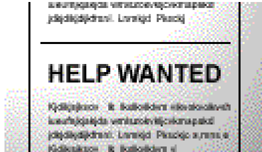
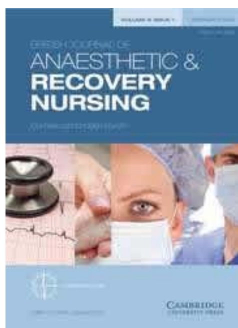
We wish you a very happy, healthy and prosperous New Year! Winter is truly here and the BARNA Committee are busy planning conference 2009, while looking at potential venues for 2010. If you would like to become part of the BARNA Committee or join one of the developing sub-committees, please contact us today! We have a variety of unique opportunities for colleagues to get involved and are eager for you to join us. Although serving on the BARNA Committee and/or sub-committees is a volunteer appointment, participation offers invaluable professional learning and development, and fantastic networking opportunities for all involved in the Association.



BJARN

The new *BJARN* edition is available on the CUP website. If you are registered with the Clinical Practice Forum you can access the *Journal* through the link on the Clinical Practice Forum main page. If you have not yet registered with the Clinical Practice Forum, please email



To comment or submit an article to the Journal, please email *BJARN* Editor Jess Inch. Submission guidance can be found on the BARNA Website.

We are currently seeking a highly motivated individual to join the Journal Editorial Team. This individual will be involved in preparing the *Journal* in conjunction with our Journal publisher. If interested, please contact the Journal Editor.

Lost in Cyberspace?

Following on from the BARNA Earth Day pledge made last year, we **would like to thank those members who have updated their email addresses** in order to support paperless communication and better environmental conservation efforts.

Unfortunately, some members have not updated personal contact information. Members with outdated information: do not receive the newsletter and must access this publication on the BARNA website, and do not have automatic Clinical Practice Forum membership (newsletters and Forum log-on details are sent by email to the address on record). To ensure that your contact details are current, please contact M&K with your membership number as the subject and provide updated information. ***Don't get lost in cyberspace - you will be missing out on some very important BARNA membership benefits!***

Patient Choice

How is your hospital performing? Are you being referred for treatment? Why not check out your own hospital and other local hospitals in your area? With the advent of Patient Choice, there is more emphasis on quality care and a cyberspace location for patients to leave comments and thoughts regarding the treatment received whilst in your hospital. Have a look to see how your hospital

compares. Some patient's comments make for a most interesting read!

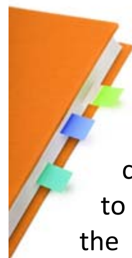
SAVE THE DATE!

BARNA Annual Conference: 5 June 2009

Conference planning is progressing quite well. We have had the opportunity to visit the venue. Devonport House is simply beautiful and has an interesting history. Word has it that this was one of the residences for nurses working at The Queen Elizabeth Hospital, Greenwich.

The conference venue is just a short walk from Greenwich train station, which is just 10-15 minutes from London Bridge Station. It is in close proximity to the Cutty Sark and Greenwich Park, among other things. There are plenty of hotels in the surrounding area. Why not make a weekend adventure out of your conference attendance? Take the opportunity to catch a show or just absorb the local atmosphere. Greenwich has three excellent markets. Our very own BARNA Treasurer, Markku, will be offering his local knowledge on what to see and do in Greenwich. Watch out for "Markkus' Must Sees" on page 3 & 4 of this newsletter!

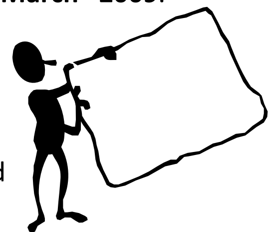
Competencies



There have been several requests to see copies of the competencies that were made available for comment at conference. In order for everyone to be able to view a sample section of the competencies, it has been decided to publish one formative and one summative section of the Airway Management competency in draft format at the end of this newsletter. If you have any comments regarding these competencies, we would like to hear from you. Please email Pat.

Conference Poster Competition

We are introducing a Poster competition at the 2009 BARNA Conference. **Poster abstracts should be submitted to BARNA electronically by 31st March 2009**.



The posters can be clinically based (i.e. educational, research based or audit based). Prizes will be awarded for the best posters.

IARNA Fall 2008 Conference

BARNA was again represented this year at the Irish Anaesthetic and Recovery Nurses Association (IARNA) Conference in Limerick. Committee members Manda Dunne, Jessica Inch and Joni Brady were on hand to participate in an excellent conference comprising a wide variety of topics and sessions, and together with attendees from several countries. This networking provides an excellent opportunity to improve and enhance national and international working relationships.

Irish, British and American nurses gathered together in Limerick, Ireland, for the October 2008IARNA Conference

Markkus' Must Sees!

Come to Greenwich to Tumble

If I would have used these words in the 19th century to invite a lady to join me for a trip to Greenwich she would have probably declined. This was not considered acceptable exercise for a lady.

It was one the most exciting forms of weekend fun you could still have in early Victorian times in Greenwich. Running down the Observatory Hill with ever increasing speed, loosing your balance and tumbling down the hill with your petticoats over your head, showing more than just your ankles was most risqué. This was an activity that men found most interesting to watch. Of course men also took part and enjoyed the ruff and tumble, not only the frequent beautiful views.

It was not just the lady's reputation that would take a few knocks, but this activity frequently resulted in fractures and even fatalities when people knocked into each other at high speed.

You might miss out if you don't come and stay in Greenwich, when you pop into BARNA Conference on 5th of June, as by 2012, the Olympic Games might have damaged our pride and joy, Royal Greenwich Park. They have decided to stage the equine events in the park and the local residents are concerned for the permanent damage that this might cause to the park. Also the horses might do a fair amount of dangerous tumbling themselves.

The hills are really what make Greenwich Park so unique. Fortunately they forgot to mention the hills to the French landscape designer André Le Nôtre so his design for flat lands resulted in quirky, but most beautiful vistas.

You can do what most tourists do and climb up the Observatory Hill to see the most breathtaking views of London. Nowadays the hill is protected by a low wall and some fencing in case you suddenly decide to loose all your sensibilities and throw yourself down the hill! If you decide to go there, please say hello to Rose, or preferably tell a joke to her. She lived in East Greenwich and she welcomed all the new comers to my home street. She was a larger than life character who liked company, refreshments and cigarettes in frequent quantities. Her ashes are just there in front of you.

General Wolfe's statue is just behind you and for a moment, look at the bomb damage in the plinth, a result of WW2 bombing. The same damage has long since been repaired in the old observatory.

Back to the magnificent views; my personal local resident's choice is what we call "the one tree hill", as it provides a more quiet view of London. Here you have a chance, after the climb, to rest your legs

on a long oak bench. Make sure you read the poem which is carved into the bench frieze. You find the hill just above the boating lake and the children's playground.

My Sunday walk usually continues to the Elizabeth I oak. The story goes that she played here as a child and even stopped to take refreshments inside the hollow trunk. The damaged tree finally fell over in some heavy rain in 1991, but it is still there, looking pretty sad, fenced off from the public. My walk continues to the formal flower gardens. Even if you do not care for gardens this takes you close to the deer park. Why don't you take the natural path that goes through the Azalea and Rhododendron bushes and at the end of the path? If you are lucky, there is a good view of these regal animals.

You now have to turn back on yourself and return to the formal gardens. At the other end the duck pond waits for you. This is a favourite place to bring children to feed the variety of birds, ducks and the numerous squirrels that you find here.

If you love gardens, you must continue your walk to the rose garden, which is just in the front of Ranger's house not far from the duck pond. Take another rest bite, sit down on a bench and take in all the colours and scents that the beautiful English roses offer you.

I have been lucky to live in Greenwich for most of my stay in England, so if you would like to know about shopping, eating out, entertainment, night life and places to visit in this area read my next instalment. By the time you come to the BARNA Conference in Greenwich on June 5th 2009, I can guarantee you will know the place like a local!

Important Message from Cambridge University Press:
***British Journal of Anaesthetic and Recovery Nursing* Online Registration**

Dear Member:
Are you aware of the benefits of activating your Cambridge Journals Online (CJO) account to access the *British Journal of Anaesthetic and Recovery Nursing*?

As a registered user on CJO, you can take advantage of the following features:

- Content alerts - Receive free email alerts to keep up-to-date with the latest research from BJARN
- Save searches and bookmarks - Save frequent searches and favourite articles and get instant access to the content that's most relevant to you. You can also ask us to run your searches periodically and email you the results
- Advanced online search facility
- PDF articles for easy reading and printing
- HTML articles for reference linking to Crossreff and PubMed

Activate your Account!
To activate your account, simply follow the instructions here:
http://journals.cambridge.org/BARNAactivation

Regards,

Sarah Sharpe
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Shaftesbury Road, Cambridge, CB2 8RU. UK
Tel: +44 (0)1223 325829, Fax: +44 (0)1223 325801
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Reports that Influence our Practice

- *Darzi Report*
- *Health Care Commission Report – Safer Management of Controlled Drugs*
- *NPSA – Clean Hands Saves Lives 2*
- *NPSA – Using NHS numbers on name bands to improve patient safety*
- *NPSA – Blood Transfusion Competency documents*
- NPSA – E-learning tools, a multitude of ideas and resources

What is the MHRA?

The MHRA – or Medicines and Healthcare products Regulatory Agency – was born out of the amalgamation of the Medical Devices Agency (MDA) and the Medicines Control Agency (MCA) into 2003.

The major function of the agency is to safeguard public health by ensuring that medicines and medical devices work properly and are safe to use.

No medicine or medical device is completely risk free, but the MHRA works to ensure that these risks are minimised by using good quality evidence in its regulatory and decision making processes.

The formal regulation of medical devices began in the mid 1990's. Prior to that there was a Scientific and Technical branch (STB) which worked to improve the quality and safety of medical equipment via a manufacturer's voluntary registration scheme.

During the 1980's the STB became part of the NHS Procurement Directorate which later split into the NHS Supplies Authority and Medical Devices Directorate. The Medical Devices Directorate became the MDA in 1994 and then in 2003 merged with the MCA to become what is now known as the Medicines and Healthcare products Regulatory Agency (MHRA).

As the regulator (or competent authority) in the UK, the MHRA transposes European Union directives for medical devices into UK law and ensures devices are acceptably safe and perform as intended when used in accordance with the manufacturer's instructions for use. The agency can also prosecute a manufacturer or distributor if the law has been broken.

So how does the MHRA monitor safety and quality?

The medical devices directives and UK regulations place a clear and mandatory reporting requirement upon medical devices manufacturers. This is known as the "vigilance system". Reports may be submitted to the MHRA by device users via this system too, if they meet the relevant criteria.

Investigation of reports identifies issues such as design faults, poor instructions, poor maintenance and incorrect use. We also investigate serious side-effects involving blood and blood products via our haemovigilance reporting scheme and medicines side effects via our yellow card reporting scheme.

We undertake regular inspections of good and safe practice which can include clinical trials, auditing of clinical inspection systems for devices and inspection of blood establishments.

We also review important new evidence on things such as implantable defibrillators and other new products and gather intelligence about illegally manufactured imported or counterfeit medical devices and medicines.

Healthcare professionals, patients, users and manufacturers can all report problems about devices via the MHRA adverse incident reporting scheme which is available through our website (**www.mhra.gov.uk**)

All these reports are risk assessed, investigated and acted upon according to the seriousness of the incident and/or the potential for future harm. The Agency has three main ways of dealing with this.

- We can issue a Medical Device Alert (MDA) giving advice to the health service;
- We can work with the manufacturer to develop changes in design or information;
- We can instigate a product recall.

In 2007 the MHRA received almost 9000 device reports as a result of which 106 MDA's were issued.

Does device reporting make a difference?

There have been numerous examples of how reporting a medical device problem has improved safety.

An expert group was brought together to look at the safety of breast implants and this resulted in certain types of implants being taken off the market. This information was posted on the MHRA website to help women considering breast enlargement to come to a decision about the safety of the implants.

Another example is that the MHRA was the first regulator in the world to pick up a problem with a particular heart valve after a UK surgeon raised concerns about its performance. This was subsequently investigated and the MHRA found the high complication rate was associated with a design fault and the manufacturer ultimately took the product off the market.

So how do you report a faulty device?

The easiest way to do this is to access the MHRA website (**www.mhra.gov.uk**) and when you do this you will open up the main MHRA page which will give lots of information about various work and alerts the Agency has published as well as instructions on how to report. Just highlight the relevant link and you are immediately directed to the appropriate page which you can then fill in like any other internet form.

Upon completion click on the submit button and this immediately comes into the MHRA who will then respond saying that it has been received and will keep you up to date on its progress.

Should you have any queries or questions about the regulatory process or how the MHRA works please feel free to contact us and we will help you in anyway that we can.

Christopher Earl RN, BA (Hons),
Nursing Advisor, MHRA
Tel: 020 7084 3128 E-mail: christopher.earl@mhra.gsi.gov.uk

British Anaesthetic & Recovery Nurses Association

CLINICAL COMPETENCIES IN POST ANAESTHETIC CARE NURSING : [FORMATIVE]

SYSTEM	AIRWAY / RESPIRATORY [4 SECTIONS]
SECTION 1	BASIC AIRWAY
LEVEL	ALL POST REGISTRATION PACU NURSES : KSF LEVEL 2
ASSESSMENT	SKILLS AND SUPPORTING EVIDENCE
TYPE	FORMATIVE PROCESS : ASSESSMENT

INTRODUCTION:

- **Basic Airway consists of 6 competency statements:**
    1. Evaluates risk of airway obstruction from knowledge of airway structure and function
    2. Evaluates risk of airway obstruction from knowledge of anaesthetic / surgical impact on normal airway function
    3. Performs basic airway assessment
    4. Recognises signs of airway obstruction
    5. Manages airway to prevent/correct obstruction
    6. Manages acute airway emergency

- The Formative grid may be adapted locally to include record of teaching / appraisals along the route to the final summative assessment. The formative process begins with a learning agreement where student and mentor set out a plan to complete the competency and is followed by informal teaching / supervised practice / testing. Prior to summative assessment it is helpful to have a ‘dress rehearsal’ to give student and mentor a chance to more formally assess the students readiness to proceed to summative assessment.

- A variety of methods should be used to teach and appraise students along this formative process. These should be designed to test students practical skills : understanding of scientific rationale for clinical intervention : clinical decision making : professional behaviour.

- Suggestions for formative preparation include :

    1. repeated demonstration of skill followed by supervised practice
    2. direct observation : how is the skill performed by student?

3. talk out loud – student rationales performance [practical interventions : clinical decisions taken]
4. mentor led : question and answer about performance : eliciting rationale
5. regular discussion between mentor : student on performance
6. theory testing : quiz : project work : talks : essay : written test
7. record of practice : log book
8. reflective exercises : looking back at a situation to make sense of it
9. patient follow through – along perioperative route

- As with the Summative Assessment document this template may be adapted locally for orientation programmes

BASIC AIRWAY 4 : Recognises signs of airway obstruction
FORMATIVE PROCESS :

KSF : Core skills & HWB5 / HWB6	**Formative process : theory taught / skill demonstrated : dates**	Student Assessment Date :	Mentor Assessment Date:
Recognises signs of obstruction : look listen feel assessment			
Looks for obstructive signs: • Patient supine : no adjunct • Unconscious/semi conscious • No cough : gag : swallow reflex • Deterioration in colour • Falling Sa02 • Limited/no misting on mask/T piece • Alteration in rate: depth of respiration • Irregular breathing pattern • Use of accessory muscles • Tracheal tug • Unstable CVS			
Listens for sounds of obstruction: • Snoring [tongue] • Gurgling [fluid] • Crowing [spasm] • Wheezing [bronchospasm] • Silence [total Obstruction]			
Feels for signs of obstruction:			

• Limited / no feel of air at mouth / nasal passages			

Basic airway 4 : underpinning theory

Identifies signs and symptoms of obstructed airway by assessment of look : listen : feel

- **<u>Looks for</u> :**
- Unconscious: semi-conscious state indicates that airway at risk if cough swallow and gag reflex have not returned
- Pallor – to cyanosis : pallor indicates poor perfusion of oxygen to tissues [may be due to primary failure of CVS] --- cyanosis is late stage of hypoxaemia when 3 grams of deoxygenated Hb existent
- Falling Sa02 : 95% is normal safe margin – any Sa02 below this must be questioned – i.e. due to primary airway disorder – breathing or both? Below 90% the Sa02 will fall off rapidly as decreased Pa02 fails to load oxygen molecule onto Hb
- Altered respiratory rate [alteration in the rate] tachypnea / bradypnoea may be associated with obstruction [falling rate below 8]
- Shallow depth of respiration : Insufficient TV may be associated with unconscious state [central respiratory depression] which will also put airway at risk.
- Irregular pattern of breathing : paradoxical breathing [see-saw] rocking pattern – a serious sign of obstruction as the patient attempts to suck air into the airway
- Use of accessory muscles : scalene & sternocleimastoids lift up the rib cage to facilitate air into the lungs : used in obstruction as patient struggle to pull in air
- Tracheal tug – base of neck : downward movement of trachea in nape of neck in struggle for breath
- Limited : no misting on mask : moist air diminished as seen on mask in obstruction
- Unstable CVS : if hypoxaemia sets in due to obstruction patient HR and BP increase to increase blood volume pumped round the body to make up for oxygen deficit. ECG may reveal myocardial irritability : ectopic beats

- **<u>Listens for obstructive breathing sounds</u>:**
- silence [complete obstruction] : if the airway is completely obstructed there will be no noise of breathing : this is first line emergency
- Snoring : noise caused by the tongue falling to the back of the oro-pharynx : may require jaw thrust : insertion of oro-pharyngeal airway
- Gurgling : clear fluid [saliva] or bleeding may obstruct the oral cavity – gurgling should alert the nurse
- Crowing [stridor] : signifies partially closed glottis : vocal cord irritation or swelling : can be first line emergency
- Wheezing ; signifies lower airway constriction as muscle of bronchioles are innervated by SNS

- **<u>Feel for breath:</u>**
- Limited or no feel of air at mouth/nostrils signifies obstruction to free passage of air

British Anaesthetic & Recovery Nurses Association

CLINICAL COMPETENCIES IN POST ANAESTHETIC CARE NURSING

[SUMMATIVE]

SYSTEM	AIRWAY / RESPIRATORY [4 SECTIONS]
SECTION 1	BASIC AIRWAY
LEVEL	ALL POST REGISTRATION PACU NURSES : KSF LEVEL 2
ASSESSMENT	SKILLS & SUPPORTING EVIDENCE
TYPE	SUMMATIVE ASSESSMENT

INTRODUCTION:

- BARNA clinical competencies relate to body systems : which are broken down into sections. Airway/Respiratory system is broken down into :
  1. **Basic airway**
  2. Basic respiratory
  3. Advanced airway/respiratory
  4. Specific airway/respiratory complications

  Basic airway consists of 6 competency statements :

  1. Evaluates risk of airway obstruction from knowledge of airway structure and function
  2. Evaluates risk of airway obstruction from knowledge of anaesthetic/surgical impact on normal airway structure and function
  3. Performs basic airway assessment
  4. Recognises signs of airway obstruction
  5. Manages airway to prevent/correct obstruction
  6. Manages critical airway emergency

- The competencies are mapped to the KSF [NHS Knowledge and Skills Framework : [www.dh.gov.uk]. The suggested level for new practitioners in PACU will be KSF level 2 for Basic Airway. KSF level 3 & 4 may be used for more experienced practitioners or for competencies requiring more complex skills : decision making : management

- The grid breaks down each competency statement into measurable criteria which can be individually assessed at the appropriate level [2,3,4] : a simple tick will suffice to demonstrate student safety in each criteria. Overall pass will be given when all criteria are ticked off

- Competencies combine skills : clinical decision making : underpinning theory to provide rationale for performance : professional attitudes. For each competency assessment the additional box for 'Assessors Comments' allow the assessor to comment on overall performance in the light of these skills and to comment on the level of expertise of the performer [over and above the ticked pass or fail].

- The document is designed for use with the accompanying formative document which duplicates the competencies and their breakdown into criteria – and allows room to document stages along the formative route leading up to summative assessment. Essential underpinning evidence appears alongside the formative grid structure.

- The document is designed for local units to adapt, incorporate into local orientation programmes as appropriate

BASIC AIRWAY 4 : Recognises signs of airway obstruction. SUMMATIVE ASSESSMENT

KSF : Core skills + HWB5 / HWB6	1	2	3	4	Assessors Signature	Date
Recognises signs of airway obstruction from look, listen, feel assessment :						
Looks for obstructive signs: • Considers patient position • Unconscious : semi-conscious state • No cough : gag : swallow reflex • Deterioration in colour • Falling Sa02 • Limited/no misting on mask / T piece • Alteration in rate and depth of respiration • Irregular breathing pattern • Use of accessory muscles • Tracheal tug • Unstable CVS						
Listens for sounds of obstruction: • Snoring [tongue] • Gurgling [fluid] • Crowing [spasm] • Wheezing [bronchospasm] • Silence [complete obstruction]						
Feels for signs of obstruction : • Limited / no feel of expired air at mouth / nasal passages						