THE UNITED NORWICH HOSPITALS NURSES LEAGUE
EXECUTIVE COMMITTEE AND TRUSTEE MEMBERS

Charity Registration Number 290456

2005-06

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NOTICES

THE REUNION AND AGM ON SATURDAY, 13TH MAY, 2006

On May 13th 2006 the 76th Reunion of the United Norwich Hospitals Nurses League will be held at the Norfolk and Norwich University Hospital, Colney Lane, Norwich. From 10.30 a.m. onwards coffee will be served in the rooms adjoining the Benjamin Gooch Hall, East Atrium. Prior to the AGM and afternoon tea, the Chapel Service will commence at 2.00 p.m. in the Hospital Chapel. Would you please ensure that you let Miss Taylor know if you are planning to join us, as this will assist with catering and seating arrangements.

THE CHRISTMAS CAROL SERVICE

This will be discussed at the AGM – please see the Message from the President.

Editor's Report

It is a pleasure to introduce this edition of the Nurses League Journal which I hope will provide insights into the Norfolk and Norwich University Hospital of today, as well as some interesting and thought provoking articles from our members. An editor has to act on instinct and try to get a feel for where people are, what they want, and what might interest them. I hope I have gone some way to achieving this.

Thanks to the amazing technology of the internet I have been able to communicate with the staff at the hospital to provide you with an insight into the way the NHS is expanding. They willingly accepted the challenge I put to them, producing some very interesting articles. I am most grateful to them for the time they committed to this, despite all having extremely busy jobs. Also to my husband for the huge part he played in collating it all on disk for the printers.

Last year you may recall I said I looked forward to receiving all your contributions in the coming years. None arrived! The offer still stands for next year's journal!

Have a good year.

Lavinia Gordon-Gray

Journals

Interest has been expressed at the Archive Centre in our League Journals. Norma Goose has kindly passed her Journals that she has saved over the years. We believe that the first issue of The Journal was in 1930. At present I have issues from 1975, some in better condition than others, up to our last edition 2005. Have any members saved any copies preceding the above date that can be passed on to the Archives Centre at a later date?

Unfortunately due to family commitments I shall be unable to attend this year's Annual Reunion. Stevie Boyd has kindly agreed to display any photographs or material sent in for display purposes on the day. If you have anything you can share with other members please could you contact me on 01493 700256. If you have a small photograph I can take a copy and enlarge it for the decade books. I would need any material in good time please in order to get it ready for the display to pass on to Stevie.

Thank you for your help in the past and I look forward to hearing from you.

Margaret Allcock (nee Zipfel) Nov 1962 - Feb 1966.

Photographs

A member at the Archive Centre suggested it would be helpful to have any information put along side the photographs sent in for our decade books.

If you have sent in a photograph I would be grateful for any information to be placed with them. I have an example from Janet Hardingham which I am sure will bring back memories for our League members who worked at the United Norwich Hospitals during the Second World War. It also makes interesting reading for those nurses who did not experience the hard times. My thanks go to John Page who has entered last year's reunion pictures on disc, also Janet and Dorothy King who have submitted information to go with their photographs.

Margaret Allcock

A MESSAGE FROM THE PRESIDENT.

December 2005

Dear Members,

I feel that I should be writing this message in the New Year but our Editor wants her copy by Christmas and so I must comply. I am cutting it a little fine, as today is the 22nd December and I am relying on Royal Mail to deliver this to her tomorrow!

The Annual General Meeting and Reunion was well attended and we discussed at length the revised Trust Document.

We would like to see an increase in membership and also an increase in the number of members attending the Reunion, and at our meeting this year I asked that members should try to bring one other person along with them on May 13th 2006.

We hope to have Christine Baxter, Director of Nursing and Education at the hospital, as our speaker and we would like to have a full house for the occasion.

We held our Carol Service this year for the first time at the hospital and our thanks go to Rev. Chris Mallett and the hospital chaplain and his team for arranging the service and to Douglas Beattie who played the organ.

Again, your committee needs to know whether you wish to continue with the Carol Service which has become an annual event and another opportunity to meet up with old friends and colleagues. Please let us know how you feel and whether the hospital is the preferred venue for this service, whether you would prefer to revert to Princes Street United Reformed Church or would prefer another venue entirely. We really do need to know what the majority of you would prefer otherwise the committee have to make the decision.

We have this Christmas contacted some of our very elderly members and as well as the Christmas cheques that we send out on your behalf, members of the committee have visited them with gifts and these have been well received.

May I ask that if you are aware of any member in need, or who is very poorly, that you contact any of the Trustees (and you should all have a list from last year) then we can pursue any appropriate needs or requests.

We look forward to seeing you in May.

Sheilah Rengert

TREASURER'S REPORT

Year ending 31st March, 2005
Prepared by Miss Bee Taylor

AGM Chapel Collection May 14th 2005
The collection at this event raised £202.50 for the East Anglian Air Ambulance.

The Nurses League Carol Service 10th December 2005
A sum of £87 was donated at the Carol Service which was sent to the Salvation Army Soup Run.

Christmas gifts
Members who had trained at the Norfolk & Norwich Hospital prior to 1935 received gifts from the League at Christmas in 2005. £130 was spent on presents and £150 on cheques.

Trainee Biomedical Scientist in Pathology Laboratory (Haematology and Transfusion Specialism) at the Norfolk and Norwich University Hospital

What goes on in the Pathology Laboratory? What does a (Trainee) Biomedical Scientist (BMS) do? What happens to the blood samples that are sent to the Pathology Laboratory from within the hospital or from the GPs? How are the results generated?

Before I started work as a Trainee Biomedical Scientist in the Haematology and Transfusion section of the Pathology Laboratory at the Norfolk and Norwich University Hospital (NNUH) I didn't know very much about the vast number of different tests that can be carried out on blood samples. My knowledge was restricted to knowing that there were different bottles that were used to collect the blood samples, but this was from personal experience at having blood taken at my GP. Having completed a Bachelor of Science degree in Biochemistry I felt that I wanted to work in a hospital environment where there would be a 'human' element to my work, rather than work in industry, where things would be more 'abstract'. There was a job advert for trainee posts in the local paper: I applied and got accepted on the basis of my science degree. As I had had no formal haematology training the training started on-the-job, as well as travelling to university once a week to complete the final two years of a Bachelor of Science degree in Biomedical Science.

In this article I'll give a brief description of the role of BMSs, then I'll discuss how the Pathology Laboratory at the NNUH is split into the different departments and next will go on to describe the training I received to become a BMS.

Biomedical Scientists are responsible for carrying out the investigations on tissue and body fluids to diagnosis disease and monitor treatment of patients; in order to do this they work in close partnership with Doctors, Nurses and other Healthcare Professionals. Around 70 percent of diagnoses are based on pathology results.

The laboratory at the NNUH receives specimens from all the General Practitioners in the area as well as those from the wards and the outpatient clinics at the hospital. On average the laboratory receives around 3000 – 4000 samples a day, which equates to 11,000 to 12,000 sample bottles a day. Pathology is divided into several departments, including Cytopathology, Histopathology, Microbiology, Cytogenetics, Clinical Biochemistry and Haematology and Transfusion. Each department has their own core working hours, and in addition, Clinical Biochemistry and Haematology and Transfusion offer a round the clock 24 hours a day, 7 days a week, 365 days a year service.

Each of these Pathology departments may employ one or more Trainee BMSs at a time and have their own specific training schedule. Trainee BMSs are closely supervised by a fully qualified BMS at first, but, slowly become more independent at performing tests, although there are always fully qualified BMSs close at hand to answer any questions and to keep an eye on the Trainees. My training was mainly within the Haematology and Transfusion departments. The Haematology department carries out investigations related to morphology and physiology of blood. At the NNUH it is further divided into:

- Haematology automation and morphology
- Coagulation
- Immunology

To get an overview of the laboratory and the different tests, training started in the Specimen Reception section of the laboratory. This is where the bulk of the samples arrive in the laboratory. It is mainly staffed by Medical Laboratory Assistants (MLAs) who carry out the important initial roles of booking samples in on the laboratory computer system; requesting tests; cross-checking patient details on sample tubes and form; placing laboratory bar code labels on patient samples; and distributing the samples to the relevant laboratory departments.

This part of my training included learning what type of anti-coagulant (if any) was in the different sample tubes and what type of tube was needed for the different tests. The volume of certain samples is another important aspect, for example, the coagulation samples must contain the correct volume of blood as the ratio of blood to anti-coagulant in the sample tube is vital (due to the specific amount of coagulant that is added during testing to initiate sample clotting): if the ratio in the sample tube is wrong to start with the results will not reflect the true clotting picture of the patient and, consequently, the wrong treatment may be given or the wrong diagnosis may be made.

As a Trainee BMS I spent several months at a time in each of the Haematology, Coagulation and Immunology sections (as well as Transfusion) and completed several rotations per section. Each section has its own standard operating procedures (SOPs) detailing the theory, method and interpretation of results per test. On rotating between the different sections I found I could use the knowledge gained in the other sections to link in with what I was learning at the time. Each time I returned to a section I was encouraged to consolidate the techniques and theories I had learned previously and then build up further knowledge and skills in that area.

Immunology

In immunology I learned about, amongst other things, leukaemia diagnosis and monitoring of HIV patient's lymphocytes.

Haematology automation and morphology

In haematology automation I was taught about relevant reference ranges and I learned to recognise when I needed to make a blood film to allow morphological examination of the patient's blood to aid in diagnosis. In morphology I was taught to systematically examine and comment on the patient's white cells, red cells and platelets, as well as when to refer the results to a Consultant Haematologist.

Coagulation

In coagulation I was taught about: the different aspects of the coagulation cascade; the screening tests (PT and aPTT) carried out to determine the ability of a patient's blood to clot; the INR tests to monitor patient's warfarin therapy; and the tests carried out to detect and aid in diagnosis of any clotting abnormalities (e.g. systemic lupus erythematosus, haemophilia).

Transfusion

The Transfusion department provides blood and blood products to patients with acute blood loss, anaemia, road traffic accident victims, as well as leukaemia patients undergoing chemo- or radiotherapy. BMSs carry out tests to ensure that the blood issued is safe to be transfused. Tests include determination of blood group; detection and determination of any red cell antibodies in the patient's blood which may cause problems on transfusion of donated blood; selection of compatible blood and blood products; cross-

matching samples of donated blood against the patient's blood and; 'issuing' of suitable blood and blood products.

As a Trainee BMS my transfusion training started with checking and booking in of samples. The importance of correct sample labelling was emphasised to me as, especially in transfusion, if the sample is from the wrong patient any results and transfusions based on that sample may ultimately lead to the patient's death. Every sample that is sent to transfusion needs the patient's first name, surname, date of birth and hospital number as minimum identification and the laboratory staff cross-check every sample for correct spelling and information to ensure it matches the form sent with the sample and any previous details recorded in the Transfusion department's computer system relating to the patient. Once this has been done the sample and form are labelled with a laboratory barcode unique to that sample and the sample is then booked in for the required test.

All samples that have been requested for a 'group and save' and a 'cross-match' are tested to determine the patient's blood group, RhD type and are screened for red cell antibodies which may cause problems on transfusion. These tests are mainly automated, but BMSs can also perform them manually (e.g. in emergency situations). Initially I watched qualified BMSs carrying out the manual tests and then was able to perform them myself under supervision.

Throughout my training, Trainee BMSs were always encouraged to attend the various laboratory meetings and as Trainees we developed from merely listening and learning to giving presentations ourselves. Though presenting often seemed daunting at first, once the presentations were over I did see them as a good learning experience, and feedback (including tips on improvement!) from colleagues was always welcomed.

As a Trainee BMS I was required to complete a portfolio of evidence which was assessed by an external examiner at the end of my training period. The evidence for the portfolio was gathered throughout my training and included a range of things: from minutes of meetings I attended to evaluations of results that were outside the normal ranges and further tests needed on such samples.

I thoroughly enjoyed my training at the NNUH: learning about the different tests, the 'hands-on' laboratory work, as well as the linking of clinical information given to test results and the variability of the job. There is also the 'human' aspect of the job – although we don't always see the patient face-to-face in the laboratory, certain names become familiar and the 'ups' and 'downs' in the patients results can be traced; it is always good to see a patient's results returning back to within normal ranges once they have been successfully treated.

The laboratory is always willing to be asked for advice on samples – if the wrong sample is sent it will delay the availability of results and may lead to delay in treatment of the patient.

At the moment the Pathology Laboratory at the NNUH is undergoing re-development, however, when building work finishes if you're interested in finding out a bit more about the Pathology Laboratory services please arrange a lab visit via the laboratory's Service Manager Dianne Gibson 01603 286936, email: dianne.gibson@nnuh.nhs.uk .

Helen Aitken
Norfolk and Norwich University Hospital

CLINICAL CODING? WHAT'S THAT?

My name is Gail Hardingham and I have been a Clinical Coder for almost twelve years. In that time I have seen the department expand from a small number of coders to approximately twenty at the present time. Basically Clinical Coding is the department responsible for collecting data based on patient activity during a hospital stay. When I first worked at the Norfolk and Norwich hospital coding was referred to as HAA (Hospital Activity Analysis). It was a bit hit and miss; some notes made it to the department whilst others didn't. There were no targets or deadlines at that time; the data was collected for the World Health Organisation (WHO) and the Department of Health (DOH) for statistics and research. Although it is essentially an administrative role it also requires a basic knowledge of anatomy and physiology, which is what initially interested me in the role. It also stimulated my appetite to undertake and successfully complete a BSc Hons. in Health Studies.

With the arrival of GP Fund Holders (GPFHs) in the early 1990's the importance of Clinical Coding took on a whole new meaning. Accurate billing was required and coding data was used as the most effective means of costing treatment. From this time, even with a change of government and the end of GPFHs as such, coding has continued to play an important role particularly with regards to NHS budgeting. To date the implementation of Payment by Results is largely reliant on information generated by clinical coding. Payment by Results uses Health Resource Grouping (HRGs) and HRGs uses the codes allocated to an individual patient to calculate the time and resources used for a hospital stay.

So what exactly do we do? Coding is essentially the translation of written medical terminology into codes using the WHO International Classification of Diseases Volume 10 (ICD 10) for diagnoses, and for procedures the Office of Population Censuses and Surveys' Classification of Surgical Operations and Procedures (OPCS-4). Our role as coders is to ensure that we not only allocate the correct primary diagnosis and operation code but record any other factors that affect the patient's stay in hospital i.e. diabetes, hypertension or any chronic disease requiring ongoing medical treatment.

Each condition is allocated an individual code but the combination of codes helps to create a picture of the resources required throughout a hospital stay. If a patient has a postoperative complication, which requires a longer stay we can identify this by the codes used. Also, a patient admitted for a routine operation such as a laparoscopic cholecystectomy may be estimated to occupy a hospital bed for no longer than twenty four hours at a cost of £x, but if that patient has many other co-morbidities requiring extra nursing care and observations then the length of stay as well as the cost may rise significantly.

It can take up to two years to become a proficient coder, which involves in-house training and coding under supervision. We are fortunate to have an experienced trainer/auditor within the Norfolk and Norwich University Hospital (NNUH) trust to help trainee coders through the processes of understanding the coding guidelines as set out in a training manual which otherwise appears to be a very daunting set of instructions! On achieving a satisfactory level of competency it is now mandatory to take the national external

examination to become an Accredited Clinical Coder (ACC). The majority of coders at the NNUH are either qualified or striving towards becoming ACC qualified.

In a hospital the size of the NNUH approximately 15,500 consultant episodes are created each month (referred to as FCEs) which have to be coded. This figure includes patients transferred to a different consultant during an admission due to a change in speciality, so that a single patient may have numerous episodes (FCEs) during one admission. A patient's hospital case notes should, ideally, arrive in the coding office within twenty-four hours of discharge, along with a discharge summary completed by the relevant clinician. We are then able to check through the case notes to see if there is any extra relevant information to record. Although the discharge letters should state the primary diagnosis we are expected to extract any further relevant details not written on the form. We also rely on the notes to check that admission data on the computer system corresponds with that in the notes. On completion of coding the case notes are returned to the ward clerk for them to be passed onto the relevant secretaries.

Each month we have to run a report of all uncoded activity according to deadlines set by the finance department which involves an enormous amount of chasing around by support staff to try and find case notes and/or missing forms as well as chasing up junior doctors to complete the blank forms. When patients are discharged 'out of normal office hours' paperwork is not always completed and discharge letters may have been accidentally forwarded to community hospitals. As a last resort if we have access to patient notes it is a case of photocopying any typed information we can find so that we can code as accurately as possible to meet deadlines. It can be very frustrating as the doctors are often too busy to be harassed by us but, without the information from them, the coding may be inaccurate or missing and the Trust possibly may be underpaid for an episode of hospital care.

Some departments such as Oncology and Obstetrics also have their own stand-alone systems which one or two nominated coders may have access to. The Obstetric package is known as Protos and midwives are expected to complete all the relevant fields on a computer screen relating to delivery events. This may be easy for a straightforward birth but where intervention is necessary details of how and why need to be recorded onto the computer system. Protos then provides a summary sheet for use by coding instead of relying on hand written notes. Mostly this provides more accurate information but occasionally we still have to return queries (which must be very annoying for a busy midwife!).

We also have access to the histology system to look up results of tests such as biopsies so that we can allocate a more accurate code (i.e. the type of tumour). Similarly we can access the Accident and Emergency system to find out how and where an injury happened if we have not had access to the case notes. The more information we are provided with (or can find) makes the more accurate the total picture of the hospital admission becomes.

It is our mission at the present time to increase awareness about the role of Clinical Coding as it will ultimately not only make things easier for us but will benefit the whole trust. Increasingly we receive requests from clinicians at all levels to supply data on diagnoses and procedures within certain time periods. This information may be for research or for the clinician to check that our data is accurate.

The department is audited externally to see how we compare nationally with other trusts and to ensure that we achieve an acceptable level of accuracy. We are also audited internally every six months to check we are all coding consistently.
As future funding will be principally calculated using coding data it is an on going commitment to ensure that we accurately record all patient activity carried out within the trust. This will hopefully mean that before too long everyone will be familiar with Clinical Coding and its important role within the hospital.

Gail Hardingham ACC

MY JOURNEY TO INDIA

In August last year I had a wonderful opportunity to visit India. I believe it is true that one never knows what is in store for I would never have dreamed that one day I would find myself in Southern India.

Through my involvement as part of the chaplaincy volunteer team at the Norfolk and Norwich University Hospital I met Rev. Pat Atkinson and learnt of her charity in India. A team of eighteen of us spent two weeks visiting and working within the projects run by her charity—the Cooper Atkinson Charitable Trust for India.

My first sight of India as we emerged from the airport was as I imagined it would be. A throng of people, white taxis everywhere and no space between them. Every one was pushing and shoving, with porters only too eager to take our bags, and having to push one's way through. Two weeks later I left with many very precious memories, and I have to admit, I have left part of myself there in India.

There is a constant hustle and bustle, masses of people everywhere, the insufferable heat and dust, the noise. The traffic is manic, every man for himself and everyone sounding their horns as they overtake each other even on the wrong side of the road. We often travelled in the small yellow auto rickshaws, a real experience! –talk about closing one's eyes and saying the odd prayer or two. It was always with great relief to arrive at one's destination in one piece! We also ended up with numerous bruises for the side roads are mainly dirt tracks with the most enormous potholes. Who mentioned any suspension?? The main roads are tarmac but no pavements as such. There are cars, bicycles, cycle rickshaws, auto rickshaws, and motor bikes – often with women riding pillion side saddle wearing their colourful saris. There are open sided buses crammed to over flowing with people - men at the front and women at the back - and lorries, some beautifully decorated. Ox carts and hand carts too. All going at a rate of knots in one heaving mass and, as I said, everyman for himself!!

One thing that struck me immediately was the gentleness of the people we met. They seemed to have a quiet acceptance of what life dealt them, a dignity and a feeling of togetherness, of supporting one another. This was very evident in the slums of Mellawassal where we met, amongst others, several elderly ladies. Meeting the children was wonderful as they were so happy, greeting us with huge smiles and numerous hugs and so pleased to see us. They look upon each other as brothers and sisters which was a little confusing at first when being introduced to yet another 'brother' or 'sister'.

Meeting the two young children I sponsor I will never forget. The feel of their hand in mine, the smile they gave and the feeling of love between us. I will be there for them as long as they need me and as you can imagine I have left part of me in India with them both. Pramod, who is nine years old, is at the boys' home in Trivandrum where there are twenty children and a short distance away is a home for around the same number of girls. Manjuladevi, who is ten years old, lives in the Mellawassal slum in Maduria and attends school through the charity,. I was fortunate to see them both several times whilst I was there.

The main reason for going was to help with the projects. So where do we begin? Let us start with the school Vidiyal (New Dawn). This purpose built building, situated a little way from the centre of town in what appears at the moment to be rather like a wilderness,

was erected two years ago with a lot of blood, sweat and tears. It has a lovely garden and play area around it that was donated and done by another charity from England. Here the Montessori school takes place every day with approximately 44 children of 3-4 years of age. They all come in their special school uniforms and look adorable although, as we were to find out, they can be rather noisy and full of energy. Also within the building is a room set aside named Joseph's House where a few disabled children are cared for.

There are three other projects within the Mellawassal slum itself:-
The Sewing Project.
Working Boys Centre.
The Mellawassel Medical Centre.

The Sewing Project: here in a very small room tucked away within the slum are six treadle sewing machines which fit in with just enough space to sit by them. Here the girls are taught how to use them and to sew properly. When they are competent they are given a sewing machine by the charity so that they can earn a living.
Working Boys Centre; this was set up with monies given in memory of Diana Russell whose husband was with us. Here is a place for the boys to come at any time they wish when they are not working e.g. as house boys in hotels, or as street vendors. Here they can sleep, it has a toilet and washing facilities, and they can be together with others and be cared for.
The Mellawassel Medical Centre; this was opened by Pat when she last came to India in July 2005. This centre is mainly for the elderly. Within a small area was an examination couch which just fitted along one wall beneath a small window, a small desk and chair for the doctor, a chair for the patient, a small metal cabinet for the drugs and a few shelves on the wall. All the basics that are necessary are there with no frills. Here local doctors will give their time free on certain evenings during the week. Pat is hoping that they will be able to employ a nurse to visit the slum regularly to see the children who often suffer from worm infestation. These worms can grow to quite a size and can perforate the gut causing a painful death.

Since returning we have heard that over 35 people are seen at each session which means over one hundred people a week, people who previously had no health care at all. There is so much more that I could tell you, and I only wish that you too could have had this marvellous experience. I am very fortunate to be able to return, at Pat's request, in January next year - 2007.
The projects that Pat has set up both in Trivandrum and Madurai are a marvellous example of how one person's dream has become a reality. It is like a pebble being dropped into a pool - the ripples will continue to spread. The pebble may be small and the pool very large but, with many others doing the same thing, so many needy people will be helped to have a better quality of life. We have so much and they have so little.

Angela Pearce (née Beare 1960-63)

NEONATAL INTENSIVE CARE IN THE TWENTY FIRST CENTURY

The Neonatal Intensive Care Unit (NICU) can be found on Level Three, West Block of the Norfolk and Norwich University Hospital at Colney. It is part of the Obstetrics, Gynaecology and Paediatric Directorate. It has 28 cots but only 22 are currently open due to financial restraints. Around 700 sick and premature babies from Norfolk and beyond are cared for each year in the Intensive Care, High Dependency or Special Care areas of the Unit, including babies as small as 420g (approximately 15oz). Many babies are admitted because they are born prematurely from 23 – 36 weeks gestation, but others have a variety of medical and surgical conditions that require specialist intervention.

There is a dedicated team of Neonatal Consultants from both Medical and Surgical specialities. The Unit is part of a larger Neonatal Network, which includes Norfolk, Suffolk and Cambridgeshire. Within this Network, Addenbrooke's in Cambridge and the NNUH in Norwich are classed as Level 3 units which mean they care for the sickest and smallest of babies.

Most of the permanent staff, who are Registered nurses, have specialised 'neonatal' training. The Unit employs a Practice Development Nurse who is there to promote development of nursing practice and support all staff training on the Unit.

To assist the Registered nurses, Nursery nurses are also employed to care for those babies categorised as being in the Special Care area of the Unit. These nursery nurses have all been educated to the NNEB (National Nursery Examining Board) Nursery Nurse Qualification standard, and some have undertaken their level 3 NVQ (National Vocational Qualification).

This Special Care area of the NICU is 'Nurse led' and overseen by the Outreach Team. This Team, who are based at the NICU in Norwich also care for and support those babies who have progressed through the Unit and have been discharged home under their supervision. The team comprises two senior Sisters and a Staff Nurse and it is their responsibility to plan any discharges and make home visits up until they feel the baby and family no longer require their support.

Adult branch Student Nurses undertaking their training do not normally rotate to the NICU. It is only the Child branch or Midwifery Students who spend a few weeks there in a supernumerary role.

Newly appointed staff nurses wishing to specialise in neonatal nursing will work with a mentor or preceptor and progress through the Unit, learning to care for each category of baby. When it is felt appropriate they may be encouraged to apply to undertake the Neonatal Intensive Care Course. This is based at the Norfolk College of Nursing and Midwifery at the University of East Anglia. Previously the nearest available course was in Cambridge, but since September 2004 it has been accessible in Norwich. Once the course has been successfully completed, they can be considered competent to care for the very sick/intensive care babies and may apply for a higher band of salary.

INFORMATION: -THE NEONATAL INTENSIVE CARE COURSE

The duration of the Course for full time staff (37.5 hours per week) is 36 weeks and for part time staff (30 hours per week) is 45 weeks. This course consists of clinical practice, theoretical study and lectures/tutorials. The course can be accessed at Level 2 (Diploma) or Level 3 (Degree). The course itself accounts for 60 credits towards the Higher Award, the total number required for the Diploma or Degree being 120 credits.

The themes of the course are: -

- Physiological Principles and Theories of Pathogenesis
- Neuro-behavioural Development of the Fetus and Neonate
- Maternal Conditions that may have Impact on the Fetus and Neonate
- Nutrition and the Neonate
- Common Congenital Abnormalities
- Partnerships in Care
- Legal, Professional and Ethical Issues
- Contemporary Issues of Care

The Practice content of the course requires the student to demonstrate competence in practice by week 35 of the programme in all areas of care. Competence is assessed by reaching the required level of clinical skills, also via the Objective Structured Clinical Examination in week 35. This consists of a practical, an oral, and a multiple choice examination.

Theoretical assessment is via an Integrated Case Study which is a documented reflective account, demonstrating personal and professional development in respect of a single case, the number of words required depends at which level the student is working, (4000 words at Level 3 and 3000 words at Level 2).

Once the Neonatal Intensive Care Course has been completed, many Registered Nurses will spend the next few years gaining experience at this level on the Unit. However, some choose to enhance their practice even further to gain additional skills and allow them to improve their holistic care of the baby.

Previously, there was an Enhanced Neonatal Nursing Practice Course, in Norwich, but it was discontinued several years ago. Fortunately though, a new course has been set up and implemented, commencing in September 2005. This is a Certificated Course attracting 40 Credits at Level 3 (Degree level). It spans 24 weeks and is a combination of 12 contact theory days, 5 of which are e-learning, 12 self-directed study days, as well as clinical practice. This course is also accessed via the Norfolk College of Nursing and Midwifery at the University of East Anglia.

INFORMATION: - ENHANCED NEONATAL NURSING PRACTICE COURSE

The Themes of the course are: -

- Physiological Principles and Theories of Pathogenesis
- Legal Professional and Ethical Issues

- Contemporary Issues of Care
- Partnerships in Care

The Practice Content includes: -

- Interpretation of Blood Gases
- Changing Ventilation/Respiratory Support
- Stabilisation of the Sick Neonate
- Intravenous Cannulation
- Clinical Interpretation of Chest and Abdominal X-Rays
- Venepuncture
- Principles of Umbilical Catheter Insertion
- Initiation of Fluid Management

The Student will be assessed via a Case Study of 4000 words and an assessment of Clinical Practice outcomes. During this course the Medical staff act as supervisors/mentors and it is their responsibility to assess the student's competence/ability.

The Neonatal Intensive Care Unit in Norwich also provides access for all its Registered Nurses to attend a Neonatal Advanced Life Support Course (NLS) of one day's duration which teaches resuscitation of the newborn infant. This course is assessed by a practical and a multiple choice examination. It is also recommended for all Medical Staff and Midwives working on Delivery Floor. The course is usually held at the Queen Elizabeth Hospital at Kings Lynn, although it may be further afield at times.

Although these are the only neonatally specific courses available locally, there are other courses available nationwide which neonatal nurses may be able to attend if funding and staffing levels permit. These include: -

- Neonatal Stabilisation Course/Transport – Cambridge and Southampton
- Delivering a Modern Neonatal Service – London
- Changing Healthcare Practice to Improve Breastfeeding Rates – Bournemouth
- Baby Friendly Initiative Workshops – Dudley
- Annual Neonatal Study Day – Uxbridge
- Supporting Families of Premature or Sick Babies after Discharge from Hospital – Nottingham

A further course, which is available to very senior experienced staff and has to be accessed via a University other than Norwich, is the Neonatal Nurse Practitioner Course. This is often at Masters Level and is of one year's full time study/duration. When qualified the Neonatal Nurse Practitioner takes on the duties of a Junior Doctor, such as attending high risk deliveries, inserting central lines, undertaking intubation, performing lumbar punctures, inserting chest drains and umbilical arterial/venous catheters and more. Norwich NICU has recently funded a candidate for this course, and we also have two Neonatal Nurse Practitioners already working in this role on the Unit.

Often funding for some courses and additional expenses can be difficult to obtain and for this reason the NICU in Norwich has set up an Education Fund which raises money via donations to support nursing staff in their development of nursing practice. This fund, although not a charity, has a committee and a constitution and each application for funding is assessed on an individual basis. Recently it has funded two Neonatal

Nurses to undertake their dissertation module of their degree and provided a large collection of Neonatal Books for use on the Unit costing in excess of £1000.

The fund also always helps with study costs for all nurses undertaking the Neonatal Intensive Care Course, who receive £200 towards their expenses. Parents of babies that have been on the Unit are the main contributors to this fund but previously we have had fund raising events such as abseiling from the old Maternity Block Roof!

Overall care of the Neonate has advanced dramatically over the past decade and it is through continued study and practice that nursing care has developed to its present level. Many babies and parents are benefiting today because of this.

Pam Duffin and Stephanie Boyd

NVQ Training at the Norfolk & Norwich University Hospital NHS Trust

I commenced working at the Norfolk & Norwich Hospital more than 25 years ago. Like many of my colleagues who started at the same time, I had returned to work after my first child, in a completely different work role. My part time night duty role as a nursing auxiliary was my introduction to the caring profession. Working with trained nurses gave me a vast insight into the role of the nursing and it was one to which I felt I could belong. I achieved my Care Level 2 NVQ 10 years ago whilst working on one of the two gynaecological wards at the 'old' N & N Hospital on Brunswick Road, Norwich. I, like others who had achieved this award, enjoyed the extra knowledge and skills that the Care NVQ had taught us.

As employees gain qualifications it is usual that they feel the need to go on to achieve more. I was no exception to this, so when the pilot scheme for the Senior Health Care Assistant Role (SHCA) became available I had to explore this opportunity. The 2 year City College BTEC (Business and Technology Education Council) National Certificate in Health Sciences course alongside the multidisciplinary skills gained in the SHCA programme forms the basis for the SHCA role at the Norfolk & Norwich Hospital. The pilot scheme I registered for and completed was a great success for the hospital, which has since run six further programmes.

The NNUH skills escalator allows nursing auxiliaries more opportunities to develop and reach their potential, allowing them to proceed through Health & Social Care NVQ at Levels 2 and 3 then on to the Foundation Degree, a multi-disciplinary programme which has been developed from the BTEC National Certificate. Achieving the Foundation Degree can lead to an employee from the multi-disciplinary programme to go on to achievements in other areas, for example colleagues have gone on to Nurse Training and Physiotherapy Training via this route. Completion of both the BTEC/Foundation Degree and SHCA competency based programme has allowed the Trust to gain l year's Accreditation of Prior Learning for those accessing the Pre-Registration Nurse Education Programme at the University of East Anglia.

Once qualified as a SHCA I had the opportunity to mentor less experienced nursing auxiliaries and become a support to the trained staff. It also enabled me to be a named nurse to suitable clients, delegated from the Nurse in charge of my shift. I continued to develop practice skills applicable to my ward area. I also trained to become an NVQ Assessor for the Trust, both roles enabling me to support and develop both junior and less experienced ward colleagues. I enjoyed both roles immensely. My role of Care NVQ Assessor seemed to fit very well with the ward's forward thinking senior staff members, who encouraged and supported training and development within a very busy environment. The additional responsibilities which both roles allowed me, made me feel a very useful and valued member of the team.

I had one year's experience in my SHCA 'C' grade role, before applying for and obtaining the role of Care NVQ Facilitator to the Trust. As Care NVQ Facilitator, I co-ordinate the study programmes and arrange support to all the candidates registered through City & Guilds, an awarding body for the National Vocational Awards. Within my role I endeavour to ensure individuals meet the requirements of their roles and realise

their potential. This in turn helps to improve the delivery and efficiency in the service that clients receive.

What is an NVQ?

An NVQ is a certificate recognising achievement by an individual. NVQs in Care are based on National Occupational Standards agreed by the Health & Social Care sectors. It is a qualification that is based on the competence of an individual to carry out work practice. NVQs give credit for what people do in their work. This makes the qualifications real and relevant to employers and employees.

NVQ are very different from traditional qualifications in many ways. For example:

- There are no formal examinations
- NVQs can be gained in a variety of different ways
- They take account of previous experience
- They allow the individual to work and achieve at their own pace
- Assessment is undertaken in the workplace
- Each unit is a separate achievement and can be separately certificated

National Standards mean the NVQs are transferable to different workplaces.

Each NVQ is made up of a number of different units of competence. Each unit describes the standard of a broad area of work. A detailed description with each unit tells you what that unit covers. Each unit is broken down into a number of elements. Taken together the elements show what evidence is needed to prove competence before achieving the whole unit.

To gain one of the NVQs for Care awards you must complete and achieve the required number of units.

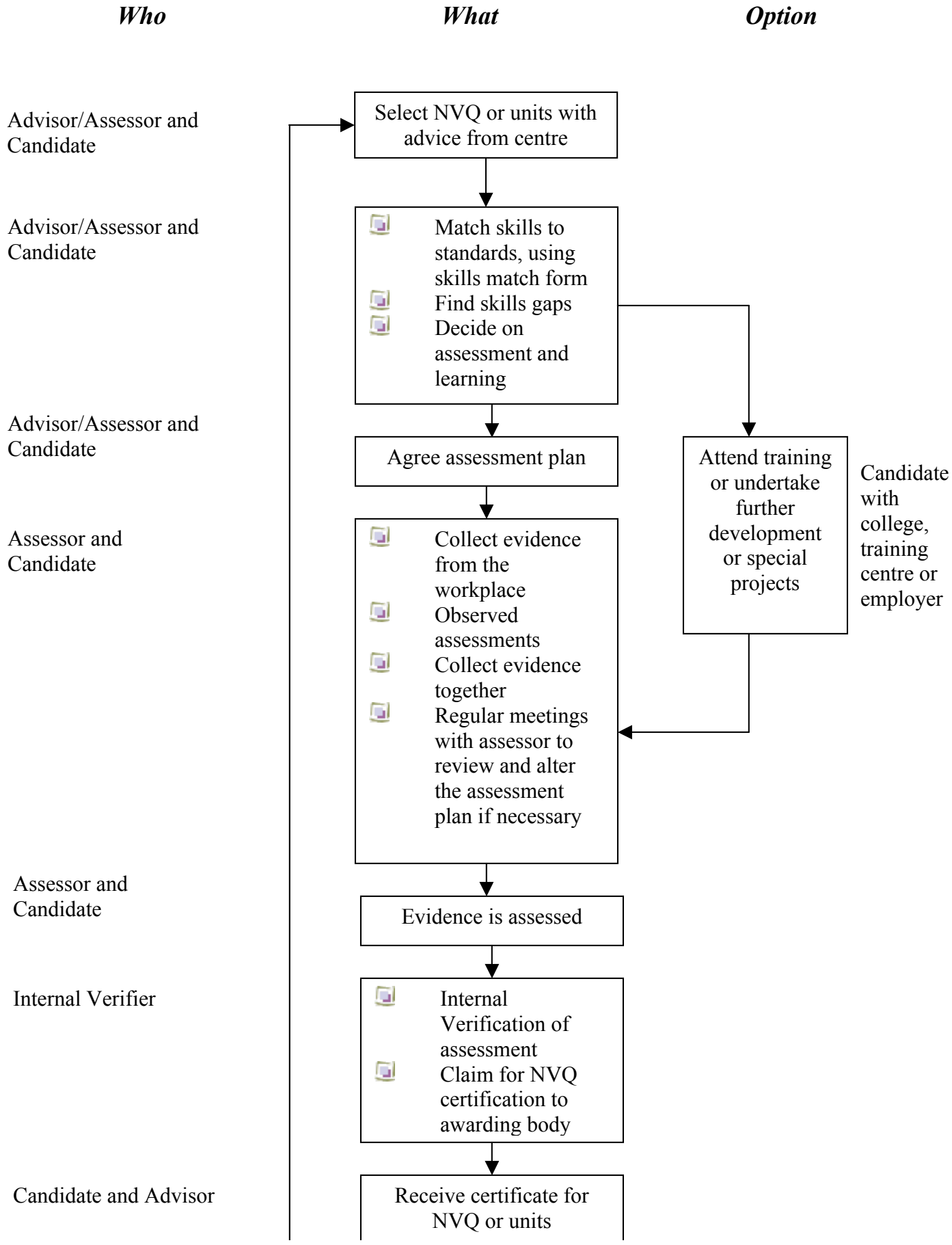
At level 2 (6 units), candidates need to show that they have good knowledge and understanding of an area of work and the skills to carry out a variety of tasks with some guidance or supervision.

At level 3 (8 units), candidates need to show that they can apply a range of knowledge, skills and understanding to their work independently.

Candidates can register for the qualification that fits the job they do without the need for previous exams or training. NVQs are structured to provide a ladder of progression according to the job responsibilities of people.

NVQs are concerned with assessing people at work. How they achieve that competence is not a factor of the qualification structure. Candidates can become competent through a mixture of work experience, company training or traditional courses. Employers have a greater choice of how they develop their workforce and are not combined to traditional methods.

HOW ARE NVQs ASSESSED?



The NVQ Centre at the NNUH has a responsibility to take care of all the administration of the candidate's NVQ. Centre staff ensure that all candidates are registered with City & Guilds for the qualification and that all certificates are applied for on completion. The Centre takes the candidates through an induction and initial assessment so that they are clear about how the whole NVQ assessment process will work, and the Centre also gives continuous support to the candidates throughout the completion of their award.
In summary, an NVQ gives students the opportunity to build on their knowledge and experience, and helps them to develop the necessary skills for confident and competent care practice.

Joy Pepper

SHEILAH RENGERT.

I worked for many years as a health visitor and clinical nurse specialist for elderly people, a job I enjoyed immensely. I left the NHS in1998 and have done a variety of things since. I am now a member of a team of nurses that run the Meningitis Trust out-of-hours help line, a role that I find most rewarding. To be able to listen and advise parents, grandparents, students and others who have concerns about meningitis, and who call from all corners of the globe, is very satisfying. Meningitis can be absolutely devastating and to be able to access a sympathetic voice as opposed to a recorded message means a great deal to the people who call at any time of day or night.
Another involvement that I have, is as a member of the Royal College of Physicians Patient and Carer Network. The College has introduced this network as a way of involving patients and carers in the work of the College and they welcome people from all walks of life.
So you see that even if you are unable to continue to nurse physically, there is still a role for you out in the community and the knowledge and skills that you gained as a nurse can always be put to good use.

Sheilah Rengert.

Re-launch of Local Cleft Lip and Palate Group (C.L.A.P.A).

Sandra Ferguson - Sister in the Neonatal Intensive Care Unit, Norfolk & Norwich University Hospital

As Neonatal Sister at the Norfolk and Norwich Neonatal Intensive Care Unit (N.I.C.U), part of my role has involved me with care of cleft lip and palate babies and their families. Over many years, this involvement has gained me experience and given me a special interest in their care. Until this year my role has been to counsel and give support to these parents antenatally and give them much needed help with feeding once the baby has been born.

Many changes have taken place with Cleft Lip and Palate Services. Centralised centres have been set up around the country with a hub and spoke arrangement. In the Eastern area babies born at the Norfolk and Norwich now go to the hub at Addenbrooke's, Cambridge, for their surgery. We at Norwich provide the spoke service, carrying out specialised services such as Speech Therapy, ENT, and Orthodontics locally.

During the time of these changes two of the parents approached me to see if we could re-launch a support group in the Norwich area. After discussions with them and head office in London we started to have some meetings with just the three of us. Some money was raised for us, with which we were able to purchase some special feeding bottles and breast pumps for loan locally. We have only just started to get established and although there is a long way to go, we are proud of our first achievements.

In September this year, with the money fundraised, we were also able to invite families around the Eastern area to a fun day at the Dinosaur Park and to provide a wonderful picnic! It was a lovely day thoroughly enjoyed by all. My crowning moment was to see each little family arrive with their beautiful children. The brave journey of these families often continues for many years so all the support we can give helps very much. I am so pleased that the collection at this year's Nurses' League AGM 2006 will go to help these children and their families locally.

Janet Hardingham

30.9.1938 – 1941	Trained at Norfolk and Norwich Hospital
10.6.1942	State Registered Nurse by Examination
1942 – 1943	Staff Nurse Norfolk and Norwich Hospital
June to December 1943	Midwifery Training at Queen Charlottes' Hospital London.
January 1944 – 1946	Staff Nurse Midwifery Wards Drayton Emergency Hospital
1946 – 1947	Assistant Night Sister Norfolk and Norwich Hospital
1947 – 1967	Casualty Sister Norfolk and Norwich Hospital
1967 – 1980	Practice Nurse at Drs Brittain and Watkins Surgery Norwich

The Best Laid Plans

In 1942, having finished training, I was a Staff Nurse on a men's surgical ward. My best friend and I had adjoining bedrooms on the second floor of the Leicester Nurses' Home. They had broad outside windowsills, surrounded by wrought-iron rails, ideal for a pot plant or two!

In the Spring of that year, we decided to grow a tomato plant. When we went home for our two days off per month, our mothers would send us back with goodies they could spare from their rations, such as a sponge cake or buns. On one occasion, my friend returned with a tin of salmon!! We decided to keep it until the tomatoes were ripe. The weeks passed by and it was June. Two of the tomatoes would be ready to eat in a day or two. We both had the coming Sunday evening off duty. Our plan was to save our butter ration, get some bread and have salmon and tomato for Sunday tea. The thought of it delighted us all week.

On the Friday evening of that week there was a Dance held at Drayton Village Hall. In the morning we went to Matron's Office to ask her permission to go. We were given a late pass. This meant we had to report back at 11pm.

After finishing the day's duty, we set off on our bicycles to Drayton. Returning home soon after 10pm, we heard the sounding of the Air Raid Siren. We pedalled as fast as we could when nearing the hospital, the drone of the German planes overhead could be heard. We rushed up to our rooms, changed into uniform as fast as we could, stopping for nothing.

In the event of Air Raids, senior nurses were instructed to go to their wards at night to help. Junior nurses had to grab a pillow and blanket from their beds and go to the basement. On this night the hospital was hit by Incendiary Bombs. Parts of it were on fire, including the Nurses' Home. All patients were evacuated and lined up in rows on the lawns outside, lying on stretchers or mattresses. By dawn the next day, all patients had been moved to other hospitals or housed elsewhere.

Tired and dishevelled, my friend and I stood on the grass below the Nurses' Home. We looked up to the shells of our burned out rooms. All we could see, propped against a contorted iron rail, was one overturned, empty, clay flower pot!

Practice Development in Midwifery

The concept of practice development means many things to many people. To start with, it is mandatory! The Nursing and Midwifery Council's requirements for Post Registration Education and Practice (PREP) ensure nurses, midwives and health visitors receive a mandatory five days (or 35 hours) training every three years. This is supported by a continuing professional development standard in which registered nurses, midwives and health visitors are required to undertake a demonstrable process of continuing professional development. To meet this standard, the evidence to support professional growth and learning is collected in a personal professional profile. Compliance with these standards is mandatory for the maintenance of registration.

The purpose of this standard and of the role of practice development midwife is to achieve the best outcome for the patient. My role is to support individual midwives develop professionally and to develop midwifery practice locally. The development of professional growth on an individual level is a prerequisite to development of practice at a local level.

Midwives newly qualified have a period of preceptorship whereby they are supported to gain confidence and consolidate their training. Midwifery covers a number of defined clinical areas, for instance working on the postnatal ward is very different to working on delivery suite, however midwives are encouraged to rotate around these areas to maintain the full competence of a midwife. Support similar to the preceptee when working in a new clinical area is seen as an important part of my role for such midwives.

There is an increasing need for practice to be evidence-based and part of my role is to ensure I keep abreast of research findings and national guidance in practice relating to midwifery. A few years back I read a systematic review on the method and techniques of perineal suturing. The technique taught at our hospital did not reflect the recommendations following the review. Having sent my self off to be taught at another hospital I came back to teach the qualified staff the technique of continuous suturing. There is little professional risk associated with individual growth, however the development of practice at a local level can lead to some resistance. My plausibility in the clinical field and ability to convince through an evidence base is often my most powerful tool available when it comes to change in practice. All staff were very receptive (even though I got them to use Ox tongue to practice on!) and within a year staff were practising a technique that is evidence based.

It is very important in this role to be interested in teaching and the principle of life-long learning. However I need to be sensitive to the clinical situation and use my knowledge of the real world of time constraints and staffing difficulties. To cover training in dealing with anaphylaxis prior to the introduction of routine prophylactic antenatal Anti-D immunoglobulin I travelled out to the health centres to teach community staff. This was so successful that I now take community obstetric emergency training to these health centres where they are well attended by community midwives. Being creative in developing a successful learning environment and encouraging staff to acknowledge that opportunistic and informal learning is as valid as formalised teaching, I believe, helps generate a culture of learning.

The role involves working in partnership, not only with the midwives, but also health care assistants, obstetricians, women and outside agencies. Clinical Negligence

Scheme for Trusts (CNST) Maternity Clinical Risk Standard 5, regarding education and training for all staff in maternity departments, warranted that I worked closely with obstetricians to ensure that we met the high standard expected to successfully maintain Level 2. Multidisciplinary training is gaining popularity and I organise the emergency obstetric drills and skills sessions for the doctors and midwives. My interest in this area generated a request to write a chapter on post partum haemorrhage for a book titled 'Managing Childbirth Emergencies in Community Settings' which was published in 2005.

Expanding the role of a midwife has become necessary as doctors' hours have decreased requiring some traditional doctors' roles being taken up by midwives. The idea of selected midwives being trained in undertaking the examination of the newborn was initially met with some hesitation. However, following an audit that demonstrated midwives were as clinically effective as paediatricians in detecting abnormalities I shared the good practice of the Midwifery Neonatal Examiners through writing a journal article published in 'MIDWIVES' the official journal of the Royal College of Midwives.

An integral part of my role is maintaining my own clinical skills and being seen both as a teacher and a student. A healthy interest in my own professional development is important. I am at present undertaking a Masters in Health Science with the theme of continuing professional development at the UEA. Returning to the basics of maintaining continuing professional development for the Nursing and Midwifery Council, and preparation for the Knowledge Skills Framework, is the focus of a forthcoming study day in March, when I have joined forces with the paediatric practice development nurse in organising this day so that we can target all qualified nurses and midwives in Women and Children's Services at the Norfolk and Norwich University Hospital.

Maggie Bunting
Practice Development Midwife
Norfolk and Norwich University Hospital

IT CAN'T HAPPEN TO ME!

A new chapter in my life started in 1996 when I retired from my post as Matron of Kelling Hospital. Time at last to enjoy my garden, to help my ageing parents, for travel and to further my musical ability in accompanying many local vocalists and the ladies' choir 'Wings of Song'.

It is usually noticeable in retirement that people (especially those employed by the NHS) begin to look younger and take on a new lease of life - but not for me. I became increasingly tired and wondered if without a structure to my day (as dictated over 36 years as a nurse) I was beginning to fail.

A chance visit to my GP in June 2003 with a suspected broken toe (ever the clumsy one) found me relating how terribly tired I felt. Blood was rightly taken to investigate for anaemia. The next day however I was 'phoned by the surgery and told an immediate appointment had been made for me with the GP for the blood test results. I thought this strange as usually in a busy practice results were given over the 'phone and a prescription prepared for collection.

I went along to see the GP and was presented, not with anaemia, but with the possible diagnosis of leukaemia or Non Hodgkins Lymphoma!! Despite the raised white blood cell count I didn't believe him and questioned whether I'd been given somebody else's results.

Within a week I was referred to a consultant haematologist at the Norfolk and Norwich University Hospital. I took a nursing colleague with me who I hoped would ask the appropriate questions and retain information given to us, as I knew I would not be able to absorb or understand what I was being told.

Basically the consultant confirmed what the GP had said but wanted further tests for an accurate diagnosis. She was extremely direct. I pressed her for a prognosis and she told me there and then to go home and put my house in order and that I had a life expectancy of no more than 3 – 18 months!!

Those who know me will appreciate what a hard time I gave her. No one can like the giver of bad news. I questioned everything she said, remained convinced that the results were those of somebody else and asked for a second opinion.

On reflection I felt so sorry for the consultant who dealt with me and the situation so well – even though my appointment over-ran to take the time of the three following patients!

After the diagnosis we left the clinic and went to the restaurant to reflect and digest what I had been told. I was numb and had only taken in about 25% of what had been discussed. I broke down and wept openly whilst everybody looked on – there was simply nowhere to go for privacy or comfort.

During the next few months I had to come to terms with the awful truth. I had regular blood tests but active treatment didn't begin until six months after my diagnosis was confirmed as Non Hodgkins Lymphoma (Mantle Cell).

My friends and family, nursing and medical colleagues could not have been more supportive and this continues unfailingly. However, there has been a noticeable gap. Time is needed for my endless questions often which no human can answer. My nursing training and experience had not prepared me for this situation - it is so very different being on the 'other side of the fence'.

Having responded well to treatment I am now in remission and leading a relatively normal life (well, as normal as it can be for me). The medical and nursing care I have received in the Colney Centre has surpassed my expectations. One couldn't receive better care anywhere. The consultant whom I doubted, I now trust implicitly and look on as a friend as well as a wonderful professional. Certain nurses remember me from training and I'm sure relish getting their own back!!! (only joking)

In gratitude many patients are anxious to give something back for the care they have received. I surprised myself in feeling the same and am active in fund raising. A CD has been produced of my piano playing and has been sold in aid of the Lymphoma Association. A considerable amount of money has already been raised but if anybody is interested in buying a copy for £6, please ring me on 01603 270090. Together with friends we have raised over £10,000 for the Opening the Door Appeal for the Big C – Family Cancer and Information Support Centre.

The Support Centre will offer:

- A purpose built centre with relaxed and informal atmosphere
- Each portion of the centre to benefit from sunlight throughout the day
- Surrounded by gardens
- Central feature fireplace with comfortable seating
- Coffee/tea making facilities and seating areas
- Call in when you wish and take advantage of programmes on offer
- Disabled facilities

Had this centre been available to me it would have been wonderful. Instead of crying in a very public hospital restaurant the centre would have provided an environment to meet my needs following diagnosis. I can now see how it will benefit so many in the future.

So friends I'm still a 'troshing'. I've remained positive knowing that without hope nothing will be achieved. I'm determined to live and have already passed my 'sell-by' date.

The next chapter of my life is about to commence. I've come this far on a very painful journey – both emotionally and physically. I remain focused on recovery.

The path before me lies open so watch out – I'm still about!

Annette Jude

Dietetics Today

Katherine Paterson, Community Dietitian from the Norfolk & Norwich University Hospital NHS Trust takes a look at where Dietitians are currently working. She homes in on the Nutritional Support aspect of her role, providing us with some key background information. Her first stop, however, brings us to a vacancy for a newly qualified dietitian.

We have a friendly team of Dietitians working in specialities such as paediatrics, renal, HIV, critical care, oncology and community…This rotational post is an excellent opportunity for an enthusiastic Dietitian at the beginning of their career … in a large, state of the art hospital.

The Norfolk and Norwich University Hospital awaits applications from newly qualified Dietitians to fill a new vacancy. Recent dietetic graduates are scanning the NHS job pages to find appropriate employment in suitable locations. Choosing where to work follows 4 years at university for most undergraduates or 2 years postgraduate study for those with a degree already. Integral to either course is a period of dietetic practice which is essential for obtaining state registration in dietetics.

Once registered with the Health Professions Council, a Dietitian may become gainfully employed in the NHS. What better way to taste a variety of areas prior to specialising than to undertake a rotational post right at the start.

Wherever our prospective employee begins, the same principles apply. Our job is to translate the science of nutrition into everyday information about food. On an individual level, this means taking the nutritional information vital for a person's well being and making its application practical, palatable and understandable, whatever the speciality.

I have chosen to specialise in Community Dietetics. Two key areas for me are managing malnutrition in older people and artificial nutritional support for individuals requiring tube feeds. I work in the community in Norwich covering patients in the Community Hospital and the Specialist Neurological Rehabilitation Services. Much of my role involves training nursing staff and Social Service personnel in identifying and managing malnutrition.

Malnutrition, unlike obesity, receives little press attention and no government policy focus. However, a recent health economic report from the British Association of Parental and Enteral Nutrition tells us that the £7.3 billion cost of Malnutrition to the country is double that of the projected obesity cost. We know that malnourished individuals stay in hospital longer, succumb to infection more often, visit their GP on more occasions and require longer term care than individuals who are adequately nourished. More than 10% of people aged 65 years or over in the community are malnourished. One of the key problems is that malnutrition is not identified in the first place, therefore no treatment is initiated. Unlike Scotland, where it is mandatory to screen all new patients for malnutrition on admission to hospital, English hospitals have no obligation to do so.

However, the Community Hospitals in Central Norfolk have a good track record having had a nutrition screening tool in place for many years. My colleagues and I are

piloting a new screening tool in residential homes and in hospital wards. Previously, there have been different tools validated for different settings with different score systems. The beauty of the new tool, *MUST* – the Malnutrition Universal Screening Tool is that the same tool can be used in hospital or in the community with the same scoring system.

We have been teaching nurses and carers to perform measurements they may not have been used to doing in the past. For example, in order to find out Body Mass Index, a weight and a height are required. Obtaining someone's height who is unable to stand is somewhat difficult. However, there are other measurements such as ulna length from which height can be estimated. As well as the measurements, our training programme includes dietary guidelines for managing malnutrition once it has been identified. We have taken a *food first* approach to managing malnutrition, educating staff how to enrich foods to increase the energy and protein content before opting for supplement drinks. Items such as butter, cream, cheese and milk enriched with skimmed milk powder all feature on the shopping list for managing malnutrition. Our audit results have shown initial success using the new tool and guidelines on a rehabilitation ward at Norwich Community Hospital.

Some wards at the Norfolk & Norwich University Hospital are piloting it too. Increasingly, Dietitians from the acute unit are finding themselves working with us in the Community. As patients spend less time in hospital, so the services move with them. The number of patients requiring artificial nutrition support and living at home or in a nursing home has increased dramatically over the last 8 years since I qualified. I see patients who have had strokes or other brain injuries and are unable to swallow, requiring tube feeding.

The most common form of feeding tube used is a gastrostomy tube. In 1980 the Percutaneous Endoscopic Gastrostomy (PEG) tube was developed and this transformed the world of tube feeding. Performed under local anaesthetic, as opposed to general anaesthetic, the small plastic tube is inserted directly into the stomach through the abdominal wall. This feeding gastrostomy is a relatively safe and effective long term way of obtaining nutrition. The advantage of this type of gastrostomy is its discreteness and the ease with which it can be removed should a person's ability to swallow return. Fine tuning the volume and type of feed is part of my work, tailoring the amount to meet the nutritional requirements of the patient. Feed comes in bottles complete with all the essential nutrients and designed to go smoothly down the feeding tube.

Our new rotational Dietitian will take on some of these patients requiring PEG feed as part of the rotation. He or she will join the team of 40 in the department which is recognised for the training of pre-registered Dietitians. We look forward to appointing.

Reference

Elia M *et al.* The cost of disease related malnutrition in the UK and economic considerations for the use of oral nutritional supplements in adults. BAPEN 2005

An Insight into the Diverse Role of Pharmacy Services at the Norfolk and Norwich University Hospital

The Role of the Pharmacy Department:

Pharmacy Services at the Norfolk and Norwich University Hospital consists of around 110 members of staff including Pharmacists, Pharmacy Technicians, Assistant Technical Officers and Admin and Clerical staff.

The pharmacy is divided into 6 sections:

Dispensary: responsible for the dispensing of medicines for in-patients, discharges, out-patients and clinical trials.

Stores: responsible for the supply of stock medicines and bulk intravenous fluids to the wards.

[On average we dispense and supply approximately 2500 items a day in total between the Dispensary and Stores sections to the wards & departments at the NNUH and community hospitals].

Preparative Services prepares over 3500 items per month to the hospital and GP surgeries including chemotherapy, Total Parenteral Nutrition, CIVAS (central intravenous additive service), and various non-sterile items in the form of creams, ointments and suspensions.

Quality Services ensure quality is maintained at all times within the pharmacy, by the monitoring and quality assurance of the environment, raw materials and products made within preparative services.

Clinical Pharmacy service involves ensuring that all medicines prescribed within the hospital are safe and effective for the individual patient – it is carried out in each section within the Pharmacy, but most clinical work is done by the pharmacists working with the multidisciplinary teams on the wards. The pharmacists make about 2000 interventions/contributions to the pharmaceutical care of patients each month.

Medicines Information department answers enquires on any aspect of medicines use. The enquiries come from all health professionals including nurses, doctors, community pharmacists, midwives, GPs, and also from members of the public. The department answers about 200-300 enquires a month.

Recent changes have occurred in the way we manage medicines at ward level including the introduction of **'One–stop dispensing'**. This is a major change for nursing staff from the traditional drug trolley, and involves the patient's medication being stored in lockable bed-side lockers. The One Stop Dispensing Scheme ensures patients have a 28 day supply of all their medicines which are used during the hospital stay (administered by nursing staff) and taken home on discharge. Patients are encouraged to bring in their own medicines to use whilst they are in hospital too. The scheme has been shown to have several advantages including reduction in wastage of medicines through re-supply, allows nursing staff to have more time to communicate with their patients about their medication, facilitates faster discharge and most importantly has been shown to cut the number of drug administration errors and missed doses significantly. This system is managed by a pharmacy team consisting of a Pharmacist and Pharmacy Technician for each ward. The Pharmacist clinically checks all the charts and discharge letters, picking up drug interactions and checking the dosage and usage of medicines before supply can be initiated and answers medicine related queries from the patients as well as doctors and

nursing staff alike. The Pharmacy Technician will then assess the patient's own drugs and re label/order more where necessary.

Future developments planned for Pharmacy include the introduction of patient **'Self-medication'** on the wards where patients, after assessment, will be able to self-medicate from the bed-side lockers used for 'one-stop' dispensing. In addition, the pharmacy will be having an **'Automated dispensing system'** (or 'Robot') which will stream-line the dispensing process and allow the pharmacy staff to change their work systems to the benefit of the patients and staff.

There are many varied roles within the pharmacy team all requiring extensive **training and assessment**. Because of the changing face of healthcare in the NHS there is a need for all pharmacy staff to embrace new roles and responsibilities within the multidisciplinary team, but always with the assurance that all staff are competent to carry out these roles.

Training of Pharmacy Staff:

Assistant Technical Officers support the Pharmacy Technicians and Pharmacists in every section of pharmacy. They are trained to NVQ (National Vocational Qualification) Level 2 in Pharmacy Services.

Training to become a **Pharmacy Technician** is in the form of an NVQ Level 3 in Pharmacy Services alongside an accredited underpinning knowledge programme such as the BTEC (Business and Technology Education Council) in Pharmacy Services or the VRQ (Vocationally Related Qualification) in Pharmacy Services. This involves spending 1 day per week at college to study for the underpinning knowledge qualification and the rest of the week at work for the practical training and collecting of evidence for the NVQ. The training takes 2 years to complete.

After initial qualification Pharmacy Technicians spend approximately 1 year consolidating their knowledge in the work place. Their roles include dispensing and supply of medication with the dispensary and stores and preparation and manufacturing with the preparative services section. At an appropriate stage they will carry out further training to take on roles with additional responsibilities. The first step is to undertake the Dispensing Accuracy Checking Accreditation Scheme. The completion of this scheme allows Pharmacy Technicians to final check dispensed medicines after someone else has carried out the dispensing process. Once a Pharmacy Technician has completed this training they can be accredited as a ward technician by following the Transcription of Medicines Accreditation Scheme to allow them to work with a pharmacist as part of the Trust's One Stop Dispensing Scheme on the wards. Pharmacy Technicians can develop their skills even further by undertaking the Patient Consultation Skills Course which on completion equips the Pharmacy Technician with the practical skills required to counsel patients on their medicines. Recently a Certificate in Medicines Management has been developed in this region primarily for ward based Pharmacy Technicians. This is a 1 year course teaching enhanced clinical skills and knowledge about a range of disease states and conditions including the skills required to read and use patient's medical notes to check drug histories.

Training to become a **Pharmacist** involves the completion of a 4-year Masters in Pharmacy degree course at university (UEA is now into its 3rd year of a brand new Pharmacy degree course). This is followed by a one-year Pre-Registration period in

practice and a professional exam, before becoming a qualified Pharmacist and a member of the Royal Pharmaceutical Society of Great Britain.

Once qualified and working in a hospital pharmacy, pharmacists will be part of a rotational training programme through the different sections of the pharmacy in order to consolidate and develop their learning from undergraduate level. Pharmacists work within all sections of the pharmacy department as senior and deputy mangers responsible for the day-to-day management and strategic development of the pharmacy service. In addition, the major role of the pharmacist is to ensure the safe, effective and cost-effective use of medicines throughout the Trust, and to manage the risk associated with medicines use. The major part of this Clinical Pharmacy service is carried out at patient level on the wards, where two teams of pharmacists from the department spend most of their time. Their varied role within Clinical Pharmacy includes drug history taking (to ensure patients are prescribed the correct drugs at the point of admission), prescription analysis and monitoring (to ensure safe and effective therapy for every patient), patient counselling (to ensure adherence to their regime) and acting as an information resource for the multidisciplinary team on the ward.

To support the above roles, most pharmacists will go on to complete a post graduate qualification in a relevant subject area e.g. Diploma in Clinical Pharmacy, MSc etc. This usually involves completing a two-year part-time course run by a university, and allows the pharmacist to develop advanced clinical skills to ensure the best possible pharmaceutical care for the patients. In addition a number of pharmacists are now completing a course to become Supplementary Prescribers, which is a new and developing role for pharmacists (and nurses!) within the Trust and will allow pharmacists to prescribe and manage drug therapy for patients according to specific clinical management plans.

Lucy Gough, Senior Pharmacy Technician, Education & Training
Catherine Heywood, Pharmacy Teacher Practitioner
Norfolk and Norwich University Hospital

OBITUARIES

Mrs. K. Abbott, née Mann 1931-34

Mrs Abbott was a loyal member of the League for very many years. Though unable to attend recent meetings and re-unions she was still interested in the League and appreciated receiving the Journal. Mrs Abbott died peacefully in June 2005 aged 94 years.

Mrs. Lucy Ellis, née Mallows 1926-29

Lucy was born in Northampton but grew up in Biggleswade Cambridgeshire. She chose to train at the N&N as her Grandparents lived in Scole near Diss. On completing her training she applied for a post with Overseas Nursing Association and was offered South America or Hong Kong. While working in Hong Kong she met

John Ellis, an Englishman, at the Bishop's House. He was an Accountant but working as a Journalist following a stay in Australia.

After taking leave in the UK she returned to Singapore where she married John in 1936 living there until just before WW11. They ran a guesthouse in Eccleston Square London during the war with Lucy working as a school nurse ('nits nurse' I was told). Afterwards they bought a farm in Wetherden near Stowmarket Suffolk living there for forty years where they brought up their two sons. Here they were very involved with their local church and enjoyed many trips to the USA visiting friends they had met through the military.

Both moved to Monmouth in 1985 for a late retirement. Lucy was widowed in 2001 but lived later with her son as her carer until she passed peacefully away in December 2005 aged 98 years.

She was, as far as we know, our oldest Member of the UNHNL and never tired of telling people of her happy days spent at the N&N.

Mrs. S.G. Grieve

Stella worked as a part-time Staff Nurse on the Male Orthopaedic Block (O.B.) for a number of years , later transferring to the Burns and Plastic Unit at the West Norwich Hospital where her husband Andrew was Head Porter.

A long-time League member, as was her daughter the late Susie Buckingham, Stella enjoyed attending meetings and carol services. Her funeral was well attended by ex-colleagues and League members.

Mrs. B.M. Mackway-Jones, née Clare 1943-46

All members will be sad to hear that Betty Mackway-Jones has died. An enthusiastic League member for many years she served on the Executive Committee giving invaluable support and help as Assistant Treasurer to Miss Taylor until recently.

Her nursing career included Midwifery, Health Visiting, and as a Practice Nurse at the U.E.A. In later years her own ill-health was a continuing and increasing problem.

Betty was proud and gratified that her son is Professor of Emergency Medicine at Manchester, and that her daughter is Sister, Day Procedure Theatre, Norfolk and Norwich University Hospital.

Mrs. Prudence Anne Page, née Hill 1962-65

Pru trained at the Norfolk & Norwich and then did her midwifery in Plymouth. She completed a course at East Grinstead and received a Diploma in Burns & Plastics. It was here she met John and they married in 1970. James was born in 1972 and Ben in 1976.

Pru did some private nursing and then worked as a Marie Curie Nurse from about 1986 until ill health forced her to retire in 1997.

She took on the editorship of the League journal before she retired from work and did a wonderful job as editor until 2004 when, despite being willing to continue, her illness forced her to give this up. She found it a lifeline and continued to enjoy writing letters and receiving and making telephone calls. She knew everything about everybody and made it her business to keep people in touch with each other.

For the past eighteen months she was completely bed bound and during this period she suffered several crises. She bore them all with great courage and fortitude and never ever complained of her lot. She always said she wanted to remain at home and John and Ben managed to care for her until an emergency on 2nd February necessitated hospital admission. Pru died on Dunstan Ward at the University Hospital on 4th February 2006.

She was an inspiration to us all and will be missed not only by her family but also by her many friends and colleagues.

Mr. J.G. (Ian) Taylor, V.R.D., F.R.C.S.

Members who worked within the Orthopaedic Department from the 1950's will remember Mr Taylor. As a Surgeon Lieutenant, later Commander, R.N.V.R he served with both the Atlantic and Artic convoys during the 2nd world War, maintaining his links with the Royal Naval Associations thereafter. Joining the orthopaedic team at the Norfolk & Norwich Hospital in 1954 as a consultant Mr Taylor was soon recognised to be a most diligent and conscientious member of this profession whose patients were of paramount importance.

Retiring in 1981 he was able to pursue the enjoyed with outdoor activities he enjoyed with his wife Fodhla (Dr Burnell) to whom we extend our sympathy and kind regards.

Miss M. Tompson 1942-45

Margaret, know to many as 'Tommy', was a pre-nursing student in her home town of Gorleston prior to joining a Norfolk & Norwich P.T.S. in 1942. Together with her fellow students she experienced many war-time difficulties, including a spell in the south of England before and after D-day until the arrival of the flying bombs meant a welcome return to their training school. During and after training 'Tommy' spent much time in Operating Theatres.

However she will be best remembered as working with Sister Tye on the Brunswick Road Private Ward and later as Sister-in-Charge. Demolition and rebuilding meant moving to the Colman Block. Later she became the Nursing Officer until retirement.

Major surgery in the 1970's did not diminish her caring and conscientious professionalism and she was highly thought of and respected by patients and staff. A League member since 1948 who gave loyal service on the Executive Committee for many years.