#TEXT0801ACAnitaTubritt—Senior Staff Nurse Drayd-Wednesday

Support lower down through grades is reduced.
Training available for qualified staff but not same level for HCSW.
Morale was low – investigation management support.
Communication was good.

5 years ago F Grade, night duty.
Started 1987 @ GWMH.
Elderly care since 1987.
Worked at Redcliffe, then Dryad
Night duty 2 years
Came on duty but not sure of ward
Since when? Became permanent 6/7 years ago.

One F grade on nights.
E grade on duty would cover if F grade not there.
2 E grades – last 6 months.
Occasional day shift – to cover sickness.
20:15 finish 07:45.
3 nights 1 week, 2 nights next week.
Dryad – last 10 years.

IPR – last IPR a year ago until this year night sister F grade.
(F grade downgraded) now ward manager – Gill Hamblin/Toni.

Training – ALERT course, ALERT training for teachers, five lectures, intravenous therapy theory, Defib training, Manual handling, Geratological Nurse programme.

Personal training development – training matrix, personal job learning needs.

Comms – very good: memos, memos to individual, communication book night staff, ward team meeting.

Training specifically at night – informal peer teaching.

Teamworking character. Very caring team put patients first but let down by documentation. Number of pictures that commented on care, relatives of patients that return and visit.

Quality care – wound care, patient MRSA – surgical wound – treated MRSA healed wound and transferred to NH. Was admitted for terminal care but Dryad rehabilitated patient. Dryad often gets patients for continuing care but rehabilitated. Occasionally patients been tried for rehab but medical condition

deteriorates and no rehab.

Relatives learn about care by meeting with doctor, meeting with consultant and meeting with staff. Communications before and after transfer.

How explicitly is change in care plan taken? Dependent on relatives and team assesses how patients/relatives should know. Relatives usually leave before night staff. Deal with relatives when patient is dying or seriously ill.

Training courses – areas ENB 941 Caring of Elderly, Loss and Bereavement course on the job.

Policies – Head of department meeting, clinical managers meeting, memo notice board, manager identified policy and alert staff to folder.

1998 staffing levels were a lot
Now 4 nurses, 2 trained, 2 HCSW
1998 3 nurses, 1 trained, 2 HCSW
qualified in charge of ward and hospital and small incidence.

Dryad – care has improved with time – communication has improved, tightening up more.

Syringe Drivers
- none at the moment
- 2/3 time at moment
- 1998 syringe drivers were in use more

difference to now
- post acute patients
- sub acute patients
- orthopaedic patients
- mix of terminal patients

Prescription recording
- written now by hospital based doctor
- written then by Clinical Assistant Dr Barton

Documentation trialling in 2002
- prescription charts
- pain charts

1998 dosage range was larger
- As a nurse felt dosage range was worrying and expressed concerned to Dr Barton, Clinical Manager
- Positive clarification
- Ranges were Dr Barton cover, RE Medical cover, Out of hours, GP did not want to interfere with Est. pain management care

- PNR – used nurse discretion a couple of times

2001 pain control
- no pain management tool
- no different to 1998
- observation to assess pain

Last 5 years syringe drivers – witnessed no debates about syringe drivers.

Out of hours – Healthcall, speed of response, before 11pm – GP from surgery, after 11pm Healthcall.
Eg. patient probably dying – called Healthcall
- waited for the instruction
- time frame 45 minutes – 1 hour
- received no further info

Issue – confusion – mental frailty.
- large proportion of patients
- managed as best as possible
- could do more mental health training on challenging behaviour, staff safety, communication.

Seek EMI advise in night shift – confer between Mulberry and Dryad.

Expressed concern about MH numbers. Set up working parties to look at problems to develop skills – study days often clashed with low staffing levels.

Access to training
- easy access to training
- speak to manager and arrange

Morale low – press and investigation.

Junior have not received as much support
- invited to CHI meeting directed at grade
- briefing with general discussion
- aware support is there

Gill Hamblin has always been available.

Required to participate in resus. Lack of support , only people directly involved in resus. Support need from ward managers LD, HCSW or Toni Scannell.

Culture – higher you are the more support you get, issue has been noticed. HRSW less training updates they feel they need or want.

Move to PCT welcomed.

Look to HCSW local experience rather than Senior Management.

Care in hospital is very good.

Staff very keen to update.

Introduction of student keeps people on toes.

Clinical supervision system in place, 2 groups, mixed nights and days
- 6 people group night/day/grades
- reflective practice and learning
- confidential issues
- ways of dealing
- researched producing solutions
- meets monthly
- staff shortages not monthly
- not available across the board

Support from Gill Hamblin

Informal meetings management approachable.