



The Advanced Nurse Practitioner

The journal for members of ACAP



www.acapscotland.org



Produced in association with **Skills4Nurses**

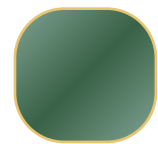
Scotland Leading the way for Acute Care Practitioners



ACAP Scotland is a new and exciting network that will enable all acute care practitioners to register as members allowing provision for bi annual forum events. These events will host guest speakers, work shops, 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 bench mark 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

Executive committee members:

Elaine Headley
Julie Smith
Ednamay Sinclair
Anne Scott
Hazel Beveridge
Agnes Allan
David Watson
Lilian Redman
Fiona Buchan
Peter Thomsom
Stephen Morrison
Lynne Demeries

Non executive committee Members:

Mr. Eddie Docherty
Dr. Mark Cooper
Mr. Douglas Allan
Ms .Janet Corcoran



• www.acapscotland.org •

Contents.....



Page 4	News
Page 5	How an advanced nurse practitioner influenced an organizational change that benefited patient care <i>Lynn Deremiens ANP --Primary Care Lanark</i>
Page 7	Assessing the Febrile In-Patient: A Missed Opportunity to Improve Sepsis Management? <i>Dr Paul Robertson, MRCP MD Specialty Doctor in Microbiology, Monklands District General Hospital, Monkscourt Avenue, Airdrie, ML6 0</i>
Page 10	Liability and Consent <i>Julie Smith & Elaine Headley</i>
Page 12	Cardiac Auscultation: What Did I just hear! <i>Kelvin Moran, H@N Advanced Nurse Practitioner NHS Ayrshire & Arran</i>
Page 14	Understanding Emotional Intelligence in Relationship to Leadership <i>Elaine Headley, Senior Charge Nurse, HECT, NHSLanarkshire</i>
Page 16	Meet your Conference Speakers

Knowledge Network

ACAP would like to thank Mark Cooper in his help getting ACAP Scotland onto the Knowledge Network. There is now a link to this site on the ACAP website, so members can gain access to this and eLibrary

Web Based Case Studies

In an effort to standardize case studies submitted onto the web site, we have produced a house style for guidance. It is hoped that a standardized format will allow for both guidance in submission of case studies and also make it easier to interpret the main points from the studies. The house style can now be found on the web site. We are also currently looking at house styles for the submission of articles onto The Advanced Nurse Practitioner journal. We would welcome any case studies/articles, for guidance or information please contact Julie.smith@aaaht.scot.nhs.uk or Elaine.headley@gmail.com

Link practitioner

Elaine Grey, from NHS Dumfries & Galloway is now the ACAP link practitioner from that area.

NHS Scotland Event

Scottish Exhibition & Conference Centre, Glasgow 23-24 August 2011
The annual NHS Scotland Event is one

Copyright Statement :
Subject to all articles submitted to and agreed for publication in The Advanced Nurse Practitioner. The author assigns to The Advanced Nurse Practitioner all copyright in and to the article and all rights therein. This will include but not limited to the right to publish, re-publish, transmit, sell, distribute and otherwise use the article in whole or in part, in electronic and print editions of the journal and in authorized works throughout the world, in all languages and in all media of expression now known or later developed, and to authorize or permit others to do so.

Registered charity no. SCO42116

of the leading health events in Scotland. It provides an opportunity for individuals working in, and with, NHS Scotland to consider and discuss some of the important challenges for health now and in the future.
www.nhsscotlandevent.com

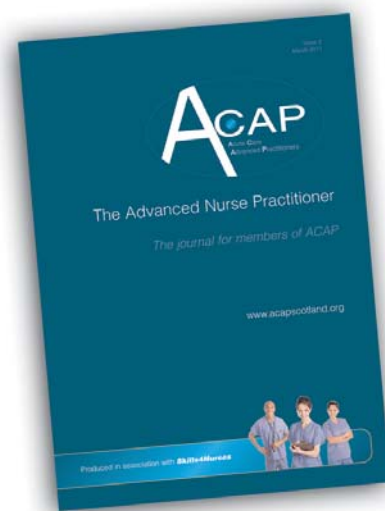
Health Promotion

Primary Care Health promotion team from NHS Lanarkshire have agreed to make available a health promotion stand at the forum conference in June. This will give delegates an opportunity to have some basic health checks carried out.

Thanks

Elaine Headley would like to thank H@N practitioners & the ACAP members from Lothian for making her feel welcome during a night visit to ERI in May.

ACAP Scotland would like to thank Mrs. Ann Cairns for her kind donation; in memory of her father, Mr. Michael McConnachie



Your feedback from the March Issue of TANP :

'.... looks amazing! Well done, this is all very impressive! Are there printed copies of that?' Dr. Michael McLaughlin

'Excellent. Well done' Dr. Mark Cooper

'I think it looks absolutely amazing! Well done. I know how much work goes into this sort of thing – and it rarely looks this good'. Pennie Taylor

'Well Done' Steven Morrison

'newsletter is looking great, really professional, it has come so far in such a short time'. David McDermott

'Thanks for forwarding the journal, it is looking good' -- Lilian Redman

'Looks very good ' Anne Scott

'Excellent, very professional, well done' Stevie McCormick

How an advanced nurse practitioner influenced an organizational change that benefited patient care

Lynn Deremiens ANP --Primary Care Lanark

Introduction

This article will discuss how an advanced nurse practitioner (ANP) influenced organizational change within an established structure in primary care. This ultimately led to better outcomes for patient care, subsequently allowing more consultation time for the doctors. Additionally this change facilitated both empowerment and utilization of the practitioner's skills and knowledge.

This was achieved through identifying the need for the change and how the change was implemented through collaborative working; ultimately leading to a win-win situation.

There has been a considerable growth in the field of advanced practice in the last decade, often with underlying confusion over the context and nature of the role (Smith & Headley 2010). The Scottish Government (2008) recognizing this confusion and recognizing the need to conceptualize advanced practice developed the Advanced Practice Toolkit (www.advancepractice.scot.nhs.uk) to provide both consistency and clarity. More recently the Scottish Government (2010) acknowledged that advanced practice roles are pivotal in the delivery of services. On reflection and after consideration of the developments that advanced practice is continuing to generate, I recognized a need within my own place of work that required me as an ANP to address and subsequently influence change.

Prior to me undertaking my current role, should a patient require to be admitted to hospital throughout the day, the general practitioner (GP) facilitated this using the Emergency Response Centre (ERC). This system was implemented in 2008 to operate Monday to Friday from 08:00 – 18:00hr. It would smooth the progress of all emergency medical and surgical GP calls and arrange transportation of patients to the required hospital (www.shiftingthebalance.scot.nhs.uk2010). The main objectives of ERC were as follows:

- Streamline patients to the appropriate point of care
- Explore alternatives to admission
- Appropriate use of resources (avoid duplication)
- More efficient use of Scottish ambulance Service (SAS) vehicles
- Incorporate discharge dispatch and community care.

The GP interface of ERC is highlighted in figure 1 identifying the links that would facilitate admission of patients into hospital. In addition to this ERC would be used as part of performance indicators in A Plan for Modernizing Health Care Services (Lawrie 2008). Fig 1 Despite the obvious advantages of this service (www.shiftingthebalance.scot.nhs.uk2010, www.lanarkshire.org.uk2008), it allowed only the GP's to admit directly to the acute sector. However, as an advanced nurse practitioner (ANP) within the primary care setting this then became an area where I would also hold responsibility. I realized that to meet these responsibilities and to ensure high quality efficient care for patients, there would need to be an organizational change and some collaborative decision making to facilitate this role.

Emergency Care Model

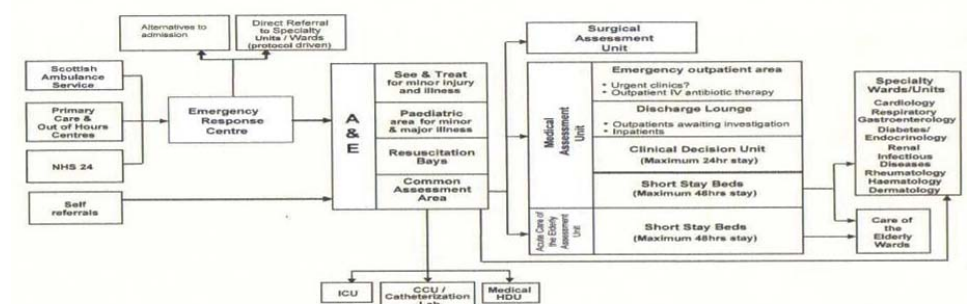


Fig 1

Subsequently, and arguably this then acts as a blockade for teams to achieve their ultimate goal. However my perceptions of conflict were indeed unfounded, as the working relationship within my team is such that the problem was recognized and understood.

I approached my GP colleagues and engaged in open discussion with them, highlighting the benefits that would be ascertained by allowing me to access the ERC, when and if, I needed to admit a patient to hospital, without their sanction. My suggestion was met more with intrigue than opposition; some of my GP colleagues had simply not considered the need for me to access this resource. However, as a result of open discussions, fuller consideration was given to the time that would be freed for the GP's, allowing them a greater degree of flexibility. Ultimately a common understanding of the need for this change was recognized and subsequently made possible. Working in collaboration, enabled the change that was required to facilitate the progression of my role and independence as a practitioner.

Conclusion

Often, we as practitioners can see benefits of how a change in our working environment can improve an established organizational structure.

We may also feel disempowered to be able to construct a change within that establishment. However with the correct approach and engaging in collaborative negotiation a positive resolution can often be achieved. It undoubtedly did in my circumstance and what was once considered non essential is now part of the working life in the practice in which I am currently employed.

References

Convey, R, C. (1999) Principle-Centred Leadership, Simon & Schuster: London

Emergency Response Centre (2010) <http://www.shiftingthebalance.scot.nhs.uk> [available] online [accessed] 29/3/2011

Huczynski, A., Buchanan, D. (1991) Organizational Behaviour: An Introductory Text. 2nd edn., Prentice Hall : Hertfordshire.

Hurst, J., Kinney, M. (1989) Empowering self and others. University of Toledo: Toledo, OH

Kinney, M., Hurst, J. (1989) Group Process in Education. Ginn custom Publisher: Lexington, MA

Lawrie, A.(2008) New horizons: A plan for modernizing primary care

services 2008-2012. <http://www.nhsla-narkshire.org.uk> [online] available [accessed] March 2011

Marquis, B.L., Huston, C.J. (2000) Leadership Roles and Management Functions in Nursing. 3rd edn., Lippincott Williams & Williams: Philadelphia

The Scottish Government (2008) The Advanced Practice Toolkit <http://www.advancepracticetoolkit.scot.nhs.uk> [online] available [accessed] 24/11/2010 The Scottish Government (2010) Advanced Nursing Practice Roles: Guidance for NHS Boards, Scottish Government: Edinburgh.

Smith J., Headley, E. (2010) "ACAP Scotland: An opportunity for acute care advanced practitioners to have a voice", Skills for Nurses, Vol.22, pp. 12-16

Swansburg, R. C., Swansburg, R, J. (2002) Introduction to Management and Leadership for Nurse Managers 3rd edn; Jones and Bartlett Publishers: London

Wedderburn Tate, C. (2001) Leadership in Nursing. Churchill Livingstone: London

Yoder-Wise, P. S. (2007) Leading and Management in Nursing 4th edn; Mosby Elsevier: St.Louise.

Assessing the Febrile In-Patient: A Missed Opportunity to Improve Sepsis Management?

Dr Paul Robertson, MRCP MD Specialty Doctor in Microbiology, Monklands District General Hospital, Monkscourt Avenue, Airdrie, ML6 0

A call to assess a febrile in-patient is a common scenario for junior medical staff or advanced nurse practitioners (ANP). Nursing and medical tradition would see this as an opportunity to administer an anti-pyretic and obtain blood cultures. Sadly these are often the only interventions that occur, with insufficient thought being given to identifying and treating the cause of the fever. I'll argue that a call to assess a febrile inpatient represents an opportunity for early identification and treatment of sepsis, and that a shift in hospital culture – particularly out of hours – is needed to improve sepsis management. I hope to illustrate this point using a case presentation based on a mixture of real life scenarios and reference to a significant national audit of sepsis management - the Scottish Trauma Audit Group (STAG) audit into sepsis management in Scotland. Although this audit focused on the first 48 hours of hospital admission, many of its learning points can be extrapolated to hospital- acquired sepsis.

Jen is an FY1 in surgery covering several surgical wards on a Saturday night shift as part of a hospital at night team. She receives a call from a general surgical ward to tell her that Mr. MacLeod, a 67 year old man who is five days post op following a colectomy has a temperature of 38.5°C. The staff nurse has given him some paracetamol, but has asked for blood cultures to be taken. Jen adds this to her list of jobs and gets round to seeing Mr. MacLeod half an hour later. The patient doesn't look too bad so Jen takes a set of blood cultures and moves on to the rest of her job list.

Can you effectively triage your patient?

Any phone call about a febrile patient cannot be properly triaged without a full set of observations and some brief clinical detail. Patients with severe sepsis frequently have little in the way of symptoms and do not

attract attention in the same way as other clinical emergencies such as myocardial infarction or GI bleeding. Patients commonly look "too well" to have severe sepsis, perhaps because early vasodilatation gives them a flushed appearance. Therefore, the severity of the patient's illness may be under-appreciated by the referring staff member. The initial phone call provides an opportunity to more accurately establish the nature of the problem and, therefore, effectively prioritise the call.

In addition to Mr. MacLeod's fever, he had a heart rate of 120 bpm, respiratory rate of 24/min and a blood pressure of 85/50. He was lucid and in no pain.

How sick is your patient?

Here, the patient fits at least three of the sepsis criteria (box 1). He has at least one feature consistent with severe sepsis (box 2). These sepsis criteria are by no means universally known by medical and nursing staff, or incorporated into clinical practice. Had this information be obtained over the phone Jen could have realized that her patient potentially had severe sepsis and prioritised this as a clinical emergency. Although there are many causes of fever in hospital in-patients, infection is by far the most common. This infection is often in the context of

sepsis, a pathophysiological state carrying a high mortality rate. Therefore, assessment of the febrile patient should be targeted towards identifying and effectively treating sepsis. This includes thorough clinical assessment and may mean obtaining blood tests looking for evidence of new organ dysfunction (such as FBC, Co-ag, U+E, LFT, lactate, ABG): as well as requesting tests to identify a source of infection (such as CXR, blood culture, urine culture, sputum culture, and culture of wound or line sites). A severity assessment – looking specifically for features of severe sepsis – should be performed in all patients having blood cultures performed (though severity assessment should not be limited to the taking of blood cultures).

Jen goes to the ward where she recognizes that Mr. MacLeod has severe sepsis. Clinical examination reveals no unexpected findings. His surgical scar appears to be healing nicely. He has a central line placed in the right femoral vein. The site does not appear inflamed. A CXR possibly show increased opacity at the right lung base. A catheter specimen of urine has one plus of protein and blood on dipstick. Jen sends blood and urine for culture. She makes a diagnosis of possible chest sepsis and prescribes co-amoxiclav (1.2g tid IV) and clarithromycin (500mg bd po). She alerts her senior colleague and moves on to her next call.

Box 1: Sepsis Criteria

HR > 90 bpm Temp >38.3°C, <35°C RR > 20/min WCC <4.0, >12.0 (x10⁹/l)

Plasma glucose >7.7 mmol/l (in non-diabetic patients) and acutely altered mental status are also used by some authorities. Consult your local sepsis management protocol.

Box 2: Markers of Severe Sepsis

Systolic BP <90mmHg Lactate >4 mmol/l Urine output <0.5ml/kg/hr for >2 hrs

Creatinine >177µmol/l Bilirubin >34µmol/l Platelets <100x10⁹/l INR > 1.5

O₂ required to keep SaO₂ >90%

This list is not exhaustive. Small variations may exist between protocols in different hospitals. Consult your local sepsis management protocol.



ACAP Scotland would like to invite you to reflect, share and recognise Advanced Nurse Practitioners' contributions to health



WHEN? 24 th June 2011
WHERE? Medical Education Centre, Kirklands Hospital, Bothwell.

Programme includes:

Penny Taylor: Leadership and ANP's
Gillian McNaughton: Head Injury Guidelines
Douglas Allan: Politics of Advanced Practice
Maggie Grundy : Advanced Practice Past, Present and Future

Master-classes and titles : Steve McCormick: Antimicrobial Management - Transforming Policy into Practice
Evidence on Mortality Outcomes

Dr. Michael McLaughlin: Management of septic shock

To book a place, please complete a booking form and return to:
Fiona Buchan, 18 Abbotsford Road, Galashiels TD1 3DS. Email to:Fiona_buchan@btinternet.com

Have you started supportive therapy?

Correcting abnormal physiology is at least as important as giving antibiotics to patients with sepsis. Jen should have given this patient high flow oxygen, an intravenous fluid bolus (such as 20ml/kg of suitable crystalloid) and observed the response. The STAG audit demonstrated that failure to give appropriate fluid to hypotensive patients is common. Persisting hypotension or elevated lactate following adequate fluid challenge is diagnostic of septic shock and requires a prompt decision by senior medical staff to outline an appropriate ceiling of therapy. Assuming no

diagnoses of respiratory or urinary tract infection is the commonest error. Misdiagnosis of the first assessing doctor is not unusual.

Getting the anatomical source wrong is important for two main reasons. First, necessary investigations and interventions may be delayed. Second, giving an effective antibiotic regime may be delayed. In the case above, co-amoxiclav and clarithromycin, while good empirical treatment for a community acquired pneumonia, is not adequate for a patient with hospital-acquired sepsis following recent abdominal surgery with a central line in place. Infection due to Methicillin-resistant Staphylococcus aureus (MRSA) or gram negative

sepsis, two pairs of peripheral blood cultures are recommended to optimise the yield, as well as cultures from the ports of vascular-access devices. In patients where endocarditis is suspected, three sets of blood cultures from different sites should be obtained. Molecular diagnostic tests (antigen and PCR-based tests) are not culture-dependant and are therefore less affected by antibiotic administration. Serological tests are not affected by antibiotic therapy, but typically require paired samples a week apart to give any useful information and so usually only give a diagnosis retrospectively. For the scenario above, appropriate microbiological tests are shown below in Box 3.

examining the relationship between mortality and time to antibiotics after the onset of hypotension in sepsis. In reality it can be difficult to deliver antibiotics this quickly even when severe sepsis is recognised. ANPs are well placed to have a pivotal role in HAN teams for ensuring the prompt delivery of antibiotic therapy.

There is very little evidence to guide an ideal time within which to give antibiotics to patients who have non-severe sepsis. Pragmatically a 4 hours cut off might be a reasonable aim. It is likely that the longer the time to effectively treat sepsis, the longer the hospital stay would be anticipated to be. In a climate of increasing efficiency in delivering health care, prompt treatment of non-severe sepsis might be warranted in economic grounds, even if mortality benefits are uncertain.

Is the initial antibiotic regime effective?

Even when prompt antibiotics are given, it is not uncommon for them to have no in vitro activity against the isolated pathogen (around 25% of bacteraemias are treated with ineffective antibiotics in Monklands). Hospital-acquired sepsis is more frequently associated with organisms resistant to antibiotics commonly used in the setting of community-acquired infection, such as MRSA, extended spectrum β -lactamase (ESBL) producing gram negative bacilli, and the various Candida species. The combination of co-amoxiclav and clarithromycin would fail to cover any of these. The ideal empirical regime should take into account the severity of illness, the source of infection, and a judgement into the likelihood of resistant organisms (based on prior history, duration of stay and prior antibiotic exposure). Precise regimes will vary between hospitals, but one suitable regime might be intravenous vancomycin, gentamicin and metronidazole. This would provide active agents against most gram positive organisms including MRSA, most gram negative organisms, and anaerobes. Gaps in its cover would include vancomycin-resistant enterococci, many ESBL-producing bacteria and Candida species. Hospital antibiotic policies are carefully designed to factor in this

complexity. Departure from the hospital antibiotic policy is more likely to lead to an ineffective antibiotic being given. Where there is doubt, or in the presence of significant allergies, seeking the advice from an infection specialist may be needed to ensure optimal first-line antibiotic treatment.

Is the team working together?

Managing a patient with severe sepsis cannot be done successfully without good teamwork between different healthcare disciplines and hospital departments. ANPs represent a vital component of that team – both in providing a thorough initial assessment, beginning prompt physiological support, obtaining appropriate specimens, and ensuring prompt delivery of antibiotics. Given their permanent presence in a HAN team, they are ideally placed to support and educate nursing and junior medical staff on sepsis management, helping to lead the cultural change required to improve sepsis management.

Summary

Sepsis is often under-recognised. When recognised, sepsis management rarely occurs with the attention to detail and urgency that its associated morbidity and mortality should mandate. Both sepsis recognition and management are poorer in hospital-acquired sepsis. Staff education and systematic improvements in enabling better sepsis recognition and care are needed. In the current financial climate, any systemic changes will likely need to be cost neutral. One such solution might be to use the blood culture as the route in to a brief, formalised sepsis assessment (or bundle). The aim should be to move Hospital-at-night culture from “I have taken blood cultures and given paracetamol for fever” to “I have identified this febrile patient as having severe sepsis, have taken appropriate diagnostic tests, escalated clinical care, and have promptly given antibiotics likely to be effective.” ANPs have the training and clinical role to help ensure that this change occurs.

References...

i STAG Audit Group (2010) Sepsis Management in Scotland accessed at www.stag.scot.nhs.uk

ii Ziglam, HM, et al. (2006) Knowledge about sepsis among training-grade doctors Journal of Antimicrobial Chemotherapy 57: 963-5

iii Bhandari, S (2009) A single-centre audit of junior doctors' diagnostic activity in medical admissions Journal of the Royal College of Physicians 39: 307-12

iv Dellinger, RP, et al. (2008) Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock. Critical Care Medicine 36: 296-327

v Kumar, A, et al. (2006) Duration of hypotension prior to initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. Critical Care Medicine 34:1589-96

Box 3: Diagnostic Testing

2 sets of peripheral cultures 1 set of blood cultures from each central line lumen

1 catheter specimen of urine for culture Chest X Ray

If Mr MacLeod's wound or central line site had appeared erythematous or purulent, swabs (or better pus in a universal container) for culture would have been appropriate.

contraindications to aggressive treatment, further fluid resuscitation – often guided by CVP measurement – and inotropic support would be indicated. This is best carried out in a CCU/HDU setting.

Are you sure where the source of sepsis is?

In this scenario, Jen decided that the patient had pneumonia. However, there's no convincing evidence pinpointing infection at any one site. Minor CXR abnormalities are common in post-operative patients and need not represent pneumonia. Similarly, blood and protein in a catheter sample of urine cannot be taken as evidence of infection. The absence of erythema at the central line site does not rule out the possibility of line sepsis. Local audit data in Monklands suggest that the both the presence of sepsis AND the source of hospital acquired sepsis at the time of blood culture is less likely to be correctly identified than for community-acquired bacteraemia. Overlooking the possibility of vascular access device infection or intra-abdominal infection in favour of tentative

organisms resistant to co-amoxiclav in this situation is a real concern.

In reality bacteraemic infection can occur with no obvious source of infection, even after thorough clinical assessment. This is due to the fact that sepsis is an evolving process, but also that definitive diagnostic tests (such as CT scanning) may not be immediately available. In the management of many septic patients, therefore, there can be a period of diagnostic uncertainty until culture results or definitive investigations to identify sources are undertaken. Where the source of sepsis is not apparent after careful initial assessment, staff should feel comfortable with the diagnosis of “sepsis, source undetermined”.

How are you going to diagnose the infection?

Establishing the microbiological cause of infection cannot normally be done without sampling body fluid or tissue. Prior antibiotic administration reduces the likelihood of culturing organisms, so samples – particularly blood cultures – are best taken before giving antibiotics. For patients with severe

Thoughtful sampling is important in patient management for several reasons. First, it can establish a diagnosis. Second, a positive culture can allow targeted antibiotic treatment, reducing the unnecessary use of costly broad-spectrum antibiotics that select for Clostridium difficile or MRSA. Third, the organism isolated can provide a diagnostic clue as to the source of infection. Fourth, knowing the epidemiology and resistance patterns of the common pathogens in a hospital informs its antibiotic policy. Lastly, clusters of unusual pathogens (such as Legionella pneumophila) or unusually resistant organisms (such as carbapenem resistant Klebsiella sp.) may indicate an outbreak requiring infection control or public health intervention.

How quickly have the antibiotics been given?

The Surviving Sepsis Campaign advocates that intravenous antibiotics be given to patients with severe sepsis or septic shock within one hour of recognition. This is based predominantly on a single paper



What you can expect to see in future editions of the ACAP journal

The ACAP journal will be produced quarterly. We aim to cater to ACAP members needs and requirements, so we would like to hear what you would like published in the journal.

Please send your requests via the web site: www.acapscotland.org

Edition	Articles
Sept 2011	Legal Issues Neuro Examination ENT Stroke thrombolysis
Dec 2011	Legal Issues Respiratory Examination BiPaP/ CPAP ABG Interpretation

LIABILITY AND CONSENT

Julie Smith & Elaine Headley

Introduction

Discussing the legal and ethical issues that surround Advanced Nurse Practitioners can only increase awareness and improve the need to question and demand clarification of all areas that create situations of ambiguity and uncertainty. This is crucial to facilitate continued development in advanced nursing and ensure it manages to survive with the utmost safety for patients.

Continuing with the legal and ethical issues pertinent to advanced practice, this article will focus on the issues of both liability and consent. Both of these issues are complex and multifaceted, it is therefore the intention of this article to give only a brief overview of the main issues regarding liability and consent. Similarly, it is acknowledged that there are differences in regards to Scottish and English law; this article will address only the main issues related to advanced practice in Scotland.

Liability

Thompson(2010) stipulate that vicarious liability is the obligation that falls on one person as a result of an action of another. Subsequently within employment law it would the liability of an employer for the acts or omissions of his employees (Thompson 2010). The Royal College of Nursing (RCN) (2008) stipulate that employers are legally responsible for your actions during the course of your employment. It is not an option and employers cannot opt out of it. Yoder-Wise (2007) explain vicarious liability as a doctrine that enforces the employer to be held responsible for the negligent acts of the employees. The rationale underlying this doctrine is that employees would not have been in the position to cause harm if not hired by their employers. Additionally (Dowling et al 1996) argue that practitioners undertaking advanced roles, must be properly trained for tasks that they are charged with; which are normally attributed to medical staff. Otherwise the NHS board may be held negligent in assigning tasks to someone who is not properly or adequately trained

for them. However, should the practitioner undertake tasks or procedures which are out with their course of employment, the NHS board will be absolved of legal liability, and the practitioner will be held legally responsible. Furthermore, employers are not responsible if you are self employed or you are sued for an action outside the realms of your employment. The RCN (2008) recognise that in rare circumstances an employer may try and recover damages or claims made by a successful claimant, as a result of vicarious liability for your negligence. In situations such as these the RCN scheme provides you with cover. Notably, Smith and Headley (2011) highlight that we as professionals have an ethical duty of care to patients. However, should this duty of care result from emergency situations out with the confines of the hospital setting, the health boards have no legal responsibility to provide vicarious liability (RCN 2008).

In recent years the number of claims against health care professionals for negligent acts, although the number is small, have been high profile and this has generated even more discussion around the need for professional indemnity (NMC 2010). The NMC citing the Department of Health (DH) (2010) in their policy review group makes twenty recommendations and the first recommendation states that: "There should be a statutory duty upon registrants to have insurance or indemnity in respect of liabilities which may be incurred in carrying out work as a registered healthcare professional." The NMC (2010) consider many aspects of nurses having to have their own professional indemnity insurance (PII). They consider the implication of insurance companies increasing the premiums on this type of insurance in relation to the complex nature of the job undertaken by the nurse. Additionally, ANP's may find that due to the nature of their work they are exposed to increased level of risk. This, the NMC argues may have implications on insurance companies, who do not have the public's best interest at heart.

dictating the limits of practice (NMC 2010). These concepts may have implications to ANP's who as stated by Baid (2006) currently work under practice that is to date is unregulated.

Consent

Over the last decade there has been a significant shift from the traditional paternalistic role within healthcare towards patient autonomy (Young 2009). Indeed The Department of Health (2009) maintain that fundamental to good practice is the provision for patients and clients to be involved in the decisions which affect their health. Similarly Jones (2001) points out that it is not the practitioners' duty to protect by withholding information which may cause the patient to worry.

Consent for certain procedures, for example myocardial perfusion scanning, once the domain of medical practitioners has increasingly become one of the duties undertaken by Advanced Nurse Practitioners (ANPs). For this reason it is imperative that practitioners are aware of the legal issues surrounding the practice of gaining consent. Traditionally, consent was used as a means to protect the practitioner against claims of battery, however taking into consideration the definition of battery by Fleming (1992) which states "intentionally bringing about a harmful or offensive contact with the person or another", it is clear that practitioners who carry out procedures have no intent to cause harm or offensive contact. As such in cases concerning consent or the lack of it, will be tried in court as a case of negligence rather than battery, except in cases where consent has been gained fraudulently. In the case of advanced nurse practitioners, it is essential that practitioners explain their identity, in order that patients can make an informed decision as to whether they consent to be treated by a nurse practitioner rather than a member of the medical profession. Should the practitioner not explain their identity and the patient assumes they are a doctor, consent can be considered invalid and legal action for battery may be sought by the patient (Dowling 1996).

For consent to be legal and valid, the practitioner must satisfy three key principles (Medical Protection Society 2009);

- the consent must be given freely
- the patient must have sufficient information to consent
- the patient must have capacity for consent.

When gaining consent from patients it is essential that full clinical information is given to allow patients the right to make an informed choice as to whether they wish to continue with the procedure/treatment or not. Young (2009) suggests that practitioners have previously only warned patients of the clinical risks of treatments, which they think in their clinical judgement, are the most significant. However, practitioners run the risk of potential negligent action against them, if the procedure/treatment goes wrong and they have not obtained lawful consent by full and detailed explanation of all the potential risks and consequences. Therefore it is essential that patients are given time to ask questions and if it is possible time to consider all the information before consenting, with no bias or pressure being given by the practitioner.

In Scotland the legal age for consent is 16 years of age, although younger children may be judged gillick competent by medical staff (Medical Protection Society 2009). To be determined as gillick competent the child must be able to prove that they have sufficient understanding and intelligence to fully understand the treatment, and the likely outcomes of either accepting or refusing the treatment. Additionally once a child has been found gillick competent, the parents no longer have the power to exercise their consent on behalf of their child.

This article will not be discussing either consent for children or adults with incapacity. However, it is essential to note that a three stage test can be utilised to test capacity:

- a) can the patient understand and retain the treatment information
- b) can the patient believe it
- c) can the patient evaluate it sufficiently to make a decision (Pattison 2006).

It is worth noting that mental illness does not prevent a patient from giving legally valid consent. What does prevent patients from giving consent, is the inability to understand the information and come to an informed decision (Jones 2001).

Finally consent is a process and not just a signing of consent sheets. Jones (2001) suggests that although consent can be held valid even in the absence of a consent form, a consent form will act as documentary evidence that the issue of consent was raised and discussed. Conversely, Young (2009) argues that consent sheets whilst providing a record that the practitioner obtained consent cannot be used to provide evidence that valid consent was received. The Medical Protection Society (2009) suggest therefore, that practitioners make short notes in the patients records including any discussions regarding consent, a note of the procedure/treatment being consented for and a list of benefits and alternatives discussed. Accurate documentation on the consent process will aid in protection of the practitioner should a claim for negligence be brought into question.

It is essential that ANPs who gain consent from patients are fully aware of current legislation and best practice in their area. They need a good working knowledge of the benefits and risks from procedure/treatment that they will be gaining consent for. They must be satisfied that the patient has capacity and is not coerced into giving consent. They must also be aware of the risk of negligence should they cause harm as a result of failing in their duty of care.

References

- Baid, H. (2006) "Differential diagnosis in advanced nursing practice", *British Journal of Nursing*, Vol. 15, no. 18, pp. 1007 – 1011.
- Department of Health (2009) *Reference Guide to Consent for Examination or Treatment*, Department of Health: London
- Dowling, S., Martin, R., Skidmore, P.,

Doyal, L. (1996) "Nurses taking on junior doctors' work: a confusion of accountability", *BMJ*, Vol. 312, no. 7040, pp. 1211 – 1218.

Fleming, J. G. (1992) *Law of Torts*, 8th edn., LBC Publishing: London

Jones, B. (2001) "Legal aspects of consent", *BJU International*, Vol. 86, no. 3, pp. 275 – 279.

Medical Protection Society factsheet, (2009) *Consent – the basics*. <http://www.medicalprotection.org>. [online] available [accessed] 2010-10-01

Nursing and Midwifery Council (2010) *Record keeping: guidance for nurses and midwives* <http://www.nmc-uk.org> [online] available [accessed] 2010-10-03

Pattison, S. D. (2006) *Medical Law & Ethics*. Sweet & Maxwell: London

Royal College of Nursing (2008) <http://www.rcn.org.uk> [online] available [accessed] Sept 30th 2010

Smith, J., Headley, E. (2011) *Duty of Care The Advanced Nurse Practitioner* Vol. 2: pp12-13

Thompson (2010) *On duty, or off duty* <http://www.thompsons.law.co.uk> [online] available [accessed] Sept 30th 2010

Yoder-Wise, P. S. (2007) *Leading and Managing in Nursing* 4th ed. Mosby Elsevier St. Louis.

Young, A. (2009) "Review: the legal duty of care for nurses and other healthcare professionals", *Journal of Clinical Nursing*, Vol. 18, no. 22, pp. 3071 – 3078.

CARDIAC AUSCULTATION: WHAT DID I JUST HEAR!

Kelvin Moran, H@N Advanced Nurse Practitioner NHS Ayrshire & Arran

Introduction

This article will aim to discuss normal/ abnormal cardiac sounds and their relevance for clinical practice.

There are a wide variety of components which are suggested as pertinent to the role of an Advanced Nurse Practitioner (ANP), (Callaghan 2008, McGee & Castledine 2003). These include:

- Leadership
- Expertise
- Autonomy
- Clinical decision making
- Research

The advancement of nursing roles and responsibilities has led to nurses undertaking roles that have traditionally been the realm of medical practitioners. Patient safety is of absolute paramount concern at all times. Coombes (2008) concurs with this observation, emphasizing the importance of the competence within advanced practice. Scott (2004) suggested that with supplemented medical education and mentorship many experienced nurses are capable of working at an equivalent level in perceived medical roles such as physical assessment and diagnostics.

Auscultation of the heart is always undertaken alongside a systematic cardiovascular examination. However, the literature suggests that despite auscultation being a critical clinical skill, it is one that is often poorly mastered (Wayne et al 2009, Dolara 2008, Barrett et al 2004). Furthermore it has been suggested that there is widespread belief that cardiac auscultation is of secondary importance because the same information is readily available using echocardiography (Dolara 2008). Auscultation of the heart is used to ascertain whether heart sounds are normal and if any additional sounds are audible. This is a skill which requires detailed knowledge, practice and experience to ensure competency at distinguishing what is normal from what is abnormal (Jevon & Cunningham 2007). Practitioners must first master recognition of what is normal as a priority, when this is achieved recognizing additional sounds becomes a necessity.

In order for us to understand cardiac sounds it is pertinent to recap on the cardiac cycle before continuing:

The Cardiac Cycle:

The cardiac cycle describes all the activities of the heart through one complete heartbeat. In other words from the start of one contraction to the start of the next contraction. A contraction event (of either the atria or ventricles) is referred to as systole, and a relaxation event is referred to as a diastole. The cardiac cycle includes a description of both systolic and diastolic activities of the atria and ventricles, additionally the blood volume and pressure changes within the heart, and the action of the heart valves.

The isovolumetric ventricular relaxation is the period during which the ventricles are

relaxed and both AV and semilunar valves are still closed. The volume of the ventricles remains unchanged (isovolumetric) during this period. Ventricular filling begins as the AV valves open and blood fills the ventricles. The ventricles remain in diastole during this period. The filling of the ventricles can be described as three successive events:

- Rapid ventricular filling occurs as blood flows into the empty and relaxed ventricles. Volume of the ventricles increases rapidly.
- Diastasis is a slower filling event than that of the preceding because most of the volume of the ventricle is already occupied by blood.

- Atrial systole (and the P wave of the ECG) occurs and forces the remaining blood from the atria into the ventricles. The blood volume at the end of this interval is called the end-diastolic volume (EDV).

Ventricular contraction (ventricular systole) begins as the action potential from the AV node enters the ventricles, the ventricles depolarize, and the QRS complex is observed on the ECG. The following intervals during this phase are observed:

- Isovolumetric contraction occurs when the AV valves are forced shut. During this brief period, while the semilunar valves are still closed, the volume of the ventricles remains unchanged.

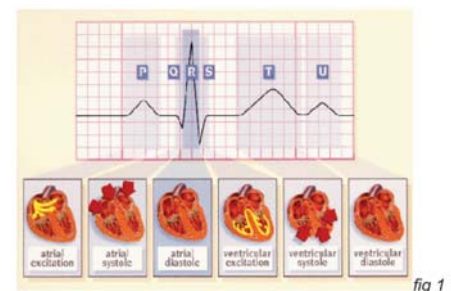
- Ventricular ejection occurs as the continuing contraction of the ventricles increases the pressure in the ventricles and forces the semilunar valves open. At this point, blood is forced out of the ventricles.

- This interval ends when the ventricles begin to relax, the blood in the aorta and pulmonary trunk begin to flow backward, and the semilunar valves, as a result, close.

- The closing of the semilunar valves causes a small increase in blood pressure visible as the dicrotic notch on a plot of blood pressure against time.

- The amount of blood remaining in the ventricles at this time is called the end-systolic volume (ESV).

Figure 1 displays the relationship between the elements of an ECG and the cardiac cycle



Heart Sounds:

Heart sounds can be classified into 2 types:

- High frequency transients associated with the abrupt terminal checking of valves that are closing or opening (Shaver et al 1985).
- Low frequency sounds that are related to early and late diastolic filling events of the ventricles (Reddy et al 1985).

Figure 2 displays is a diagram identifying heart valves and their correlation with recognized auscultation landmarks.

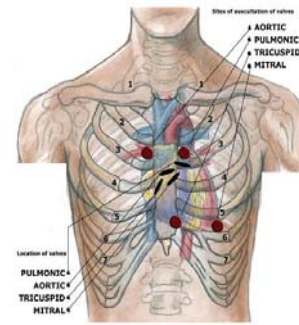


Fig 2

1st Heart Sound (S1):

S1 occurs just after the beginning of systole and is predominantly due to mitral closure, it can also include tricuspid closure components. As the ventricles contract, the pressure rapidly exceeds that of the atria which forces the closure of the mitral and tricuspid valves. The intensity of S1 can often be affected by the distance and mobility of the valve leaflets and the rate of rise in ventricular pressure. S1 can be accentuated by: a shortened PR interval, mild mitral stenosis and a high cardiac output.

S1 can be diminished by 1st degree AV block, mitral regurgitation, severe mitral stenosis and left ventricular hypertrophy. S1 is usually heard best in the apex region using the diaphragm of the stethoscope, following on from this it should be pressed firmly along the left lower sternal border. In healthy individuals S1 will be loudest in the apex (mitral area), if audibly louder at the left lower sternal region it would suggest that the mitral component of S1 is diminished and we are only hearing the tricuspid element of S1 (Shindler 2007).

2nd Heart Sound (S2):

S2 occurs at the beginning of diastole, this is due to aortic and pulmonic valve closure. This is caused by an increase in ventricular pressure which opens the valves and the blood is then ejected. As the contraction finishes, pressure falls causing the valves to snap shut due to arterial pressure.

S2 can be accentuated by systemic or pulmonary hypertension, it can be diminished in severe aortic or pulmonic stenosis.

S2 is extensively transmitted across the thorax and can be heard at the apical left lateral chest, upper right sternal edge and upper/lower left sternal edge. Clinically it is most audible at the upper right sternal edge, this is principally due to the proximity of the aortic valve and therefore we are hearing aortic valve closure. Auscultation at the upper left sternal edge may produce a split S2, this can be termed reduplication because as well as hearing aortic valve closure, due to the close proximity of the pulmonic valve in relation to the upper right sternal edge, it is possible to hear pulmonic closure (Shindler 2007).

Extra Heart Sounds: S3

S3 can often described as S3 gallop, ventricular gallop or protodiastolic gallop (Shindler 2007). The S3 sound is one of the first clinical sounds associated with decompensated systolic heart failure. Vibrations are caused by rapid passive ventricular filling as blood enters a left ventricle which is non compliant (Woods et al 2005). S3 occurs at the beginning of diastole after S2. The frequency is much lower than S1 and S2, this is because it is not valvular in origin. S3 can also be a physiological clinical finding and will be audible in high cardiac output states, for example clinical conditions such as:

- anaemia
- pregnancy
- thyrotoxicosis

S3 is audible over the mitral area. By placing the patient in the left lateral position and using the bell of the stethoscope will improve transmission of S3. This is primarily due the left ventricle position and the low frequency sound of S3 (Massey 2006).

S4:

S4 occurs after atrial contraction, it signifies diastolic dysfunction. It is resultant by blood being forced into a stiff non-compliant ventricle (Massey 2006). S4 will occur directly following diastole and therefore it will be audible immediately before S1. It can also be described as S4 gallop, atrial gallop or presystolic gallop (Shindler 2007). Most frequently it is associated with:

- left ventricular hypertrophy, this can be due to uncontrolled hypertension
- following a myocardial infarction.

S4 occurs after atrial contraction, subsequently in certain cases of atrial fibrillation when the atria are not contracting S4 will not be audible (Massey 2006). As with S3; S4 is also a low frequency sound and therefore is best heard using the bell of the stethoscope over the mitral area.

Cardiac Murmurs:

These should always be evaluated after auscultating the heart sounds. Murmurs are caused by turbulent blood flow and can be either pathological or benign. Murmurs have 3 main causative factors:

- High blood flow rate through normal or abnormal orifices,
- Forward flow through a narrowed or irregular orifice into a dilated vessel or chamber
- Backward or regurgitant flow through an incompetent valve (ACC/AHH Guideline 2008).

Seven characteristics are used to describe cardiac murmurs:

- Location
- Intensity
- Duration
- Frequency
- Quality
- Timing
- Configuration

Location: refers to the anatomical region which the murmur is audible the best.

Intensity: refers to how loud the murmur is on auscultation and can be classified by using the Levine grading scale: table 1

Duration: refers to length of time that the murmur is audible through systole and diastole.

Frequency: can be described as high or low. **Quality:** describes the sound that is produced, it could be described for example as harsh or blowing.

Levine grading scale:

Grade 1	Barely audible with stethoscope
Grade 2	Audible when placing stethoscope on chest, however quiet and faint
Grade 3	Easily audible on auscultation and moderately loud, no palpable thrill
Grade 4	Moderately loud murmur with palpable thrill
Grade 5	Audible when only edge of stethoscope on chest
Grade 6	Audible to the naked ear, accompanied by palpable thrill and often radiates to other structures

Table 1

Timing: refers to where the murmur occurs during the cardiac cycle. It can therefore be described as systolic or diastolic. Consequently they can be further classified according to their timing within each specific phase of the cardiac cycle. For example if a murmur is audible throughout the whole of systole, this could be described as holosystolic (pansystolic).

Configuration: refers to the pattern of a murmur as it is recorded on a phonocardiogram (Massey 2006). It is defined by the changes in intensity during systolic or diastolic. This is determined by flow across pressure gradients. For examples crescendo murmurs which increase in intensity as the pressure gradient increases, decrescendo murmurs decrease in intensity as the pressure gradient rises. Crescendo-decrescendo murmurs initially increase and then decrease as the pressure gradient changes and a plateau murmur will remain at an equal intensity throughout.

Systolic and diastolic murmurs.

Systolic murmurs may be normal or abnormal. They can be sub classified by their timing into

- Early
- Mid
- Late systolic
- Holosystolic

Systolic murmurs can then be divided into

- Ejection
- Regurgitant
- Shunt murmurs

Ejection systolic murmurs are caused by turbulent blood flow through narrowed or irregular valves. Below are common clinical conditions which can cause ejection systolic murmurs (Chatterjee 1999):

- Aortic stenosis,
- Pulmonary artery stenosis
- Hypertrophic cardiomyopathy
- Atrial septal defect

Regurgitant murmurs represent abnormal flow into chambers that are of lower resistance, this could be due to tricuspid and mitral valve regurgitation, typically they are holosystolic and loud.

Shunt murmurs can originate at the site of the shunt i.e. ventricular septal defect or they are the result of altered haemodynamics remote from the shunt.

Diastolic murmurs are always abnormal and predominantly are

- Early
- Mid systolic.

Early diastolic murmurs are usually due to aortic or pulmonic regurgitation. Aortic regurgitation could be the result of infective endocarditis which can cause the destruction

of the valve leaflets. Typically aortic regurgitation is described as having a decrescendo configuration because the magnitude of regurgitation progressively declines. The area of maximum intensity may vary considerably, some patients it may be audible over the mid precordium, left sternal edge and on occasion over the cardiac apex. Mid diastolic murmurs are typically due to mitral or tricuspid valve stenosis. They are the result of turbulent blood flow across the atrioventricular valves during the rapid filling phase. Mitral stenosis is low pitched and has a crescendo-decrescendo configuration, audible best over the apex with the patient in the left lateral position.

A simple mnemonic that can be used as a trigger to remember which murmur is systolic and which is diastolic is:

PASS: • Pulmonary, Aortic Stenosis = Systolic
PAID: Pulmonary, Aortic Insufficiency = Diastolic
Conclusion:

As practitioners our roles are continually evolving to meet service demands within the healthcare environment and we therefore have an obligation to both our patients and employers to continuously strive to update our skills and knowledge. This article has given an overview of cardiac auscultation incorporating both normal and abnormal sounds. As previously discussed it is imperative that we refine our skills and master what is normal during auscultation, this will then enable us to confidently establish what constitutes abnormal sounds.

References:

- Barrett, M.J, Lacey, C.S, Sekera, A.E, Linden, E.A, Gracely, E.J. (2004) "Mastering Cardiac Murmurs", Chest, Vol. 126, pp. 470-475.
- Callaghan, L. (2008) "Advanced nursing practice: an idea whose time has come", Journal of Clinical Nursing, Vol. 17, no.2, pp.205-213.
- Chatterjee,K, (1999) Auscultation of cardiac murmurs, available online at: <http://cmbi.bjmu.edu.cn/~cardiac%20evaluation/Auscultation%20of%20cardiac%20murmurs.htm>. Accessed: 25/04/2011.
- Coombes, R. (2008) "Dr Nurse will see you now", British Medical Journal, 337: a1522.
- Dolara, A. (2008) The decline of cardiac auscultation: 'the ball of the match point is poised on the net', Journal of Cardiovascular Medicine, Vol. 9, pp. 1173-1174.
- Focused Update Incorporated Into the ACC/AHA 2006 Guidelines for the Management of Patients With Valvular Heart Disease. (2008) Journal of American College of Cardiology, Vol.52, no.13, pp. 1-142.
- Jevon, P, Cunningham, A. (2007) Cardiovascular Examination- Part Four Auscultation of the heart, Nursing Times, Vol.103, no. 28, pp. 26-27.
- Massey, D. (2006) Cardiac Assessment Part 2: Auscultation, British Journal of Cardiac Nursing, Vol. 1, no.3, pp.126-130.
- McGee, P, Castledine, G. (2003) Advanced Nursing Practice, 2nd Ed, Blackwell Publishing, Singapore.
- Reddy, P.S, Salerni, R, Shaver, J.A, (1985) Normal and abnormal heart sounds in cardiac diagnosis. Part 2: Diastolic Sounds, Current Problems in Cardiology, Vol. 10, no.4, pp.1-58.
- Scott, H. (2004) "Should nurses in emergency care have practice boundaries?" British Journal of Nursing, Vol.13, no.1, pp. 707-710.
- Shaver, J.A, Salerni, R, Reddy, P.S, (1985) Normal and abnormal heart sounds in cardiac diagnosis. Part 1: Systolic Sounds, Current Problems in Cardiology, Vol. 10, no 3, pp. 1-68.
- Shindler, D.M. (2007) Practical Cardiac Auscultation, Critical Care Nursing Quarterly, Vol. 30, no. 2, pp. 166-180.
- Woods, S.L, Sivarajan Froelicher, E.S, Underhill Motzer, S, Bridges, E.J, (2005) Cardiac Nursing 5th Ed, Lippincott Williams and Wilkins, Philadelphia.
- Wayne, D.B, Butter, J, Cohen, E.R, McGaghie, W.C. (2009) "Setting Defensible Standards for Cardiac Auscultation Skills in Medical Students", Academic Medicine, Vol.84, no. 10, Supplement, pp. 161-167.

Understanding Emotional Intelligence in Relationship to Leadership

Elaine Headley . Senior Charge Nurse . HECT . NHSLanarkshire

Introduction

What makes a good leader? Is there a simple uncomplicated answer to that small question? In all probability that is unlikely. Finding a definition that would describe this concept has never been agreed (Swansburg & Swansburg 2002). In all probability the lack of a clear concise definition is almost certainly due to the fact that leadership is a multi-complex concept; taking in styles, personality, organisational and political influences, ones ability to mentor or coach, effective communication, critical and creative thinking and effective team building. These are just a few titles of the many aspects of this concept, with each aspect further covering a vast array of sub headings.

It is the focus of this article to look at a very different area - the area of emotional intelligence (EI/EQ)—for the essence of this article emotional intelligence will be abbreviated as EI. Caruso et al (2002) described EI as the ability to perceive emotion, to access and generate emotion, to assist thought, and finally to understand emotion, emotional knowledge and intellectual growth. Additionally, Goleman (2001) puts forward the notion that EI refers to ones ability to recognise and regulate emotions in oneself and others.

Background

Traditionally emotion and intelligence were considered two separate entities. Emotion was considered to perceive feelings, empathy and sentiment, whereas intelligence was considered analytical, aptitude and intellect. Charles Darwin, who, in 1872 published his work on emotions in man and animals, viewed the emotional intelligence system as a necessity for the survival of the fittest. According to Darwin it is not the strongest of the species that survives, or the most intelligent, but the one most responsive to change.

Subsequently EI would appear to follow on from Robert Sternberg's (1985) work on 'practical intelligence' and is consistent with theorizing by Nancy Cantor and John Kihlstrom (1987) about 'social intelligence'. Considering briefly the work of Wechsler (1940), who argued that intelligence carries two elements, non-intellective' and 'intellective'. These 'non-intellective' elements, as argued by Wechsler (1940) were affective, personal and social factors. Additionally he argued that the non-intellective abilities were necessary for predicting one's capabilities to succeed.

Mayer & Salovey (1995) brought the concept of emotional intelligence to the forefront of contemporary ideology, with the conceptualization that they describe more specifically by outlining the competencies it encompasses. In their well published 'Ability Model' (1995) they organize these competencies along four branches:

- (1) The ability to perceive, appraise, and express emotion accurately;
- (2) The ability to access and generate feelings when they facilitate cognition;
- (3) The ability to understand affect-laden information and make use of emotional knowledge; and
- (4) The ability to regulate emotions to promote growth and well-being.

It could perhaps be argued that EI is rather broad and includes a range of adaptive characteristics associated with emotions for example, the ability to effectively communicate emotions (Goleman, 2001). Whereas, other principles of EI places emphasis on the cognitive elements, such as emotions aiding judgment and memory (Mayer et al 2000). Furthermore, researchers have conceptualized emotional intelligence both as an ability and as a trait (Goleman 2001 Mayer et al 2001, Schutte & Malouff 1999).

Conversely, it has been argued that EI provides little in the way of substantial evidence and that it is no more than assumptions which is contrary to what researchers have come to expect when studying types of intelligence (Eysenck 2000). Similarly, Locke (2005) claims that the concept of EI is in itself a misinterpretation of the intelligence construct, and he offers an alternative interpretation: it is not another form or type of intelligence, but intelligence—the ability to grasp abstractions—applied to a particular life domain: emotions. He suggests the concept should be re-labelled and referred to as skills.

How does EI link with Leadership?

Looking at the arguments discussed here, how does EI link with leadership? Does it have a place? Leadership is the ability to get the job done with and through others, while at the same time winning their confidence, respect, loyalty and cooperation. Arguably the first part of this statement could also be akin to management. However, the second part of the statement highlights the differences that can exist between a leader and a non-leader. Empirical evidence suggests that the ability for a leader to identify

emotions and feelings within themselves also allows them to accurately identify with the emotions of peers and groups, and correctly identify these emotions (Caruso et al 2002).

George (2000) suggests that leaders' use of emotions can enhance cognitive processes and decision making. He furthermore reports on evidence that positive EI triggers optimism and initiates positive perception and perspectives. George (2000), additionally offers the contrasting comparison of negative EI triggers, proposing that this will ultimately result in pessimism and negativism. There are many styles of leadership and it is unlikely that any one leader uses the same style all of the time. As situations change then styles will adapt to accommodate that change. However if we briefly examine two of these styles, that of transformational and transactional leadership. Then the link between EI and transformational leadership is fairly obvious. Figure 1 highlights some of the qualities that are considered core elements of transformational leadership. It would be somewhat difficult to disassociate these qualities with the positive qualities of EI.

Transformational leaders raise the motivation of followers to reach far beyond their established standards and are individuals who promote effective change individually and holistically in their organization. They achieve this by understanding their followers.

Subsequently it could be argued that this holistic understanding is achieved by the leader having a commonality of understanding with their followers and their EI. Research undertaken by Palmer et al (2001) provided evidence that emotional intelligence correlated with several components of transformational leadership suggesting that it may be an important component of effective leadership.



fig 1

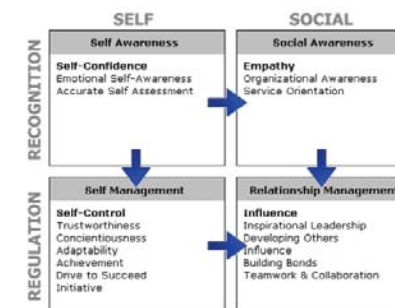


Fig 2

In particular emotional intelligence may account for how effective leaders monitor and respond to subordinates and make them feel at work.

Conversely, transactional leaders are essentially extrinsic motivators, achieving their outcomes by being target orientated. The transactional leader is much more akin to the traditional managerial concept and recognizes the need for the day-to-day running of the organization (Marquis & Huston 2003). Marturano (2004) argues that transactional leadership is built on reciprocity, the idea that the relationship between leader and their followers develops from the exchange of some reward, such as performance ratings, pay, recognition, and praise. Subsequently, Marturano (2004) suggests, that it involves leaders clarifying goals and objectives, communicating to organize tasks and activities with the co-operation of their employees to ensure that wider organizational goals are met.

Although transformational leadership is held as the current ideal and leaders with these qualities are highly desirable, many theorists argue that this style alone will fail if not coupled with transactional qualities (Bass et al 1987, Dunham and Klafehn 1990, Bennis 1989). Perhaps the most effective leaders are the ones who practice situational leadership. Arguably this encompasses all elements of leadership and adapts and changes as the situation dictates. The fundamental ethos behind this theory is that there is no one leadership style that will suit every occasion (Hersey 1985). To link EI with situational leadership, Goleman et al (2004) identified with the elements of EI and situational leadership emphasizing the need for managers/leaders to change as the situation changes fig2. This can be compared with Hersey (1995) descriptor, fig 3, which depicts similar concepts.

Conclusion

Emotional intelligence is not a new concept, but it would appear to be one that is divided between what can be proven by scientific evaluation and the concept of theorists. It can however display many benefits in its understanding that intellect and intelligence are not necessarily the same. I feel that it can be argued that if EI is used in conjunction



fig 3

with transformational leadership then it can enhance the emotional intellect of followers and motivate them to levels that they may have been essentially unaware of. Subsequently if it were possible to enable leaders to have less managerial responsibilities and focus on their leadership qualities then the need for the transactional element would be greatly reduced. However in today's health care culture the latter suggestion is unlikely to materialize. Therefore we look set to adopt a multi-faceted style of leadership, ideally one that also enables us to allow the development of emotional intelligence. Perhaps this concept would provide accommodation for more situational leaders to emerge?

References

- Bass, B.M., Avolio, B.J., Goodheim, L.(1987) "Biography and the assessment of transformational leadership at the world-class level", *Journal of Management* (Jan), pp.7-19.
- Bennis, J. L.(1989) *Why leaders can't lead*. Jossey-Bass: San Francisco
- Cantor, N., Kihlstrom, J. F.(1987). *Personality and Social Intelligence*. Prentice-Hall: Englewood Cliffs, New Jersey.
- Caruso, D.R., Mayer, J. D., Salovey, P. (2002) *Emotional Intelligence and Emotional Leadership*. In F.J. Pirozzolo (2002) *Multiple Intelligence and Leadership*. Mahwah, N.J: Lawrence Erlbaum Associates, Inc., Publishers
- Darwin, C. (1872) *The Expression of the Emotions in Man and Animals*. University of Chicago Press: Chicago.
- Dunham, J., Klafehn, K.A.(1990) "Transformational leadership and the nurse executive", *Journal of Nursing Administration*. Vol. 20, no. 4, pp. 28 – 34.
- Eysenck, H.J. (2000) *Intelligence: A New Look*. ISBN 0765807076
- George, J.M.(2000) "Emotions and Leadership: The Role of Emotional Intelligence", *Human Relations*, Vol. 53, no.8, pp.1027-1055
- Goleman,D.(2001). *An EI- Based Theory of Performance*. In D. Goleman (2001) *The Emotional Intelligent Workplace: How to select for, Measure and Improve Emotional Intelligence for Individuals, Groups and Organisations*, Jossey-Bass: San Francisco.
- Goleman, D., Boyatzis, R., & McKee, A. (2004). *Primal Leadership: Learning to Lead with Emotional Intelligence*. Harvard Business Press. (ISBN: 1591391849)
- Hersey, P. (1985). *The situational leader*. New York, NY: Warner Books
- Locke, E. A. (2005). "Why emotional intelligence is an invalid concept". *Journal of Organizational Behaviour*, Vol. 26, pp. 425–431.
- Marturano,A.(2004) *Transformational and Transactional Leadership: A critique*. <http://www.centre.exeter.ac.uk> [online] available [accessed] April 2011
- Mayer, J. D., Salovey, E. (1995). *What is emotional intelligence?* In Salovey, P., Sluyter, D. (1995). *Emotional development and emotional intelligence: Educational implications*. Basic Books: New York.
- Marquis .B.L., Huston,C.J.(2003) *Leadership Roles and Management Functions in Nursing: Theory & Application* (4th ed). Lippincott, Williams & Wilkins: Philadelphia.
- Mayer, J.D., Salovey, P., Caruso, D.R., Sitarenios, G. (2001) "Emotional intelligence as a standard intelligence", *Emotions*. Vol. 1, no.3, pp. 232-242.
- Palmer,B., Walls,M., Burgess,Z., Stough,C.(2001) *Emotional Intelligence and Effective Leadership*. *Leadership and Organisational Development Journal* 22:1 pp5-10
- Schutte, N.S., Malouff, J. M. (1999) *Measuring emotional intelligence and related constructs*. Edwin Mellen Press: Lewiston, New York
- Sternberg, R. J. (1985) *Beyond IQ: A Triarchic Theory of Human Intelligence*. Cambridge University Press: Cambridge, England
- Swansburg, R.C., Swansburg, R.J. (2002) *Management and Leadership for Nurse Managers*, 3rd ed., Jones and Bartlett: Massachusetts.
- Wechsler, D.(1940) "Non – intellective factors in general intelligence", *Psychological Bulletin*. Vol. 37, pp. 444 – 445.

MEET YOUR CONFERENCE SPEAKERS

MAGGIE GRUNDY

Before joining NES in 2006 Maggie held various positions in both the NHS and Higher Education sectors. She has extensive experience of education in both clinical and educational settings and is committed to providing relevant, accessible and flexible education to meet the changing demands of health care practitioners. Since joining NES Maggie has led various strategic educational initiatives working closely with Health Boards, Scottish Government and the voluntary sector. Her main areas of responsibility include cancer, palliative care, communication and interpersonal relationships and advanced nursing practice which brings her here today.

PENNIE TAYLOR

3 Queen Margaret Road,
North Kelvinside, Glasgow G20 6DP
Tel 0141-946 4263
Mobile 07718-523 418
E-mail pennie.taylor@ntlworld.com

Pennie Taylor is a Glasgow-based journalist, broadcaster, and health communications specialist. She has a particular interest in effective change management, and is a renowned champion of public and staff involvement in the development of public services. A former Health Correspondent for BBC Scotland and Health Editor of the Sunday Herald newspaper. Pennie continues to cover health issues as a freelance writer and broadcaster. She has also worked within the NHS, acting as Head of Communications for Lothian University Hospitals from: 2000-2002. Pennie met ACAP member Elaine Headley at a meeting of the NHS Lanarkshire Leadership course in 2010. Ever since, she has been thrilled to follow what Scotland's Acute Care Advanced Practitioners are achieving on behalf of patients.

STEVE MCCORMICK

Lead Antimicrobial Pharmacist,
NHS Lanarkshire BSc (Hons)
Pharmacy graduate from University
of Strathclyde in 1992.

Clinical Pharmacist training position with Ayrshire & Arran Health Board followed. Post Graduate Diploma in Clinical Pharmacy gained from University of Strathclyde in 1997.

After a year's sabbatical working & travelling Australasia, varied experience as independent locum clinical pharmacist over 2 years for a number of hospitals throughout south of England/London area led to the position of Specialist HIV Pharmacist at Guys & St Thomas' NHS Trust in 2000. Teacher practitioner position afforded numerous research opportunities & attainment of Non Medical Independent Prescriber status with particular focus on antiretroviral management in a busy London HIV outpatient clinic setting. 10 years clinical experience in managing severely immunocompromised inpatients with complex opportunistic infection completes infection management background & led to application to current antimicrobial post early 2009. Introduction of initiatives advocated by ScotMARAP to improve quality of antimicrobial prescribing within NHS is the focus of all current activity.

DOUGLAS ALLAN

Douglas Allan is a Senior Lecturer in the School of Health at Glasgow Caledonian University and is also the Post Graduate Framework Coordinator with responsibility for overseeing all the health and social work related Master's programmes. He has 35 years experience of teaching in both the NHS and Higher Education sector and prior to this worked as a nurse in the NHS. He has an active interest in advanced practice and is Chair of the Association of Advanced Nursing Practice Educators (www.aanpe.org) a UK wide consortium of 40 universities engaged with teaching advanced practice. He is also a member of the NES Advanced Practice Succession Planning Steering

Group and was involved in the development of the Advanced Practice Toolkit.

DR. MICHAEL MCLAUGHLIN

Michael McLaughlin is a registrar in anaesthetics currently working in the Royal Alexandra in Paisley. He graduated from the University of Dundee in 2006, MBChB, and was the undergraduate prize winner in paediatrics. He worked as a JHO at the Victoria Infirmary then spent his SHO year working in Ayr (Acute stroke, A&E and orthopaedic jobs). He started training in Anaesthetics at Monklands in 2008 and is currently on specialist rotations. He is a trained undergraduate PBL facilitator and OSCE examiner. He also teaches on the undergraduate acute care days as well as on the IMPACT course. Research - 'The effects of epilepsy on adolescents and their parents. A qualitative study.' - shortlisted for undergraduate award. Audit - 'Junior doctors knowledge of resuscitation guidelines.' Ongoing audit - 'Assessment of current LMA cuff pressures and how to combat high pressures.' He is also developing a nausea and vomiting guideline for anaesthetists at the RAH.

GILLIAN MCNAUGHTON

Gillian is currently an Advanced Nurse Practitioner on the Hospital at night team at Ayrshire & Arran. She has a BSc Professional Development (Nurse Practitioner) and is currently working on her MSc in Nursing. She has over 20 years nursing experience, working in various settings, her most recent posts prior to Hospital at Night is as a Clinical Night Co-ordinator within Ayrshire & Arran, prior to that she worked in orthopaedics at the Southern General Hospital. She has been involved in developing a patient safety guideline on early management of head injuries sustained whilst in hospital, and is now currently involved in developing guidance on the essential care of the patient who falls in hospital.