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Arise the Professional Nurse Advocate (PNA)

This year three ICU nurses at **Buckinghamshire Healthcare NHS Trust** were in the first cohort of Professional Nurse Advocates (PNAs) to be trained as part of CNO England, Ruth May's vision for nursing. In 2017 this clinical leadership role was introduced into midwifery (PMAs) and has achieved good results using the A-EQUIP model of supervision to support staff in being more effective and to flourish. We believe it can transform the entire philosophy of nursing and in addition help in the recovery of our staff and services from the challenges of 2020/21. It aims to sustain our workforce and enable it to grow through continuous improvements in practice.

Our PNAs have focused on different areas of personal interest which broadly encompass all the functions of the A-EQUIP model: **Ciara Wharton** in Training & Education and Wellbeing, **Dawn Barrios** in Civility and Diversity, and **Helen Gadsby**, in Quality Improvement through our 'Humanisation of ICU' Programme.

Amidst ongoing uncertainty for critical care services it has been difficult chartering into unknown territory with a new role. Involvement in both regional and national groups and networks is helping us to forge the way as well as create guidance for trust managers. We are achieving much but have struggled to set up Restorative Clinical Supervision (RCS) sessions due to the inability to release staff from clinical duties in such busy times. We have been raising awareness of the PNA role and what RCS is at every opportunity and speaking on numerous study days and meetings. Beginning with an introduction to RCS on foundation ICU nurses' study days we are embedding the right listening culture. We are assured that RCS will be given protected time and roles will be clearly defined as specified in new business plans. A valued workforce should begin with valuing and investing in the PNA role, this will go some way towards setting the culture for an influx of new staff. The sooner stakeholders work together, the sooner staff will have the benefit of this support. There should be no delay. In the meantime through the pure dedication of the PNAs they have begun some innovative developments which form an essential foundation for the programme finding momentum in our trust.

Critical care was the initial pilot area of the PNA Programme and it has developed at pace with 436 PNAs now in critical care across England. At BHT Critical Care we operate across 2 sites and in addition to the 3 PNAs trained, we now have 3 further PNAs in training. There will be 9000 PNAs across nursing in England by March 2022; an immense achievement of which all directors of nursing should be aware and embrace as the way forward.

There is further information about the PNA programme and the PNA role if you follow this link to NHS England:

https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate

Helen Gadsby - ‘Humanisation of ICU’ Programme

Across critical care the pandemic highlighted how dehumanising our work environment had become during surge capacity. This was not only terrible for patients but also for staff causing the highest sustained rates of moral injury, compassion fatigue and emotional exhaustion ever known in our profession. We decided to address this by setting up a 'Humanisation of ICU Programme' visiting different themes each month centred around the patient experience, respecting and valuing patients as human beings, and delivering person-centred care.

Our monthly themes have initially addressed how we communicate with our patients, appreciating what they perceive through their senses: What is the patient seeing? What is the patient hearing? etc. Future themes will focus on rehabilitation, excursions outside, sleep, communication, family involvement and beyond. We have ensured our humanisation actions are thoroughly evidence based. The whole MDT has been involved in making changes that improve patient care and recent literature has been analysed to guide our themes. We have used a dedicated MSTeams channel, a notice board, handovers and safety huddles to keep all team members informed.

To explain further here are some examples of things we gave renewed attention to and changes we made during 3 of the monthly themes:

July: Introductory theme - the essence of humanisation
We raised awareness of respect and dignity of/to individuals and how we talk and listen in building trusting relationships at every contact (handovers, ward rounds, clinician visits). ‘Patient First’ approach at bed spaces was promoted, also giving explanations, orientating, providing plans for the day, ‘what is happening' conversations for reassurance, listening including ‘What is important to you today?’ on ward rounds, and ‘This is me’ booklet to aid knowing the individual. We have focused on dialogue, active listening and have introduced some Appreciative Inquiry techniques in safety huddles and colleague check-ins.

August: What is the patient hearing?
We made the ICU soundscape a target for improvement and reduced the overall burden of noise, safely balancing alerts and interventions with a quiet and peaceful environment for patients’ sleep, enhanced recovery and overall experience. We highlighted the negative consequences of noise burden and how ICU Delirium is linked to outcome. As a result of technological advances dangerous decibels exist through proliferation of high frequency non-actionable alarms, and pandemic surges created noise chaos that contributed to stress for nurses to operate in. Authentic learning took place through simple exercises in understanding the burden of noise (‘shut your eyes and listen, what do you hear?’). Staff heard some powerful patient stories (from multiple sources) which valued the patient’s voice and experience in improving practice. Through differentiating between comforting sounds and frightening, unexpected and intrusive sounds we were able to implement noise reduction strategies: staff empowerment to prompt behaviour modifications, appropriate alarm adjustment to avoid alarm fatigue and unnecessary alarms, explanation of sounds to patients (what they may hear to provide meaning), quiet time (natural rest time 14:00 - 16:00) to restore circadian rhythm for long term patients, functional improvements (new bins ordered to eliminate banging), ‘Sound Ear’ meters installed to provide cues for taking action. Alongside we have been promoting comforting, calming sounds. We have made an inventory of our devices and are using applications for personalised communication and entertainment.

September: What is the patient seeing?

The opportunity was taken to emphasise the numerous negative visual effects of the ICU environment, eg losing day/night patterns, flashing lights/monitors/waveforms, seeing other patients in distress, no-one being familiar, staff in PPE, hallucinations and delusions. Natural light is now a design component for ICU environments and has been written into GPICS standards since 2019. We have little natural light in our ICU and have secured charitable funding for LED sky ceiling panels to be installed which will provide therapeutic administration of daylight through technology. They have the appearance of windows to the sky simulating outdoor light. We now have digital dementia clocks visible from all bed spaces and some that can display a stream of family photographs at individual bed areas. Staff are routinely using privacy/modesty signs (STOP THINK INTRODUCE WAIT) which are available to help prevent inappropriate invasion of the patient's space and provide shielding from unpleasant/frightening things. Staff have been acquiring more skills in connecting with families through video calling on devices and we have adjustable arms which attach at bedsides and hold devices for enabling ease of connection as staff continue their work. Family photos are encouraged and we have a scheme providing 'hearts for loved ones'; matching knitted hearts are given to the patient and the special people in their lives as symbols of connection in these times of restricted visiting. Initially this was for patients at end of life but it was felt to be useful for all patients at times of great worry. We refer to them during our video calling with families so they can visualise the symbol and feel closer. We also write patient diaries. A rehabilitation box is stocked with activities, magazines, games, puzzles including the book 'The Boy, the Mole, the Fox and the Horse' by Charlie Mackesy which can provide hope, wisdom and compassion.

These 3 monthly themes of our Humanisation of ICU Programme demonstrate examples of the multiple small steps taken, and how we are finding ways within practice to make things better. Much of what we do in ICU treats harm, not just the harm from illness. Critical Care Outreach and ICU Follow-up Teams support our patients post discharge and help them manage Post Intensive Care Syndrome (PICS). Proactive PNA prevention of harm in ICU with a Quality Improvement (QI) Humanisation Programme could negate the need for treating avoidable excessive harm during recovery. Similarly the response by trusts to staff burnout has been well-being packages and MH support. The PNA role can inject a proactive element in preventing well-being decline through clinical supervision and optimising the work environment for increased satisfaction with care delivery.

In this vein and through generous sponsors we have created a new and larger break room for staff. Having a space where we can pause, rest, recharge and congregate over a cuppa quite definitely has an impact on staff well-being and performance. Above all it is totally in keeping with our Humanisation of ICU Programme which ultimately benefits patients too. Through providing the optimal workplace environment and culture in which staff work, they can be more emotionally present to care for their patients. They can de-stress by finding a few moments for themselves and approach the rest of their shift with a clearer mind. Our PNAs have found that the different zones in this space have been conducive to beneficial interactions and encounters with individual team members. It is surprising what inner strength can be gained from a place of peace and positivity. We have a long way to go to truly recover our staff but these humanising actions have gone some way towards beginning that process.

The Humanisation of ICU programme is all about emphasising nurse patient synergy which depends on mutual respect. If we can provide psychological safety for all our staff, and deliver patient care that respects the person beneath the illness, we can achieve

multidimensional QI; an optimal workplace culture for job satisfaction and staff sustainability, and a humanising environment for recovery and improved outcomes for patients. These are initiatives that the PNA can promote to help them in their ambitions.