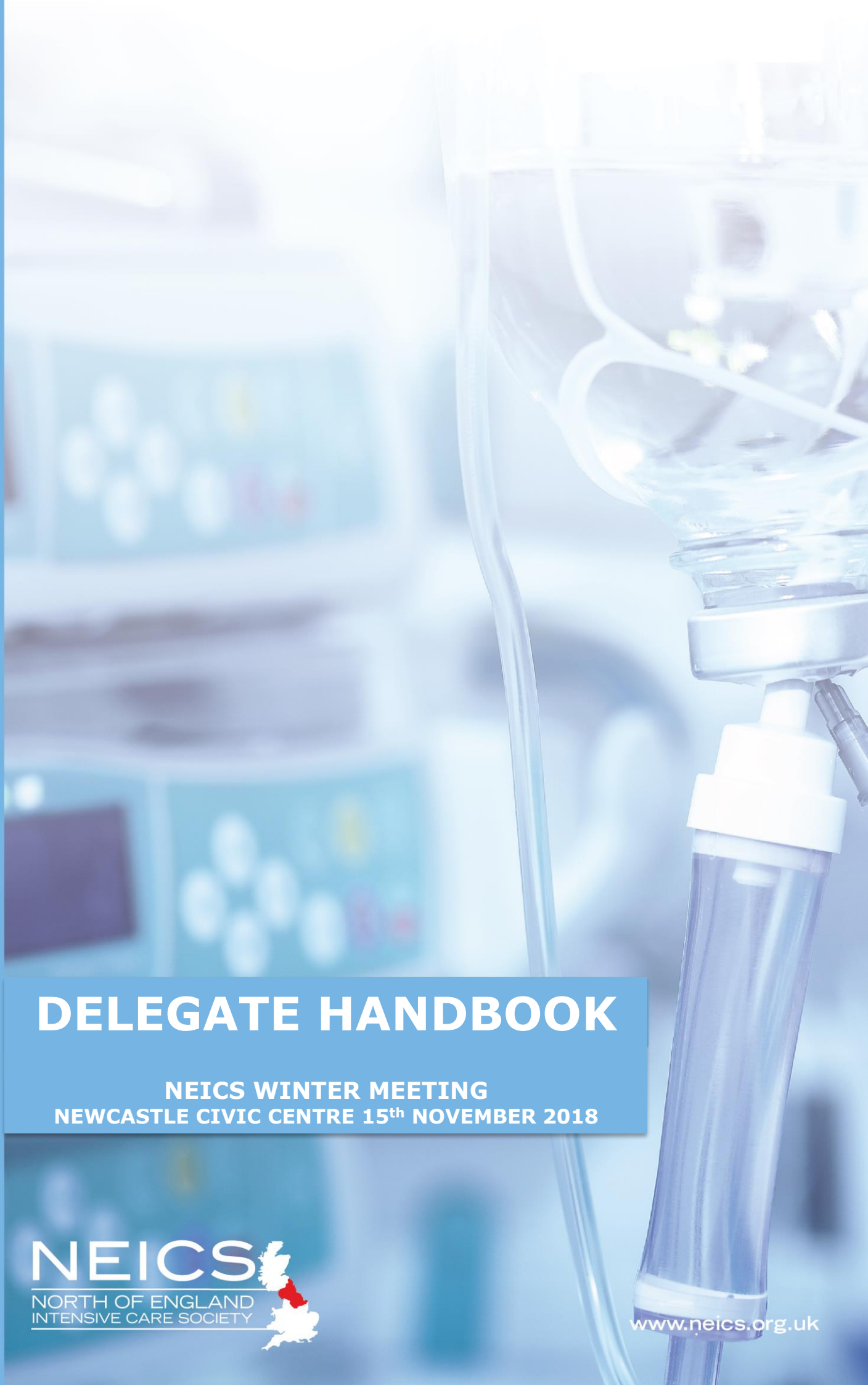
NORTH OF ENGLAND INTENSIVE CARE SOCIETY



DELEGATE HANDBOOK

NEICS WINTER MEETING
NEWCASTLE CIVIC CENTRE 15th NOVEMBER 2018

NEICS
NORTH OF ENGLAND
INTENSIVE CARE SOCIETY

www.neics.org.uk

Welcome to the North of England Intensive Care Society Winter 2018 Meeting

We extend a warm welcome to all delegates joining us for our Winter Meeting at Newcastle Civic Centre. As ever our society remains completely reliant on its members. Your continued support allows us to further develop the society as a platform for furthering high quality clinical practice and research in the North. The Spring and Winter Meetings are now well established events and the introduction of an Summer Evening Symposium at Lumley Castle last year was a great success.

This year's programme promises to be one of the most exciting to date. We are privileged to have some of the leading clinicians and academics in critical care sharing their latest work with us. Today we are also proud to exhibit the high caliber quality improvement and research achievements of our trainees and ACCPs here in the North East through the oral poster presentation competition. We continue to be strongly supported by our industry sponsors. Please take time to visit the trade stands during the breaks.

During the meeting please feel free to tweet us (@NEICS14; #NEICSWM18) and also visit our growing website (www.neics.org). We will be using the app Slido again to help ask questions after the success previous meetings.

We hope you enjoy the meeting.

Winter 2018 Meeting Organising Committee:

Dr Christian Frey
Committee Member

Dr. Chris Johnson
Committee Member

ACCP Alexandra Gatehouse
Non-Medical Representative

ACCP Sadie Diamond-Fox
Non-Medical Representative

Programme of Events

08:15-09:05	**Registration. Tea, Coffee and trade stands**	Banqueting hall
09:05-09:10	**Welcome and Introduction**	Dr Ian Nesbit NEICS President
09:10-09:50	**The pre-hospital response to the Manchester bombing**	Dr Theo Western MBE
09:50-10:30	**Northern Trauma Network and Trauma in the Trauma Unit**	Dr Laura Duffy
10:30-10:40	**Questions and discussion**	
10:40-11:10	**Refreshments and trade stands**	Banqueting hall
11:10-11:30	**5 Papers you need to know**	Dr Chris Johnson
11:30-12:10	**HECTOR Course/Silver Trauma**	Dr Charlotte Bates
12:10-12:20	**Questions and discussion**	
12:20-13:20	**Lunch and trade stands**	Banqueting hall
13:20-14:20	**Head injury rehabilitation and patient experience**	Helen Hastie and patient
14:20-15:00	**Trainee presentations**	
15:00-15:30	**Refreshments and trade stands**	Banqueting hall
15:30-16:00	**CBRN Incidents**	Dr. Chris Johnson
16:00-16:30	**Birling Gap CBRN incident**	Dr. Zeki Aztrelli
16:30-16:40	**Questions and Discussion**	
16:40-16:50	**Trainee Prizegiving and meeting close**	Dr Ian Nesbit NEICS President

Speaker Biographies & Abstracts

DR. THEO WESTON, MBE MBBS, DRCOG, MRCGP, Dip. IMC (Ed)

Dr Weston has been a GP in a Medical Practice in Penrith, Cumbria, since 1992 but retired from this Practice in June 2015 in order to spend more time being involved in pre-hospital emergency medical care work. He has worked as a HEMS Doctor with The Great North Air Ambulance Service for 15 years and has been a BASICS/Pre-Hospital Emergency Care responder/practitioner since 1993, attending regular medical emergencies (such as RTC's) in a voluntary capacity in North Cumbria.

Theo has been Chairman of BASICS Penrith (BEEP Fund Ltd.) for 23 years & of BASICS Northwest for 7 years. He has been a Medical Officer for the Patterdale Mountain Rescue Team, Cumbria, since 1993 & also a MERIT Doctor (Major Incident Silver Officer) for North West Ambulance Service for 5 years, attending six major incidents in/around Cumbria including the recent Manchester bombing. Dr. Weston was awarded the MBE for services to emergency care in the New Year's Honours List in January 2015.

Dr Weston's talk concerns "The pre-hospital response to the Manchester bombing". Unfortunately, with the threat of terrorism as well as day to day emergencies, Major Incidents are becoming all too common place. The specialty of pre-hospital emergency care has been developing rapidly in recent years and along with this has been the advancement of management techniques in dealing with Major Incidents. Ambulance Trusts now have an obligation to provide a robust emergency response to Major Incidents, which includes Doctors as part this response, and also that dovetails in with the other two main Emergency Services.

Theo's talk aims to give an insight into how recent developments in pre-hospital emergency care have advanced to give a more reliable & joined-up response when it comes to dealing with Major Incidents, whether terrorism related or not. To illustrate this, there will be a description a part of the medical response to the Manchester bombing in May 2017 played by Dr. Theo Weston and a couple of his colleagues who were called to this incident, including his personal reflections as well as a summary of the findings from the subsequent debriefs & official enquiry.

DR. LAURA DUFFY

Dr Laura Duffy is a consultant in Emergency Medicine at the Cumberland Infirmary Carlisle. She is an aircrew doctor for the Great North Air Ambulance Service and a medical officer in 201 (Northern) Field Hospital, British Army Reserve through which she has deployed to Iraq and Afghanistan giving her valuable hands on trauma experience. She serves as the clinical lead of the northern trauma network.

Laura lives in the lake district and has an active outdoor lifestyle. She can often be found on ski slopes all around the world and amongst other things she loves poetry, a glass of scotch and her dog Dexter.

Dr Duffy's talk focuses upon the northern trauma network which encompasses one of the largest areas of the country and a significant amount of trauma. It is at the cutting edge of innovation with its trauma bypass tool and app. Working in both the network management team as well as a trauma unit within the network gives Laura a valuable insight into the challenges faced managing trauma out with major trauma centres.

DR. CHRIS JOHNSON

Dr Chris Johnson is a consultant in anaesthetics and critical care medicine at the Royal Victoria Infirmary in Newcastle where he works on the neuro trauma ICU. He is an aircrew doctor for the Great North Air Ambulance Service, a medical officer in 201 (Northern) Field Hospital, British Army Reserve and an Associate Clinical Lecturer at Newcastle University.
He cultivates an interest in trauma care through these roles and has been involved with the provision of trauma care whilst deployed in Afghanistan and in resource poor settings in Sub-Saharan Africa.

Another of his roles within the military is as a member of the Joint CBRN Medical Faculty at the Defence CBRN Centre where he indulges his geeky side teaching on CBRN medical courses and helping to develop CBRN related guidelines and doctrine. He has lectured on CBRN medicine extensively within the UK as well as in the USA and Norway.

Chris will be delivering two talks at this year's winter meeting;

1. 5 papers you need to know – A traditional talk given at the NEICS winter meeting delivered by a recently appointed consultant. A slight variation on the theme including discussion of chest compressions in traumatic cardiac arrest, if we can safely treat traumatic pnemothoraces conservatively and what we should do about the incidental things we stumble across during trauma pan CTs.

2. CBRN Incidents – Chemical, Biological, Radiological and Nuclear weapons have been used in war for centuries and have become more prolific (and deadly) over the last 100 years. More and more they are a threat in the civilian world as well and whilst this talk won't make you an expert or cover the full spectrum it will hopefully make you think and keep the weird and wonderful in the back of your mind when you are back at work in the NHS.

DR. CHARLOTTE BATES

Dr Charlotte Bates having completed her first consultant post in Perth West Australia has been a consultant in the North East in Emergency Medicine since 2011 and was part of the team that opened the Northumbria Specialist Emergency Hospital. Having developed an interest in COTE early in her career, completing the Diploma in Geriatric medicine as a registrar and being involved in numerous GEM related QIPs she has continued this interest as a consultant. She is Geriatric lead for the ED, a member of the Trust Frailty Board and Older Person Trauma lead for the Northern Trauma Network, chairing the regional group for Older Person Trauma. More recently she has become one of the founder members of the GEM special interest group for RCEM and a member of the very recently formed HECTOR committee.

Charlotte's talk will present a recap on the current national picture regarding trauma in the older patients and the issues in terms of impact and changes required in assessment and management. There will be discussion around current work going on regionally and nationally, highlighting areas where further information required. Charlotte will also present an introduction to the HECTOR in the North course and the multidisciplinary learning opportunity available to those with an interest in this area.

HELEN HASTIE – HEAD INJURY NURSE SPECIALIST

Helen Hastie qualified in 1987 from the School of Nursing, Newcastle upon Tyne Hospitals. Her first Staff Nurse position was within the Neuroscience Department at the RVI. After two years, she travelled to Hong Kong where she worked in an American Missionary Hospital, before moving on to Australia where she worked for the Perth Nursing Agency, which included a month working in an Aboriginal Leper Colony, 'Numbala Nunga'. Helen then returned to Neurosciences in Newcastle and remains there to date, as the Head Injury Nurse Specialist. Her role is to support patients and their families following traumatic brain injury, ensuring that their patient pathway supports their rehabilitation needs.

DR. ZEKI ATESLI

Dr. Atesli is an Emergency Physician working as a Consultant in ED of Eastbourne DGH.

Zeki will be presenting the day's events how they unfolded and what we learnt from the incident of a toxic cloud involving a local Beach, Birling Gap in Eastbourne in August 2017. Dr. Astesli happened to be on duty on that day. The event was of national importance and the interest from the media was huge. Because of the unknown nature of the event and the fear that resulted, people presented themselves in large numbers, which was not anticipated. Patients presenting complaining of burning eyes, sore throat and nausea.

A major incident was called and the team had to carry out wet decontamination procedures as recommended by National Poison Centre. This was the biggest wet decontamination event recorded in the recent history of the UK. Still to this day the cause of the incident of this toxic cloud is unknown. In conclusion, Dr. Atesli would like to share his experiences with this major incident.

ACCEPTED ABSTRACTS FOR ORAL PRESENTATION AT THE NORTH OF ENGLAND INTENSIVE CARE SOCIETY WINTER MEETING 15TH NOVEMBER 2018

1. Pulmonary fibrosis and critical care: survival to discharge

D.Morris[1], I. Forrest[2]

[1] Speciality Doctor; [2]Consultant Respiratory Medicine, Royal Victoria Infirmary

Background:
Pulmonary fibrosis encompasses several conditions that can cause respiratory failure. Current national guidance only relates specifically to idiopathic pulmonary fibrosis (IPF), stating invasive ventilation should not be routinely offered, and that patients are counselled within 6 months of diagnosis on the poor outcomes from mechanical ventilation (1). This guidance is supported by several studies that show poor outcome in both invasive and non-invasive ventilation for respiratory failure specifically due to IPF (2-3). Current guidelines leave a gap in their advice for escalation decisions for patients with other forms of pulmonary fibrosis. In addition to this, new treatment options have developed in the long term management of IPF. The aim was to determine if patients admitted to critical care with a primary problem of respiratory failure due pulmonary fibrosis of any cause survived to discharge

Methods:
Discharge records for a general critical care unit (both high dependency and intensive are) were searched for any patients who had a discharge diagnosis of pulmonary fibrosis over a five-year period. 16 patients were identified. CT imaging reports were reviewed to clarify evidence of fibrotic lung disease. Discharge documentation was reviewed to establish if patients survived to discharge from hospital.

Results:
16 patients were identified; 14 had CT evidence consistent with either IPF, or unspecified widespread fibrosis, 1 of asbestosis, 1 of radiation fibrosis. Only one patient of the sixteen survived to discharge from hospital, a male with an IPF pattern who was not previously known to suffer from fibrotic lung disease.

Discussion
Escalation to critical care has a poor outcome for patients with life threatening respiratory failure due to pulmonary fibrosis. This should be considered when making escalation plans for patients with pulmonary fibrosis suffering respiratory failure. These results show poor prognosis is likely not simply limited to idiopathic pulmonary fibrosis. These results are limited by the fact that pulmonary fibrosis should normally be confirmed at an MDT, whereas for most of these patients the diagnosis rests on radiological findings.

References:
1. National Institute for Health and Care Excellence. Idiopathic pulmonary fibrosis in adults: diagnosis and management. [Internet]. [cited 10th October 2018]. Available from: https://www.nice.org.uk/guidance/cg163
2. Al-Hameed FM, Sharma S. Outcome of patients admitted to the intensive care unit for acute exacerbation of idiopathic pulmonary fibrosis. Canadian Respiratory Journal. 2004; 11(2):117-122.
3. Mollica C, Paone G, Conti V, Ceccarelli D, Schmid G, Mattia P et al. Mechanical ventilation in patients with end-stage idiopathic pulmonary fibrosis. Respiration; International Review of Thoracic Diseases. 2010; 79(3):209-215.

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2. HIC Clinical Indicator Testing in Critical Care

SKD Hamilton1, J Malkin2, C Dawson3

University Hospital North Durham, Country Durham and Darlington NHS Foundation Trust

[1]Core Trainee Anaesthetics [2]Consultant Microbiologist [3]Consultant Anaesthetics and Intensive Care Medicine

Background:

Human Immunodeficiency Virus (HIV) is a major concern in healthcare systems throughout the world. NICE NG60 recommends that the UK match HIV in Europe's guideline [1]. Many regions within the UK meet the prevalence threshold for universal HIV screening and there is growing interest in clinical indicator testing within Critical Care [2]. Whilst County Durham and Darlington has low HIV prevalence rates of 0.7 and 0.9 per 1000 respectively (compared to 2.31 per 1000 for England) the North East of England does have the highest rate of late HIV diagnosis (CD4 count <350cells/mm3) nationally. Our trust educates staff to offer HIV testing. A guideline is also being developed for the Emergency Department staff to encourage HIV testing in patients with clinical indicator conditions who are not admitted. We evaluated HIV testing in patients with clinical indicator conditions admitted to Critical Care at University Hospital of North Durham (UHND)

Methods:

Retrospective data was collected for all medical admissions to Critical Care, UHND, from December 2016 to December 2017. Admission, discharge and death dates were recorded. Primary and secondary diagnoses were captured and compared against national HIV testing guidelines. HIV testing was cross checked for those presenting with a clinical indicator condition. A testing guideline was produced in line with NICE NG60.

Results:

There were 305 medical admissions over the specified period. Of these, 59% were male and41% female with a mean age of 57 years. The average length of stay was 5 days. An indicator condition was present in 94 patients (31%). HIV testing was performed in 25 (27%) of these cases. Pneumonia was the clinical indicator condition in 78 (83%) patients. There has been an increase in HIV testing since work began. Numbers are, thus far, too small to allow robust statistical analysis.

Discussion:

A clinical indicator condition was identified in almost a third of the medical admissions to Critical Care (31%). Pneumonia was the most common clinical indicator condition (83%). An HIV test was sent in 27% of those with a clinical indicator condition. We confirmed that a significant proportion of our medical patients present with an HIV clinical indicator condition. This is in a region where late diagnosis of HIV is high. Patients diagnosed late in their disease have increased morbidity and mortality. We feel that improvements can be made to increase HIV testing in these patients. Some Critical Care units in the UK have begun to introduce HIV testing for patients admitted with severe pneumonia [3]. Our results were presented to the department and there was enthusiasm to introduce a HIV testing guideline. This guideline was been produced and introduced based on the HIV in Europe's guideline. We plan to re-evaluate our HIV testing in clinical indicator conditions after the guideline has been in use for 6 months.

Data collection is on-going and may be considered for future presentation and publication.

References:

1. National Institute for Health and Care Excellence (2016). "HIV testing: increasing uptake in those who may have undiagnosed HIV". NICE Guideline [NG60].
2. M Dodd, A Pyrce (2012). "A national survey of HIV testing in intensive care: moving forwards". Journal of the Intensive Care Society Vol 13, Issue 2, 136 – 139
3. R Sharvill, A Fernandes, K Allen, J Astin (2016). "Adopting universal testing for HIV in intensive care for patients admitted with severe pneumonia: results from our change in practice". Journal of STD & AIDS Vol 28, Issue 1, 88 - 90

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3. Procedural Sedation Practices in a Major Trauma Centre

B. Deeming, R.Mackie & P. Johnstone[2]
[1] Speciality Doctor; [2]Consultant Emergency Medicine, Royal Victoria Infirmary

Background:
The National RCEM Audit of Procedural Sedation in Adults in 2017-18 identified that Great North Trauma and Emergency Centre, Royal Victoria Infirmary, was far below the national average, and poorly compliant with the eight RCEM standards. Recommendations were made following this, including introduction of an ED Sedation Checklist Form and an ED Sedation Lead in August 2018. Given the potential risk to patient safety from the suboptimal provision of procedural sedation, we aimed to reassess GNTEC compliance with these key RCEM standards and see if these changes had resulted in improved practice.

Methods:
A retrospective case note review of all adult patients coded as receiving intravenous sedation, using the FirstNet system, during the period June to September 2018. After the exclusion of non-procedural sedation (cardiac arrest, rapid sequence induction), these were then interrogated against the RCEM standards.

Results:
18 patients received procedural sedation during the study period, 8 pre-introduction of the ED sedation checklist, and 10 after. The compliance with standards was poor in the pre-checklist group, mirroring the findings from the national RCEM audit, with 0% compliance with 3 of the 8 standards and an average of 20% compliance with standards. The post-checklist group demonstrated improved practise, with an average of 26% compliance with standards. Particular areas of improvement were in the percentage of sedations undertaken in Resus (60% vs 38%) and the presence of all three required members of staff (40% vs 12%). Only 2 sedation checklists were completed among the 10 patients in the post-checklist group.

Discussion
Despite the introduction of an ED Sedation Checklist, documentation of practises conforming with RCEM standards remains poor, as does the uptake and use of the new checklist. In order to improve documented sedation practise we believe there is a need for departmental education on procedural sedation, as well as the importance of the ED Sedation Checklist as a tool for documenting compliance with RCEM standards. Given the relative infrequency of procedural sedation and variation in practice, particularly with drug selection, we also believe there is also significant value in the use of the checklist as an aide memoir for the non-anaesthetic sedating practitioner.

References
1. Johnstone, P. (2018) *Royal College of Emergency Medicine Procedural Sedation In Adults 2017-18 Audit Report*

4. A Quality Assurance Survey to Evaluate the Perceptions of the Multi-disciplinary team on the Role of the Advanced Critical Care Practitioner (ACCP)

J.Thomas1, S.Colling1 & M.Faulds2

ACCPs[1], Consultant Anaesthetist[2]: Critical Care Departments, Newcastle-Upon-Tyne Trust Hospitals, U.K.

Background:

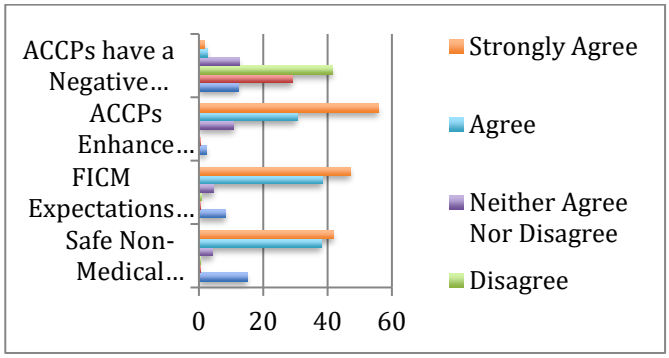
This was a single centred Quality Assurance Survey in two teaching hospitals evaluating the perceptions of the ACCP role across four adult Critical Care Units. The survey had three aims; 1.To assess that all current qualified ACCPs were working to the expectations of the role described by the Faculty of Intensive Care Medicine (FICM), 2. To evaluate whether the introduction of the ACCP role had a negative impact on medical trainee training and 3.To identify concerns or improvements that could be addressed.

Methods:

A total of 610 surveys were sent out through SurveyMonkey, to staff that predominantly worked in all Units. The survey consisted of both open and closed questions and was divided into eight sections; 1.Personal Attributes, 2.Communication, 3.Management, 4.Decision Making, 5.Support to Colleagues, 6.Clinical, 7.Non-Medical Prescribing, 8.General. Sections 1-7 covered the expectations of the role as defined by FICM. Section 7 covered all aspects of non – medical prescribing.

Results:

The graph below demonstrates the main findings, with the numbers representing percentages. There were 221 replies (response rate of 34%) but the group specific rates varied between 67% (pharmacists) and 24% (staff nurses). The open questions identified that the respondents perceived the ACCP role to be unclear.



Discussion:

In this survey the concerns that ACCPs would have a negative impact on medical training were perceived untrue by the majority of the respondents. Was this due to the way in which the role had been introduced into this Trust, and would a multi-centred survey have the same outcome? Many respondents described how the role was unclear, this related to ACCP function, development, limitations and expectations of the role. Does the role need clarification and a national scope/ framework of practice?

Acknowledgements:

There were limitations to the survey. This was a single centred survey only. The junior nursing staff equated to the largest staff member group but the lowest response rate therefore this may not represent a true reflection of opinions from this professional group. There were two expectations described by FICM not surveyed.

References:

Faculty of Intensive Care Medicine. Available at, www.ficm.ac.uk.

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Dates for your Diary

NEICS Spring Meeting
26th March 2019
Wynyard Hall

Summer Evening Symposium
June 2019
Lumley Castle

NEICS Winter Meeting
TBC

For further details & booking information please visit www.neics.org.uk

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