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HEADLINES

When we were at the Conference in Leeds at Halloween Christmas seemed far enough away for me to have plenty of time to get all my jobs done.
As usual it has crept up on me and suddenly it's school concerts, parent evenings and parties to juggle trying to be in two places at the same time – oh and there's work – a minor consideration! Did I mention a husband?...

First of all I would like to say a very big thank you to Jim, Elaine, Natasha and all the team in Leeds for doing such a splendid job. In true BANN spirit I think a great time was had by all – and as usual more by some than others! It was good to see old faces and welcome new. The membership has certainly increased and some units that were members have returned to the fold which is excellent to see.

Joint working with BJNN has also brought in new members while at the same time increasing subscribers to the journal. I hope more people will feel inspired to write articles for BJNN. There are a variety of formats – they don't all have to be research articles. If anyone is interested please contact Liam Benison.

When I reflect on the number of BANN Conferences I've been to over the years I've always come away feeling inspired to do things, change things and convince my colleagues to do the same but unfortunately once back in the day to day slog that enthusiasm soon wanes...until the next time. I hope with the renewed energy within the Board, Unit representatives and new/renewed connections we can continue to make a significant contribution to the Neurosciences community in the years to come.

I wish you all a Merry Christmas and a Happy New Year.

Anne

Anne Preece
President BANN

Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

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REPORT ON THE BANN CONFERENCE LEEDS 2008

Heather Lyle Education Co-ordinator Western General Hospital Edinburgh

Heather has been sent £20 gift Voucher for her contribution to HEADLINES

Matron Elaine Andrews from Leeds chaired the first day and discussed what Leeds has to offer its nurses. This includes a well-developed 2-year introductory and rotational programme for all newly qualified nurses, a mini-neuro course, and a specialised 1-year Band 6 development course. They also run a neuro module at Leeds University.

The Chief Nurse Ruth Holt gave a talk on **patient's expectations** on coming to hospital and emphasised the need for all nurses to have a positive attitude, and all care be given with equality, dignity and respect for service users (www.rcn.org.uk/dignity). She highlighted the benefit of patient involvement and patient centred care. In Leeds, hand hygiene audit results are displayed throughout the wards, and regular surveys are undertaken via the Institute of Health Improvement.

Tracey Kershaw and Emma Jackson discussed the **centralisation of the neurosciences centre** at Leeds, with the amalgamation of various community and differing hospital based services into a purpose built unit (Jubilee Unit). Throughout the reprovision project they could work closely with the contractors to ensure there was sufficient planning of the new build to include design, ward layout, adequate storage, new equipment. Staff from the different hospital bases were rotated around so that in the new Jubilee Unit staff were already familiar with their colleagues and practices shared. The claim was that only 2 nurses resigned during the reprovision stages. I think that the robust education, competency, team building and support for the staff were a key to this; and also the KSF Agenda for Change programme.

A debate on **whether nurses should advocate the presence of solicitors on wards** was the next topic on the agenda. This was carried out between Jane Horton who is a lawyer specialising in brain and spinal cord injury claims; and Dr Bell a consultant anaesthetist. Jane emphasised the importance of early intervention of a solicitor to aid the speed and efficiency of accident investigation and compensation to release funding for the immediate and long term care of patients and families. Jane emphasised how nurses on the wards should be providing advice on local specialist solicitors. Jane debated on how solicitor and compensation claims could provide private rehabilitation to speed up referral to social care and provide funding for private therapy.
Dr Bell, on the other hand, felt there was no need for legal personnel on the ward; that advocating legal services with patients and relatives could lead

to a minefield of gross negligence, and medical misadventure claims as a result of postoperative complications etc. He feels that medical staff provide the best advise possible for end of life decision making, without the need for legal input. Arguments for and against solicitors were well contested but Dr Bell gained the majority of votes from the audience.

Ann Hurley is the Yorkshire regional Co-ordinator for **Headway**. Ann gave a very personal and moving recount of her experiences with Headway as a mother of a young adolescent who sustained a diffuse head injury and hemiplegia after falling off a moped whilst abroad. The talk was entitled "if I'd known then what I know now". In a very emotional way Ann discussed how we do not appreciate the limited knowledge that the public have of head injury, and how education and support of patients and family members is essential.
Ann discussed various areas in which nursing care for psychological needs of patients and more so families is neglected. What we as nurses see simply as a patient going on pass is such a trauma for families who do not appreciate the care required to look after these patients. It is only when the patient is home, that the families realise and understand the problems they will face.
Poor delivery of news
Poor discharge planning
Poor consultation with patients and families
Lack of co-ordination between services
General lack of knowledge into families coping mechanisms
Ann went on from being the mother of a head injured son, to providing support services through headway for others in similar situations, and now she is the co-ordinator of Headway in Yorkshire.
The whole topic was emotive and allowed nurses to think about their own practice and how much involvement we allow relatives to have in patient care, and how communication could be increased to break down barriers and provide a trusting relationship with the patient and family.

Alastair Bailey, a Brain Attack Clinical Specialist Nurse, discussed the **Setting Up of a Stroke Intervention Pathway**. Alastair discussed the importance of early treatment of thrombotic ischaemic strokes through thrombolysis.
TPA should be given within 3 hours of the patient's stroke – which includes paramedic involvement, transfer to a specialist hospital, and CT scanning to rule out haemorrhagic stroke. A typical patient loses 1.9 million neurons each minute in which stroke is left untreated.

We were very fortunate to have the presence of Professor Sir George Castledine at the conference. He emphasised the importance of **patient involvement and patient centred care** and his talk was extremely moving and emotive.

George showed a DVD that I will endeavour to get for the unit. It was a short film based on an anonymous poem that was found by the bed of a female patient on her discharge from a ward. It was entitled “What do you see nurse?” and was directed by Amanda Wareing. The poet had suffered a stroke and because she was aphasic following the stroke the poem allowed her to address the carers she had encountered during her inpatient stay. The carers talked over the patient, and could not remember her name. They were impatient at mealtimes and rarely gave her eye contact or sought to converse with her. All the carers could see was a mute, elderly bad tempered old lady; with staff not considering the previous life the lady had led. The DVD showed the poet’s family life, loves and losses.

What do you see, nurse... what do you see?
Are you thinking - when you look at me:
"A crabbed old woman, not very wise;
Uncertain of habit with far-away eyes,

Who dribbles her food and makes no reply
When you say in a loud voice 'I do wish you'd try.'"
Who seems not to notice the things that you do
And forever is losing a stocking or shoe;

Who, resisting or not, lets you do as you will
With bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
Then open your eyes, nurse.
You're not looking at me!

I'll tell you who I am as I sit here so still.
As I move at your bidding, eat at your will:
- I'm a small child of ten with a father and mother,
Brothers and sisters who love one another;
- A young girl of sixteen with wings on her feet,
Dreaming that soon a love she'll meet;
- A bride at twenty, my heart gives a leap,
Remembering the vows that I promised to keep;
- At twenty-five now I have young of my own
Who need me to build a secure, happy home.
- A woman of thirty, my young now grow fast.
Bound together with ties that should last.
- At forty, my young sons have grown up and gone,
But my man's beside me to see I don't mourn;
- At fifty once more babies play 'round my knee
Again we know children, my loved ones and me...

Dark days are upon me, my husband is dead.
I look at the future, I shudder with dread.
For my young are all rearing young of their own,
And I think of the years and the love that I've known.

I'm an old woman now, and nature is cruel.
'Tis her jest to make old age look like a fool.

Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

The body, it crumbles, grace
and vigor depart.
There is a stone where I once
had a heart.

But inside this old carcass a
young girl still dwells,
And now again my bittered heart
swells;
I remember the joys, I
remember the pain
and I'm loving and living life
over again;

I think of the years, all too
few, gone too fast
And accept the stark fact that
nothing can last;
So open your eyes, nurse, open
and see...
not a crabbed old woman.
Look closer... see me!

When I looked on the Internet I found this response in contrast:

NURSE'S RESPONSE TO CRABBIT OLD WOMAN
Author Unknown

What do we see, you ask, what
do we see?
Yes, we are thinking when looking
at thee!
We may seem to be hard when
we hurry and fuss,
But there's many of you, and
too few of us.

We would like far more time to
sit by you and talk,
To bath you and feed you and
help you to walk.
To hear of your lives and the
things you have done;
Your childhood, your husband,
your daughter, and your son.

But time is against us, there's
too much to do -
Patients too many, and nurses
too few.

We grieve when we see you so
sad and alone,
With nobody near you, no
friends of your own.
We feel all your pain, and know
of your fear
That nobody cares now your end
is so near.

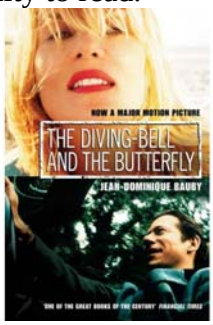
But nurses are people with
feelings as well,
And when we're together you'll
often hear tell
Of the dearest old Gran in the
very end bed,
And the lovely old Dad, and the
things that he said,
We speak with compassion and
love, and feel sad
When we think of your lives and
the joy that you've had.

When the time has arrived for
you to depart,
You leave us behind with an ache
in our heart.
When you sleep the long sleep,
no more worry or care,
There are other old people, and
we must be there.
So please understand if we hurry
and fuss -
There are many of you, and too
few of us.

What are your thoughts and feelings on this??????

George then discussed the book about a patient with locked-in syndrome, narrated solely through blinking - "The Diving Bell and the Butterfly" by Jean Dominic Bauber which the

majority of staff will have heard of but possibly not had the opportunity to read.



George listed the main <u>patient concerns</u> he had gathered through audit, questionnaires, own experience and discussions with patients/relatives:
Understanding of the situation
Information and guidance
Individualised personal care and consideration
Holistic and nurturing nursing
Compassionate and knowledgeable care
Relationship building
Dignity, respect and patient involvement

George highlighted <u>what we as nurses could do</u> to better address the above patient concerns:
Listen
Communicate
Get to know patients and relatives
Make time to care
Stop being task orientated and functional
Don't impose our values
Don't be bitchy – support your colleagues
Moaning achieves nothing – it instils negative attitude in others and yourself
Involve patients in communicating and decision making – don't hide behind monitors and machines – get into the habit of purposefully talking to patients and relatives
Impart our knowledge – also challenge practice and ask questions
Be advocate for patient
Have the right attitude
Smile!!!!
Know your own strengths and weaknesses
Work hard to do things well
Work with the patient – not for them
Role modelling – people judge you on what you say and what you do
Compliment patients and staff - positive reinforcement

Embolisation of aneurysms

– Dr Tony Goddard, Consultant Neuroradiologist
Dr Goddard showed us a variety of slides and x-rays to help us envisage the coiling procedure. He discussed timely intervention following sub-arachnoid haemorrhage.
He obtained statistics from the US that indicates that 1 in 10 die prior to reaching A+E. A further 50% die of complications arising from the SAH. There is a 5% risk of death and stroke peri-operative, and further risk of coil slippage post procedure. Peri-operative rupture has over 50% mortality.

Coiling aneurysms is to achieve "protection – not perfection". The aim is to minimise further risks of bleeding from the aneurysm. Stenting can occur concurrently with coiling and involves a stent being placed around the vessel walls to strengthen the vessel prior to coil insertion. This is particularly useful in broad necked aneurysms, where there is

increase risk of coil tails and slippage of the coil bundle.

Other complications include a coil tail breaking and occluding other vessels; vasospasm, hydrocephalus

Tony emphasised the need for aspirin, clopidogrel, and hypertensive therapy as indicated by the radiology team.
Other indications to protect the patient are renal functions tests (for post contrast), minimising relatives, pain management, and the avoidance of stress.

A one-stop care centre for **motor neurone disease** has been created in Leeds. Linda Tuttle is the MND Clinical Nurse Specialist and she described how the creation of a care centre for MND has brought together all the involved multi-disciplinary team to give increased patient centred care.
At the MND clinic there is representation from physio, speech therapist, dietician, MND care advisor, MND CNS, neuro-consultant, and palliative consultant. Due to the creation of the centralised service and clinics patients did not need to keep several appointments for differing specialist services that led to increased fatigue. Patients and carers attend once a month to receive ongoing support and education throughout their rapid disease progression.

Adam Tucker is a CN in rehabilitation. He described the process of **innovation and invention**; and encourages nurses of all backgrounds to enhance practice through innovation and invention of new equipment, etc. With this proactive talk there was also a great caution about what to do to prevent others stealing your ideas. If you have thought about a new piece of equipment, or another innovation in the field of nursing care, you should seek advice from the Innovation Property Protection and have a "property advisor" to work on your behalf. They can then see your invention through copyright, trademarks and patent processes. See ennovations.co.uk for more information. His main advice was to keep silent about your invention – don't tell anyone until the patent has been created- otherwise another company may steal your idea and you receive no credit for it. Your organisation and division will receive a percentage of sales, and therefore my be able to supply funding for introduction to the "Dragon's Den".

Workshop 1:**Understanding and adapting neuropsychological rehabilitation after head injury**. (Amanda Stroud – Consultant Clinical Neuropsychologist)

This workshop was very informative and practical and through our participation allowed us to explore our own perceptions of what it is like to be confused and have psychological and cognitive problems.

The class was spilt into 2 and each group had a scenario to role-

play. Group A were BANN conference nurses who had a hangover, had lost their purse and were trying to quickly check out the hotel prior to the start of the morning lectures. Group B had to role-play being at work in the ward and a patient was awoken from a 3 week coma and is now mobile and has Post Traumatic Amnesia.
Therefore what ensued was myself in Group A trying to find the hotel receptionist to check out, and the "receptionist" Group B couldn't help me and kept insisting I was in hospital. This caused a whole new set of confusion for me as the "patient". Telling me to sit and have a cup of tea only made me more frustrated.
We then as a whole group discussed what we were feeling: Frustration, patronised, "doesn't make sense", confused expectations

Successful cognitive and psychological neurorehab leads to an acceptance of change and allows clients to integrate into the wider social circle. Patients who become aware of their cognitive problems and gain insight into their reduced functioning can go through the grieving process – anger, denial…acceptance. With increased awareness often comes increased depression.

Rehabilitation includes using SMART objectives and short-term goals to work towards larger objectives.

Problems faced by patients with cognitive problems include problems in the following areas: Insight, memory, concentration, distraction, unsafe environment, institutionalism, inappropriate boundaries, inter-relationships, grieving, anger, safety awareness, depression, anxiety, euphoria.

Amanda discussed tools we could use on neuro wards to help with memory focused on memory rehabilitation. These include diary of events, signage around the ward, laminated date and location sheets at the bedside to re-emphasise orientation. All these tools could help you to guide the patient to reading their own diaries and recalling events on their own. This helps with independence, and gives the patient some control over their activities.

Cognitive and therapy testing ascertain as basis on with to build the psychology sessions around. Using recollection, memory enhancement, and through relatives' opinions, all these can ascertain positive progress which will lighten the patient's mood and see progress made for themselves.

Workshop 5: **Nutrition support in the Head Injured Patient**. (Emma Whitehurst, senior dietician)

Emma discussed the importance of high calorie intake of food and fluid to the group. Patients with head injuries have a 30-60% increased metabolic rate and therefore the need for high protein diet and high calorie diet is paramount to reduce weight loss and sustain body mass.

Calorific intake should exceed 3000 calories per day.

Hyper metabolism in head injured patients has various causes:

Stress response – repair of brain tissue, presence of cytokines

Potential damage to hypothalamus and pituitary

Secretion of hormones that oppose the action of insulin

Protein catabolism occurs in head injured patients and leads to rapid loss of lean body mass

Breakdown of protein

Breakdown of amino acids to produce glucose

Increased excretion of nitrogen as a by-product of glucogenesis

Head injured patients will excrete 2-3x more nitrogen

The importance of early administration of nutritional support was emphasised to minimise malnutrition, hypermetabolism and hypercatabolism. Nutrition should be given via the most appropriate route. Always refer to a dietician.

Oral feeding and supplements

Consider snacks, calogen, fast foods, and extra desserts. Don't promote healthy eating – a McDonalds will provide far more calories than hospital food. Water is essential, but provides no calories, so supplement with high fat fluids also e.g. fizzy drinks. Keep an accurate food and fluid chart

Enteral Feeding

Start ASAP to maintain and promote intake. Address poor absorption with metoclopramide or erythromycin.

Total Parenteral Nutrition (TPN)

Only in limited cases. Last resort only indicated when the gut is not functioning and all other options have been explored e.g. post pyloric feeding via jujenostomy.

Monitoring of Progress

Nutrition screening (MUST)
Regular weighing of patients (weekly)
Nutrition link nurse should be identified in each ward area to promote dietetic needs

Zoe Beardow discussed

Cerebral Salt Wasting.

Patients most at risk of cerebral salt wasting are those who have suffered cerebral disease, head injury and sub arachnoid haemorrhage. Hyponatraemia causes reduced nerve conduction and compartmental fluid imbalances. Zoe firstly discussed the physiology and homeostasis of sodium.

Sodium regulation or homeostasis:

Hypothalamic secretion of ADH (antidiuretic)

Adrenal secretion of aldosterone (antidiuretic)

Cardiac secretion of atrial natriuretic peptide (diuretic)

Brain natriuretic peptide released from ventricles (diuretic)

Normal sodium level in blood is 135-145 mmols

Differentiation between cerebral salt wasting (CSW) and Syndrome of Inappropriate Release of ADH (SIADH):

CSW = Hypovolaemia + Hyponatraemia
SIADH = Hypervolaemia + Hyponatraemia

Effects of hyponatraemia include headache, nausea, vomiting, confusion, seizures, respiratory arrest, agitation and death.

Treatment of cerebral salt wasting hyponatraemia should be carried out slowly to reduce severe neurological complications. Increase fluid intake with 0.9%Sodium Chloride consider Fludrocortisone therapy.

A drug rep discussed **beta interferon**. Beta interferon is used in Multiple Sclerosis and has shown to have major benefits for sufferers in terms of reduced disability and reduction in relapses. Well he would say that wouldn't he (being a rep).

Statistics quoted were:
Reduction in relapses by 34% over 2 years
Reduction in severe relapses by 48% in 2 years
Reduction in MRI lesion presentation by 80% in 2 years
A 16 year study showed a much longer length of life without neurological disability.

The development of an **Acquired Brain Injury Pathway** was discussed by Karen Wilcock-Collins. Karen gave us national statistics of head injury incidence that is far more than I expected.

2% of the UK population have had a head injury in the last year
80-90% of these are not admitted to hospital

Acquired brain injury (ABI) is described as any injury to the brain following birth. This includes all trauma, infection, haemorrhage, lesions.

The development of the ABI pathway was following various government and department of health white papers:
National Service Frameworks
Our Health, Our Say
Independent Living guidelines
NICE guidelines
Rehabilitation guidelines

The cost of caring for ABI far exceeds the cost for cancers, heart disease etc due to the amount of care, and rehabilitation within hospitals and communities and especially due to the longevity of the care required.

The pathway would provide guidelines and sources of information for staff, patients and families within hospitals and the community with access to local support groups and information. The creation of head injury nurse specialist posts was emphasised.

Unfortunately, Karen did not show us an actual pathway.

Dr Bamford discussed the **Challenge of Hyper-acute Stroke Care**. The annual cost of stroke in England and Wales is £7bn. Despite modern techniques and treatments, stroke is still on the increase due to the ageing

population. Research is limited due to lack of funds from donations and charities compared with cancer and cardiac charity foundations.

Dr Bamford discussed the emergence of thrombolysis techniques and how these have revolutionised acute stroke care and given vast improvements in thrombotic stroke treatments since 1998. 1 in 10 patients will be completed cured following thrombolysis.

The diagnosis of TIAs and appropriate treatments with aspirin, statins and antihypertensives can significantly reduce the likelihood of a stroke.
Neurosurgical techniques such as decompressive hemicraniectomy can allow for brain swelling following stroke, minimising secondary pressure complications.
There are various frameworks in use for stroke care including:
Department of Health National Stroke Strategy
NICE guidelines
National Clinical guidance for stroke

Post stroke care has much better patient prognosis if carried out in a specialised stroke ward rather than general ward. This is down to specialised nursing care, and the emphasis on hydration, speech / swallow therapy and early mobilisation with rehabilitation.

Emphasis now lies on getting the message across for specialised nursing care education into community hospitals to lessen the gap in patient care from district general hospitals and specialised stroke facilities.

Zoe Barrett discussed the **Psychological care of patients with Spinal Injuries**. She explained the psychological impact a spinal cord injury (SCI) has on its victims in all aspects of their lives – home, work and social.
The suicide rate of SCI sufferers is 4x the national average. Depression is also 4x more likely in SCI patients than the national average. Post Traumatic Stress Disorder is present in 10-40% of all SCI patients.

Zoe emphasised the need for patient centred care and rehabilitation to allow patients as much control over their SCI as possible. Listening to patients concerns and allowing them to follow the grieving process is a large part of their acceptance of SCI and mood stabilising.

Pain control and cognitive behavioural therapies, combined with good social family support can offer patients coping mechanisms to more effectively deal with SCI and its after effects.

Nurses who are patient, empathic but not condescending can achieve the best results. Some patients may develop attention disorders and have excessive emotional dependency. Zoe stated that the best way to combat these dependencies is to prescribe to the person how much time you have to spend with them so that they know there is a limit to your attention – and therefore they can

better prioritise what needs done for them within that set period. This also gives them direction and goals to achieve within that period.

Organ Transplantation was discussed by Dr Paul Murphy. He explained the urgency and importance of promoting organ transplantation in ICU.
2 people die daily whilst on the waiting list for a transplant. 50% of cystic fibrosis sufferers will die whilst awaiting a lung transplant. Paul discussed recent audit findings within Europe; the UK has a very poor record of organ donation as a whole compared with countries such as Spain or Portugal.
Brain Stem Death patients have reduced in number due to modern interventions and treatments. However, within these cases, there is a lot of inconsistency surrounding organ transplantation. It is worth noting that brain stem death patients provide the most viable organs for transplantation as they have a heart beat and circulation is intact.

Recommendations were for all people to consider registering onto the organ donor register. Communicate your wishes with your immediate family (as your wishes may be overridden at that crucial time). Get the organ transplant co-ordinator involved as soon as possible. The involvement of the tissue transplant co-ordinator to discuss transplantation with families was found to be crucial in increasing the consent for transplantation.

Uncertainty surrounded the ethics of placing a brain stem dead patient onto an ICU from A+E solely for the transplant and harvest. Also how far you treat cardiac, renal or blood instabilities to maintain organs. How long do you wait to wean off sedation before brain stem death testing can occur? How ethical is it to expect families to keep a bedside vigil until harvesting occurs? All these are current debates.

The most common reason for lack of organ donation in the audit was haemodynamic and cardiac instability.

Duodopa is a relatively new treatment for Parkinson's disease. This treatment was discussed by Cheryl McGurk a Parkinson's disease Nurse Specialist.
Duodopa is a form of levodopa but gives greater stability in the peaks and troughs of plasma levels than conventional drugs. The "get it on time" campaign for PD drugs indicates the importance of timely drug administration to maintain plasma levels of levodopa.
The cost of Duodopa treatment is £28,000 annually for one patient. Clients have a NG / PEG inserted into their duodenum with a separate inner cannula solely for duodopa administration.
The daily dosage consists of a morning bolus dose, a maintenance continuous daily dose and additional doses as required. Patients carry the heavy pump around in a bum bag or other belt device.

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Dr Rory O'Connor discussed **discharge planning and rehabilitation of brain injured patients**. He discussed the importance of contracture and malnourishment correction and management prior to rehabilitation for best prognosis. He referred to national papers and frameworks such as NICE guidance and National Service Frameworks for long term conditions.
Appropriate treatments in the acute setting, with mobilisation, management of nutritional status, maintenance of muscle tissue and other multidisciplinary involvement can greatly increase the potential for effective rehabilitation and eventual discharge into the community and society.
Quickly patients in the acute care sector can develop body and muscle changes such as:
Osteoporosis, and other musculoskeletal changes
Cardiac changes – reduced fitness
Urinary system changes
Changes in the regulation of cortisol / insulin
All these affect how well a patient can rehabilitate.

Tysabri in MS Treatment is another new drug in the treatment of MS. Dr Cord Spilker explained its effects.
Tysabri costs around £13000 per patient per year.
Clinical trials have shown positive benefits, except for the incidence of progressive multifocal leukoencephalopathy that has occurred in 6 clients on the drug.
Dr Spilker recommends the use of Tysabri as a first line treatment for relapsing/remitting MS.
He described the process involved in the manufacture of the drug that involved the use of mice. The monoclonal antibody was injected into the mouse that then developed Beta lymphocytes in response. These fused with myelin cells causing the formation of Hybridom cells. (somehow!!!)
The myelin sheath could then be regenerated.
More trails need done on this drug to note its full effects and side effects.
Watch this space…

Conclusion

Overall the talks were productive and made me consider my role in nursing at this moment.
Do we spend enough time with patients and relatives?
Do we encourage and promote self-help groups?
Do we provide enough information?
Do we promote patient centred care?
Are we aware of advances that are ongoing in the field of neurosciences?

If we answer "no" to any of the above and we are all in the profession – how do you think the patients and relatives cope when they have different backgrounds, different ethnicity, differing coping mechanisms, and no knowledge of the life changing events which have led to their hospital admission – and how their neurological illness will affect them for years to come.

Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

SPORT, REHABILITATION AND BRAIN INJURY 2009 CONFERENCE

THURSDAY 19TH February 2009
Faculty of Health, edge Hill University, Ormskirk,

Lancashire L39 4QP

COST

The cost of the Conference including lunch, refreshments and delegate pack is £100 (£75 if application is received by 20 December, 2008). Concessionary places (for patients and carers) cost £25. There are a limited number of free places for EHU health and sports students.

How to register

Please complete the attached conference registration form and post it to:
Sports Injury 2009, Conference Administrator,
Faculty of Health, Edge Hill University,
St. Helens Road, ORMSKIRK, Lancashire L39 4QP
Confirmation of places, maps and a programme will be despatched on receipt of the delegate booking form. If you have not received your confirmation letter one week prior to the Conference date, please contact us to check we have received your registration form.
Tel. 01695 650 738
Email: sportsinjury2009@edgehill.ac.uk

The Conference will focus on Brain Injury caused during sports participation, how the risk of injury can be minimised or averted and the key role of sport and exercise in the recovery phase.

Target Audience:

- Medical / Health professionals
- Sport therapists
- Rehabilitation Specialists
- Sports managers and Coaches
- Former patients and their carers
- Students of sports and health sciences

Background

Brain Injury caused by taking part in sport, at whatever level, is not uncommon. The consequences for survivors are often severe and can include physical, cognitive and behavioural impairment. Effective rehabilitation is the key to optimum recovery and sport and exercise can play a significant part in this.

Conference organisation

The conference is organised by Neurosupport and Edge Hill University Faculty of Health with the collaboration of Headway, the Greenbank Centre and the Walton Centre for Neurology and Neurosurgery. Neurosupport, Greenbank and Headway are charitable organisations that support individuals and families affected by brain injury. Specifically, Neurosupport aims to raise awareness about the effects of nervous system diseases and traumatic brain injury and to help patients achieve a good quality of life.

Posters

The conference organisers are inviting abstracts for poster presentations on the conferences main themes: Brain Injury, Sports Therapy and Rehabilitation. There will be a prize of £100 (kindly donated by Elsevier)

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for the best poster. Further details will be on the Neurosupport and Edge Hill websites. Deadline and submission date: 1st December 2008.

Exhibition Stands

A limited number of places are available for exhibition stands. Charities and professional commercial organisations should contact the organisers if they would like a presence. Rates (inclusive of one delegate place) are £125 for registered charities and £175 for others. (Additional delegates standard delegate rate applies).

Programme

Registration and coffee 08.45

Welcome and Introduction 09.15
Keynote address (A tribute to the life and work of Professor Bryan Jennett, CBE, a pioneer of research and treatment in brain injury)

'Sport & Brain Injury: an Overview'
Professor Gregor McLatchie
Consultant Surgeon, University Hospital, Hartlepool

'Football and Brain Injury - is heading the ball dangerous?'
Professor Adrian Lees Professor of Biomechanics,
Liverpool John Moores University

Refreshments

'Concussion & Assessment'
Mr Neil Buxton, Consultant Neurosurgeon,
the Walton Centre for Neurology & Neurosurgery NHS Trust.

'Boxing and Brain Injury'
Dr Mike Loosemore, Lead Clinician,
London English Institute of Sport, Olympic Medal Institute.

'A Neurologist's Experience of Sports-related Brain Injury'
Dr Mark Doran Consultant Neurologist,
the Walton Centre for Neurology & Neurosurgery NHS Trust.

'Dehydration, Brain Volume and possible increased Risk of Brain Injury'
Dr Phil Watson, Research Fellow,
School of Sports & Exercise Sciences, Loughborough University

Questions and Panel Discussion

Lunch 12.30

'Use of Cogsport in Rugby League'
Mark Leather, Chartered Physiotherapist and Senior Lecturer in Sports Therapy, Centre for Sport and Exercise Rehabilitation, EHU

'Sport and Exercise in Recovery from Head Injury'
Dr Colin Pinder, Consultant in Rehabilitation Medicine,
Clatterbridge Hospital, Wirral

Case Studies: Patient/Public/Carer contributions
'Experiences at the Greenbank Sports Academy'
Mark Palmer, Sport Development Officer and Gerry Kinsella,
Chief Executive, the Greenbank Sports Academy, Liverpool.

Questions and Panel Discussion

Tea and Close 16.30
Awaiting confirmation of CPD points from the Royal College of Physicians and other specialist organisations.

Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

DELEGATE BOOKING FORM

Sport, Rehabilitation and Brain Injury 2009

Please reserve a place at the Conference on Thursday, 19th February, 2009.

Delegate details (please use BLOCK CAPITALS)

Name .....

Organisation .....

.....

Address .....

.....

.....

Post code .....

Tel. (day) .....

Email .....

I intend to submit a poster abstract Yes No

I require information about exhibition stands Yes No

Cheques should be made payable to Edge Hill Education Ltd.

I enclose a cheque for £100/£75 (delegate fee)

I enclose a cheque for £25 (delegate fee)

Please invoice me.....

Dietary/other special requirements .....

.....

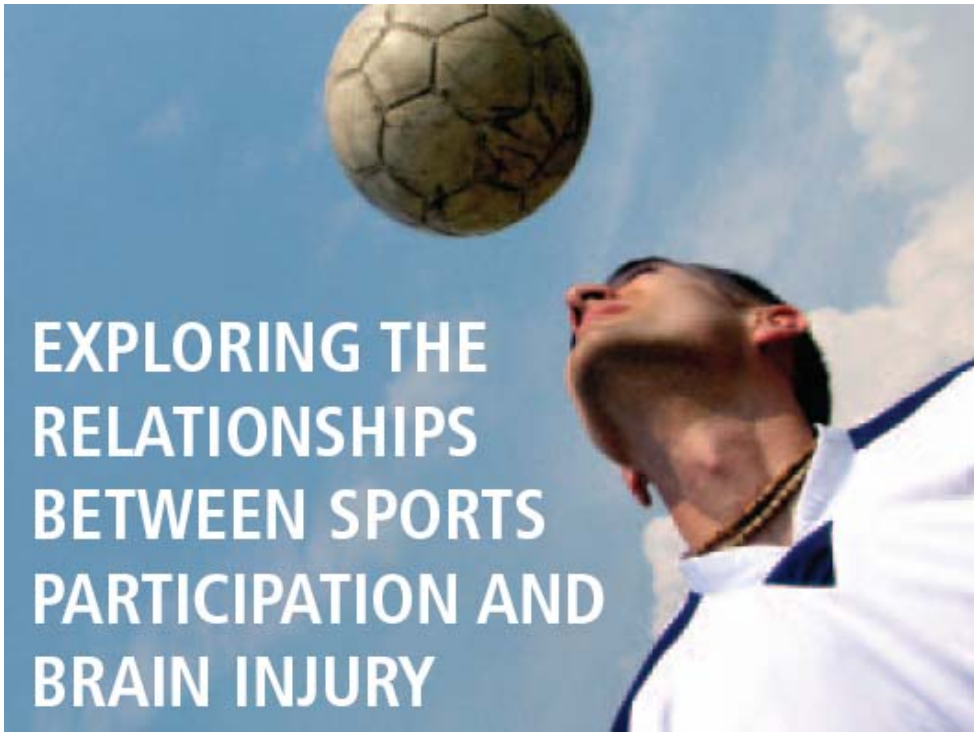
Signature .....

Date .....

(Photocopies of this form are acceptable)

Term and Conditions

Applications are accepted on the understanding that the applicants agree to the following terms and conditions. All conference fees remain payable once a registration is received by Edge Hill University. Edge Hill University's terms of payment are 30 days from date of invoice. Cancellations are not possible. A substitution may be made in the event of withdrawal. Neurosupport and Edge Hill University reserve the right to make changes to the published programme if necessary.



Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

DECEMBER 2008 VOL 3 NO 3
WWW.BANN.ORG/UK

The World Federation of
WFNN | Neuroscience Nurses

Coming back to North America for the 1st time in nearly two decades:

The 10th Quadrennial Congress of The World Federation of Neuroscience Nurses

York University, Toronto, Canada, May 23-28, 2009

The World Federation of Neuroscience Nurses (WFNN), in collaboration with the Neuroscience Nurses Foundation (NNF), the Canadian Association of Neuroscience Nurses (CANN) and York University invite you to join your friends and colleagues at the 10th Quadrennial Congress and Career Fair, Toronto May 23-28, 2009.

"**FOUNDED ON TRADITION - FOCUSED ON TOMORROW"**

The Congress is the ideal setting for clinicians, managers and educators with an interest and passion for Neuroscience Nursing to come together and exchange ideas, discuss innovations, successes and challenges from their own experiences in an effort to inspire and provide insight to those attending.

Look out Toronto – the World is coming!

The Agnes Marshall Research Grant

The Grant deadline has been extended to December 19th 2008. Please visit http://www.wfnn.nu/agnus_flyer09.pdf for more information.

New member organisations

WFNN welcome several new member organisations including Austria, Croatia, Iceland and India. New individual members have joined from Cameroon, Thailand, UAE and Bangladesh.

Would you like to host the WFNN congress in 2013?

Applications need to be submitted by 15th January 2009
www.wfnn.nu

Travel Grants

Grants to attend to Congress will be posted on the WFNN website by January 1st. Be sure to visit the website in December to obtain additional information.

Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

DECEMBER 2008 VOL 3 NO 3
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THE BRAIN DETECTIVES

As a social worker in the Western General Hospital, Edinburgh much of my work focuses on supporting adults and their partners deal with the effects of an acquired brain injury. Dealing with the practicalities of discharge can leave little time for other support and the needs of children, although not forgotten, are often not given the priority they deserve. Literature suggests that the impact of brain injury on children is one area which has received little attention (Oddy, 1997) and as Pratt and Baldry (2002) suggest, children are often aware of changes but are unable to understand explanations or left to work things out for themselves.

The Brain Detectives (named by my nine year old daughter Laura!), is an information day for children of primary school age who have a relative with an acquired brain injury and was set up by myself and my colleague, Neliss Baxter. The idea came both from an acknowledgement of unmet need and our experience of helping out at a similar day run at the Maggie's Centre for children with a parent with a cancer diagnosis. The aim of the day is to focus on the children; to give them the opportunity to participate in games and activities that allows them to understand some of the effects of acquired brain injury and to help them realise they are not alone in their experience.

The day itself is held in the Old School at Astley Ainslie Hospital and runs from 10.00 to 2.00pm. It is staffed on a voluntary basis by social workers, OT's, nurses and physiotherapists all currently working in the field of acquired brain injury. After being dropped off, the kids spend some time getting to know each other over juice and badge making. The morning is then spent taking part in "brainy" activities, including body pictures where they get a chance to draw round each other and see how their brain makes different parts of their body work and a treasure hunt to demonstrate the importance of memory. Then it's into the gym and a chance to try out wheelchairs, hoisting and balance exercises. After lunch, things quieten down with an art workshop where the children make something to remember the day by such as a treasure box or scrap book. The kids leave with a goodie bag filled with their treasure and other literature, games and puzzles about the brain.

So far two days have been held, the first with 12 children (too much!) and the second with 3. The body pictures activity has proved to be very successful, especially with the smaller group as it gave the children the chance to open up about their own personal experiences. The treasure hunt was fun but needs more work as both groups said our clues were too easy. The kid's favourite so far has been the gym and there was lots of fun and laughter as they zoomed around in the wheelchairs. On a more serious note, feedback from relatives and kids has all been positive so far and indeed all the kids have asked if they can come back again!

Three further days have been planned for 2009 on 28th February, 20th June and 7th November. If you know anyone who might like to come along or would like any more details about the day itself, please feel free to contact either myself or Neliss.
Carol Dow, Social Worker, Western General Hospital, tel no 537 1411.
Neilss Baxter, Brain Injury Outreach Nurse, Astley Ainslie Hospital, tel no 537 9075.

Articles to the Editor: shanne.mcnamara@luht.scot.nhs.uk

Carol and Neliss have been sent a £20 gift token for their contribution to HEADLINES

DECEMBER 2008 VOL 3 NO 3
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ANN DOUGLAS RETIRES FROM NURSING (AGAIN)

Ann started her nurse training in 1962 at the Western General Hospital, Edinburgh. Following this she went on to become a Midwife and spent time in Queen Charlotte Hospital, London and the Queen mother Hospital in Glasgow.
However the Western General once again lured her back and she was a Staff Nurse in Gynaecology for a period of time.
Ann then moved overseas and spent 13 years of her nursing career in Canada where she concentrated on Obstetrics, Health Visiting and School nursing.
When Ann returned to Edinburgh she spent 6 years working at a GP Practice in Stockbride (an area of Edinburgh quite close to the Western General Hospital.
Finally, she came back to the Western General hospital and took up post in the Department of Clinical Neurosciences X-ray. She was one of the first nurses to be involved in Neuro-radiology and presented at 3 conferences; the WFNN in Australia, and the EANN in Rome and Amsterdam. Ann was also a frequent visitor to the local university where she taught students about neurological radiology and interventions.
In total Ann has worked in the department of Clinical Neurosciences for 21 years. She retired 3 years ago but came back part-time to work in our pre-admission service.
Her initial plan is to visit her sister in Australia and friends in Dubai, followed by skiing. She also hopes to spend time with family, her garden and maybe embark on some interest courses at Open University.

We wish her well.

Ann has been awarded Honorary Membership for BANN.

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