and knowledge to meet the changing needs of people with learning disabilities, now and into the future.

The knowledge gained by undertaking this review will be instrumental to informing efforts to strengthen the capacity of the learning disabilities workforce through development of their skills to deliver change and improvement thus ensuring LD nurses provide the person-centred care that people with Learning Disabilities and their families and carers need want and deserve.

Reading list

Strengthening the Commitment (2012) The report of the UK Modernising Learning Disabilities Nursing Review. Scottish Government

Northern Ireland Action Plan available at www.nipec.hscni.net/RegionalCollaborativeforNIActionPlan_NOTES.aspx

Biography

Frances is a Senior Professional Officer in the Northern Ireland Practice Education Council (NIPEC). NIPEC aims to promote high standards of practice, education and professional development of nurses and midwives within Northern Ireland. Frances has worked in a variety of settings and held a number of roles throughout her career including, clinical, management and education. Within her current role Frances areas of responsibility include the implementation of NMC Revalidation in NI , the development of a Professional Framework for Emergency Care nursing and Learning Disabilities Nursing particularly supporting the delivery of the NI StC Action Plan

Poster number 9

The use of physical restraint: what nurses think and feel? A qualitative study

Author Anna Castaldo, Director of Continuing Education, Don Orione Nursing Home, Italy

Theme Knowledge for change and improvement

Aim

1. Disseminate the results of the Italian research on nurse' attitude related the use of physical restraint in hospitals and nursing homes

2. Knowing the main factors facilitating the reduction of physical restraint

3. Learn about the elements to improve decision-making towards the prevention of physical restraint

Abstract

Objectives: The use of physical restraint depends on the personal and ethical beliefs of nurses, their knowledge of alternative interventions and organizational aspects. The aim of this study is to identify nurses' motivations, attitudes, values and feelings about the practice of physical restraint and which factors favour or hinder its use.

The study follow a multicentric research that investigated the prevalence of physical restraint in hospitals and nursing homes.

Method: This qualitative study was conducted through focus groups. The sample, enrolled on a voluntary basis, consisted of 60 nurses, 40 ward sisters and 30 nursing directors working in nursing homes and hospitals in Italian provinces of Aosta, Brescia, Milan, Lodi and Monza and Brianza, and who already taked part in the first research (. The interviews of 16 focus groups were recorded and transcribed verbatim, with the consent of the participants. Content analysis of the data was validated by the moderators together with the observers.

Results: The use of physical restraint induces in nurses ambivalent and conflicting emotions like anger, compassion and frustration. The main topics of the discussions were the definition of physical restraint – is it a protection intervention or a restriction of freedom? – and the frequency and duration of physical restraint – is it an extraordinary intervention (as indicated in Italian Nurses Code of Ethics or ordinary intervention?

Conclusions: The study highlighted the conflict experienced by the nurses toward the use of physical restraint, especially if it is used as a routine practice. Despite the presence of discouraging factors toward the reduction of the use of physical restraint, this research showed the nurses' need and intention to implement every possible alternative.

Key words: Physical restraint, attitude, emotions, nursing, focus group, ethical issue.

Biography
Castaldo Anna, PhD, RN, MSc Nursing. Lecturer in geriatric nursing and research methodology in Milan University; Director of continuing education Don Orione, Milan; Advisor at the Milan Nursing Council. Expert teacher in geriatric nursing.

Reading list
Hamers JP, Meyer G, Köpke S et al (2009) Attitudes of Dutch, German and Swiss nursing staff towards physical restraint use in nursing home residents, a cross-sectional study. Int J Nurs Stud, 46(2), 248-255.

Möhler R, Richter T, Köpke S et al (2011) Interventions for preventing and reducing the use of physical restraints in long-term geriatric care. Cochrane Database Syst Rev, 16(2), CD007546.

Goethals S, Dierckx de Casterlé B, Gastmans C (2012) Nurses' decision-making in cases of physical restraint: a synthesis of qualitative evidence. J Adv Nurs, 68(6), 1198-1210.

Poster number 10

Nutritional care for the elderly: an observational study in a Italian nursing home

Author: Anna Castaldo, Director of Continuing Education, Don Orione Nursing Home, Italy

Theme: Knowledge for change and improvement

Aim
1. Disseminating the results of the Italian research on the nutritional care in nursing homes

2. Raising awareness of the healthcare team about malnutrition in the elderly

3. Debating about the role of nurses and nurse aids in nutritional care

Biography
PhD, RN, MSc Nursing. Lecturer in geriatric nursing and research methodology in Milan University; Director of continuing education Don Orione, Milan; Advisor at the Milan Nursing Council. Expert teacher in geriatric nursing.

Reading list
Jefferies D, Johnson M, Ravens J. Nurturing and nourishing: the nurses' role in nutritional care. J Clin Nurs. 2011; 20 (3-4): 317-30.

Abbott RA, Whear R, Thompson-Coon J, Ukoumunne OC, Rogers M, Bethel A, Hemsley A, Stein K, Effectiveness of mealtime interventions on nutritional outcomes for the elderly living in residential care: a systematic review and meta-analysis. Ageing Res Rev. 2013 Sep;12(4):967-81.

Bonetti L., Bagnasco A., Aleo G., and Sasso L. Validation of the Staff Attitudes to nutritional Nursing Care Geriatric scale in Italian. International Nursing Review. 2013. 60: 389-396.

Poster number 11

Withdrawn

Poster number 12

Withdrawn

Poster number 13

The role of day therapy in improving patient wellbeing in specialist palliative care

Author: Samuel Clements, Nurse Manager, Marie Curie, UK

Theme: Knowledge for change and improvement

Aim
100% of outpatients attending the Marie Curie Hospice in Wales will conduct a "pre-education" and "post-education" self assessment. Using the principles of "NHS: Improving Quality Together", changes will be implemented to the education programme to ensure patients have a measurable improvement in physical health and general wellbeing.

Abstract
Marie-Curie outpatients referred to the "Wellbeing Programme" receive structured education to develop skills to manage symptoms (i.e. Fatigue and shortness of breath). This has a direct impact on patient wellbeing and reduces potentially avoidable hospital / hospice admissions.

To date the quantitative and qualitative data drawn from this has not been audited. Anecdotally, improvements are reported.

This poster will present data supporting the significance of outpatients palliative day therapy and the benefits of nurse led change in improving day therapy services.

Biography
Samuel qualified as a RGN in the summer of 2009 and commenced his career in community nursing, working initially as a district nurse in the Vale of Glamorgan. During this time Sam assisted with the transition from paper documentation to electronic and transformed elements community oncology such as PICC line care.

Samuel later worked as a community palliative care clinical nurse specialist in central Cardiff. Managing large numbers of complex palliative community patients.

Samuel also spent time working with Prostate Cancer UK as Community prostate cancer CNS for Wales - the first and only in Wales. During this time he assisted with the commissioning of services such as Tenovus' ManVan. He supported Welsh Government in the development of equitable services for men living with and after prostate cancer.

Samuel also worked as a hospital based CNS in the NHS award winning Acute Oncology Service. Currently Samuel is the Nurse Manager for Marie Curie Outpatients in Wales.

Poster number 14

Raising awareness of the issues of childhood obesity in the Emergency Department

Author: Siobhan Corbett, Advanced Nursing Pratitioner, ED UCLH, UK

Theme: Knowledge for change and improvement

Aim

To increase awareness of the health problems and growing concerns associated with childhood obesity. To supply information and education regarding healthy lifestyle in compliance with Government initiatives.

Abstract

The height and weight of all walking children presenting to the Emergency Department were measured over a month period to establish the Body Mass Index (BMI). The local Apples and Pears weight management service was also approached for support and information on this health promotion scheme. The results showed that 247 patient details were used with 6 patients (2.4%) being overweight and 2 patients (1%) were obese aged from 12-17. As a result a poster was designed to highlight and educate patients on BMI, weight issues and healthy lifestyle choices, including options for healthy lifestyle choices and programmes that could be accessed for support with weight issues. The World Health Organisation regards childhood obesity as one of the serious global challenges for the 21st century. The implications to the health service mean that failing to tackle this 'national crisis' is not an option. Although not large numbers were established in this exercise, obesity is notoriously difficult to treat so prevention and early intervention is crucial. A multi agency approach has been identified as the most appropriate and effective means to tackle this growing health concern. The Emergency Department is in contact with large numbers of children with an array of conditions and so in a prime position to deliver health education regarding weight issues

Reading list

www.who.int/topics/obesity/en/

RCPCH Royal college of Paediatrics and Child Health Position Statement Childhood Obesiy April 2012

Department of Health, Obesity: General Information www.dh.gov.uk/en/Publichealth/Obesity/DH_078098

Biography

After qualifying in 1998 as an RN Adult from Surrey University the author went straight in to Emergency Department before travelling to Australia for a year and working in multiple clinical settings. After returning to the UK the Author established her career in the ED specialising and undertaking many courses to gain the necessary skills and knowledge to forge a successful senior ED career. After several years as a Senior nurse in the Ed the author progressed to become an Emergency Nurse Practitioner folowed by further study to become an Advanced Nurse Practitioner in the ED where she still works. Added to this the author has developed her teaching skills and lectures part time at University at degree and masters level

Poster number 15

The expansion of the Advanced Nurse Practitioner role within the Emergency Department

Author: Siobhan Corbett, Advanced Nursing Pratitioner, ED UCLH, UK

Co-presenter: Jennifer Williamson, Trainee Advanced Nurse Practitioner, UCLH NHS Foundation Trust, UK

Theme: Knowledge for change and improvement

Aim

To increase the number of Advanced Nurse Practitioners working within the Emergency Department providing a 24/7 service

Abstract

Two senior Emergency Nurse Practitioners (ENP) were interviewed for the post of trainee Advanced Nurse Practitioner (ANP) and once successful enrolled at a London University to attend study days once a week. Simultaneously 50% of their clinical shifts were identified as supernumery where they worked alongside an existing ANP assessing and managing patients in the ED. On completion of a successful Masters programme they will then work as autonomous ANP in the ED. The Advanced Nurse Practitioner role was introduced in the author's ED 5 years ago and has been widely successful in delivering the most high quality and appropriate care in the most efficient manner. This role does not work in isolation and a collaborative approach among disciplines and users has been instrumental in the success. This is viewed as an innovative means to modernise the service provided in the ED, standardising practice without compromise to patients or care. Developing higher levels of care is an enabler for meeting the service

and workforce challenges, grounded in direct care provision. Thus investment into the training and education of future Advanced Nurse Practitioners is paramount for succession planning and to maximise the workforce. This is an area that requires much further investment for progression but with publication of an ED ACP Curriculum and specified competencies is one that should proliferate in the upcoming years.

Reading list

THE ROYAL COLLEGE OF EMERGENCY MEDICINE Emergency Care Advanced Clinical Practitioner Curriculum and Assessment Version 1.0 April 2015

Griffin. M. Melby. V. 2006. Developing an advanced nurse practitioner service in emergency care; attitudes of nurses and doctors. Nursing and Healthcare Management and Policy. 292 – 301

National Leadership and Innovation Agency for healthcare. 2010. Advanced Practice; The Portfolio. Wales

Biography

The author qualified as an RN Adult in 1998 at Surrey University and began her career in the Emergency Department before travelling to Australia and living abroad for a year. In this time she acquired multiple skills and experience working in a variety of challenging settings before returning to the UK and settling back into the Emergency Department in central London. Over the years the author undertook multiple course and acquired specialist skills for the Emergency setting before qualifying as an Emergency Nurse Practitioner. After completing a 3 year Masters programme the author began working as an Advanced Nurse Practitioner in the ED which she has been doing for the past 5 years, as well as becoming a part time lecturer at a London University lecturing on post grad courses

Jennifer Williamson: I qualified as an adult nurse in 2000 with a BSc (Hons) Nursing degree from Buckinghamshire University College and Charing Cross Hospital. Since then I have worked in Australia and in a neurosurgical unit but since 2004 I have specialised in Emergency Nursing. I am an Emergency Nurse Practitioner since 2010, non-medical prescriber and I am due to complete my MSc in Advanced Nursing Practice at London South Bank University next year. I have completed aspects of year one and two of The Royal College of Emergency Medicine Advanced Clinical Practitioner Curriculum as part of my Advanced Nurse Practitioner training which includes the European Trauma Course Team Leader.

I currently work in UCLH NHS Foundation Trust Emergency Department as a Trainee Advanced Nurse Practitioner for 50% of my role, the remainder of my role is a senior Charge Nurse / Emergency Nurse Practitioner. On successful completion of my MSc I shall continue to focus in the emergency care setting diagnosing and treating emergency majors, resuscitation and paediatric patients.

Poster number 16

Implementation of a child public health module as part of work force development training

Author: Cameron Cox, Senior Lecturer Children's Nursing, Kingston University, UK

Theme: Populations, health and economic growth

Aim

To share knowledge and experience of developing a Child Public Health Module

Abstract

Environmental and familial social and economic factors greatly influence child health. (Wolfe and Mckee 2013). The module will show how health professional can utilise every encounter with the child and family to improve health and prevent ill health in the future.

"A key objective of child public health is to explore and elucidate changes in health and diseases in children" (Blair et al 2010). Students undertaking this module will be equipped with the knowledge and understanding of factors that influence the future adult health of today's children. Preventative health measures will be examined together with the knowledge and skills required to work within multidisciplinary settings. A wide range of health issues such as sexual health, Diet and nutrition, oral hygiene, and mental health will be explored. The aim being to understand respond to changes in child health (Blair 2010) preventing ill health and improving well-being into adulthood.

The module is at academic level 7, 15 Credits, and can be completed a stand-alone module or as past or as part of the healthcare Practice PgCert/PGDip/MSC.

The target audience is qualified practitioners in health and social care working with babies, children and young people.

The duration is 5 teaching days over a 5 week period. Assessment will consist of an in-depth critical essay incorporating a proposal for a resource for service improvement.

The history of public health will be discussed together with public policy, epidemiology and child health in the UK, Europe and worldwide. Health inequalities with reference to child public health will be examined alongside children's rights, and ethics.

Health education can be seen as a as a major component in health promotion (Green and Tones 2015).

Therefore strategies to improve health and prevention of ill health will be explored in conjunction with health education and health promotion models.

Reading list

Blair, M., Stewart-Brown, S., Waterston, T. and Crowther, R. (2010). Child Public Health. 2nd Edition. Oxford: Oxford University Press.

Linsley, P., Kane, R., Owen, S. (2011) Nursing for public health: promotion, principles, and practice. Oxford: Oxford University Press.

Sines, d., Aldridge-Bent, S., Fanning, A., Farrelly, P., Potter, K and Wright, J (ed) (2013) Community and Public Health Nursing, 5th edn, West Sussex, Wiley Blackwell.

Biography

Cameron qualified with a BA in Paediatric nursing and has been employed in children's day Unit, Children's Acute Care ward, where she undertook the ENB 998 teaching and assessing.

Cameron gained further experience in a Neonatal Unit, followed by children's oncology and Paediatric Pre – Anaesthetic Nursing.

Cameron moved from hospital to community care working as a school nurse in special needs schools and mainstream schools. During this period Cameron gained an MSc in Health Care Practice and Clinical Leadership as well as an interest in lecturing.

Cameron has recently completed her first year as a senior lecturer in children's nursing.

Poster number 17

Introducing the role of Ophthalmic Nurse Practitioner to the macular service: Northern Ireland

Author: Catherine Dardis, Opthalmic Nurse Practitioner, Macular Service BHSCT, UK

Theme: Knowledge for change and improvement

Aim

This Poster will outline the background behind the new role, how we developed our technique in administering intravitral injections used in the treatment of macular degeneration and how we evaluated the impact on our service.

Abstract

Background: The Macular service in the Mater Hospital (NI) treats several sight threatening conditions. The service was opened in 2009 in response to the approval of a new family of drugs approved to treat wet ARMD. The introduction of anti – Vascular Endothelial Growth Factor (Anti VEGF) drugs has revolutionized the treatment of wet ARMD. The clinic is quite unique as it is a regional service and accommadates a large proportion of the population of Northern Ireland. Since 2009,the service has grown dramatically. From 2010 and 2014, the amount of injections that have been given in the macular service has quadrupled indicating a huge demand for this service.Last year we administered over 12,000 injections. Before 2013, the injection were traditionally done by ophthalmologists in Northern Ireland. The growing demands for the service required consideration into innovative ways in meeting service needs. One solution was to introduce the role of Ophthalmic Nurse Practitioners to the Macular Service to administer injections.

Method: The poster will include a brief summary of how injections are administered and what they are used for. It will include local policies and procedures developed to implement the new advanced nursing skill. There will be a brief outline of national protocols and guideline required to develop the role. The poster will include what steps were required when learning how to administer the injections as well as other factors that made our new role sucessful.

Evaluation: An audit that explored patient satisfaction regarding this new approach to administering injection. The feedback and reaction to the changes were extremely positive, giving a 92% overall patient satisfaction to the introduction of nurse practitioner to the macular service. Positive feedback from patients has indicated that the new role is helping to improve the service and promotes a better continuity of care because they are more likely now to see the same injector twice.

Summary: The introduction of this advanced nursing role in Northern Ireland is one of many ways that the macular service has streamlined to the expanding needs of the service, and it has been very successful. An innovative sucess story for Ophthalmic Nursing in Northern Ireland.

Reading list

DaCosta J, Hamilton R, Nago J, Mapani A, Kennedy E, Luckett T, Pavesio C and Flannigan D. (2014). Implementation of a Nurse-Delivered Intravitreal Injection Service. EYE. 28 (6), 734-740

Simcock P, Kingett B, Mann N, Reddy V and Park J (2014) A safety

Biography

Catherine is currently working as an ophthalmic nurse Practitioner for the Macular Service in Belfast. Catherine completed her undergraduate nursing degree at Queens University Belfast in 2007 and has recently completed an MSc (Ophthalmic Nursing) with City University London. Catherine started her ophthalmic career working for the Belfast Trust, in an Eye Outpatients' department/ Eye casualty before moving to an Ophthalmology surgical ward for 2 years. In 2009, an opportunity to move to London resulted in joining the Medical Retina team at Moorfield's Eye Hospital for over 4 years. A lot of training and support from both teams at Moorefield's and Belfast has been a great basis for beginning a new role as one of the latest Ophthalmic Nurse Practitioners in the Belfast Trust. This new role has included being a part of introducing Nurse Injectors into the Macular Service in Northern Ireland.

Poster number 18

Improving standards of bowel and bladder management for spinal cord injuried patients

Author Deborah Davies, Clinical Nurse Specilist, Rookwood Hospital, UK

Theme Technology and innovation

Aim

Rehabilitation, planning and acute management of patients with spinal cord injuries should be a contiuum of care. Effective bowel and bladder management within the spinal cord injury patient continuity is essential for them to lead a normal life.

Abstract

A six month retrospective qualitative notes review examining bladder and bowel management in the Welsh Regional Spinal Injury Rehabilitation Centre [WRSCIRC] demonstrated that 81% of all admissions within a six month period in 2013 were admitted with faecal loading requiring treatment delays. This indicated that bowel care management for spinal injured patients admitted from other hospitals has been inadequate, which is a major concern and is perceived to be their major disability, impacting on quality of life.

A nurse led clinic for those patients with acquired and long term spinal cord injuries has been piloted which aims to support bowel and bladder function. 213 patients have been seen since the start of the clinic in 2013. Of these 57 were new referrals t the clinic and were seen within 2 months of referral. Prior to this clinic patients would be waiting from 4-6 months for a review.

66 of these patients reviewed in clinic would have previously been admitted to WRSCIRC. The nurse led clinic has allowed these patients to be seen in a timely manner reducing the need for admission. This has saved approximately 1926 bed days and provided a releasable cost of approximately £230.000 to the unit The results of a recent patient questionnaire demonstrated that the nurse led clinic has had a positive impact on the spinal injured patients quality of life

Reading list

Guidelines for the Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions

Royal College of Nursing ;Digital Rectal Examination and Manual Evacuations

Prudent Health care

Biography

A passionate and enthusiastic spinal rehabilitation nurse and has 24 years caring for patients. I also deliver the patient education and training programme and I have helped produce national guidelines which provide guidance, standards protocols and information to support effective bowel care. Patients have stated the clinic has had a positive impact on their quality of life and feel comfortable speaking to me regarding very personal issues.

Poster number 19

Delirium NICE Clinical Guideline 103 critical care network audit

Author Nichalus Dawson, Charge Nurse, Royal Surrey County Hospital, UK

Aim

Is to describe the rational and outcomes of a network wide audit, examining whether the standard that 100% of patients in Intensive Care are being assessed, as set by the Core Standards for Intensive Care Units (2013).

Abstract

Delirium NICE Clinical Guideline 103 critical care network audit: Is the standard of 100% of patients in Intensive Care being assessed, as set by the Core Standards for Intensive Care Units (2013)?

N Dawson, M Carraretto, W Fuller

Critical Care Unit, The Royal Surrey County Hospital NHS Foundation Trust, Guildford, Surrey

Delirium is defined as fluctuation in acute mental state (Mallett et al. 2013, Barr et al. 2013). Over 65% of patients in Intensive Care Units (ICU) are not formally assessed and have undetected delirium (Morton and Fountaine, 2013). This results in rising ICU cost and extended hospital costs (Connor and English, 2011).

A pathway was introduced within the Royal Surrey County Hospital, complying with National Institute for health and Care Excellence (NICE) Clinical Guideline (CG) 103 (2010). The pathway formalised diagnosis, anticipating an increase in early detection and treatment, empowering nurses to initiate management. This aimed to assist in reducing patient length of stay in hospital, also improving patients' outcome.

The aim of this audit is to identify if the 19 ICUs within the South East Coast Critical Care Network (SECCCN) are compliant with the national standard for the care of critically ill patients. The standard is that 100% of patients in ICU are assessed, as set by the Core Standards for Intensive Care Units (ICS, 2013); meeting the NICE CG103.

A questionnaire was developed, based on the standards by ICS and NICE CG103. These questions were reviewed by the SECCCN leads, who gave their approval. Each department sampled ten patients. The data was sent by each department to the researcher, who then analysed the data.

The results are still being collected and collated. However it is expected, as suggested in Page et al.'s (2009) work, that a use of a delirium pathway has not been widely initiated. It is predicted that half of the ICUs will have a pathway. Also Barr et al. (2013) suggests the incidence of delirium will be high.

The learned outcomes are to introduce a standardised pathway and implement a generic teaching programme. Further re-audit would be recommended ensuring effective change has been maintained.

Reading list

National Institute for health and Care Excellence (2010) [Online] Delirium: prevention, diagnosis and management, NICE guidelines CG103, Available from: www.nice.org.uk/guidance/cg103/chapter/Introduction

Intensive Care Society (2013) Core Standards for Intensive Care Units, edition 1, UK, Intensive Care Society

Biography

Nichalus Dawson is a Junior Charge Nurse, who has worked in Critical Care for nearly 6 years. Prior to that he worked in an Emergency Assessment Unit from being newly qualified. Throughout this he has work with the Royal College of Nursing as a Steward. Nick leads the critical care units nursing Delirium Service Development Group.

Poster number 20

Choice of Accommodation Policy (CoAP)

Author: Richard Desir, Divisional Nurse, Aneurin Bevan University Health Board, UK

Theme: Society, communities, relationships

Aim

The aim of the Choice of Accommodation Policy (CoAP) is to improve patient engagement, information, choice and proactive support to reduce lengths of stay in hospital which is so often the cause of a loss of independence for older people.

Abstract

Recognising that older people were spending long periods of time in hospital whilst waiting for a care home, Richard proactively engaged stakeholders in the development of a Choice of Accommodation Policy (CoAP). The aim of the policy is to improve patient engagement, information, choice and proactive support to reduce lengths of stay in hospital which is so often the cause of a loss of independence.

Through the establishment of a multi-agency project board, he has ensured that the CoAP supporting processes have been designed in such a way that individuals who lack capacity have not been deprived of their liberty, and have full access to advocacy services. Policy implementation has been supported through specific work streams such as staff education, communication and quality outcomes; each embedding a governance framework. Richard has also developed an information pack and 'frequently asked questions' leaflet for older people and relatives to help support care home choices. Richard is a highly motivated and compassionate nurse who constantly strives to improve patient's experiences.

Reading list

NHS choices (2015) Your guide to care and support – care homes (Online). Available at: www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-homes.aspx

Alzheimer's Society (2014) Care homes today (onine). Available at: www.carehomestoday.co.uk/article17/choosing_a_care_home.html

Biography

Richard qualified as a Registered Nurse in 1989 He has worked in variety of clinical and senior managerial roles in England and Wales, holding positions in the community and hospital settings. Richard has also held professional nurse roles such as LHB Nurse Board member for Swansea LHB and Professional Executive Nurse for South Manchester Primary Care Trust.

Poster number 21

A microbiological comparison of new and existing environmental cleaning methods in MTW trust

Author: Sarah Fielder, Nurse Consultant, Infection Prevention and Control, Maidstone and Tunbridge Wells NHS Trust, UK

Theme: Populations, health and economic growth

Aim

The aim of the paper is to compare total viable bacterial counts from set points within a set number of patient rooms at Maidstone and Tunbridge Wells NHS Trust, following different levels of cleaning

Abstract

Maidstone and T Wells NHS Trust uses different methods of cleaning categorised as levels in the Environmental Disinfection Policy. The levels of cleaning depend on the level of contamination or the infectious nature of the patient. The levels of cleaning include Microfibre, detergent, chlorine dioxide, steam, hydrogen peroxide vapour and ultraviolet light, on both acute hospital sites in the Trust.The time taken to effectively clean a patient environment according to the policy can be challenging in times of winter pressure. Maidstone and T Wells NHS Trust wanted to identify if there was an effective cleaning regime that was time efficient and safe for patient contact. The introduction of Ultraviolet light cleaning (UVC) had the potential to decrease cleaning time per room by up to 2 hours.The Infection Prevention and Control team inquired how effective each level of clean in our policy was. Therefore a project was devised to test the efficiency of each level of clean to establish if the current environmental cleaning policy still meets the needs of the Trust.The project identified touch points within a single patient room. These points were sampled using

microbiological contact plates before each stage of cleaning and on completion of the process. A total viable bacterial count was undertaken by manual inspection. The results were analysed and fed back to the Infection Prevention and Control Committee to reinforce the decision to make changes to the Environmental cleaning policy

Reading list

Loveday H., Wilson J.A.,Pratt R.J., Gorsorkhi M.,Tingle A., Bak A.,Browne J., Prieto J., Wilcox M., (2104)epic 3 National evidence based guidelines for preventing healthcare associated infections in NHS hospitals in England. Journal of Hospital Infection 86 1-70

Biography

Sarah qualified as an RGN in 1986 from the The Middlesex Hospital, London. She has always had an interest in teaching and have had three educational games published, two were on general nursing principles through Solent Simulations Ltd. The third was an Infection Control game – Infobug, published through Johnson and Johnson and endorsed and distributed via the Infection Prevention Society/Fitwise. With over 24 years experience in Infection Control in all settings she is pleased to be able to combine this passion with teaching in her current role as a Nurse Consultant at Maidstone and T Wells NHS Trust.

Poster number 22

Improving individual and population health through the pillars of advanced nurse practice

Author Kath Goode, Nurse Practitioner, Aneurin Bevan University Health Board, UK

Theme Society, communities, relationships

Aim

Research demonstrates that individuals with mental illness are likely to have poorer physical health and life expectancy than the general population. Life style factors such as lack of exercise, poor diet and smoking are contributory factors as are metabolic, cardiac and respiratory conditions. A national audit identified that 33 % of patients with schizophrenia did not receive physical health monitoring of risk factors and a local audit identified that despite checklists and guidance being provided, monitoring of risk indicators was not always undertaken. The pilot aims to address areas of treatment and care improvement in patients with serious mental ill-health.

Abstract

Kath has led on a pilot study in her health board that aimed to address areas of improvement in the treatment and care of patients with serious mental ill health. The main point of concern regarding these individuals is that they were unable to maintain their personal safety and wellbeing within the community. Following the pilot, the evaluation outcomes demonstrated that a number of improvements had taken place in the population as a result of the changes that were implemented. An audit of case notes led to many of these changes being rolled out, such as education sessions with ward staff, easier access to physical health assessment's weight management and smoking cessation advice as well as referral to other services where necessary.

As a result of the positive outcomes of the study, Kath demonstrated to colleagues how they can empower patients and conversely, how patients can take ownership of their care. She achieved this by asking nurses to take a holistic approach and identify 'homework' that patients could undertake to improve their health choices they make as an individual.

Further developments to the project include a service review identifying the benefit of using a National Early Warning Score (NEWS) and comparisons between its use in standalone units compared to wards within general hospital settings and differences in need compared to that of rehabilitation wards, adult wards and older adult wards. Alongside this the physical health checklist has been developed further. Finally there are plans to develop a mentorship programme, with yearly reviews and monthly meetings providing, research, clinical decision making and reflection through case studies, whilst providing ongoing support and supervision.

Kath is a supportive figure for both staff and patients and leads by example in improving the health of patients and their experiences of health care.

Reading list

Royal College of Psychiatrists, (2009) No health without mental health. The Alert Summary Report, Academy of Medical Royal Colleges. London Royal Colleges of Physicians.

Royal College of Physicians, (2012) National Early Warning Score (NEWS): Standardising the assessment of acute-illness severity in the NHS. Report of a Working Party. London.

Thornicroft,G (2011) Physical health disparities and mental illness; the scandal of premature mortality British Journal of Psychiatry 199(6):441-2

Biography

Kath achieved a diploma in mental health nursing in 2002 and went on to complete a BSc in psycho-social interventions in 2008. She has also gained an ILM in management level 5, she is an independent prescriber and is currently studying towards an MSc in Advanced clinical practice. Kath worked as a staff nurse until 2004 when she was promoted to deputy ward manager. She is currently working towards achieving advanced practice status under the Welsh Governments Advanced Practice Framework.

Poster number 23

Passport to care

Author Tracey Grint, Education Faclitator, St Richard's Hospice,UK

Aim
To enable and support the advancement of the skills and knowledge of both registered and unregistered healthcare clinicians within a palliative care setting.

Abstract
At the Hospice we identified the need to provide a consistent structure for our staff to enable them to develop and maintain their clinical skills and knowledge in order to deliver evidence based safe and effective practice which could impact positively on patient experience.

- In Line with The Care Certificate (2014) which identified a set of standards that health and social care workers adhere to in their daily working life.
- In Line with the updated Nursing and Midwifery Council, NMC Code (2015) which presents the professional standards that nurses and midwives must uphold in order to be registered to practise.

As an enabler the four themes identified by the NMC regulated professionals:

- Prioritise People
- Practise effectively
- Preserve safety
- Promote professionalism and trust

The 15 standards identified within the Care Certificate (2014) were also utilised to create the core passport and competency framework.

Our aims were:

- All Healthcare professionals have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care to patients and their families.
- To support the further development of all healthcare professionals knowledge and skills base and to identify personal learning needs.

Our Objectives were:

- To develop a portfolio and competency passport for all grades of staff that maps against the NMC and Care certificate requirements which also encompasses individual organisational job description profiles and independent performance reviews.
- Trained and untrained staff will have the same opportunities to develop within their chosen roles.

Learning outcomes:

- Providing participatory learning in the form of classroom based works shops along with encouraging reflective practice and will aim to meet individual learning needs.
- Health care professional will be able to apply theory into practice which underpins the fundamentals of care so that the quality of the patient experience will be enhanced.
- Feedback from participating individuals to empower and sustain new ways of learning and reflecting.

Reading list
www.nmc.org.uk/standards/code

www.skillsforhealth.org.uk/standards/the-care-certificate

Duke.S. and Appleton.J.(2000) The use of refection in a palliative care programme – a quantitative study of the development of reflective skills over an academic year. Journal of Advanced Nursing, 32(6), 1557-1568

Biography
Tracey trained as a Registered General Nurse and has gained a wealth of experience in acute and community settings. Tracey was recruited by St Richard's Hospice as a Clinical Nurse Specialist in 2006 and made an immediate impact by developing one of the first nurse-led clinics in a GP practice. The clinic specialised in providing expert support and advice for patients and their families who needed specialist palliative care. Following this Tracey was lead on the successful implementation of Advance Care Planning Project (ACP) across Worcestershire that included the planning and delivery of education programmes for health and social care staff in the use of ACP and Advanced Decisions to Refuse Treatment protocols and documentation.

Tracey has a special interest in dementia care and is also an Associate Lecturer at the University of Worcester. Developing specialist education modules within the Association of Dementia Studies examining issues for people with dementia at end of life.

Poster number 24

Developing teamwork and sustainable changes in clinical practice for nurses and doctors in Myanmar

Author Nang Chaw Chaw Aung, University of South Wales, UK

Theme Knowledge for change and improvement

Aim
Mortality and morbidity are often highest during the first 48 hours of presentation to hospital due to delayed and inappropriate assessment and emergency management. We describe the development of an Emergency Paediatric Care Programme (EPCP) in Myanmar for front-line nurses and doctors often with limited experience in caring for seriously sick newborns and children. The EPCP supports the Ministry of Health's priority of reducing neonatal and child mortality.

Abstract
Methods: A five day EPCP course was developed through the adaptation of World Health Organisation and Kenyan Paediatric Association Emergency Triage Assessment and Treatment (ETAT+) teaching materials in accordance with Myanmar's national guidelines and disease burden.

Experienced international ETAT+ instructors supported the development of a faculty of Myanmar EPCP instructors.

During the EPCP course, participants review the hospital facilities and make recommendations that guide an implementation plan for change. Ongoing mentorship and support is then provided through the development of local hospital ETAT+ Teams.

Results: In 2015, 47 nurses and 56 doctors successfully completed 4 EPCP courses in Myanmar. 2 Voluntary Service Overseas (VSO) international paediatric nurses were also invited to attend the course to ensure consistent teaching.

The nursing participants had very limited previous experience of simulation and skills training and found these interactive sessions extremely useful and "exciting". Feedback included:

- "I think the course is excellent and should be expanded into the rural healthcare centres"
- "We need to practice what we have learnt in the real setting"
- "Need to include all doctors and nurses in this training"
- "We need to be more systematic in our management of sick children in Myanmar "
- "I get so much knowledge and skills – much more than any other time"

Three exceptional nurse participants together with 11 doctors were invited to attend a Generic Instructor Course to form a highly-skilled faculty of Myanmar EPCP instructors. They were then mentored as instructor candidates on three subsequent EPCP courses. One of these nurses, as part of the local ETAT+ Team and implementation plan, developed a continuing nurse education programme that included simulation training based upon the EPCP.

Conclusions: Training nurses and doctors together is a relatively new concept in Myanmar. The success of this EPCP demonstrates that multi-professional training is both feasible and brings significant advantages. The development of teamwork and critical thinking are essential elements in improving care provided for newborns and children.

EPCP also provides support for facility improvement through the development of local implementation plans and ongoing mentorship through the ETAT+ Teams. This essential component reviews barriers to change and supports learning to be put into practice.

Five UK paediatricians have been recruited to support the local ETAT+ Teams with clinical duties, training, quality improvement, monitoring and evaluation. The recruitment of experienced international neonatal and paediatric nurses is planned for 2016 with the support of UNICEF and VSO.

Reading list
Ayieko P, Ntoburi S, Wagai J, et al. A Multifaceted Intervention to Implement Guidelines and Improve Admission Paediatric Care in Kenyan District Hospitals: A Cluster Randomised Trial. PLoS Medicine 2011; 8(4).

Molyneux E, Ahmad S, Robertson A. Improved triage and emergency care for children reduces inpatient mortality in a resource-constrained setting. Bull World Health Organ. 2006 Apr;84(4):314-9. Epub 2006 Apr 13.

Rowe AK, de Savigny D, Lanata CF, Victora CG: How can we achieve and maintain high-quality performance of health workers in low-resource settings? The Lancet 2005, 366:1026-1035.

Biography
Dr. Jay Halbert is a Specialist Paediatric Registrar working in paediatric oncology and haematology at Addenbrookes Hospital in Cambridge, UK. He has a Diploma in Tropical Medicine and extensive experience working in resource-limited countries in Africa, Asia and Latin America. Together with colleagues from the Royal College of Paediatrics and Child Health, Myanmar Paediatric Society and Kenyan Paediatric Society, he has developed an Emergency Paediatric Care Programme for nurses and doctors in Myanmar designed to promote teamwork and sustainable changes in clinical practice.

Poster number 25

Delivering the stroke design programme

Author Claire Harris, Ward Sister, Aneurin Bevan University Health Board, UK

Theme Knowledge for change and improvement

Aim
The aim of this project is to outline how Aneurin Bevan University Health Board, supported by the Community Health Council implementing a stroke services re-design Programme. The key changes include: Centralisation of emergency stroke care for the first 3 days in one hyper-acute stroke unit. Delivery of step-down acute stroke care, a reduction in the number of sites delivering inpatient stroke rehabilitation and continuation of Community Neuro-rehabilitation Service to deliver Early Supported Discharge for mild to moderate stroke patients.

Abstract
Stroke remains the third most common cause of death and disability with approximately 150,000 people having a stroke each year in the United Kingdom accounting for over 56,000 deaths in England and Wales. Ward sister Claire has been instrumental in delivering the stroke design programme within her health board. This programme aimed to create a single site stroke service and has seen the introduction of six hyper acute stoke beds at the Royal Gwent Hospital. Claire has used hard work, professionalism and commitment in achieving this with the existing resources

available. As a result the acute stoke unit has seen an increase in discharge rates and a reduction in the average length of stay for patients. This has had a direct effect on stroke patients, enabling them to be gtransferred to the acute stroke unit sooner, meaning their patient journey could begin earlier. To aid this Claire has created strong links with ward sisters in the community setting, allowing a swift and seamless flow to community hospitals.

Claire strives for excellence in her work and has created relationship with other acute stroke units around the UK in order to learn from best practice. She has raised staff perception of the importance of communication with patients and relatives, which has been achieved through carer's clinics and other proactive communication tools. She is an exceptional individual who puts patients and their families at the centre of care.

Reading list

Mant, J; Wade, D and Winner, S (2004). Health Care needs assessment: Stroke.

In: Stevens et al (eds). Healthcare needs assessment: the epidemiologically based needs assessment reviews. 2nd Ed. Oxford: Radcliffe Medical Press.

National Institute of Clinical Excellence (2007). Alteplase for the treatment of acute ischaemic stroke. NICE technology appraisal 122. Available from: www.nice.org.uk/TA122

Multivariable analysis of outcome predictors and adjustment of main outcome results to baseline data profile in RCT: Safe Implementation of Thrombolysis in

Stroke-Monitoring Study (SITS-MOST). Stroke (2008); 39(12): 3316-22

Biography

Claire Harris started her nursing career in the emergency admissions department at the Royal Gwent Hospital. For the last four years she has been the ward sister of the Aneurin Bevan University Health Board's stroke ward which also has hyper acute beds. Claire was the winner of the RCN Wales Nurse of the Year award 2015 for her work with stroke services.

Poster number 26

A forum project on the role of the CNS in endometriosis

Author: Debra Holloway, Nurse Consultant, Guys and St Thomas NHS Foundation Trust, UK

Theme: Society, communities, relationships

Aim

The aim of this poster is to highlight the development of a document on the role of the CNS in Endometriosis and its establishment within the workforce

Abstract

The aim of this poster is to highlight the development of a document on the role of the CNS in Endometriosis and its establishment within the workforce.

Endometriosis is a complex condition that affects 1 in 10 women in the UK. The BSGE and Endometriosis UK have been working to highlight the care for women with this condition, and in 2014 specialist commissioning commissioned the care of women with complex endometriosis under endometriosis centres. The requirement of these is that they are registered with the BSGE and have a CNS. anecdotally it was suggested that some nurses were being given this title without any insight into the role or educational preparation.

In response to this and being aware of the vague nature of the statements of the role of the CNS a project group was formed of the RCN, Endo UK, a patient representative and BSGE to define the components of the role. In addition to this a booklet was developed as a guide to nurses who were not working within women's health to try and aid a speedier diagnosis.

The publication breaks the role down in to components and domains with the women at the centre of the care and provides a framework for nurses to work within.

These booklets have been launched at the RCN with a meeting of most of the CNS's, at congress and at BSGE meetings, and a second follow up educational meeting.

This project highlights the importance of collaboration, with charities, pateints and multi professional working to enhance the care of women with a particular disease process.

Reading list

Brown J, Farquhar C. Endometriosis: an overview of Cochrane Reviews. Cochrane Database of Systematic Reviews. 2014;10;3:CD009590.

Moradi M1, Parker M, Sneddon A, Lopez V, Ellwood D. Impact of endometriosis on women's lives: a qualitative study. BMC Womens Health. 2014;14:123.

Biography

Debby Holloway is a Nurse Consultant in gynaecology at Guys and St. Thomas' NHS Foundation Trust in London. Her current clinical caseload is one-stop outpatient procedure clinics, mainly outpatient hysteroscopy, women who have bleeding problems, problems with IUS, cervical polyps and Post Menopausal bleeding. Other clinics include menopause and a joint clinics in the haemophilia centre for women with bleeding disorders. She also runs the gynaecology nursing course at KCL. Her background is in gynaecology nursing, where she has held a number of posts from staff nurse to Clinical Nurse Manager, before returning to this clinical role.

Debby is involved with the RCN and is currently the chair of the women's health forum.

Poster number 27

A nurse led minor procedure clinic in UK – activity, income and patients satitisfaction

Author Debra Holloway , Nurse Consultant, Guys and St Thomas NHS Foundation Trust, UK

Aim

To describe a years worth of activity in a unique nurse led MPC, demonstrating the use of Advanced Nursing Practice within a secondary care setting in a London Teaching Hospital.

Abstract

Within the gynaecology department we run a one stop nurse led MPC. This has 7 sessions a week and is delivered by a Nurse Consultant and a Clinical Nurse Specialist who also provide training for medical staff in hysteroscopy and outpatient procedures. Both nurses are trained hysteroscopists and non medical prescribers. In having nurses who routinely provide this service on a daily basis we have shown in audits that the procedures take less time and are less painful. In addition we also have a follow up clinic to provide ongoing care and a dedicated telephone clinic for women to access if they have any queries or questions.

The clinics incorporate a mixture of referrals from primary care and internally from gynaecology. The reasons for referral include: Post menopausal bleeding, abnormal bleeding, abnormal scan, post cotial bleeding, cervical polyps, IUS/IUCD problems, including failed fittings in the community and lost threads, vulva cysts and tags and hysteroscopy for assessment of cavity. Within the clinic we also undertake Essure hysterscopic sterilisation and removal of polyps.

Audits from the clinic have shown consistently high patient satisfaction and acceptance of outpatient procedures.

In 2014 60% of patients were referred directly their General Practitioners. 277 women required only consultation and advice/medical treatment. The procedures performed include: IUS insertions (179) and hysterosocpic removal and removal of cervical polyps (74).Our largest income generator is from performing hysteroscopy, in 2014 we performed 1039 hysteroscopies at £599 per procedure.

40% of patients were discharged after the first visit to the one stop clinic and 20% of patients were added to the waiting list for operative procedures either under general anaesthetic or in our ambulatory clinic.

This service provides consistent and dedicated practitioners who ensure that women receive evidence based care, in line with national guidelines. we believe that it is a unique service being totally run by nurses. The aim of the service is to provide comprehensive care with as few hospital visits as possible. Outpatient procedures allow women more flexibility, control and allow for less disruption to their normal lives.

Reading list

RCOg green top guidelines, outpateint hystersocopy

Biography

Debby Holloway is a Nurse Consultant in gynaecology at Guys and St. Thomas' NHS Foundation Trust. Her current clinical caseload is one-stop outpatient procedure clinics, mainly outpatient hysteroscopy. The clinic sees women who have bleeding problems, problems with IUS, cervical polyps and Post Menopausal bleeding. Other clinics include menopause and a joint clinics in the haemophilia centre for women with bleeding disorders. She also runs the gynaecology nursing course at KCL . Her background is in gynaecology nursing, where she has held a number of posts from staff nurse to Clinical Nurse Manager, before returning to this clinical role.

Debby is currently the chair of the RCN women's health forum.

Poster number 28

Withdrawn

Poster number 29

How can we maximise the use of schools to improve health outcomes for children?

Author Maxine Jameson, Associate Professor, London South Bank University,UK

Theme Society, communities, relationships

Aim

Learning Outcomes:

1. Understand the value of schools not just for education but also for building stronger communities.

2. Explore the meaning of 'Asset Based Community Developments', what do they look like in your practice area? How can they be utilised to build health literacy levels and stronger communities?

3. Understand why as nurses we need to focus on the assets not the needs in the communities in which we work.

Abstract

A complementary approach to curriculum based health education is to change the school environment to promote health and well being. As well as a setting for health promotion individual schools are distinct societies. There is an increasing recognition that the health of young people can be influenced by broader social factors, Bronfenbrenner (1982) and Brooks-Gunn (1997) state adolescence and early adulthood represent a key time to intervene for a number of reasons. Adolescence represents the second fastest growth spurt after infancy Rogol et al (2000) and periods of change can offer opportunities for intervention. Research by Guo (1999) shows that the consequences of poor health

in adolescence last a lifetime. Furthermore adolescence can be a time of increased health risk often resulting from peer and societal pressure and personal vulnerability. Fuller (2013) found adolescence to be the time when young people were most likely to experiment with alcohol, tobacco and drugs in the UK. There is also evidence of health inequalities in adolescence, vulnerable groups such as those living in local authority care or in the youth justice system can reap major benefits from interventions and help, the Department of Health (2009) found young people in care wanted advice around health and social issues to be on available more easily in secondary schools.

The health of children and young people is influenced by a range of factors including according to Bowling (2011) 'subjective feelings as well as social, physical and psychological aspects'. Consequently schools are key places for forming and shaping wellbeing.

'Promoting physical and mental health in schools creates a virtuous circle, reinforcing children's attainment and achievements that in turn improves their wellbeing, enabling children to thrive and achieve their full potential'

(Brooks 2013 p 247)

The environment in which students and staff spend a large proportion of their time every week may have profound effects on their wellbeing. Having a sense of belonging to a school and of the school being a safe and supportive place may well have lasting effects on social and physical wellbeing.

Reading list

Viner R (2013) Life Stage Adolescent. In the Chief medical Officers Report Prevention Pays :Our children deserve better. London Department of Health

Marmot (2015) The Health Gap: The challenge of an unequal world. London Bloomsbury Press

Biography

Maxine is Associate Professor for Primary Care at London South Bank University where she also runs the School Nurse programme. Maxine is committed to raising standards and numbers in school nursing and co-authored 'Getting it right for children and young people' 2012 Dept of Health and played a key role in the development of the school nurse 'call to action' (2014). Maxine is very proud to be a Queens Nurse and works with other QNs exploring community nurse development across London. Maxine is a keen researcher and passionate about the health and well being of all children, especially teenagers attending London schools. She believes community nurses are the key to a healthy societies, nurses who understand the profile of their areas of practice and fit their work accordingly. Nurses who are able to see the valuable assets our communities possess and use them to build relationships, trust and health literacy.

Poster number 30

The cube approach to resuscitation audit

Author Angela Jones, Senior Nurse, Cardiff and Vale UHB, UK

Theme Technology and innovation

Aim

The aim of the project was to maximise collection and analysis of essential data related to Resuscitation and Emergency Care throughout the UHB. Data was used to improve patient safety and address clinical governance issues. This data can be used to inform resource planning and educational requirements, in-line with Organisational Policies and Strategies and complies with National Guidelines.

In 2014 Resus Staff spent over 2,415 hours completing manual audits. The equivalent amount of work can now be completed in 621 Hours.

It used to take several weeks to identify 'worrying' trends through audit.

Abstract

The Resuscitation Service collates data for all Resuscitation calls throughout the UHB. Information collated exceeds the universally accepted Utstein data requirements. The data has been highlighted as best practice by RRAILS and Welsh Resuscitation Forum.

The aim was to maximise collection and analysis of data related to Resuscitation and Emergency Care. Data will be utilised to improve patient safety. Utilisation of this data will also be used in resource planning, and educational requirements in-line with Organisational Policies and Strategies and in compliance with National Guidelines.

An opportunity arose for the Service to enhance the ability to provide time and resource efficient data. The Cube is a software package that can be used to provide operational performance information and analytics. An opportunity arose for the Service to enhance the ability to provide time and resource efficient data. Through collaboration with the Business Intelligence Warehouse an electronic "Resuscitation Cube" was created.

The Cube, since its inception (April 2015), has already improved the efficiency of data analysis. This has been achieved by streamlining processes for data extraction, including automatic collation of survival to discharge. This was previously obtained through time consuming manual interrogation of several databases.

The Cube allows the Service to utilise our extensive data set, which covers all 2222 calls over the last seven years.

Data is now immediately accessible. Improvement in standards can be measured quickly.

In 2015, we have been able to provide information to current research including 'PUMA' (a 4 year multi centre study) within minutes.

The service has more time to work clinically and improve standards.

More time can be spent achieving Resuscitation Council Standards.

This data is used to assess the effectiveness of preventing harm using initiatives such as National Early Warning Score (NEWS).

Reading list Resuscitation Council UK. 2013. Quality Standards for Cardiopulmonary Resuscitation and Training. Resuscitation Council UK, London.

Biography
Angela Jones is a Senior Nurse for the Resuscitation Service in Cardiff and Vale University Health Board. She started her career in Intensive Care in 1998 at the Royal Gwent Hospital before receiving promotion into the Resuscitation Service.

In 2008, she accepted an equivalent position in Cardiff and Vale. Following this, she then became Senior Nurse for the Resuscitation Service. Angela has undertaken her MSc in Advanced Practice. The Service has a data set pertaining to Resuscitation that has been highlighted as an exemplar of best practice by the Welsh Resuscitation Forum (WRF).

Poster number 31

Proactive waiting list management to improve access to patient education

Author Claire Jordan, Lead Nurse Patient Engagement and Education, Anuerin Bevan University Health Board,UK

Theme Knowledge for change and improvement

Aim
To demonstrate that it was noted that a waiting list for patients to access education was unacceptably long and action was needed to improve the situation. Working directly with patients, acknowledging the situation and asking them to decide if they would like to access education enabled us to refresh waiting lists. The lists were reduced by over half so that patients who are motivated to access education will have the opportunity to attend sooner. It also opened an opportunity for people to discuss the option with the team if they wished to learn more about the course.

Abstract
Aneurin Bevan University Health Board (ABUHB) has been delivering Diabetes education in the form of X-PERT© for nine years. Over the last year the waiting lists in some areas of the Health Board became longer, partly due to "referral to patient education" becoming a part of the GP Quality and Outcome Framework. This has meant that some patients have waited over a year to access a course.

Reading list
Structured patient education: the Diabetes X-PERT Programme makes a difference. Deakin et al 2006. Diabetic Medicine 23, 944 – 954 2006.

Our plan for a primary care service for Wales up to March 2018. Welsh Government. February 2105

Biography
The author has a midwifery/nursing background and for the last 12 years has worked in the Primary Care Directorate of Aneurin Bevan University Health Board (ABUHB) where she was initially involved in the clinical effectiveness of the primary care diabetes service. This work included becoming an X-PERT educator and inspired her to do her certificate in Education and Training which has been invaluable in all aspects of her role. She has developed the diabetes education service in Caerphilly and Blaenau Gwent and is now supporting the diabetes team in developing further education opportunities for patients across ABUHB.

Poster number 32

Withdrawn

Poster number 33

Enabling recognition of the deteriorating patient through 'monitor'

Author Alison Kirton, Practice Educator, Aneurin Bevan University Health Board, UK

Theme Knowledge for change and improvement

Aim
Meaningful Observations to Notify and Inform Treatment or Response (MONITOR) reflects the recommendations of the National Institute of Health and Care Excellence guidance for acutely ill hospital patients. It aims to assist the development of advanced physiological knowledge and skills, understanding the importance and relevance of physiological observations, performing full clinical patient assessment and physiological observations. MONITOR teaches how to competently apply the NEWS tool and to interpret its significance along with interpretation of clinical assessment findings. It also teaches instigation of appropriate actions, including treatment planning, implementation and evaluation of effectiveness to deliver prompt treatment or activate escalation.

Reading list
Cuthbertson BH et al (2007) Can physiological variables and early warning systems allow early recognition of the Deteriorating surgical patient. Critical Care Medicine; 35(2), 402-409

NICE (2007) Acutely Ill Patients in Hospital: Recognition and response to acute illness in adults in hospital; NICE Clinical Guideline 50. NICE, London

McQuillan P et al (1998) Confidential enquiry into the quality of care before admission to intensive care. BMJ; 316, 1853-1858

Biography

Starting as an enrolled nurse grounded my professional career in Nursing, influencing my development and contribution to the profession. I am committed to developing evidence based clinical excellence. My vision for quality care delivery in the clinical area is to prepare and endorse clinical staff's clinical knowledge and competence. Hence my educational contribution to the workforce has been developing clinically based competency skills programmes, providing staff with a clinical learning log to guide their learning. Finally, providing a platform for ward managers to monitor staff competency progress, accompanied by skills education through human factors and clinical scenario simulation training.

Poster number 34

Integrating sex and gender into medical education across the European Union

Author: Peggy Maguire, Director General, European Institute of Women's Health, Ireland

Theme: Populations, health and economic growth

Aim

The interaction of sex and gender (SandG) leads to different manifestation of diseases in women and men. The failure to acknowledge the impact of SandG differences affects the quality of health care, precisely what medical education seeks to prevent. There must be a commitment to mainstream an evidence-based SandG perspective throughout medical curriculum, including in graduate, medical, nursing, rehabilitation, pharmacy, CME and continuing nursing education programmes. This concurrent will examine the current medical education policy environment in the EU. Then, how SandG consideration can be best integrated into medical education will be discussed using good practice. Finally, existing challenges will be explored and recommendations for action made.

Abstract

Medical education remains the remit of each individual country. Each EU Member State has its own regulatory body that accredits, regulates and evaluates medical education. However, some steps have been taken at European level to harmonise third level educational systems and to increase mutual recognition of professional qualifications across Member States.

The lack of one pan-European regulatory situation impedes regulatory development at a European level. However, Member States are bound by EU Directive to provide some form of regulation and most collaborate in the Bologna Process. Consequently, there might be an opening to raise awareness of the issue of sex and gender and encourage coordination across borders to share best practice. The inclusion of vocabulary such as "socio-economic realities" and the "social surrounding of the human beings" in EU Directive 2005/36/EC highlights an existing awareness to combine the clinical component of medical education with social and cultural questions.

Sex and gender awareness must be included in the dialogue. Medical education in Europe involves many bodies at multiple levels, such as governments, physician associations and local universities. Although the Bologna Declaration works towards greater harmonisation of both undergraduate and graduate programmes across countries in Europe, the aim of the Declaration is for workforce mobility and comparability of degrees, not universal uniformity of curricular content.

There are different approaches to integrate sex and gender into medical education: single courses (sometimes electives) or integrated (mainstreaming throughout the curriculum) or both. Sex, gender and diversity must be included in final objectives of programmes, as part of accreditation, in quality criteria and considered by visitation committees. A multilevel approach is needed and experts much work with each other, Ministries of Health, Ministries of Education, medical schools, universities, student organisations, patient organisations and NGOs and physicians associations to integrate sex and gender into medical education and training.

The three learning outcome for the concurrent are: 1) to understand the medical education regulatory environment in the EU 2) to explain the importance of integrating sex and gender into medical education 3) to identify good practice and challenges for integrating sex and gender into medical education in Europe.

Biography

Peggy Maguire is the Director General of the EIWH and the former President of the EPHA. She is a political scientist working at EU level to highlight the need for gender equity. She has worked with the Commission External Advisory Group on ageing and disability, and WHO expert group on gender mainstreaming. Peggy initiated many research projects and publications, including the development of a cancer information site for women and families. She has published on topics such as women's health, discrimination and reducing inequities. Peggy was previously the Director of Development at the National Maternity Hospital, Dublin where she initiated and coordinated the first National Survey of Women's Health, Attitude and Behaviours and Director of the Research and Education Foundation at the Irish College of General Practitioners. Peggy served on the Boards of APHEA, the National Women's Healthof Ireland and the Board of the Institute of Public Administration.

Reading list

Integrating sex and gender into medical education throughout the European Union

Poster number 35

Revalidation ready – the experience of one RCN branch

Author Celia Manson, Independent Nurse Adviser – Palliative Care, Self-employed, UK

Theme Society, communities, relationships

Aim

To describe and disseminate the experience of RCN West Kent and Medway branch in preparing and supporting its members who are registrants with NMC revalidation.

Abstract

West Kent and Medway RCN branch was launched in October 2015, as a merger between West Kent branch and Medway branch. This merger coincided with the formal adoption of revalidation by the Nursing and Midwifery Council.

The new branch launched with an education event at which half the programme focused on revalidation, with presentations from some of the NMC revalidation pilot sites. Feedback from members at this event indicated that they would like their branch to develop activity on supporting them with revalidation in the coming year.

The merged branch has almost 6000 members, ranged across West Kent and Medway and employed in a variety of settings and nursing branches and specialisms. Almost one third of the branch members work outside the NHS.

The branch identified supporting its members (especially those working independently, in relative professional isolation, and for small organisations) with revalidation as a work priority for 2016.

The branch aims to achieve this by holding a series of workshops and setting up learning sets. Members will be asked to evaluate these activities and the branch will review and publish a summary of evaluations.

The branch plans to work with employers, educationalists and RCN learning and development facilitators on this project.

Reading list

NMC information on revalidation

RCN guidance on revalidation

Revalidation article published in Nursing Standard, October 16, 2015

Biography

Celia Manson is a registered nurse and currently chairs RCN West Kent and Medway branch.

Along with fellow registrant branch members she has a professional and personal interest in revalidation.

Celia and her five colleagues on West Kent and Medway branch committee have identified the support of branch members with revalidation as a branch priority for 2016.

Poster number 36

Getting to know me: delivering person-centred nursing care for people with dementia in hospital

Author Ruth Mantle, Alzheimer Scotland Dementia Nurse Consultant, NHS Highland, UK

Theme Knowledge for change and improvement

Aim

The aim of the abstract is to provide an overview of qualitative research undertaken by the author to explore the experience for nurses of using the 'getting to know me' personal profile tool with people with dementia admitted into a general hospital setting. It looks at whether the use of the 'getting to know me' tool contributes towards the delivery of person-centred nursing care for people with dementia.

Abstract

The nursing team undertook an audit of patient accessing education. Data for the courses in early 2014 – 15 illustrated:

Reading list

Mccance, T., McCormack, B. and Dewing, J. (2011). An exploration of person-centredness in practice. Online Journal of Issues in Nursing, 16 (2), Manuscript 1.

McCormack, B. and McCance, T. (2010). Person-centred Nursing: Theory and Practice. Oxford: Wiley Blackwell.

Biography

Ruth Mantle is the Alzheimer Scotland Dementia Nurse Consultant for NHS Highland, honorary lecturer at the University of Stirling and a Winston Churchill Memorial Trust fellow. After qualifying as a mental health nurse in 1995, Ruth has worked in a variety of practice settings before moving to her current role in 2012, a post developed in partnership with Alzheimer Scotland and the Scottish Government. A key focus of her work is on improving the experience for people with dementia admitted into general hospital through the implementation of the Standards of Care for Dementia.

Poster number 37

Withdrawn

Poster number 38

Growing our own: building our future community workforce from the bottom up

Author Marie Therese Massey, Senior Lecturer, Sheffield Hallam University, UK

Theme Knowledge for change and improvement

Aim

This workshop aims to bust the myth that primary care particularly general practice is not a suitable career for new registrants or by presenting effective models of student nurse placements in General Practice and the successful implementation of the General Practice Nurse Career Framework.

Abstract

All the evidence is that the Community nursing workforce is aged 50 plus and in some areas nearly 80% of the workforce is due to retire in the next 5 years. If we are to meet the aims set out in the 5 year forward review we need a robust plan to grow the workforce from the bottom up. Firstly by starting with exposing student nurses to general practice and the new models of community care such as Primary Care Home and GP Federations. Then by moving on to provide an identified career framework and a period of supported preceptorship we can entice new registrants to a career in primary care.

This workshop will present examples of projects, research studies and models of education that are successfully meeting this agenda and hear from new registrants who have not taken no for an answer and been determined to work in general practice on qualification. There will be the opportunity for further discussion after presentations.

Reading list

1. Five Year Forward View – NHS England

2. An uncertain future – Royal College of Nursing

3. The Community Nursing Workforce in England – Royal ...

Biography

Marie Therese Massey QN is a Senior Lecturer at Sheffield Hallam University and works as a General Practice Nurse in an inner city Practice in Sheffield. Her research interests include sexual health and workforce issues particularly growing the community nursing workforce. She has presented at national an international conferences and is the Chair of the RCN General Practice Nursing Forum

Poster number 39

Incorporating the contribution of marginalised groups in the undergraduate curriculum

Author Marie Therese Massey, Senior Lecturer, Sheffield Hallam University,UK

Theme Society, communities, relationships

Aim

This presentation intends to share the findings from a project to involve service users in the teaching content of a pre and post graduate nursing public health module by encouraging their contribution to a 'patient voices' digital resource.

Abstract

Enabling service users particularly from marginalised groups to contribute to the education of students in the health care sector has been supported and encouraged by educators and professional regulatory bodies as essential in connecting the learner with the consumers of health care outside of the clinical placement area.

In order to address this new and innovative ways to engage service users in nursing education need to be created. Coupled with this the use of simulation and digital resources are becoming widely used as tools to link module content and clinical situations in the classroom setting.

This poster presents the findings from a project that explored the attitudes to physical activity in BME women utilising a focus group with semi structured questions. The meeting was recorded and examples of patients voices were incorporated into a digital platform that the students could engage with not just listen to.

Evaluation demonstrated that students gained insight into the barriers the women face in maintaining a healthy lifestyle and racial stereotypes were challenged.

Reading list

K Gardner, S Salah, C Leavey'(2010)The perfect size': perceptions of and influences on body image and body size in young Somali women living in Liverpool–a qualitative study

R Carroll, N Ali, N Azam – 2002Promoting physical activity in South Asian Muslim women through" exercise on prescription"

Gregory YH Lip, C Luscombe, M McCarry, I Malik (1996) Ethnic differences in public health awareness, health perceptions and physical exercise: implications for heart disease prevention

Biography
Marie Therese Massey QN is a Senior Lecturer at Sheffield Hallam University and works as a General Practice Nurse in an inner city Practice in Sheffield. Her research interests include sexual health and workforce issues particularly growing the community nursing workforce. She has presented at national an international conferences and is the Chair of the RCN General Practice Nursing Forum

Poster number 40

An attributes framework: supporting leadership for quality improvement and safety

Author Cathy McCusker , Senior Professional Officer, Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), UK

Aim
The Attributes Framework enables individuals to assess their:

- current attributes (knowledge, skills and attitudes) in relation to leadership for quality improvement
- learning and development needs for their current or future roles.
- Organisations can use the Framework to build the capability and capacity of the workforce to contribute to, or lead, initiatives which develop quality care and services.

The NI Department of Health's Quality 2020 Steering Group is facilitating the implementation of the Attributes Framework within Health and Social Care (HSC) Trusts through a multidisciplinary Leadership Task Group co-led by Chief Nursing/AHP Officer and a Director of Medicine and Social Work.

Abstract
The development of the Attributes Framework was led by the HSC Safety Forum and NIPEC during 2014 on behalf of the Q2020 Leadership Task Group. They collaborated with stakeholders representing Nursing, Medicine, AHPs and Social Work and included clinical staff, educators and those responsible for services in HSC Trusts across NI. The Framework's remit covered all staff working/in-training in HSC.

The Attributes Framework comprises simple, concise and unambiguous QI competency statements arranged in 4 levels, reflecting potential QI roles within organisations. An online self-assessment tool enables individuals to quantify the QI development they require for each competency. In December 2014, the Framework was launched by the NI Minister for Health, Chief Nurse and other Chief Professional Policy Advisors for Medicine, AHPs and Social Care.

A guide is available on the Department of Health website on how to embed the Attributes Framework into existing processes and a number of activities have been introduced to support its implementation. HSC Trust Chief Executives commenced a process of monitoring the implementation of the Framework and identifying the numbers trained/ competent at each of the Levels by end of March 2016. To test implementation, it is planned to train a minimum of 1000 staff at Level 1 of the Framework during 2015/2016 prior to wider dissemination of training.

Education providers including HSC Trust learning and development teams are supporting the above by:

- aligning and harmonising existing programmes against Level 1 and 2 of the Framework
- arranging QI and patient safety training appropriately within programmes
- designing new programmes with additional QI training to address gaps.
- Queen's University Belfast has already adapted curricula to support Foundation Year Doctors to attain Level 1 and plan to extend this approach across the other undergraduate professions.

Reading list
Department of Health and Social Services and Public Safety (2014) An Attributes Framework for Health and Social Care: supporting leadership for quality improvement and safety. Belfast: Public Health Agency.

Department of Health Social Services and Public Safety (DHSSPS (2011). Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland.

Belfast: DHSSPS.

Biography
Cathy McCusker is a Senior Professional Officer for Professional Development at the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC).

Cathy was appointed to her current post in 2006 and leads on a wide range of projects. The most recent of which have been the development of:

- a regional preceptorship framework;
- an Attributes Framework supporting leadership for quality improvement and safety in Health and Social Care;
- the health care support worker role;
- a Framework to support Advanced Nursing Practice;
- refresh of NIPEC's online portfolio.

Poster number 41

Knowledge for change as a universal preventive measure to combat NCDs: are nurses the main key actors of health promotion?

Author Ntombizifikile Mkoyana, Volunteer Equality Consultant, UK

Aim

This paper uses both national and international figures to identify the need of embarking on a universal preventive and management strategies that support communities, health professionals and government policies towards achieving and advocating preventive measures against cancer, cardiovascular diseases, chronic lung diseases and diabetes. This paper echoes the vision of United Nations recent NCDs summit.

Abstract

Introduction: The underlying principle of this study is to determine how Non – Communicable Diseases (NCDs) can be prevented speedily by utilising a universal influential tool that gives effective worldwide guidance. The nurses play a big part in minimising the impact of ill health. Therefore, raising awareness on preventive measures against NCDs benefits most communities, so that they can continue their roles within either their homes or any other places where they normally maintain their daily activities. For that reason, sharing knowledge for changing unhealthy behaviour patterns can prevent new cases. Maintenance of equality during nurses' interaction and intervention is vital for building a good functioning relationship with service users. It is important that any efforts have to foster high standards of quality health education. The countries with badly programmed health services, economic constraints, community literacy and minimal resources may struggle to fulfil the purpose of this paper.

Aims: This paper uses both national and international figures to identify the need of embarking on a universal preventive and management strategies that support communities, health professionals and government policies towards achieving and advocating preventive measures against cancer, cardiovascular diseases, chronic lung diseases and diabetes. This paper echoes the vision of United Nations recent NCDs summit.

Method: In 2012 within the Royal College of Nursing headquarters the world statistics presented by C3 revealed how NCDs has affected the world, the study shown South Africa in lead. This study pays more attention in the United Kingdom, South Africa, Europe and the world.

Results: It is revealed that in the UK 1.4 million people were diagnosed with diabetes in 1996 unlike a massive increase in 2010 where the figure increased to 3.1 million. In South Africa it is revealed that 29% deaths were caused by NCDs whereas the recent study reveals that they (NCDs) are the European's biggest cause of death. It is understood that NCDs are world's number one killer that claims more than 63% lives, with 80% deaths associated with "low and middle-income countries." Additionally, it is estimated that 8.1 million will die before 60 years of age. In 2008 the Department of Health published causes of mortality from non-communicable conditions as heart disease 8.7%, stroke 4.1%, cancers 5%, respiratory diseases (non-infectious) 3.3% and diabetes 3.3%.

It is important to mention that the South African strategic plan attracts sensitive glasses because its goals have to be achieved by 2020 – 2030; it's a matter of concern because the time frame and necessity for immediate action are not identical.

Implication: Close consideration of the available resources, accessibility of the information, regular studies especially in rural areas where most poor communities are forgotten. NCDs prevention and management have to be made part of educational curriculum worldwide. Country like South Africa has to build its own NCDs academy in rural areas of Eastern Cape which is a poorest province hence NCDs are more likely to affect people living in poverty.

Reading list

RCN (2012a, p.3) Going upstream: nursing's contribution to public health: prevent, promote and protect. RCN guidance for nurses (PDF 342KB). London: RCN

Webber, L et al. The future burden of obesity-related diseases in 53 WHO European – Region countries and the impact of effective interventions: a modelling study. BMJ Open 2014, 4:E 004787 doi 10.1136

United Nations General Assembly Resolution on Prevention and control of non – communicable diseases.

Mayosi BM et al. The burden of non communicable diseases in South Africa. Lancet 2009, 374 (9693): 934-47.

Afro.who.int

South African Strategic Plan for the Prevention and Control of Non Communicable Diseases 2013-2017: p.g 5

Biography

I worked as a professional nurse, during my time I was practicing as a nurse, I observed lack of fairness and equality but as a professional I always knew how to respond on condemning inappropriate behaviour at work. I worked and helped as Royal College of Nursing Representative, I argued many cases within a Trust which had 4 hospitals then. It was during that period when I worked with the employer (staff side) on analysing the policies for the benefit of all employees; once the policies were drafted I was also amongst those who were adopting the policies before any implementation within the Trust

Additionally, I was a member of Independent Advisory Group of Hertfordshire Constabulary and I fulfilled my role. I was a Shadow Cllr in Hertsmere Council in a programme organised Operation Black Vote. Therefore, my professional practice wisdom is a guiding tool towards decision making towards facilitating a best possible outcome.

In 2013 I wrote my first academic paper for the South African Nurses Conference, I spoke about importance of professional development in order to combat the world's most killer diseases (NCDs)

Poster number 42

Exploring experiences of mental health nursing and care from perspectives of the transgender community

Author Rachel Morris-Davis, Student Mental Health Nurse, Coventry University, UK

Theme Knowledge for change and improvement

Aim

To explore and discuss the opinions and experiences of Transgender, Gender variant and Gender Non-Binary+ persons who have experienced contact with Mental Health Services. Gain their views, thoughts and experiences; in order to increase knowledge from both positive and negative experiences.

The focus of this presentation is to increase awareness to generate a more socially inclusive perspective for nursing staff delivering care to persons who identify as transgender, gender variant or non-binary. Also to consider where we – as professionals, can bridge any gaps in nursing education and practice, which could become barriers to care within this community.

Abstract

Presentation delivered by Mental Health Nursing student from Coventry University; examining the findings of a qualitative study exploring the opinions and experiences of Transgender, gender variant and Gender Non-Binary+ persons who have experienced contact with Mental Health Services. Over 50 members of the LGBTQIA+ community have been interviewed on their experiences, the main themes and findings of which will be discussed in this concurrent presentation.

It is understood that there are many gaps in nursing education when it comes to delivering care to persons who identify as transgender, gender variant or non-binary. This is mainly due to a lack of research and historical stigmas. This study aims to engage the LGBTQIA+ community to discuss with them directly what they feel is appropriate from the care that they have received, and for them what still needs addressing to improve nursing standards for this often overlooked section of society within Britain.

The persons interviewed have shared their experiences positive and negative of accessing Mental Health services and being a Patient or client. Through this process they have identified gaps in learning for nurses and care staff as well as the process of assessment and care planning in mental health. Their recommendations to improve future mental health education and practice, when caring for members of the LGBTQIA+ community are also discussed.

The presentation will also outline and examine many social factors that statistically are more likely to affect the LGBTQIA+ community that may contribute to their need to engage with health services such as: stigmas, discrimination, hate crime, domestic violence and health inequalities. Alongside this barriers to care and health promotion will be investigated and appropriate treatment and care for victims and their communities can be discussed. Information from international studies and experiences will be discussed in comparison to services offered in the UK. Any positive international changes within this area that can be reflected within UK practice will be examined.

Reading list

Who Cares If It Is a Hate Crime? Lesbian, Gay, Bisexual, and Transgender Hate Crimes-Mental HealthImplications and Interventions.Hein, Laura C.; Scharer, Kathleen M. (2013), Perspectives in Psychiatric Care, Apr2013; 84-93.

Challenges to and opportunities for improving mental health services for lesbian, gay, bisexual, and transgender people in Ireland: A narrative account. McCann, Edward; Sharek, Danika (2014), International Journal of Mental Health Nursing, Dec2014, 525-533.

Critical Issues in Mental Health, Tummey.R; Turner.T (2008) Palgrave Macmillan: London

Biography

Student Mental Health Nurse at Coventry University, course representative and student ambassador. 10 years' experience of working in the field of health and Social Care. Past working experience as the Registered Manager of a domiciliary care service, Health Care Support Worker within an acute hospital setting and within the community. Volunteer for Coventry Mind and Dementia Champion for the Dementia Friends Campaign. Fundraiser for Warwickshire Air Ambulance Service and fundraiser and former trustee at Coventry and Warwickshire Friend LGBTQIA+ support service.

Poster number 43

Prevalence of physical restraint in hospitals and nursing homes: multicentric cross-sectional study

Author Giovanni Muttillo, Head Nurse, Teaching Hospital Fondation IRCCS Policlinico, Italy

Aim

1. Disseminate the results of the Italian research on the use of physical restraint in hospitals and nursing homes

2. Spreading the culture of prevention of physical restraint

3. Debate on the practice of physical restraint in an international context.

4. Sensitize the professional community on policies of non-restraint

Abstract

Objectives: In their Deontological Code, Italian nurses agree that "the use of physical restraints should be an extraordinary event, supported by medical prescription or documented evaluations".

On the basis of this premise, the IPASVI Colleges of Aosta, Brescia and Milano-Lodi-Monza and Brianza promoted a multicenter research to assess the prevalence of restraints in hospitals and in nursing homes for the elderly.

Methods: The study used an observational cross-sectional design. The survey was conducted in June 2010 on a convenience sample consisting of 39 hospitals (with a total of 2808 patients in surgical, geriatric, medical, orthopedic and intensive care units) and 70 nursing homes (6690 residents in ordinary and specialized dementia units).

Results: During the survey period, 15.8% of hospital patients and 68.7% of nursing home residents were restrained.

The prevention of falls, alone or in combination with other reasons, was given as a reason for restraint in 70% of hospital patients and in 74.8%of nursing home residents. Side rails were the most used means of restraint (75.2% of restraints in hospitals and 60% in nursing homes).

Conclusions: The results document the extent of the problem of physical restraint in hospitals and nursing homes. Given the size of the sample and the correlation with other similar studies, these data presumably provide a realistic picture: a starting point for interventions aimed at reducing the frequency and duration of restraint use by implementing evidence-based alternatives to achieve the objectives – as prevention of falls or management of agitated behaviors – for which, even if with many

Key words: Physical restraint, prevalence, hospital, nursing home, nursing

Reading list

de Vries OJ, Ligthart GJ, Nikolaus T (2004) Differences in period prevalence of the use of physical restraints in elderly inpatients of European hospitals and nursing homes. J Gerontol A Biol Sci Med Sci, 59 (9), M922-923.

Meyer G, Köpke S, Haastert B et al. (2009) Restraint use among nursing home residents: cross-sectional study and prospective cohort study. J Clin Nurs, 18 (7), 981-990.

The Nurses' Deontological Code (2009), The Code of Ethics and conduct. Approved the Executive Board of the Federazione Nazionale Collegi IPASVI with the deliberation n. 1/09 of 10.01.2009 and by the National Council of the Federazione Nazionale Collegi IPASVI during the meeting held in Rome on 17.01.09. available on: www.ipasvi.it/static/english/the-nurses-deontological-code-2009.htm

Biography

Muttillo Giovanni: RN, MSc Nursing. President of IPASVI Nurses Council of Milan, Lodi, Monza and Brianza. He is Director of the Journal "Italian Journal of Nursing". He published several books about nursing sciences. He is the director of Deontonursing Project and a big project about online long life education (Nursing-fad). He is a member of the Italian consortium for research in medicine (CIRM). He is a lecture in professional Liability at University of Milan

Poster number 44

A woman's journey

Author Buddug Nelson, Immunisation and Vaccination Coordinator, Hywel Dda UHB, UK

Theme Populations, health and economic growth

Aim

To advertise and inform the delegates of the project set up between Hywel Dda UHB and Ministry of Health, Zambia

Abstract

the poster will demonstrate the work currently undertaken by the partnership – including the introduction of self-tesing of HPV in Lusaka Province, re introduction of HPV Vaccination within the Chongwe District. Development of maternal zonal, cluster health facilities aimed to reduce maternal mortality rates of 398 per 100,000. Education and empowerment of nurses and midwives in developing their leadership skills. Empowering and education the community on health issues.

Biography

Buddug Nelson is currently working as the Immunisation and Vaccination Co-Ordinator for Hywel Dda UHB, prior to this Buddug has practices as a paediatric Nurse, Clinic nurse and a School Nurse.

Dr Charles Msiska, trained in Cuba before returning to Zambia to spend more than 20 years in two different districts as the Director. Charles has extensive knowledge of the public health needs of the Zambian population and is an equal partner in A Woman's Journey Project.

Poster number 45

The evolution of the role of the advanced nurse practitioner within the United Kingdom

Author Ellen Nicholson, Senior Respiratory Clinical Nurse Specialist, Homerton University Hospital, UK

Theme Knowledge for change and improvement

Aim

The evolution of the role of the advanced nurse practitioner (ANP) within the United Kingdom, it development and challenges for its continuing advancement.

Reading list

Advanced Level Nursing: A Position Statement. 2010 Department of Health

Advanced nurse practitioners, An RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation 2012, Royal College of Nursing

Developing people for health and healthcare. District Nursing and General Practice Nursing Service Education and Career Framework October 2015. NHS Health Education England

Biography

Ellen Nicholson qualified first as an enrolled nurse in 1988, and registered nurse in 1991. After a hiatus working in medical ward settings, primary care and the community in the United Kingdom and abroad, she gained a BSc Hons Nurse Practitioner in 2010 and qualified as a Non Medical Prescriber in 2011. She is currently partway through a Masters in Advanced Practice with the University of Bournemouth.

Ellen combines her nurse practitioner skills and scope of practice with her current role as a senior respiratory clinical nurse specialist, leading an integrated service for adult asthma patients in East London, she is a member of the association of respiratory nurse specialists (ARNS) and currently participates in the process of drafting NICE guidelines around asthma management guidance.

Poster number 46

Building together using knowledge/experience to improve the development of new healthcare facilities

Author Liz Norris, Clinical Property Advisor, NHS Grampian, UK

Aim

The aim is to demonstrate how clinical knowledge and experience can be used to facilitate the process when planning a new or refurbished healthcare facility by working with public, staff and design teams ensuring compliance with NHS guidance and challenging excessive demands if necessary and thereafter to carry out post project evaluations to identify lessons to be learned – good or bad.

Abstract

Planning and developing a new healthcare facility or refurbishing an existing one, is a complex process and having an experienced Clinical Property Advisor in post helps facilitate this process from concept to opening of the development, improving the outcomes for staff and patients.

This presentation outlines the role of a Clinical Property Advisor and is divided between the current postholder and the previous postholder of this role within NHS Grampian. The progress of a project is outlined and the role of the Clinical Property Advisor at each stage.

- Areas covered include:
- Public and user involvement
- Identifying functional flow and adjacencies of departments throughout the building
- Developing room data sheets
- Sign off of general building plans
- Sign off of individual rooms
- Compliance with building regulations and infection control strategies
- Preparation of equipment lists
- Development of policies
- Planning and implementation of commissioning of building
- Relocation to new facility

To be able to carry out these successfully the post holder must have a good clinical background to understand how these facilities operate, the equipment and procedures involved but must also be able to challenge the demands of clinicians and work to the limitations of the project which could be constraints of space and/or finances.

Post Project Evaluation

- Mandatory requirement by the Scottish Government
- Timing
- Information included
- Methodology

- Lessons learned
- Dissemination of information

The aim of the exercise is to identify any lessons which can be learned and shared with other staff in NHS Grampian and other Boards in Scotland. This could be identifying areas of good practice or things that did not go well to benefit future developments.

Liz Norris MLitt MSc Sue Harrison TD BSc RGN

NHS Grampian NHS Grampian

Reading list

Reforming Healthcare by Consent: involving those who matter.

Ling. Tom, 1999 (Abingdon: Radcliffe Medical Press)

Future Care: new directions in planning health and care environments.

Salter, Derek, 1996 (Blackwell Scientific)

Biography

Liz Norris – Trained/staffed at the Royal Hospital for Sick Children in Glasgow from 1965-69 and then worked in London at St Thomas', King's College and Greenwich Hospitals and Medway Maritime Hospital, Kent.

In 1977 returned to Scotland to the Royal Aberdeen Children's Hospital as Staff Nurse then Night Sister.

Was Commissioning Nurse for the new RACH then became Physical Planning Nurse Advisor for NHS Grampian which involved giving clinical input into the planning and construction of new/refurbished healthcare facilities.

Retired in May 2014 but stayed on in a part-time role to initially mentor successor and then to carry out Post-Project Evaluations for all NHS Grampian projects

Gained Certificate in Managing Health Services, the Robert Gordon University (1998), MSc in Advanced Nursing, University of Aberdeen (2001) and MLitt in Change Management, University of Aberdeen(2009). Currently studying for a PhD in Sociology.

Enjoys ballroom and Latin American dancing, baking, writing

Poster number 47

Facilitation of equitable access to healthcare for asylum seekers

Author Riosin O'Hare, Asylum Seeker Nurse, Aneurin Bevan University Health Board, UK

Theme Society, communities, relationships

Aim

Generally health professionals can feel ill-equipped to manage the complex mental and physical health needs of those seeking asylum. This complexity can be related to numerous factors including the burden of disease in the country of origin, the state of and access to healthcare in that country and also traumatic adverse events that the individual may have suffered prior to seeking asylum. Having a dedicated service can assist people in appropriately accessing a full range of health and social care services to maximize their physical and mental health.

Abstract

It could be argued that asylum seeking has never been such a topical subject and Roisin's role is to facilitate equitable access to healthcare for those seeking asylum in the Newport area of South Wales. Roisin's role requires her to meet with each new arrival and assess their physical and mental health needs, inform their GP and refer them to relevant agencies who can assist with addressing their health needs. This particular patient group has a broad range of physical and mental health needs due to the impact of their experiences, such as: trafficking for sexual exploitation or labour, torture, rape, effects of war, poor health care provision in their country of origin, traumatic loss of family members or false imprisonment.

Roisin has a strong sense of going beyond the call of duty in her role as an asylum Seeker Nurse, often working in challenging circumstances which she tackles with empathy, professionalism and dignity. Her work in empowering a particularly troubled group of people demonstrates her deep humanitarian values, truly delivering non-judgemental care in a safe environment where patients can talk about heir health care needs.

Reading list

Spector, R., (2008) Cultural diversity in health and illness 7th Ed. New Jersey: Prentice Hall.

Haroon, S. (2008) The health needs of asymum seekiers.

London: Faculty of Public Health.

McColl, H., McKenzie, K., Bhui, K. (2008) Mental healthcare of asylum seekers and refugees. Advances in Psychiatric Treatment 14 (6) 452-459.

Biography

Roisin works as the Asylum Seeker Nurse for ABUHB, having worked in AandE, cardiac ITU, the prison service and medical assessment since qualifying. Having travelled for both pleasure and to volunteer with charities, Rosin has discovered a fascination with different cultures and ways of life. She has an interest in working with people from multi-ethnic backgrounds and enjoys the challenge of breaking thorough any barriers.

Poster number 48

Surgical virtual inpatient (vip) – there is no place like home

Author Jackie Price, Nurse Practitioner, Nevill Hall Hospital, UK

Theme Knowledge for change and improvement

Aim

The problem of bed capacity management in hospital is topical issue which is constantly featured in the media. Emergency pressures can lead to cancellation of elective operations. This abstract demonstrates how the VIP service provides an additional option for patients and clinicians besides inpatient admission or outpatient appointment. VIP provides a robust, safe and cost effective nurse led service option for managing both elective and emergency patient needs effectively. It also offers effective and timely access to diagnostic assessment, reduction in average patient length of hospital stay leading to very significant cost savings.

Biography

Jackie Price and her three colleagues, Gemma Couch, Rose Davies and Cheryl Williams are all Surgical Nurse Practitioners working at Nevill Hall Hospital within the Aneurin Bevan University Health Board in South Wales, and are jointly responsible for setting up the Virtual system of patient care. All four nurses have a vast amount of surgical nurse experiences, having previously been surgical ward managers. All four registrants have successfully completed a Masters degree and all four are Independent prescribers utilising patient assessment, management and prescribing skills on a regular basis. Jackie and her team are motivated innovative and exceptional practitioners.

Reading list

Geraint H. Lewis, Theo Georghiou, Adam Steventon,Rhema Vaithianathan, Xavier Chitnis, John Billings, Ian Blunt, Lorraine Wright, Adam Roberts, and Martin Bardsley (2013) Impact of 'Virtual Wards' on hospital use: a research study using propensity matched controls and a cost analysis. National Institute for Health Research

Service Delivery and Organisation Programme available at: www.nets.nihr.ac.uk/__data/assets/pdf_file/0011/87923/FR-09-1816-1021.pdf

National Institute for Health Research Service Delivery and Organisation and described in numerous articles in the International Journal of Integrated Care and Health Service Journal.

Poster number 49

Impact of early miscarriage on women and the implications for the nursing care they receive

Author Eleanor Radford, Staff Nurse, Brighton and Sussex University Hospital NHS Trust, UK

Aim

Early miscarriage is experienced by women globally and is considered to be a universally traumatic and distressing experience (Murphy and Merrell 2008). This poster presents a systematic review of the qualitative literature since 1990 of women's "lived" experience of early miscarriage by a novice researcher. The findings of nine papers were analysed and four major themes were identified. The presentation will focus specifically on the theme "care for me and communicate with me". By understanding the theme "care for me and communicate with me" nursing practice and education can be shaped to provide individualised and compassionate care.

Reading list

Schott J, Henley A and Kohner N (2007) Pregnancy Loss and death of a baby: Guidelines for Professionals, 3rd edn. Bosun Press: London.

Royal College of Obstetricians and Gynaecologists (2006) Green top guideline No. 25. The management of early pregnancy loss. RCOG: London

Biography

Eleanor Radford qualified as a Registered Nurse in 2011 from the University of Birmingham. Currently she works as a Peri-operative Research Nurse at the Royal Surrey County in Guilford. Previously she has worked as a trauma and orthopaedic Staff Nurse and within the elective orthopaedic peri-operative setting as a Scrub Nurse at Brighton and Sussex University Hospitals. Eleanor is currently undertaking a National Institute for Health Research funded MRes at the University of Brighton. Her current research interest is the role and training of peri-operative nurses.

Poster number 50

A suite of quality assurance tools from ward to board

Author Diane Read, Head of Transforming Care, Betsi Cadwaladr Health Board, UK

Theme Knowledge for change and improvement

Aim

To define and discuss the suite of Quality Assurance tools developed by a Health Board for use from Ward to Board across both secondary and primary care settings. The paper will discuss the implementation and the impact of the quality assurance tools on process measures leading to impact on patient outcomes.

Abstract

The questions required answering were:

- How do we know from ward to board that we are delivering a quality service for our patients?
- How do we highlight the areas for improvement before things go wrong for our patients?
- How can we highlight and share good practice and innovation?

The suite of Quality Assurance tools developed and under implementation by a Health Board are:

- Monthly quality and safety audit;
- Quality coaches (external reviewers);
- Safety walk prompt card for use by senior leaders within the Health Board;
- Matrix for patient care record review to determine the health care impacts on patients in relation to the Older Peoples Commissioners recommendations.

These suite of tools provide more meaningful data from ward to board and provides a level of assurance of care delivered following the release of high profile reports such as Trusted to Care (2014).

The tools are of mixed of methodology which include the reviewing of patient care records, observation of specific care practices, discussion with patients and implementation of newly developed matrix document review process for patient care records.

The health board is introducing a system of quality coaches or external reviewers who are equipped with the knowledge and skills to initiate the quality improvement work on completion of the collection of the data using the tools at ward level.

The introduction of the 'safety walk prompt card' an adjunct to be used by senior leaders on Leadership walks when visiting the wards. The paper will discuss the impact of this in greater detail once further evaluation and analysis, an area with limited evaluation (Wagner et al 2014).

One can argue that the assurance tools during this period of scrutiny should focus solely a definitive patient outcome measure; however, Rubin et al (2001) demonstrates the validity of monitoring process measures as a means of highlighting processes for focused improvements with the ward teams that will have an impact on the patient outcomes.

The Health Board took this approach for measuring quality beyond the usual performance indicators as all data can then be triangulated to give an indication of wards prior to entering difficulty and compromising the patient and staff experience. The data will provide supporting evidence against NHS Wales Health and Care standards and Older Peoples Commissioner for Wales recommendations.

References

Health Foundation Quality Watch Annual Statement 2013: Is the quality of care in England getting better?

Rubin, H Pronovost and Diette, G (2001) International journal of Quality Volume 13,Number 6:pp.469-474.

Wagner N et al (2014) A checklist for patient safety rounds at the care pathway level. International Journal for Quality in Health Care, Volume 26, number S1:pp.36-46

Trusted to Care report (2014).

Reading list

Older People's Commissioner for Wales recommendations;

Trusted to Care – 2014 report;

Health and Care Standards for Wales.

Biography

The author became a Registered Nurse in 1990 and gained experience on a Trauma and Orthopaedic ward within North Wales attaining the ENB 219 Orthopaedic course at the RNOH Stanmore and then a Ward Sister role in 1999. Opportunity arose to facilitate the RCN Clinical Leadership Programme in 2006 which led to an opportunity to complete the Lean Leadership programme with Airbus UK. This encouraged the author to become more involved in quality and safety of patient care which led to their involvement of Safer Patient Initative and its successor the 1000 lives programmes.

Their current role is part is part of the health board improvement faculty.

Poster number 51

Building a community of critical friends?

Author Diane Read, Head of Transforming Care, Betsi Cadwaladr Health Board, UK

Theme Society, communities, relationships

Aim

To define and to discuss the impact the role a community of volunteers or Critical Friends (retired healthcare professionals) has a had upon the quality and safety of the delivery of care for patients within a Health Board.

To discuss the role as part of the quality improvement work, their vital role as the external eyes and ears and their developing role as part of a suite of tools for quality assurance and improvement mechanisms.

Abstract

The term and role of Critical Friend is familiar within the sphere of education and within medical training (Franazak 2002) however the use of a Critical Friend as part of the quality assurance and quality improvement process is less well recognised. McSherry et al (2015) make reference to the need for further external scrutiny in healthcare with development of partnership between education and clinical practice.

The poster will discuss and demonstrate the impact the development of the role within the Health Board.

Critical friends are all retired healthcare professionals currently nursing background whom provide external scrutiny as part of the established quality assurance and quality improvement process. All have a cultural understanding and background knowledge of the health board and all have the desire to share their experience and continue to contribute to the NHS.

The role has varying levels of commitment the most active critical friends strengthening the quality assurance process as being part of the observations of care on the wards and discussing the patient experience this contributes to the assurance against the NHS Wales health and Care Standards and for the Older Peoples Commissioner recommendations.

It is anticipated that the role will further develop into a more defined quality improvement aspect as well as the assurance aspect. This is timely following the publication of reports such as Trusted to Care (2014)and the Older Peoples Commissioners Recommendations for patients within the hospital care setting and the health and Social Care Standards for NHS Wales (2015)

References

Franzak JK. 2002. Developing a teacher identity: The impact of critical friends Practice on the Student Teacher. English Education 34 (4): 258-280

McSherry R., Cottis K., Rapson T., and Stringer M. 2015 Embracing external scrutiny to build bridges and genuine partnerships between education and clinical practice. Nurse Education in Practice. 15: 149-154.

Trusted to Care report (2014)

Reading list

Older People's Commissioner for Wales recommendations;

Trusted to Care – 2015 report;

Health and Care Standards for Wales.

Biography

The author became a Registered Nurse in 1990 and gained experience on a Trauma and Orthopaedic ward within North Wales attaining the ENB 219 Orthopaedic course at the RNOH Stanmore and then a Ward Sister role in 1999. Opportunity arose to facilitate the RCN Clinical Leadership Programme in 2006 which led to an opportunity to complete the Lean Leadership programme with Airbus UK. This led to the involvement of Safer Patient Initiative and its successors the 1000 lives programmes. All add to the authors aspirations for the pursuit of patient centred quality care for quality outcomes for both patients and frontline staff.

Poster number 52

Recording nursing care: it's personal and professional

Author Angela Reed, Senior Professional Officer, NIPEC, UK

Theme Knowledge for change and improvement

Aim

To raise awareness of the improvement work and good practice examples in Northern Ireland relating to person-centred record keeping practice in nursing.

To demonstrate how professionalism is supported through this vital area of practice.

Abstract

Accurate record keeping practice linked to the provision of safe, effective, person centred care has been a subject addressed in public inquiries over the last 10 years in Northern Ireland (NI) and is recognised across professions as an essential responsibility within the role of all registrants.

The Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC) has led a strategic collaboration since 2009 with the five Health and Social Care (HSC) Trusts in NI with the overarching aim of improving nurse record keeping practice.

The methodology was constructed following a review of literature exploring approaches to achieving and sustaining improved standards of nurse person-centred record keeping practice. Following an initial pilot of improvement methods, NIPEC and Trusts implemented the approach across 105

adult wards in the region alongside testing of a regional person-centred nursing assessment and plan of care document. NIPEC also worked collaboratively with the RCN who have endorsed person centred standards for record keeping practice, launched by the Chief Nurse in 2013.

NIPEC has worked in partnership with senior nurse leaders in HSC Trusts to ensure consistency, and to enable benchmarking of practice standards. This has generated learning for subsequent improvement cycles, achieving an improvement of 30% across audit indicators. Considerable improvement has also been achieved in the engagement of patients and clients in the process of recording nursing care.

Following robust evaluation, the successful methodology has been adopted into HSC Trust safety and quality processes, and is now included within health care regulator inspection criteria. Adaption is on-going across a range of other care settings including, children's and learning disabilities. Further to this, work continues and includes review of person-centred care planning to develop a model for NI. This practice improvement methodology has been recognised as helpful to demonstrating evidence for revalidation, linked to the Nursing and Midwifery Council Code (2015).

Following this session delegates should be able to:

1. Articulate a renewed understanding of the importance of person-centred nurse record keeping practice

2. Demonstrate an understanding of linking record keeping practice to professionalism

3. Demonstrate an understanding of linking record keeping practice to revalidation.

Reading list

Northern Ireland Practice and Education Council for Nursing and Midwifery. (2010). Systematic Review of Northern Ireland Public Inquiries and Reports.

Northern Ireland Practice and Education Council for Nursing and Midwifery. (2013). Recording Care: Evidencing Safe and Effective Care Phase 1. Available to download at: www.nipec.hscni.net/Image/SitePDFS/Final%20Report%20Phase%201%20April%202013.pdf

Northern Ireland Practice and Education Council for Nursing and Midwifery. (2013). Standards for person Centred Nursing and Midwifery record Keeping Practice. Available to download at: www.nipec.hscni.net/recordkeeping/docs/Standards%20for%20Nursing%20and%20Midwifery%20Record%20Keeping%20Practice.pdf

Biography

Angela registered in 1988 and has held a variety of clinical posts, including Ward Manager and Patient Flow coordinator. Practice improvement has always been a part of her work, through leading organisational projects and initiatives.

Angela has been a Senior Professional Officer since 2007 with a focus on practice and was as a member of the Chief Nursing Officer's team at the Department of Health, Social Services and Public Safety during 2014/15.

Angela has continued her professional development in a number of ways including: BSc (Hons) Health Studies, Master's degree Medical Law and Regional Leadership Development Programme for Service Improvement.

Poster number 53

A career in nursing? Attributes which are valued – a pre-registration journey

Author: Angela Reed, Senior Professional Officer, NIPEC, UK

Theme: Knowledge for change and improvement

Aim

At the end of the session delegates will:

1. Be aware of the collaborative work in Northern Ireland to identify attributes which are valued to realise future potential in a career in nursing.

2. Have an understanding of the identified attributes.

3. Be able to consider the connections to on-going strategy and policy work in the United Kingdom related to attributes which are valued to realise future potential in a career in nursing.

Abstract

Work began in Northern Ireland in 2011 to develop a strategy to optimise efficiency of application and selection processes and enable the identification of individuals who display attributes which are valued to realise future potential in a career in nursing. The initial phase completed in 2013 and comprised the exploration of methods to streamline the process of application and selection for pre-registration nursing programmes, resulting in a regionally agreed scoring process for personal statements and principles for consistency of face-to-face interviews.

The second phase sought to gain professional agreement on the identification of attributes which are valued to realise future potential in a career in nursing.

Engagement occurred across statutory, independent and voluntary sectors, RCN and members of the public to establish views around the attributes valued to realise future potential in a career in nursing. This included possible methods of assessment of the attributes.

Methods included a consensus workshop held in March 2014 and a consultation exercise, the purpose of which was to test defined attributes with a wider audience.

A summary of professional values, attributes linked to the values and related assessment methods themed within five domains reflecting the ethos of Nursing and midwifery Council Code (2008) were identified via the workshop.

Subsequently, an online questionnaire was developed and hosted within the main NIPEC website during July 2014 to test consensus for the attributes which were identified including possible methods of assessment. In addition, the Patient Client Council in Northern Ireland designed a blog entitled 'What Makes a Good Nurse' to which 24 members of their scheme responded.

A total of 299 individuals responded to the questionnaire, 5.7% (n= 17) of which were members of the public. This information, coupled with the responses to the blog identified attributes and potential methods of assessment within five domains: Person-Centredness, Commitment to Personal Development, Accountability, Integrity and Trustworthy.

This led to a regional recommendation to continue with the existing methods of application and selection to pre-registration nursing programmes and to explore opportunities for use of Multiple Mini Interviews, incorporating assessment methods through which the identified attributes might be tested.

Reading list

The Willis Commission. (2012). Quality with compassion: the future of nursing education. London, Royal College of Nursing.

Taylor, R., Macduff, C. and Stephen, A. (2014). A national study of selection processes for student nurses and midwives. Nurse Education Today. 34, 1155-1160.

Waugh, A., Smith, D., Horsburgh, D. And Gray, M. (2014). Towards a values-based person specification for recruitment of compassionate nursing and midwifery candidates: A study of registered nurses' and student nurses' and midwives' perceptions of prerequisite attributes and key skills. Nurse Education Today. 34, 1190-1195.

Biography

Angela registered in 1988 and has held a variety of clinical posts, including Ward Manager and Patient Flow coordinator. Practice improvement has always been a part of her work, through leading organisational projects and initiatives.

She has been a Senior Professional Officer since 2007 with a focus on practice and was as a member of the Chief Nursing Officer's team at the Department of Health, Social Services and Public Safety during 2014/15.

Angela has continued her professional development in a number of ways including: BSc (Hons) Health Studies, Master's degree Medical Law and Regional Leadership Development Programme for Service Improvement.

Poster number 54

Influencing care nationally

Author Jane Robinson, Improvement Coach, Monitor, UK

Theme Knowledge for change and improvement

Aim

This concurrent session demonstrates how nursing contributes to the delivery of improved health nationally, via regulation. It is presented by one of Monitor's Improvement Coaches, who is a Registered Nurse. Case studies illustrate improvement. The audience will be micro-coached to develop their own ideas for future improvement.

Abstract

1. What does Monitor do?

We work with organisations to 'make the health sector work better for patients.'

2. The changing role of Monitor.

Our role has evolved from financial and performance regulation of foundation trusts to NHS Improvement (April 2016).

3. The conscious decision to recruit staff with clinical backgrounds and NHS experience highlighted in Monitor's strategy 2014-2017.

The team includes colleagues from occupational therapy, physiotherapy, mental health, emergency care, elective care and cancer.

4. Monitor's values:

- Patients first
- Support the frontline
- Work with partners
- Professional
- One team

5. Comparison between the NMC Code and Monitor's values:

a. Patients first
- Prioritise people
- Act as an advocate
- Consider cultural sensitivities
- Act without delay
- Reduce harm

b. Support the frontline
- Communicate clearly – use terms that the public and colleagues can understand
- Rely on the evidence base

c. Work with partners
- Provide leadership
- Work in partnership
- Work co-operatively

d. Professional

- Uphold the reputation of the profession
- Recognise limits of competence
- Keep accurate records

e. One team
- They are the same. We are one team with the patient at the heart of what we do

f. My role as an Improvement Coach:
- Working with clinical teams
- Coaching
- Service improvement
- Training staff in improvement skills
- Spreading good practice
- Networking

g. Sharing knowledge, skills and experience as a RN, for the benefit of people receiving care and colleagues.
- Examples of working with Monitor colleagues
- Examples of improvement coaching with hospitals

h. How can you influence care?
- 10 minute improvement micro-coaching (one-way coaching with the whole audience.

Recommended reading

Monitor (2014) Monitor's strategy 2014 to 2017: helping to redesign healthcare provision in England

Ford S and Merrifield N (2015). Regulator Monitor appoints Ruth May as nurse director. Nursing Times.net 12.3.15. Retrieved on 13.10.15 from www.nursingtimes.net/home/specialisms/leadership/exclusive-regulator-monitor-appoints-ruth-may-as-nurse-director/5083215.article

Davies G (2015). A bad CQC report can help to improve a suboptimal service. Nursing Times vol 111 no 41 p7

Biography

Jane is a Registered Nurse and a qualified Midwife.

She has 12 years experience in service improvement and introduced coaching into service improvement. She then spent 12 months as a Leadership Coach and most recently worked for the Chief Nurse as Senior-Co-ordinator. This involved implementing national initiatives into practice: for example Safer Staffing and NMC Revalidation. She combined this role with working clinically both in in-patient and out-patient areas. She joined Monitor as Improvement Coach in September 2015.

Jane has presented her coaching work nationally and has had a number of publications in national and international journals.

Poster number 55

Transforming care together

Author: Paula Simpson, Deputy Director of Nursing, Wirral Community NHS Trust,UK

Theme: Knowledge for change and improvement

Aim

The aim of this abstract is to inform the reader of a transformation programme based on knowledge for change and improvement aimed at addressing the complexity of developing new models of out of hospital care. The programme has been established in response to the changing demands of the sector and aims to create an environment where the workforce can drive forward transformational change at pace. The vision is that we will develop a local health system which provides safe, high quality, integrated care focussing on prevention, early intervention and self-care, supporting all people to live longer, healthier lives in their own homes.

Abstract

The vision for better and more sustainable care by 2020 rests on community-based models of care that are coordinated around people's needs. To ensure that clinical services develop in a way that supports this vision Wirral Community NHS Trust has introduced a major transformation programme 'Transforming Care Together'.

The programme will ensure that our services are more integrated and patient focused, will help people to remain living at home at times of vulnerability, and will achieve improvements in quality alongside financial savings and efficiencies whilst still delivering the same high standard of care.

The key outcomes of the transformation programme are to transform the model of out of hospital care and the systems which support clinical care delivery. This will include a clear focus on the community workforce model and the partnerships that will ensure integrated, patient centred care is delivered.

The programme is based on increasing knowledge for change and improvement and will prioritise four areas of development; data and intelligence, workforce development, patient pathway development and procurement. A diagnostic tool has been developed to enable a clear assessment of clinical services in the context of the changing system, enabling clarity of issues that exist and areas that require development. In addition, the programme intends to develop a bespoke community workforce planning model which takes account of indicators of clinical complexity as well as psychosocial, environmental and health behaviour indicators. This will allow a more intelligent analysis of individual needs, supporting more sophisticated workforce planning.

The bedrock of the programme is workforce engagement with our Clinical Forum and service specific clinical reference groups leading the assessment and developmental elements of the programme. Wirral Community NHS Trust has a workforce that is passionate and committed to making a difference every day.

Alongside the Transforming Care Together Programme, Wirral Community NHS trust has also launched a Leadership for All model which creates an environment for individual personal growth and talent management opportunities for staff at every level.

Reading list

Health Education England (2015)District Nursing and General Practice Nursing Service Education and Career Framework.

QNI (2014)Developing a national District Nursing workforce planning framework.

QNI (2014)The District Nursing Workforce Planning Project. Literature Review.

Biography

Paula Simpson is Deputy Director of Nursing at Wirral Community NHS Trust. Mrs Simpson obtained a Bachelor of Nursing Honours degree at the University of Liverpool during which she qualified as a Registered Nurse and Health Visitor. She has gone on to obtain an MSc in Applied Public Health and has worked across a range of healthcare settings in both clinical and commissioning roles.

Mrs Simpson has over 27 years of nursing and public health experience and has gained considerable expertise in clinical practice, service and strategy development, quality improvement and clinical governance.

Poster number 56

'All about me'

Author Laura Skinner, Senior Play Specialist, Royal Brompton Hospital, UK

Co presenter: Laura Ettery, Complex Care Lead.

Theme Knowledge for change and improvement

Aim

To high light how effect a compulsory team system can be with complex care patients in an acute setting. To demonstrate how a system can help overcome the common communication problems we see in a busy Paediatric Intensive Care Unit.

Reading list

Francis Report, 2013.

Biography

The role of the author has been a Play Specialist at the Royal Brompton Hospital for five years, working across all areas of paediatrics. The author advocates and supports the holistic needs of long term patients on Paediatric Intensive Care Unit. Throughout the project the author spent time gathering feedback from all members of the multidisciplinary team. The author has shown a special interest in the needs of long term complex care patients, looking at how to ensure that all areas of their development are being met whilst spending a long periods of time in an acute setting.

Poster number 57

The introduction of mental health nurses into The London Ambulance Service

Author Briony Sloper, Deputy Director of Nursing and Quality, The London Ambulance Service NHS Trust, UK

Theme Society, communities, relationships

Aim

This presentation describes an initiative by the London Ambulance Service to improve the specialist response we are able to provide mental health patients calling into the service and supplement the knowledge, skills of our clinical hub staff.

Abstract

The Trust had noted that there was an on-going increase in demand from callers with mental health needs. Specific drivers for patients with mental health needs include the limited availability of mental health service provision out of hours and the increased focus on community care. This led the service to examine other ways of supporting the specific needs of mental health patients. There was also the desire to up skill and supplement the knowledge and skills of our existing staff.

The service committed to create six full time mental health clinical advisor posts to supplement existing clinical advisor roles within our Emergency Operations Centre to support the service's hear and treat model and enhance MH skills and expertise available to the paramedic workforce.

The work of the mental health nurses is broad and varied and the nurses report high levels of job satisfaction. They undertake full mental health risk assessments with patients and are expected to have an understanding of mental health referral pathways and services available to patients pan London. They also provide an advisory role for frontline crews, fellow clinical staff and have the ability to take on challenging calls from call takers.

From April – September 2015 2.5 WTE MH nurses responded to 3,299 calls, 420 of which closed with hear and treat (12.7%)as opposed to an ambulance being dispatched. On average the nurses are responding to 19 calls per 12 hour shift. An additional 3 WTE have been recruited to commence in post in from January 2015.

Reading list

www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf

Biography

Briony Sloper is the Deputy Director of Nursing and Quality for the London Ambulance Service NHS Trust. She previously spent 10 years as the Head of Trauma, Emergency and Urgent Care at Kings College Hospital (KCH). She has extensive experience in the field of urgent and emergency care, which includes the development of the Major Trauma Centre at KCH and the associated Trauma Network across South East London Kent and

Medway. She has led on a variety of work programmes focussed on patient centred care including mental health, the frail elderly, patient engagement, frequent attenders/ callers and end of life response models. She has developed new workforce models and has a successful history of redesigning pathways to have the maximum impact on both operational delivery and quality of care.

Poster number 58

Withdrawn

Poster number 59

Health promotion hubs: a model for rural community hospital out-patient departments

Author Anne Thomas, Staff Nurse, Out Patient Department, UK

Theme Populations, health and economic growth

Aim

Our aim is to improve individual and population health in a rural community. The Welsh Government (2009) acknowledges that gaps in rural health provision have resulted in health inequalities. This includes restricted accessibility to support services to make lifestyle changes that can reduce levels of avoidable ill health. There is a need to provide rural communities with accessible, acceptable, relevant and effective health education to reduce these inequalities. The Dolgellau Healthy Hearts Programme (DHHP) provides easier access to health education for the wider community. Optimising health can further reduce rural inequalities as good health plays a substantial role in economic growth (Welsh Government 2011)

Abstract

Method: The two issues that we needed to address were reducing barriers to health education in rural areas and to develop a strategy to improve the health of patients by encouraging lifestyle changes. The DHHP is the foundation of the Health Promotion Hub, based on BHF training and materials. Patients with chronic illness who may benefit from lifestyle changes are offered a 30 minute discussion on their lifestyle and how their choices can affect their health. They may then take part in an individual 6 session programme of education and support to help them to make positive lifestyle changes in weight, healthy eating, increasing activity, smoking and reducing salt intake with the aim of reducing cardio-vascular disease (CVD) risk.

Outcomes of the effectiveness of the strategy could best be measured by comparing the lifestyle risk factors at baseline, then at 1 year following the DHHP. If risk factors were reduced then in theory, improving accessibility to health education in a rural area will have been successful. 20 patients were randomly selected. At baseline we recorded their BP, weight, activity, diet, smoking status and salt intake. Their CVD risk was calculated over 10 years using Q-risk2 score based on the CVD risk factors of each patient. They then attended the programme. 1 year later we interviewed the patients, recorded the same factors and calculated their Q-risk2 score.

Results: There was some reduction in most lifestyle risk factors with the highest reduction in salt intake at 1 year. Overall there was a statistically significant reduction in the number of patients with Q-risk2 score >20 at 1 year. The study demonstrates that small improvements in each individual lifestyle CVD risk factor have a cumulative effect in reducing the overall CVD risk. These results reflect the conclusions of the Caerphilly study (Elwood 2013).

Conclusion: The Welsh Government (2009) states that 'accessing services is the foundation of effective rural health care and a basic human right'. OPDs of rural community hospitals are well placed to break down barriers of rurality by providing a centre for health education activities that is accessible to the community.

Reading list

Elwood (2013) Healthy lifestyles reduce the incidence of chronic diseases and dementia: Evidence from the Caerphilly Cohort Study

Available from: www.10.1371/journal.pone.0081877

Welsh Government (2009) Rural health plan: Improving integrated service delivery across wales. Cardiff: Welsh Assembly Government

Welsh Government (2011) Rural economy taskforce. Summary report. Cardiff: Welsh Assembly Government

Biography

Anne Thomas is a Band 6 Staff Nurse responsible for the Out Patient Department of a community hospital since 2000. Previous roles:

Midwife (1992-2000) BCUHB

Community Nurse and Midwife (1986-1992) BCUHB

Midwife (1984-1986) St Georges Hospital

Staff Nurse (1981-1982) St Helier Hospital

Publications: Assessing and addressing lifestyle cardiovascular risk in rheumatoid arthritis: A rural community hospital health promotion project. Anne Thomas and Dr Sarang Chitale. Rheumatology (2014) 53 (suppl 1):i36-i37 doi:10.1093/rheumatology/keu089.003

Presentations: British Society of Rheumatologists Conference 2014 (oral); 2015 (poster)

Awards: Nursing Times Awards finalist 2014; Runner Up in the RCN Wales Nurse of the Year Awards 2015

Poster Number 60

Parenting a child with metabolic diseases: impact on health related quality of life of parents

Author Deepa Shaji Thomas, Sultan Qaboos University, College of Nursing, Oman

Theme Society, communities, relationships

Aim

Inborn error of metabolism is a rare disease which requires a lifelong treatment for children and it can cause significant lower health related quality of life of parents. Providing education and psychosocial support may improve the parental health related quality of life which indeed results in a better care for their children. Assessment of health related quality of life of parents if done routinely could benefit the parents by rendering extra support and education for the parents when required. Empowering the parents by helping them to actively seek and maintain social support is another important step in improving the health related quality of life of parents.

Abstract

Introduction: Inborn errors of metabolism are chronic disorders causing mild and long term consequences on health of the child and it profoundly affects the quality of life of the child and the parents. Little is known about the recognition and determinants of quality of life among parents of children with inborn error of metabolism. The aim of this study is: to assess the health related quality of life (HRQoL) among parents whose children are suffering from inborn error of metabolism and to find out an association between the HRQoL among parents of children with inborn error of metabolism and the demographic variables.

Design: This explorative descriptive survey was conducted at the outpatient department of a tertiary care center. 72 parents completed the RAND 36-Item Health Survey and demographic data sheet. Convenient sampling technique was be used and data was collected for period of 6 months.

Methods: The parents were interviewed at the outpatient department by using RAND 36-Item Health Survey and demographic data sheet. The data was analysed using SPSS version 20.

Results: Parents of children with metabolic disorder had lower mean scores in general health(56.18) and Vitality (56.94). The subscale pain (70.6) has the highest score. The physical component summary score (PCS) is 64.6 and mental component summary (MCS) is 60.1. Significant association was found between supporting persons and social functioning (p< .04), General health and preparation of special diet for the child p<.02).

Conclusions: The current study indicates that parents of children with metabolic disorders are a vulnerable group and a good quality of life of the parent will prevent any additional health and adjustment problems of their chronically ill children.

Clinical relevance: Members of the health care team should be able to identify these parents and to enable them to improve their general health through supporting measures like counselling, relaxation methods and special training to look after these children. Future studies which can predict the potential factors for lower quality of life of parents can empower a social support system.

Reading list

Fidika, A., Salewski, C., and Goldbeck, L. (2013). Quality of life among parents of children with phenylketonuria (PKU). Health Qual Life Outcomes, 11, 3-9.and#8207;

Al Riyami, S., Al Maney, M., Joshi, S. N., and Bayoumi, R. (2012). Detection of inborn errors of metabolism using tandem mass spectrometry among high-risk Omani patients. Oman medical journal, 27(6), 482.and#8207;

Amber, E., Maurice-Stam, H., Boelen, C. C., Rubio-Gozalbo, M. E., van Spronsen, F. J., Wijburg, F. A., ... and Grootenhuis, M. A. (2011). Parenting a child with phenylketonuria or galactosemia: implications for health-related quality of life. Journal of inherited metabolic disease, 34(2), 391-398. and#8207;

Biography

A highly accomplished healthcare professional with extensive experience teaching nursing students in a variety of institutions as well as worked as a clinical nurse in peadiatric settings and Operation Theatre.

Believes strongly in the importance of educating future nurses through evidence based nursing process by providing high-level nursing care.

Successfully published articles in peerand#8208;reviewed journals; also presented at international conferences.

Poster number 61

Withdrawn

Poster Number 62

The mentor's legacy

Author Claire Uren, University Practice Learning Adviser, Bournemouth University, UK

Theme Knowledge for change and improvement

Aim

To explore the influence of the mentor's role, in pre-registration education, in developing safe and effective practice.

Abstract

Chan (2013) purports that nurse education is a transition to a critical thinker, essential for care delivery, rather than that of a vocational doer. The role of the mentor is crucial to this process, ensuring that new graduates develop a level

of autonomy that will equip them with the ability to practice independently. Developments in nurse education would not be sustainable without strong partnerships between practice and higher education institutes.

Francis (2015) and Willis (2012) recognise the value of pre-registration students in driving standards through their presence in clinical practice. Students spend 50% of their programme in practice, highlighting the influence of mentors and clinical staff in developing critical application to practice. This illustrates the value of effective role models who promote change and improvement in health care.

Experienced staff can be critical of current educational standards arguing the need for practical experience to apply theory to the real world. In reality a vocational element must be present but this must be in conjunction with an ability to critically problem solve in order to focus on person centred care.

Whilst there are specific standards for mentorship it could be questioned that standards are not enough to enable mentors to facilitate learning effectively in practice. What is evident, in our experience, is that mentors who are confident in their clinical knowledge, understand the educational programme and value learners in practice, are able to develop and inspire students who provide high quality evidence based care.

Using a case study approach this paper will explore the importance of effective role modelling in developing learners as agents for positive change. By examining how these mentors have enhanced the student experience, strategies can be identified that illustrate the value of degree led education in promoting safe and effective care.

Intended learning outcomes

1. To consider the influence of Government, public and professional bodies on the nursing education programme

2. To explore the role of practice education in applying theoretical principles

3. To identify effective role modelling and its influence on student development

Reading list

Chan, S., 2013. Nursing education makes a difference, International Journal of Nursing Practice. 19 (Suppl.1), 1-2.

Francis, R., 2015. Freedom to Speak Up. [online]. London: www.gov.uk.

Willis, Lord., 2012. Quality with Compassion: the future of nursing education. Report of the Willis Commission on Nursing Education. London: Royal College of Nursing.

Biography

Claire Uren qualified as a registered general nurse in 1990 and worked on an acute surgical unit in a district hospital for five years before moving to community nursing. Claire became involved in education in 2001, taking on the role of Practice Educator for Bournemouth University, whilst continuing with her practice role as a community nurse. Claire has become increasingly involved in education as a lecturer and practice education link for pre and post registration education in health and social care. Claire completed her Masters degree in Health and Social Care Education in 2010.

Poster Number 63

Promoting clarity of role within a specialist nursing respiratory service

Author Emma Vincent, Interstitial Lung Disease Nurse, University of Hospitals Leicester, UK

Theme Knowledge for change and improvement

Aim

Lack of role clarity pose barriers to the integration and effectiveness of clinical nurse specialists.

The prospective project has two aims

1. To enhance the use of resources within an interstitial lung disease (ILD) nursing service, by improving stakeholders understanding of the clinical nurse specialist role.

2. To improve referral pathway to the service and to integrate/share resources with other stakeholders where roles may overlap.

Reading list

Cornwell J. and Edwards N. (2013) NHS: Changing Culture. tinyurl.com/nwg5mk

Huntington (2000) Clinical Governance in primary care: organisational development for clinical governance. British Medical Journal. 321;7262:679-682

NHS Leadership Academy (2014) Leadership Framework NHS Leadership Academy. tinyurl.com/qew9ese

Biography

Emma is in clinical practice as an interstitial lung disease nurse specialist. She has been a respiratory nurse for 15 years. Emma is a committee member of the Association of Respiratory Nurse Specialists and The British Thoracic Society Nurses. She has a diploma and BSc in Nursing, with a further BSc in Respiratory. Emma is currently working towards a MSc in Leadership and Ethics. She has published widely on both respiratory and nursing topics, with a keen interest, and background in research related to pulmonary rehabilitation.

Poster number 64

Gamification: student feedback and pedagogical reflexivity, creation of a bespoke board game served

Author Melanie Webb, Senior Lecturer (Children's Nursing), University of Bedfordshire, UK

Theme Knowledge for change and improvement

Aim

The presenters aim to attract those who already use, or wish to use simulation games as either 'introductory, strategic or specialist' (Vos, 2014) facilitative tools in the learning process.

Workshop: Opportunities to discuss the concepts and play the game itself will be achieved through the workshop.

Poster: Exploring the principles of pedagogical reflexivity, the Poster will summarise the journey from concept to implementation and evaluation.

Abstract

The pedagogical value of educational games is well researched in many disciplines (Vos, 2014; Dicheva et al, 2015). The author and co-author summarise involvement of co-creating and playing a clinical practice simulation board game.

Outcomes following introducing the board game as an intervention to facilitate collaborative student engagement, critical analysis and clinical decision making included:

- Dynamic, evidence based decision-making experience of real case vignettes, integrating theory (potentially from a range of relevant knowledge bases) to practice
- The facilitation of an enjoyable, competitive atmosphere in which the realities of change and uncertainty were explored in a low risk setting
- Safe experiential learning of the leadership, team working and time management attributes valued when negotiating for individual patient/client advocacy in practice.

The presenters explore the validity of gamification in nursing education as effective learning strategies, the relationship of game content to unit learning outcomes and as tools to underpin student motivation, creativity in determining content and leading learning. Child, Adult and Mental Health students' evaluations evaluation included recognition of their more sophisticated involvement, enhanced application of their clinical knowledge, decision making and team-work and leadership and teamwork. Of note was students' involvement in plans for development of the vignettes to represent progression through all three years of nurse education.

Reading list

Dicheva, D., Dichev C., Agre G., and Angelova G. (2015). Gamification in Education: A Systematic Mapping Study. Educational Technology and Society, Vol.18. No.3., pp. 75–88.

Vos, L. (2014.) Marketing simulation games: A review of issues in teaching and learning. The Marketing Review. Vol.14. No.1. pp.67-96.

Biography

Melanie Webb is a Senior Lecturer in Children's nursing. She is an Advanced Nurse Practitioner and Non-Medical Prescriber. She has just completed the PgC(THE). Her current interests include gamification within pedagogical strategies and student stress in simulated scenario assessments.

Poster number 65

Developing and implementing a community-based prostate cancer awareness campaign for hard to reach men

Author Roger Wheelwright, Prostate Cancer Nurse Specialist, John Taylor Hospice, UK

Aim

Black men are more likely to get prostate cancer (PCa) than men of other ethnicities (PCUK, 2013). It's really important that Black men know about this. We are introducing an initiative to raise awareness of these risks and sign post this group of men to appropriate services that are available. We aim to explain this risk in a clear way that men can relate to – this will help us raise awareness of PCa and help men understand their risk.

Abstract

Introduction: Black men are more likely to get prostate cancer (PCa) than men of other ethnicities (PCUK, 2013). It's really important that Black men know about this. We are introducing an initiative to raise awareness of these risks and sign post this group of men to appropriate services that are available. We aim to explain this risk in a clear way that men can relate to – this will help us raise awareness of PCa and help men understand their risk.

Method: PCUK have funded the project for 18 months, and building upon and developing the initiative with key members of the black and African Caribbean community through the Benjamin's Brothers project at John Taylor Hospice, a concept set-up with the local community, including religious and community leaders, carers and prostate cancer survivors.

Clinical support from consultant oncologists from University Hospitals Birmingham, as well as a variety of professionals across Birmingham Cross City Clinical Commissioning Group.

Outcomes: In addition to raising awareness we will recruit 'health activists to support and enable men to live longer with PCa, supporting them and their families in the community closer to their homes offers many benefits, including:

- Improved access to advice and support will help equip men and their families with the knowledge, understanding and support to self-manage their health.
- Provide men and their families with a point of contact within the community setting, who can signpost them to the appropriate services and act as a liaison between the multifaceted multidisciplinary team across secondary, tertiary and primary care settings.
- By providing support and education to the GP's who monitor these men in the community setting, to enable men to have access to advice and support.
- This initiative offers us a new way of working and enhances the way information and support is disseminated through these communities.

Discussion: Black men in the United Kingdom have substantially greater risk of developing prostate cancer compared with white men.

The aim of the post is to:

- Offer advice and support of African-Caribbean Heritage
- Enable those living with prostate cancer to lead as full a life as possible, taking the whole family context into account.
- Reduce the risk of suicide among men diagnosed with PCa.

This gold standard ambition for people, designed with health economics in mind we envisage to be a game changer in prostate cancer survivorship. We want brothers to become uncles, daughters to have grandfathers and sons to live longer than mothers.

Reading list

Ben-Shlomo Y et al. (2008) The Risk of Prostate Cancer amongst Black men in the United Kingdom: The Process Cohort Study. European Urology 53(1): 99-105.

Chinegwundoh F et al. (2006) Risk of presenting features of prostate cancer, amongst African-Caribbean, South Asian and European men in N.E. London. British Journal of Urology International 96(6): 1216-20.

Prostate Cancer UK. (2013) Working out the risk of prostate cancer in Black men Prostate Cancer UK

Biography

Profile – Roger Wheelwright

MSc, PG Dip, PGCE (FE), MISM, RN

Prostate Cancer Nurse Specialist, with previous posts including Prostate Cancer Specialist Nurse and Senior Research Nurse in Oncology at the Dorset Cancer Centre, Poole Hospital NHS Foundation Trust, since 2011 with a clinical interest in patients with prostate cancer. After gaining my research MSc from the University of Bristol in 2008 I moved to Southampton as Senior Nurse Manager at the Wellcome Trust Clinical Research Facility. Following this, worked on trials at Oxford University and then University of Southampton, including work on developing an EORTC QoL Module for Elderly Patients with Cancer. Previous experience includes Critical Care nursing, establishing a Nurse Practitioner and site management service for the surgical at the University Hospital of Wales in Cardiff. Research experience ranges from participating in multi-centre trials to set up and managing a Regional NHS RandD funded trial.

Poster number 66

Caring for care homes collaboratively

Author Sarah Winfield-Davies, Safeguarding Nurse, Northern Devon Healthcare Trust, UK

Theme Knowledge for change and improvement

Aim

The Northern Devon Care Homes Team is a team of nurses and an occupational therapist. The team have transformed the way organisations work collaboratively together with a focus on providing on-going support, education and building upon existing good practice to care home staff across North Devon. The team can evidence that avoidable harm, hospital admissions and safeguarding concerns have been reduced as a result of the service they offer. Furthermore, the quality of life and death for this client group has been improved with a focus on dignified, person centred care, in turn improving care home staff and relatives experience.

Reading list

National service framework for older people : modern standards and service models. London : Department of Health, 2001

Care Act 2014 : Chapter 23. London : The Stationery Office 2014

Owen, T. (2008) 'Healthcare in care homes: a vision for improvement', Journal of Community Nursing, 22(5), pp. 10-14.

Biography

Sarah Winfield-Davies is a Safeguarding Nurse working in the Northern Devon Care Homes Team. Sarah qualified as an Enrolled Nurse General (ENG) in 1992, converting to Registered General Nurse (RGN) in 1995.

Sarah went on to complete a Diploma in Professional Nursing Studies and BSc Honours in Health Care and has recently been awarded the Queens Nursing Title for pledging her commitment to the delivery of high standards of practice and patient-centred care in the community.

Sarah has spent the majority of her professional life working in the primary care setting with a special interest in documentation and wound care.

Poster number 67

A study to investigate parental satisfaction with the allocation of respite care by a children's hospice

Author Carol Wylde, Clinical Manager, Brian House Children's Hospice, UK

Theme Knowledge for change and improvement

Aim

Prior to this study the hospice had no evidence base to determine parental satisfaction regarding the allocation of respite care for their child. This study explored the opinion and understanding of parents whose children received respite care from a children's hospice as to how it is allocated to their child and their satisfaction with what they receive. The study invited all parents to contribute to the research by completing a questionnaire and participating in a semi-structured interview. Analysis of the data received contributed to the knowledge required to make change and improvements to practice.

Reading list

Champagne,M.and Mongeau,S.(2012)"Effects of respite care services in a children's hospice: The parent's point of view." Journal of Palliative Care. 28 (4) 245-251.

Ling, J.(2012) "Respite support for children with a life-limiting condition and their parents: a literature review." International Journal of Palliative Nursing.18 (3) 129-134.

Malcolm, L. and Forbat, K.(2008)"Exploring the experiences and perspectives of families using a children's hospice and professionals providing hospice care to identify future research priorities for respite care." Palliative Medicine. 22,921-928.

Biography

Carol Wylde is Clinical Manager at Brian House Children's Hospice in Blackpool. She has specialised in paediatric palliative care for over fifteen years and is passionate about seeking the views of children, young people and their families to ensure the hospice provides a service that is relevant and useful to them. She has led a multidisciplinary team in writing a model for palliative and end of life care for children and young people to ensure best practice and consistency of care across their locality. Carol has studied at Coventry University achieving a masters' degree in paediatric palliative and complex care.



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