Scotland Leading the way for Acute Care Practitioners

ACAP Scotland is a new and exciting network that will enable all acute care practitioners to register as members allowing provision for annual forum events. These events will host guest speakers, workshops, master classes and the opportunity for discussion on topical subjects. Most importantly the forum will facilitate educational and professional development.

Members will also be entitled to quarterly newsletters and unlimited ACAP web site access.

Acute care practitioners in Scotland have never had until now:
- The privilege of having an arena to showcase areas of good practice,
- The opportunity to benchmark other practices throughout Scotland,
- A national opportunity for education
- And most importantly have their voice heard.

Now with the onset of ACAP forum Scotland all this will be possible.

Mission Statement
The purpose of the forum is to promote and develop the professional role of the acute care advanced nurse practitioner in partnership with stakeholders, in order to advance the quality of care delivered to patients and clients.

ACAP Scotland Leading the way

Support given by:
AANPE
CS MEN

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Retirements
Ednamay Sinclair HECT Nurse NHS Lanarkshire and ACAP steering group member, and Douglas Allan Senior Lecturer in Advanced Practice Glasgow Caledonian University and ACAP non executive member have both taken their retirement this year. They will be missed in both their substantive posts and for their contributions and support to ACAP over the last 3 years. ACAP would like to take this opportunity to wish them all the best for their future.

Congratulations
ACAP would like to congratulate David Watson, HECT nurse NHS Lanarkshire and ACAP steering group member on his recent appointment as ERU manager NHS Lanarkshire

Social networking
ACAP Scotland now has 270 followers on Twitter and 120 members on its open Facebook page. This is a great way to interact in a very informal manner. Follow us and join the chat.

Thanks
ACAP would like to thank Atrium Marquet and EL Medical Aesthetics Ltd for their support in helping with this year’s event.

Future Developments
ACAP steering group are currently working on OSCE/Crib sheets to be made available on the web site. If anyone would like to contribute to this process please contact Julie on juliesmith69@hotmail.com The steering group remain committed to delivery and provision of what the members want, therefore we would welcome some feedback, as to where you would like ACAP to develop and what you would like to see from future events/journals/web site. Contact Elaine or Julie.

Annual Report From Chairs –September 2013
ACAP Scotland at its inception set the following objectives:

**OBJECTIVES:**
- To provide a platform for sharing evidenced based practice.
- To provide a link between Acute Care Advanced Practitioners (ACAP’S) and major stakeholders.
- To provide an arena for networking.
- To provide ACAP’s with a “voice”.
- To provide an opportunity for education

These objectives were constructed from the 4 overarching themes of advanced practice:
- Clinical/professional leadership
- Facilitating Learning
- Research and Development
- Advanced Clinical Practice

In the past year ACAP Scotland has met all the set objectives and has covered the 4 key principles of advanced practice as detailed below:

This has been achieved by way of:
1. Forum conference events
2. Production of “The Advanced Nurse Practitioner” – the ACAP journal
3. Web site, providing education and information availability

**Forum Event**
ACAP Scotland 3rd forum event – held on November 2nd 2013 at the Lighthouse Glasgow: 92 delegates attended a 1 day conference, which included lectures and masterclasses. APNs were invited to lecture and present posters; additionally this provided an invaluable setting for networking and sharing of best practice. The Lighthouse attracted a number of reps who provided support for ACAP whilst displaying their products.

**Journal**
ACAP Scotland has produced 3 journals in the past year, incorporating case studies, literature reviews and research based articles. A hard copy of the latest journal is available in each delegate pack at the conference events

**Web Site**
The ACAP website continues to go from strength to strength. There are now 230 registered members. Additionally ACAP now has a twitter account with 266 followers and 76 on facebook

**Further Achievements**
- ACAP Scotland continues to have registered charity status.
- Treasurers report available as a separate document.
- ACAP has now forged links with Advanced Practitioners in AHP sector
- Succession Planning questionnaire completed and analysed – awaiting feedback from non exec members on how to proceed.
- ACAP steering group working on OSCE sheets for the web
I watched the staff do everything they could to try and save me. However, the reality was that there was nothing that could be done and somehow I was to blame. I felt I had failed her.

I knew before any of them said anything that we had lost her. The lead consultant told me that she had arrested whilst in theatre and that they had brought her back twice, but ultimately, the sepsis and septic shock had overwhelmed her body and they had not been able to save her. She said how sorry they all were. The whole family were all left profoundly shocked, devastated and simply bewildered.

I remember asking over and over, ‘What the hell just happened?’ My world had imploded within the space of 62 hours: sepsis had just killed half my family.

Before all this happened, I had known nothing about sepsis. I knew a little about septicaemia and vaguely understood it, but had never heard of sepsis at all. Over the days following Fiona’s death, I was able to ask questions about what had happened and I learned more – much more – about sepsis.

What I found out shocked me to the core and made me realise that there was an urgent need to raise awareness about the condition and to begin tackling the appalling mortality figures.

Hence, the idea for the Trust named after Fiona was formed.

What is sepsis?

Sepsis is a life-threatening condition that arises when the body’s response to an infection injures its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly.

It remains the primary cause of death from infection, despite advances in modern medicine, including vaccines, antibiotics and acute care.

It kills more people in the UK than lung cancer. It claims more lives than breast cancer, bowel cancer and prostate cancer combined.

At least 37,000 people die from sepsis each year in the UK alone, but this number may be a significant underestimate as coding of the condition in hospitals remains piecemeal; the true figure may be as high as 64,000 deaths per annum.

Globally, 20-30 million cases of sepsis occur each year and the incidence is increasing dramatically.

At least 8 million people per year worldwide die from the condition - and if you have severe sepsis, the mortality rate is around 40%.

If the 37,000 figure is accurate, it is the UK’s 5th biggest killer condition. If the number is closer to the 64,000 figure, it is the 4th biggest killer.

These numbers are grim and simply unacceptable.

Recognising Sepsis

Sepsis should be suspected if more than one of the following occurs:

- Very high or low temperature, which may be accompanied by chills or shaking, or other flu-like symptoms;
- Difficulty breathing;
- Rapid heart beat;
- Low blood pressure;
- Change in behaviour: slurred speech, confusion, drowsiness or loss of consciousness;
- Changes in skin colour;
- Reduction in the amount of urine passed.

Immediate medical attention should be sought.

Dиagnosing and treating sepsis

Sepsis should be treated as a medical emergency. In other words, sepsis should be treated as quickly and efficiently as possible as soon as it has been identified. Research shows early recognition and treatment saves lives. Unfortunately, the diagnosis is often missed or delayed due to multiple factors, including the complexity of sepsis, unspecific and rapid nature of the symptoms, poor awareness or inadequate diagnostic tools.

Evidence-based guidelines are available but are used inconsistently.

If sepsis is treated within the first hour, ‘The Golden Hour’, the risk of death is halved and survival rates can be more than 80%.

This means rapid administration of antibiotics and fluids. A 2006 study showed that the risk of death from sepsis increases by 7.6% with every hour that passes before treatment begins.

Until a cure for sepsis is found, early detection and treatment is the best hope for improved survival rates.

This rapid treatment will not save everyone who has sepsis, but it is a crucial start in reducing the death toll – a ‘quick win’.

The more difficult cases will require research to more fully understand why some patients do not respond as well to antibiotics and fluids.

FEAT’s aims and objectives

FEAT core and immediate aim is to raise awareness and recognition of sepsis at all levels amongst medical professionals and the general public.

In addition, we are fundraising to support longer-term research into better diagnostic testing and improved treatment, particularly for those who do not currently respond as well to rapid administration of fluids and antibiotics. In order to save more lives, we need to understand why this is so.

Since FEAT was established, we have received a great deal of anecdotal evidence that some 60-80% of sepsis survivors do not make a complete recovery from the condition.

Many are left with organ damage, cognitive problems, difficulties with affected limbs or simply a general feeling of never being well in the way they were before they were ill. This area, the quality of recovery and the after-effects of sepsis, is another area that FEAT will fund research into in due course.

We don’t just want people to survive sepsis; we also want to help ensure the best possible quality of life for sepsis survivors.

I was Fiona’s last patient and I owe my life to her.

Tragically, Fiona herself also became seriously ill just 24 hours later. Fiona was taken to Forth Valley Royal hospital on the evening of Friday 24th after suddenly falling ill. She had been perfectly well up until then and had an antenatal scan the evening of Friday 24th after suddenly falling ill. She had been admitted to Edinburgh Western, my life was saved. I was and am very sorry they all were. The whole family were all left profoundly shocked and pretty much the entire medical team who had been treating Fiona – using the latest medical techniques, machines, technology, blood transfusions (some 56 units of blood), antibiotics and three surgical procedures. They tried everything they could – and nothing worked.

Baby Isla was stillborn at 5.10 am on the Saturday morning. We had chosen not to find out whether we were having a wee boy or a wee girl. Now, I held her and named her – alone.

For the remainder of the day and into the night the medical staff worked tirelessly to save Fiona’s life. She remained critical and unstable throughout the day and had continued to bleed following the birth. Her condition gradually deteriorated; she was being ventilated and was on dialysis by this stage.

By around 9pm on the 25th, Fiona’s condition had become more unstable than previously and the doctors still couldn’t get her to stop bleeding.

The medical staff fought to stabilise her so they could attempt a third procedure to try and halt the bleeding. This was the priority, as all that was happening was each time she was given a blood transfusion, she would stabilise for a short while and then gradually become more unstable again – until the next blood transfusion.

By around midnight, she was stable enough for her to be taken to theatre. I told her that I loved her and would see her again soon and then she was wheeled away.

I had continued to be treated for my own infection in A&E throughout the day and was wheeled down to A&E for my final antibiotic treatment of the day at around quarter past midnight.

I was wheeled back upstairs to the relatives waiting room where our family had spent much of the previous 24 hours, at 2.20am. A few minutes later, there was a knock on the door and much of the entire medical team who had been treating Fi was lined up outside.

Background

Before the weekend of 23rd – 26th August last year, I had never heard of sepsis. I was living in Edinburgh with my wife, Fiona Agnew and our young 2 year old son, Robert. We were expecting our second child at the end of September and had just recently moved house. I was working for one of the ‘Big Four’ accountancy firms based in Edinburgh and Fiona was a GP retainer working two days a week in Bo’ness. Our life together was full and as hectic as it is for most couples with a young family and both parents working. We were both looking forward to the baby’s arrival to complete our wee family.

This was all to change in the most ghastly and shocking fashion over the course of just 62 hours that weekend.

I am a very lucky man to be alive. I am here and able to write this today because of Fiona’s quick action in getting me to my GP. I had gone home from work on Thursday 23rd August to crawl into my bed and sleep off what I thought was flu. It would have been my final sleep.

In fact, I had a virulent infection which led to cellulitis and sepsis, and by the time I reached A&E at Edinburgh Western, this had become septic shock. Without treatment, I would have been on my way out; I now know that by the time sepsis has reached that stage, the survival rate is only 50%.

Thanks to Fiona’s intervention and quick thinking, and the prompt action of my GP and treatment by the medical staff in A&E at Edinburgh Western, my life was saved. I was and am very fortunate: at each stage, things had happened quickly and go the right way, they did.

Recognising Sepsis

• Low blood pressure;
• Rapid heart beat;
• Difficulty breathing;
• Changes in skin colour;
• Loss of consciousness;
• Loss of appetite;
• Clay coloured stools;
• Mosquito bites;
• Changes in their levels of consciousness;
• Changes in their general appearance.

Sepsis – a personal perspective

(The Fiona Elizabeth Agnew Trust)

and an introduction to FEAT

febstopsepsisnow.com

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**Sepsis is one of the leading causes of death around the world**

Simulation based learning (SBL) has been around for much longer than practitioners may imagine. As far back as 17th century France, birthing manikins were known to be used for teaching purposes. (1) For decades simple part task trainers and manikins have been used to teach basic and advanced life support, airway and obtunded skills and drills, amongst others. However, it is not until the late 1990’s that simulation technology is “now a central thread in the fabric of medical education” (1) Many health service organisations, health care professionals, medical students and nurses across the world have implemented simulation as a means to provide training not only in clinical skills, but for team training, human factors and ergonomics. Increasingly, simulation based learning (SBL) is seen as an integral tool in the drive towards improving quality and patient safety (2).

The following article highlights how simulation training has been developed and implemented in NHS Ayrshire & Arran (NHSS&A) and discusses the benefits to staff development and patient safety locally.

**BACKGROUND**

In 2008, through Additional Contribution to Training (ACT) funding, 1 Laerdal mid fidelity Simman simulators were purchased in NHSS&A – one for each acute hospital site i.e Ayr and Crosshouse. Unlike other centres whereby these expensive manikins were left to gather dust at the back of the training rooms and cupboards (3), we committed to utilising these immediately for the training of medical students, auxiliary nurses, trainee doctors and other clinical staff. Provision was also made for the appointment of a Resuscitation Officer who would have the responsibility of developing a simulation service across each acute care setting. The latter has been a major challenge and at times daunting. However, with small steps, enthusiasm, determination and support from the Lead Clinician and the simulation team, the Simulation User Group has been central to the continuing development of a simulation service across each hospital site and has enabled simulation to become an integral part of the education and training of medical undergraduates and postgraduate trainees alike.

In 2009, simulation as an educational tool has been developed and implemented in NHS Ayrshire & Arran (NHSS&A) and views this as an integral tool to the development of clinical skills for both undergraduate and postgraduate clinical staff.

**SIMULATION USER GROUP**

The Simulation User Group has been central to the continuing support and development of the simulation service, even the name has evolved from that of Simulation Interest to Simulator User Group, and has gone from an initial membership of less than 10 clinicians (doctors & nurses) to a healthy membership of around 40. The group has ‘link’ clinicians from various specialties including Emergency Medicine, Anaesthetics, General Medicine and Paediatrics. To ensure quality of service delivery, 24 of the group members have undergone the Faculty Development Course provided by the Scottish National Simulation Centre at Larbert. As a minimum standard, at least one trained faculty member attends each of the simulation sessions provided. Simulation User Group members work together to provide a variety of SBL opportunities in the simulation lab and in a variety of clinical settings as follows.

**FIXED SIMULATION**

These are held in the dedicated simulation lab within the Emergency Clinical Skills Centre, Ayr Hospital. Our aim is to provide a safe and supportive educational environment for various specialties including, general medicine, paediatrics, emergency medicine, anaesthetics, obstetrics and advanced nursing practitioners (general & mental health). The ethos is to ensure that all learners can practise and develop skills with the understanding that mistakes carry no judgement and harm neither patients nor learners. Errors are seen as a shared opportunity for learning. Indeed, as are the successes. Recording and debrief facilities ensure that participants can reflect on their individual and team performance. Educational feedback is facilitated by trained faculty members and it is this feedback that has been identified to be one of the essential features to the success of SBL. (4,5) To achieve maximum benefit, feedback must be non-judgemental or threatening, focus on improvement and ultimately be constructive. As patient care and safety relies on the efforts of the wider team, inter professional (IPL) sessions are supported wherever possible. We have had a variety of disciplines and levels of staff collaborating and learning together in the simulation lab such as; undergraduate nurses, medical students, and doctors of varying levels of experience and seniority, as well as orderlies, nurses of varying levels of experience and doctors from FY1 through to consultant level. It is recognised that inter professional team based care provision is associated with improved patient outcomes and a reduction in adverse events. (6) It makes sense then to train together rather than training in isolation. The Simulation User Group has also hosted an innovative development in collaboration with NHS Lanarkshire and Glasgow University. All Year 5 Medical Undergraduates now receive SBL 3-4 months prior to appointment as Foundation Year One Trainees (FY1’s). Whilst SBL cannot replace, it can complement traditional training methods in the clinical environment. (4) Particularly, if education is seen as an integral part of the clinical curriculum and integrated with other educational methods. Thus, we set out to ensure that all Glasgow students to be appointed to NHS Ayrshire & Arran as FY1’s were adequately prepared for their first year. As part of this, simulation sessions were designed around the Acute Care Competencies within the framework for the Foundation Year Curriculum UK and simulated deteriorating patients that the students would be likely to encounter once appointed as FY1’s.
Learning from a case review of a real life ‘near miss’ has highlighted that high performance measures according to Resuscitation Council UK are always being met, time to first defibrillation was greater than the recommended 3 minutes in some areas - as a result feedback was provided to the relevant areas and there has been a change in the focus of our resuscitation training updates for nurses to highlight and improve upon this issue.

A year of the training of verbal for mental health nurses to ensure that they will now achieve life support training that includes advise defibrillator competence – historically the majority of them received basic life support training only.

Reinforcement of the procedure to ensure that the cardiac arrest team gain rapid access to the psychiatric wards at Crosshouse. Under the umbrella of primary care the psychiatry department has separate ID badge access from that used in the main hospital – this is currently being addressed with the redevelopment of the main entry to the psychiatry wards.

Paediatrics

Two monthly in situ SBL sessions are held. These are open to all specialties such as anaesthetics and emergency department practitioners to encourage collaborative working.

These sessions have affirmed to all levels of paediatric staff that they each have a responsibility towards patient safety and the value each brings to the team in terms of recognition of system and process errors and highlight any latent safety threats (9,10).

Paediatrics and latent issues identified through immersive SBL have been noted in paediatrics and general ward areas. Some of the benefits of this style of SBL are providing more and more of this style and latent environmental safety threats (9,10).

Testing of protocols & clinical pathways

In situ simulation is also known to be of use in testing the reliability and feasibility of protocols (12) and has been used locally to test the protocol in the paediatric emergency department clinical systems for timely telemetry-based resuscitation and use of equipment (13). As this is written, preparations are underway to test the recently built Clinical Decision Unit at Ayr hospital with the aim of helping staff to familiarise themselves with the layout, the equipment and clinical pathways prior to caring for patients there. It is anticipated that the use of SBL will help to identify any unanticipated latent safety threats. There is clearly scope to do this kind of SBL in any new clinical environment, making it a safer place for patients and staff to be.

In conclusion, simulation is a realistic and safe method of teaching and learning for the benefit of individuals, teams and organisations. It is a valuable tool in the healthcare environment. SBL can identify system and process errors and highlight any latent safety threats within clinical settings. Future efforts for our service development must drive towards increasing both the fidelity and immersion in situ capabilities that we have currently. In particular towards targeting team training, encouraging collaborative working within varying specialties and a variety of clinical teams from emergency medicine, paediatrics, intensive care, theatre, maternity and radiology to mention just a few. A colleague once told me: “patient safety is the only game in town” and simulation training is the ultimate interactive and immersive teaching and learning tool to help us in our drive towards a safer patient climate.

Acknowledgments

None of the aforementioned developments and achievements would have been possible without the continued support, encouragement, involvement and innovation of the following key people:

Mr. Michael Canavan – Lead Resuscitation Officer
Dr. Julie Mardon, Consultant in Emergency Medicine and Joint Clinical Lead for Simulation
Dr. Caroline Whymark, Consultant in Anaesthesia and Joint Clinical Lead for Simulation

Dr. Mrs. Caroline Whymark, Dr. Mrs. Caroline Whymark, Consultant in Anaesthesia and Joint Clinical Lead for Simulation

Mr. David Campbell – Resuscitation Officers

Mr. Michael Canavan – Lead Resuscitation Officer

Dr. Caroline Whymark, Consultant in Anaesthesia and Joint Clinical Lead for Simulation

Dr. Mrs. Caroline Whymark, Mrs. Caroline Whymark, Consultant in Anaesthesia and Director of Medical Education

Dr. Mrs. Caroline Whymark, Consultant in Anaesthesia and Joint Clinical Lead for Simulation

Mr. David Campbell – Resuscitation Officers

Words seem inadequate. Thank you.

References

4. Issenberg S.B. et al. Features and uses of high-fidelity medical simulations that lead to effective learning: A BEME systematic review. Medical Teacher 2005; 27 (1) 10–28
**Final Frontier: Offshore Medic**

**EMERGENCY NURSING BACKGROUND**

“Probably the single most important choice I made was to become a registered nurse, but also to continue my education and strive to continually develop my skills. Without this background I would never be able to function in my role as an Offshore Medic.”

When ACAP Member Elaine Headley asked me to write an article on what a remote offshore medic does and the role we play in providing healthcare remotely I had to pause and ask myself

“How do I begin to explain what we do?

So now is an opportunity for me to at least give a brief overview of what actually happens when you are responsible for the medical/Health & Safety Executive (HSE)/welfare of fifty crew members on a working seismic survey vessel pretty much anywhere in the world.

**BACKGROUND**

Working offshore as a remote medic is not generally considered a career aspiration. It’s something that one kind of stumbles upon. I started my Dip HE General Nursing at Paisley University, graduated in September 2001, and then started my first job in Glasgow Royal Infirmary in the Surgical Receiving Unit. I then moved to Monklands hospital to the Emergency Care Unit and finally worked in the nurse bank in accident and emergency (A&E) department Wishaw General Hospital. During this I studied for my BSc. in Nursing, successfully completed Major Injuries and Trauma (MINTs) course, which like an advanced nurse practice (ANP) qualification, but was certainly in its infancy when I completed the course. Now it is common place in hospitals in various forms along with hospital emergency care team (HECT) nurses who specialise in acutely unwell adult care. I now had the CV required to work offshore.

At this time I had come in contact with a colleague in intensive therapy unit (ITU) in Wishaw General who was looking into working offshore as an alternative career. After extensive research I decided that this would be something I would like to pursue. In order to work offshore either on rigs or marine vessels it was a requirement to have an HSE offshore medic certificate which is recognized by Oil and Gas Industry. This consists of a four week intensive in house course in Nottingham Acute NHS Trust which consisted of advanced life support (ALS), Pre Hospital Trauma Life Support, Prolonged Transport Care, ECG, thrombolysis and a two week clinical placement one of which is working in A&E then another in GP placement.

“The 4 week intensive Offshore Medic Course prepares the candidates for life offshore with lectures from industry professionals”

**24/7 STANDBY ON CALL**

“You really have to be ready for any eventuality on the vessels. We are autonomous practitioners who do not have the benefit of crash teams, anesthetists, and doctors so its import to be ready and prepared’

After much help and assistance from my unit manager the emergency care unit (ECU) and A&E, I finally left NHS in May 2009, though still working as a bank nurse until I could secure my first assignment. By this time I had completed the four week residential medic course, completed my Offshore Survival BOSIET/HUET (helicopter transfers are standard offshore), this with my acute experience, medic certificate and offshore survival I was ready to go.

**FRONTIERMEDEX**

FrontierMEDEX were the first provider I contacted and are a Global leader in design and delivery of medical solutions in the world’s most complex and challenging environments. They bring together healthcare professionals, equipment, local knowledge and provide international medical care anywhere in the world.

submitted my CV to FrontierMEDEX and after a very rigorous recruitment process, which included telephone interviews and face to face interviews with FMX Medical Director Dr Phil Sharples and various personnel staff; I was informed that I would be contacted in due course if an opportunity arose.

**FIRST ASSIGNMENT**

I was called in August 2009 by FrontierMEDEX to work as a medic on a survey vessel offshore Greenland. This was a seven week job which required very clear objectives. It was a new vessel and the hospital had to be stock, set up and all medication had to be inventoried. Medical equipment checked and first aid with HSE training for all 35 crew members. This was a learning curve for me as FrontierMEDEX have very specific standard operating procedures which include comprehensive clinical guidelines, equipment, drug
formulary and reporting system. The very nature of working offshore means that topside advice is essential. FrontierMEDEX have an excellent topside doctor service where highly experienced doctors can be contacted at any time for advice on treatments, drug clarification and more complex medical problems, support is always on the end of the phone.

The transition from working in an NHS hospital to be on a vessel in Greenland was challenging and exciting at the same time. The rotations are as such we work five weeks on and five weeks off. It might seem long but in actual fact it the time off is a bonus as you have ‘quality’ time with family and home life. It was difficult at first but now after four years offshore it’s as normal as working a 9 to 5 job. Professionally it was difficult to adjust to the responsibility that you have. But I always say it can’t be any more daunting than being responsible for a thirty five bedded receiving unit. Therefore it gave some importance to the perspective of my new working environment.

NHS NURSE TO MARINE OFFSHORE?

‘The transition from working in the NHS to working offshore can be daunting but with drive and a clear desire you will be surprise at what you can achieve and how you deal with working in challenging locations’

OFFSHORE LIFE / WHAT WE DO

Currently I now have been contracted to a major client via FrontierMEDEX to provide medical and HSE cover on a seismic survey vessel, the first stage in oil detection and exploration. I have worked for the client for four years and it is stable and challenging. The role of the offshore medic is wide and varying as the expectation of the client should mirror the expectation of the medical provider.

MEDICAL

The primary role is one of the ships medics. You will have an average of fifty plus crew members who will visit your hospital in all weathers which may be 6ft swells or nice calm seas in the Gulf of Mexico. So it certainly has its challenges. Presentations of complaints range from primary care such as, dermatology, cardiac, minor/major trauma and the occasional dental issue. FrontierMEDEX have very concise clinical guidelines which must be referred to for all conditions and patient confidentiality is of primary concern. Therefore it is really important for the medic to have a very broad spectrum of knowledge. Casualty transfer is important and having paramedic or pre-hospital care experience is essential: and if you don’t have it you must learn. There are times where crew members must be medically evacuated by helicopter for shore-side consult so thinking on your feet is critical.

‘It is important those first aid teams are trained in casualty transfer and first aid in order to assist the medic in all aspects of medical care and medical evacuation transfer to shore’

TRAINING

Training is a very strong offshore requirement and certainly medical first aid is high up in the priority list. It is the medics’ role to ensure all crew members are trained in first aid situations such as immediate life support, (ILS) automated electrical defibrillator (AED), trauma management, musculoskeletal trauma, bleeding, burns and the list goes on. This is addition to more in-depth medical training with the first aid team facilitating a safe working environment with the ability to function and provide quality medical care to the crew in the event of any emergency. Additionally the in house training the medic may be asked to travel to the supply boats to train the crew in the HSE topics specific to clients’ requirements. This normally involves a fast response boat transfer which in good weather can be fun but in bad weather is not for the faint hearted.

QUALITY / HEALTH / SAFETY AND ENVIRONMENT

It is fair to say that working offshore is not like working in A&E, so if you are lucky enough to have a quiet day then the role will change. The medic has a very strong focus on HSE and they are utilised accordingly. We are involved in all matters relating to HSE; client meetings, toolbox talks, active reporting on hazardous situations and loss prevention. So to say we are not busy is a myth; the medics are busy trying to prevent injuries but also treating injuries and learning from incidents.

CONCLUSION

So a very brief story of what we do and our roles within health care away from the busy wards up and down the country. Life here is good and is rewarding in many ways. Being offshore for six months with a crew brings a ‘camaraderie’ and crew becomes an extended family. The very nature of the job means you get the opportunity to travel pretty much anywhere in the world. Places as diverse as Gulf of Mexico to Equatorial Guinea from Greenland to Australia. The crew work hard but also there is time for recreation activities such basketball on helideck, deck hockey and circuit training. So there is an incentive to keep healthy and fit. It’s the medic’s role to use the holistic care approach to everything we do in the remote setting. FrontierMEDEX have provided me an opportunity to provide quality health care and also to step outside the box and think critically. There was an occasion once when I was home and doing a shift in a local Glasgow hospital I spoke to a student nurse about my job and she asked for advice. I pointed out that completing her degree and becoming a registered nurse will bring many opportunities both in hospital and in primary care but sometimes it’s important to step outside the box as you never know what opportunities might be around the corner.

FrontierMEDEX

Steven Kemp has been working for FrontierMEDEX for 4 yrs as a Remote Site Medic /FMX Mentor/HSE Medic /RGN
More Information please contact Steven on following email: steveckemp29@yahoo.co.uk
Sponsors of ACAP Scotland Events

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