The role of the clinical nurse consultant in intensive care

Schlict K
Intensive Care Unit, The Royal Melbourne Hospital, Victoria

The Royal Melbourne Hospital's Intensive Care Business Unit recently created a clinical nurse consultant (CNC) position, which has two major functions: to follow up patients after their discharge from intensive care, and to provide psychosocial support for patients, staff and families in the intensive care unit (ICU). This paper concentrates on the first function.

The first 12 months of data collection, from June 1995 to June 1996, showed that 5 per cent of patients were readmitted to ICU within 14 days, 80 per cent because of respiratory failure. The degree of respiratory failure depended on physiological factors, the inexperience of ward staff (for example, with tracheostomies) and poor staff-patient ratios on the wards.

The CNC has addressed these needs in several ways. Currently, all patients receive at least one visit post-discharge from ICU, with the aim of ensuring that: the patient has settled into the ward; his/her vital signs are stable; the equipment is set up correctly; appropriate referrals have been made (for example, social work); families are aware of the transfer, and the ward staff are fully informed. Feedback from both medical and nursing staff on the ward has been positive, since they feel supported by the ICU back-up. Patient follow-up and staff support are continued, depending on a risk analysis made by the CNC; for example, patients discharged with adjustable flange, single-lumen, long tracheostomies are seen daily. As health professionals we have an obligation to ensure that patient care is optimal at all times, not just in our own area, and care should be viewed as a continuum. I believe the CNC role facilitates this process and helps break down any ICU/ward barriers.

Long-term outcome of intensive care – the psychosocial and cost impact on carers

Verrender P, Robson S, Southan K, Lee S & Jacques T
St George Hospital, Kogarah, New South Wales

Research into outcome of patients to date has ignored the impact on families. This exploratory study aimed to identify the psychosocial and cost impact on carers.

In all, 388 patients were admitted from July to December 1995. Mean APACHE II = 17.04.

Carers participating in the study numbered 146. Structured interviews with carers were conducted and the questionnaire completed. Health status information on the patient was collected using the Sickness Impact Profile (SIP) and Short-form 36 (SF36). The study looked at three aspects of care-giving: workload, resources and crisis of decline. The supervisory and emotional support workload factors of the carers' questionnaire had the strongest relationships with SIP and SF36 (r ranged from 0.36-0.40).

Carers received little in the way of community support: 36.70 per cent used the GP and 15.4 per cent community nurses. They were reticent about asking for help (23.6 per cent will ask willingly). Factor analysis of coping strategies revealed two factors: emotional/nurturing (α=0.66) and stoicism (α=0.81). The study found that the less well the patient, the greater the impact of time constraints on the family. A range of questions on financial impacts found that these were small.

Conclusion: we have demonstrated and detailed the impact on carers. Once patients leave the hospital, responsibility for their care rests with family or close individuals rather than society as a whole.

The role of the UK hospital-based resuscitation training officer: lessons learned

Mayor D
King's College Hospital, London, England

Survival from a cardiac arrest is most likely when the arrest is witnessed, basic life support is started promptly and defibrillation is carried out early. This concept of 'chain of survival' provides the framework of resuscitation training programs and resource allocation but, as with any chain, it is only as strong as its weakest link. Studies in the UK identified nursing and medical staff as neither confident nor competent to perform resuscitation. Coupled with the publication of the joint Royal College of Physicians/ Resuscitation Council (UK) paper 'Resuscitation From Cardiopulmonary Arrest – Training and Organisation', resuscitation training officer (RTO) posts were introduced in 1987-88.

The RTO is responsible for implementation of the resuscitation policy. Links in the chain of survival are strengthened by way of an organised, structured teaching program, which guarantees that employees are trained according to current Resuscitation Council (UK) guidelines. Training and cardiac arrest management is audited internally and through regional research. With 210 full-time RTOs in the UK, hospitals employing an RTO note a marked improvement in the performance of staff, through a systematic approach to resuscitation and a reduction in anxiety. Standardised treatment protocols with simplified regimens, together with improved staff performance, are resulting in an increased number of patients who return to a normal life after suffering cardiopulmonary arrest.

Is one-to-one nursing in intensive care always necessary?

Blair K, O'Connor C, Cumming A, Brown E, Howes R, McCormack E, Regan J, Tomlinson S, Kelly W, Matson H, Wilson J, Pilley H & Kakris A
Intensive Care Unit, St Vincent's Hospital, Melbourne, Victoria

Intensive care is characterised by a worsening worldwide shortage of critical care-trained nursing staff, funding and beds. At St Vincent's Hospital, Melbourne it became apparent that the blanket application of a one-to-one patient/nurse ratio in the intensive care unit (ICU) was not always the most efficient way of allocating nursing resources. In May 1996, the intensive care staff began a study to investigate and develop ideas for providing a more flexible patient/nurse ratio in the unit.

The aims of the study were to:

- investigate current Australian practice in nursing allocation;