Issue 2
March 2011

ACAP
Acute Care
Advanced Practitioners

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

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Advanced Practitioners

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DELEGATE RESERVATION FORM

ACAP FORUM EVENT

24th June 2011

Medical Education Centre, Kirklands Hospital, Bothwell

Full Name of Delegate.....

Designation.....

Organisation .....

Address .....

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TelephoneNo.....

Email address.....

Special dietary requirements.....

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I attach a cheque for £30 payable to ACAP Scotland.
If you require a receipt, please tick here ☐

Signed: .....

Date: .....

Please note

No registrations will be accepted without an accompanying cheque.
One form should be completed for each delegate attending the Conference.

Completed forms and accompanying cheques should be forwarded to:
Fiona Buchan ACAP Treasurer
18 Abbotsford Road, Galashiels TD1 3DS
Fiona_buchan@btinternet.com

Places are limited so please book by 24th May 2011

To receive a copy of future ACAP publications please email elaine.headley@gmail.com or jsmith53@nhs.net

Feedback

Feedback from the first issue of The Advanced Nurse Practitioner has been extremely positive. Many practitioners have taken time to get in touch with Elaine & Julie to state how professional and informative the journal is. Also that the layout and design displays a modern feel and is easy to read through.

Themes

Over the course of the next few issues of The Advance Nurse Practitioner there will be a theme which will look at some of the legal and ethical issues that surround advanced practice. It is hoped that this will provide a deeper awareness and prompt discussion within the practice of current issues that can/could affect the level we work at.

More articles

A great deal of practitioners are now keen to have their work published. ACAP is delighted by this, as it is important to encourage writers to have their work put into print. Please continue to send your articles to us and we will endeavour to get them published for you.

ACAP is still fortunate to have Felicity Garvie, from Dundee University as proof reader for many of the articles.

Words of support

Many congratulations on the work that you've managed to take forward in such a short space of time.

I'm delighted to see the growing network of ANP's across NHS Scotland and the increasing clarity and consistency emerging around this role.

Indeed, one of the key messages which underpinned the Advanced Practice Toolkit has been the need to support and build-upon consistency, both within Scotland and across the UK and I hope that your forum will continue to support this process.

I'm pleased to see links to the Toolkit and the NES website on your site and would encourage you to disseminate any new information regarding advanced practice as it emerges.

Mike Sabin

ACAP a charity

The ACAP team is delighted to inform all its members that we have secured charity status, from OSCR. This has been a fairly lengthy process that we have been working on for several months, but all the hard work has paid off. Becoming a registered charity will provide ACAP with much more credibility from a governance perspective. Fiona and Hazel (ACAP treasurers) have done a tremendous job in achieving this.

Link Practitioners

A new ACAP member, Cecila Findlay, from Ninewells hospital, has nominated herself as the 'link' person for that area. This is a really good idea, so if there are other practitioners who would be keen to do the same can you let Julie or Elaine know.

June Event

Preparation for the Forum conference in June is well underway. ACAP have called for posters and have included delegate registration forms within this issue. The places will be taken up quickly, so please return your form promptly when you receive it.

ACAP is delighted to have kept the cost for the day to a minimum. £30 will provide you with delegate packs, a full day of speakers, education, interaction and networking. Tea, coffee and a buffet lunch is also provided.

there will be photographs on the day if anyone objects to their picture being taken or used in future journal editions please indicate to an ACAP commitee member.

Apologies

ACAP would like to apologise for the error in printing Mr. Tim Davison name - we printed it as Tim Davies

Proof readers for this issue:

Felicity Garvie - Dundee University
Douglas Allan- Glasgow Caledonian University.

Clinical Management of a patient with actual or suspected head injury (sustained in hospital)

Gillian McNaughton

Advanced nursing practice is increasingly recognised as a way to deliver new service models. However nurses in these roles often find themselves in the role of follower, with few percieved opportunities to broaden and deepen their leadership and management skills. Leading involvement in patient safety initiatives is one route where advanced nurse practitioners can demonstrate their organisational leadership contribution.

Following a local adverse incident review within NHS A&A it was identified that guidance was required, for healthcare professionals, aimed at improving the clinical management of patients who have had an actual or suspected head injury sustained while in hospital. A small working party was brought together and a comprehensive literature review carried out. The review concluded that the only currently available guidance was specifically for patients presenting to Accident and Emergency departments with a head injury. To use the guidance more widely there was an element of individual interpretation required depending on the clinical setting, and staff groups across a variety of in hospital settings.

The author, supported by the Practice Development Unit developed a local guideline on the "Clinical management of a patient with actual or suspected head injury (sustained in hospital)". It features an easy to read Algorithm for healthcare professionals to follow, thereby ensuring that the care patients can expect is:

- Prompt (timely)
- Person centred (based on the need of the individual)
- Safe (evidence based)
- Effective (appropriate treatment at the appropriate time)
- Equitable (available uniformly across the hospital)
- Effective (appropriate use of evidence based intervention at the appropriate time)

(Healthcare Quality Strategy 2010).

Box 1
• Most only received training on head injury whilst they were a student nurse
• There was a lack of clarity on: ○ what age groups were at highest risk; ○ what groups of patients were at highest risk; ○ what presentations would alert staff that the patient had a suspected or actual head injury/possible brain injury ○ Frequency of carrying out observations.

Prior to the development and implementation of the guideline, a Training Needs Assessment (TNA), supported by the Clinical Effectiveness Support Department, was undertaken to obtain a 'baseline', on the current knowledge level of registered nursing staff on the clinical management of a patient with actual or suspected head injury. The issues identified in the TNA carried out with the registered nursing staff are shown in box 1.

A further TNA will be undertaken in May 2011 to evaluate the effectiveness of the guideline, one year after it's roll out.

The guideline has provided a nursing solution to an organisational concern. The solution was evidenced based, met the six areas of quality discussed in The Healthcare Quality Strategy (2010). Of significance in the current financial climate, this patient safety initiative was cost neutral.

It is argued that by being involved in this process the lessons learned have improved the skill set across the four areas of clinical/professional leadership; facilitating learning; research and development; and advanced clinical practice recognised by both the Scottish Government Health department (2007) and The Department of Health (2010).

Developing leadership, follower and management skills across the four themes would not have been easy to obtain through just academic or clinical learning. As a result there is a call for ANP's to be actively involved in more than just clinical service delivery.

Gillian Mc Naughton
Advanced Nurse Practitioner
NHS Ayrshire & Arran

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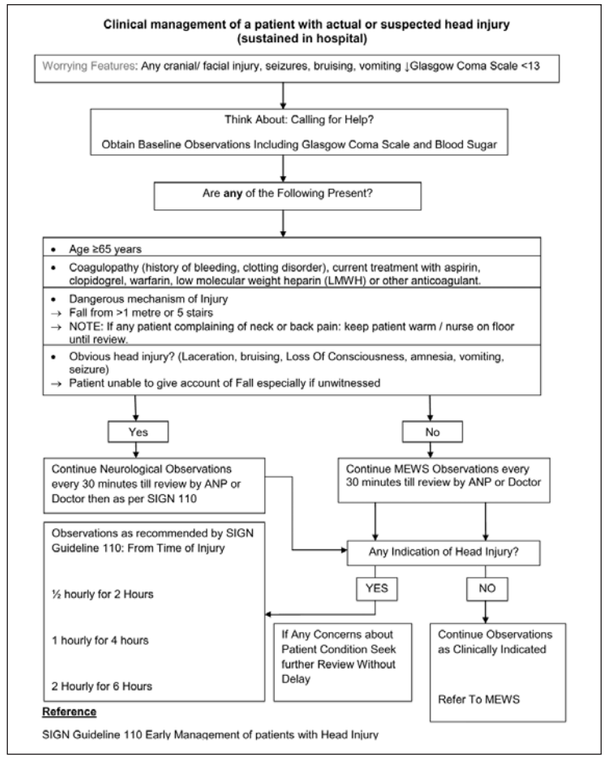
Clinical management of a patient with actual or suspected head injury (sustained in hospital)



The impact upon mortality due to sepsis following the introduction of a restrictive empirical antibiotic policy in NHS Lanarkshire

White B[1], Inverarity D[2], McCormick S[3], Dundas S[1]

1. Infectious Diseases Unit, Monklands District General Hospital, Lanarkshire
2. Department of Microbiology, Monklands District General Hospital, Lanarkshire
3. Pharmacy Department, Monklands District General Hospital, Lanarkshire

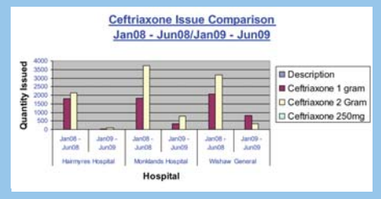
Introduction
In 2008 the Scottish Antimicrobial Prescribing Group (SAPG) set Minimum Requirements for Antimicrobial Prescribing policies in NHS Scotland, to advance implementation of the Scottish Management of Antimicrobial Resistance Action Plan (ScotMARAP) [1]. NHS Boards were required to ensure that empirical antimicrobial policies met standards developed to reduce the rise in antimicrobial resistance and Clostridium difficile infection (CDI) [2]. In response NHS Lanarkshire (NHSL) implemented a restrictive empirical antibiotic policy across 3 acute hospitals in August 2008.

In February 2009 a bacteraemia audit in NHSL [3] provided evidence of significant delays in initial effective antibiotic administration, largely attributable to delayed administration of gentamicin which is a critical component of the new antibiotic regimens. Consequently there was concern that there may be increased sepsis related mortality since the introduction of the new policy.

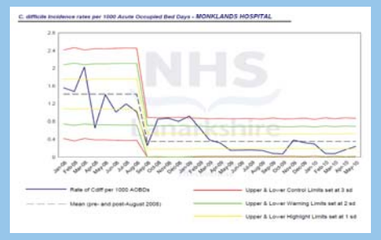
Objectives
Our primary objective was to determine sepsis related mortality rates before and after the introduction of the restrictive antibiotic policy, to identify any increase in mortality attributable to the reduction in use of broad spectrum antibiotics. A secondary objective was to show the impact of the new policy on CDI related mortality.

Methods
ICD 10 data was obtained for in-patient mortality due to septicaemia (including Gram negative, staphylococcal and streptococcal sepsis), pneumonia and CDI for 6 months before the introduction of the policy (1st January to 30th June 2008), and the same 6 month period the year after the policy was introduced (1st January to 30th June 2009) for Monklands, Wishaw and Hairmyres Hospitals. Pharmacy provided data on ceftriaxone consumption for the same periods.

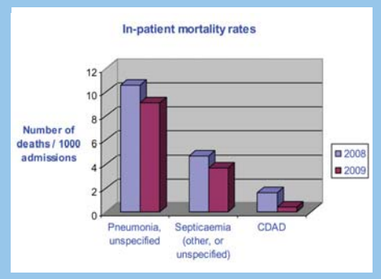
Findings
1. Reduction in ceftriaxone consumption: There was evidence of the impact of the restrictive policy on antibiotic prescribing with an 83% reduction in ceftriaxone consumption between the two periods (from 14754 to 2428 ceftriaxone issues).



2. Reduction in Clostridium Difficile infection rates: There was also a significant decrease in CDI incidence from 1.98 to 0.65 per 1000 acute occupied bed days ($p<0.0001$). Mortality attributable to CDI was significantly reduced from 1.6 to 0.4 per 1000 admissions ($p<0.0001$).



3. Reduction in in-patient mortality: The in-patient mortality rate due to septicaemia showed a non-statistically significant reduction from 4.7 to 3.7 per 1000 admissions ($p=0.061$), and for pneumonia a statistically significant fall from 10.6 to 9.1 per 1000 admissions ($p=0.045$).



Discussion
Our data demonstrate no increase in mortality due to sepsis following the introduction of the restrictive antibiotic policy. This is reassuring, particularly in view of evidence of delayed administration of gentamicin. In NHSL gentamicin prescription is facilitated by an online calculator however dose calculation requires the patient's creatinine, weight and height and some delays are unavoidable. Interventions have taken place in NHSL to facilitate and emphasise the urgency of initial gentamicin prescription.

There is clear evidence of a significant reduction in CDI infection and mortality rates after the introduction of the restrictive antibiotic policy.

Conclusions
The introduction of the restrictive antibiotic policy has led to a significant reduction in CDI and CDI related deaths. There is no evidence of an increase in mortality, despite the increased use of antibiotic regimes which require more time and information to prescribe.

References

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[2] Minimum Requirements for Antimicrobial Prescribing www.scottishmedicines.org.uk/smc/6627.221.286.html

[3] Robertson P, Hunter P, Inverarity D. An Audit of the Recognition and Management of Early Bloodstream Infection at Monklands District General Hospital. March 2009 (unpublished)

Acknowledgments
Thanks to Kathleen McArthur, pharmacist, for collection of antibiotic usage data and to Alex Royle of the NHSL IM&T department for obtaining mortality data.

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Renal HDU / Critical Care Article:

Tracy Laird / David Watson

Tracy Laird and David Watson are both senior charge nurses working in the Hospital Emergency Care Team (HECT) in NHS Lanarkshire. Both have a background in renal care.

In keeping with the ethos of this journal and advancing practice, the following article will explore the development of high dependency care with the realms of renal nursing.

Florence Nightingale wrote about the advantages of establishing a separate area of the hospital for patients recovering from surgery (Society of Critical Care 2001). However, as a consequence of poor facilities and small numbers of trained staff, little changed regarding where and how patients were nursed at this time. It was not until the 1950's that the first specialised critical care units were established, primarily as a result of an outbreak of polio where specialised ventilatory support was required to maintain life (Cahnman 2008). Since then the concept of specialised or intensive care has grown steadily partly due to the increase in medical and nursing expertise to care for critically ill patients. However, the increased dependency of the patient highlighted a shortage of well equipped specialised areas to care for these patients and to address the shortfall the number of critical care units were increased to meet demand (Cullen et al 2003).

The past decade has witnessed dramatic changes in the delivery of critical care services within the United Kingdom. The catalyst for these changes was the publication of Comprehensive Critical Care (Department of Health 2000). This report emphasised that patients should receive care in relation to their individual needs and not the designated ward area or bed in which they occupied. Essentially, the phrase "critical care without walls" introduced the concept that critical care was not merely in relation to intensive care, but focused on those who were critically ill, recovering from critical illness, or those who have the potential to become critically ill (Department of Health 2000). As critical care delivery has evolved, more and more high dependency areas have also emerged. The Department of Health (DoH) recommends that patients should be classified according to the severity of their illness and as such, NHS sites adopted this classification of level of care throughout their clinical areas (figure1).

A similar classification was implemented in Scotland from the recommendations made in the Better Critical Care Report (SEHD 2000). NCEPOD reported in 2009 a study of 215 hospitals nationwide that the number of patient deaths from ARF to be 976 (following exclusion criteria). When auditing patient outcomes it was found that of 564 patients, only 113 were transferred to renal/ critical care for escalation of care and that another 44 patients should also have been escalated to a higher level of care. Renal Replacement Therapy (RRT) for Acute Renal Failure almost doubles the number of patients having to commence this treatment. A study of Scottish Renal units in 2002 outlined that 203 patients per million per year require dialysis with Chronic Kidney Disease. Sadly of those requiring RRT for ARF 73.4% died within 90 days (Metcalfe and Simpson et al, 2002). Liano in earlier work (1996) also produced documentation that showed mortality in patients suffering with ARF was found to be 27%, with almost 45% of these cases having a diagnosis of Acute Tubular Necrosis (ATN).

Level of Care	Needs
0	No organ support , monitoring that can be maintained on a general ward
1	Epidural , Higher frequency or level of observation than can be provided in general ward
2	One Organ Support
3	Advanced Respiratory Support (Ventilation) or Two organ systems support , or one organ support and a different organ chronic failure.

Figure1 : Level of Care (NHS National Services Scotland 2010)

More recently in the past few years, we have witnessed the evolution of Renal High Dependency nursing and medical care. Historically those patient who needed critical care provision would need to be transferred to an intensive care unit, where they would receive care from both a renal physician and an intensivist. Now these patients are able to stay in the Renal Unit, under the care of staff with whom they and there families have built a rapport and receive the appropriate care. It should be emphasised that these patient should still be transferred to intensive care in a timely fashion if their clinical condition warrants.

The issue of appropriate training in relation to critical care has been identified in numerous reports (DoH 2000, DoH 2005). A key recommendation arising from these reports was that a framework of courses should be developed and available to sustain the development and improvement of critical care services. The need for appropriate training is still being identified in more recent publications by the Royal College of Anaesthetists (2009).

They emphasise that all members of the care team involved in the delivery of critical care services should be trained appropriately with identified continuous professional development in place. For those staff working within the renal unit, a large learning curve was undertaken with the installation of HDU level beds. Staff had to further develop their recognition of sick patient skills, utilisation of increasingly complicated technology and devices, delivery and administration of advanced treatments' to critically ill patients. A variety of approaches were utilised. Staff partook of the courses offered by our Practice Development Centre. These covered such topics as Invasive monitoring (Central Lines and Arterial Line management), Male catheterisation, Non Invasive Ventilation. Small workshop type sessions were held in the ward a list of topics covered is summarised in figure 2.

Topic	Rationale
12 Lead ECG	High incidence Coronary Artery Disease in the patients with Renal Failure. Multiple risk factors
Cardiac Monitoring	High Incidence Coronary Artery Disease in patients with Renal Impairment. Risk of Arrhythmias due to electrolyte disturbance.
Hemodynamic Monitoring	Facilitate the safe use of administering inotropic support to patients, sensitive monitoring of hemodynamic status.
Electrolyte Disturbances	High incidence of Hyper and Hypokalaemia and other electrolyte disturbances
CPAP	Allow the safe implementation of Non Invasive ventilation for patient in renal impairment presenting with pulmonary oedema.
Sepsis	High prevalence of sepsis currently in healthcare, with it a high mortality rate. Sepsis common cause of ARF.
Arterial Blood Gas Analysis	Enable accurate assessment of patients acid base and clinical needs

Figure 2 : Teaching Topics

Supervised bedside teaching was also incorporated in training the staff and allowing them to feel competent. In conjunction with the Hospital Emergency Care Team, a training programme and supervision were adopted to allow the safe implementation of CPAP (Continuous Positive Airway Pressure). Appendix 1 shows flow chart that was designed to facilitate this. Interestingly, an audit of critical care services in Scotland (NHS National Services Scotland 2009) found that specialist HDU's rarely provided Non Invasive Ventilation.

In conclusion, Renal HDU can be a challenging yet rewarding place to work. With the increasing numbers of patients being admitted with ARF and more patients commencing renal replacement therapy for ESRF, the evolution of Renal HDU is a logical progression. The key is structured implementation and ongoing support. With these in place, this challenging yet rewarding field of renal nursing can expand. For future development, perhaps other specialities, like renal, should take the opportunity to develop higher levels of care within their own areas, but only if appropriate training and support are available.

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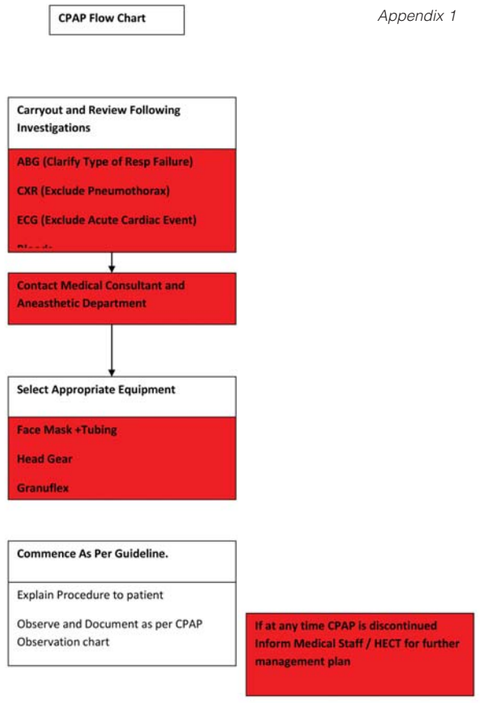
Appendix 1



ACAP
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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

Master-classes and titles :
Steve McCormick: Protocol to Practice- Does it Work? - Antimicrobial 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

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
March 2011	Infection Control Legal Issues Head Injury Guidelines
June 2011	Legal issues Primary Care Issues Cardiovascular Examination Sepsis
Sept 2011	Legal Issues Neuro Examination ENT Stroke thrombolysis
Dec 2011	Legal Issues Respiratory Examination BiPaP/ CPAP ABG Interpretation

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ACAP Conference : June 24th 2011

ACAP are delighted to have secured a booking for their first forum conference at the new Medical Education Centre (METC) at Kirklands in Bothwell, Lanarkshire. This venue, which opened in May 2010, will provide ACAP with all the facilities required for our first Scotland-wide event. Hosting state-of-the-art simulation and training facilities coupled with well-appointed lecture theatre and syndicate rooms, it is exactly what ACAP was looking for.

The lecture theatre is equipped with a 4-metre projection screen, so regardless of your seating area you will not miss anything. There are radio and hand-held microphones to accommodate audience interaction. Touch-screen panels offer effortless access to operate the multimedia equipment. The syndicate rooms are equipped with Smartboard projection facilities; in addition, the main conference room has a large drop-down projection screen and multi-media projector.

The centre is a collaboratively funded venture by NHS Lanarkshire and the University of Glasgow, in association with NHS Education for Scotland (NES). It is designed to enable competency-based learning for a wide range of users including medics, medical students, nurses and allied health professionals. This provision will enable ACAP to showcase master classes, facilitate networking and benchmarking from regions throughout Scotland, as well as enhance educational development, which ultimately will smooth the progress of improvement in patient care through growth in advanced practice.

These sentiments were endorsed at the opening of METC, when Ken Corsar, Chair of NHS Lanarkshire, said "Thanks to these facilities, we can offer our clinical staff excellent educational and development opportunities which will be of great benefit to patients."

Tim Davison, Chief Executive, NHS Lanarkshire

Hazel Scott, Director of Dept. of Medical Education, NHS Lanarkshire

Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing

Ken Corsar, Chair, NHS Lanarkshire.

The centre is easily accessible from all areas within central Scotland. Situated just off the M8, it is ideally located on the route from Glasgow to Edinburgh.

See more of the venue at - **www.metc.scot.nhs.uk**

Bothwell village houses one of the area's most prestigious hotels, which is only a short drive from the venue. This would make the ideal stopover for those who need to travel.

Duty of Care

Julie Smith & Elaine Headley

The legal and ethical mechanisms involved in healthcare are multiple and complex. This article and subsequent articles in following journal issues are intended to present the reader with an overview of the main legal and ethical issues pertinent to advanced practice. It is intended to provide Advanced Practitioners with the main points of each subject and thus to encourage food for thought and promote discussion with fellow colleagues.

The term "duty of care" is frequently used by both nursing professionals and the media, but what exactly does duty of care mean? How does this translate into clinical practice and what constitutes a breach of that duty? A duty applies anytime a professional undertakes the care of a patient or performs an activity. A duty of care can therefore be explained simply as a professional acting appropriately when providing said care or delivering a service to the public (Mikos-Schild 2008). The same patient may be owed a duty of care by a number of healthcare professionals, and whilst the professional performing a particular task is said to owe a direct or primary duty of care, it must be noted that if that task has been delegated by a more experienced member of the team, the person delegating that task may also hold a direct duty of care, in ensuring the task was delegated to an appropriately trained individual.

Subsequently, when considering a duty of care it is essential to bear in mind that in today's ever increasing sick society, nurses merely work in the shadow of the legal sphincter, with only the minimal training in legal aspects of healthcare (Roberts 2007). This can often, as suggested by Roberts (2007), leave us feeling hesitant with our management and initiation of treatment. Additionally, as advanced practice becomes more widespread, with advanced nurse practitioners displaying autonomous practice, making complex decisions and prescribing for the most part to the sickest patients in the hospital, the need to be aware of the legal implications of our practice is now more essential than ever before.

As advanced nurse practitioners (ANPs) we hold a duty of care to the patients that we are required to review in the course of our work. However, is it always clear and concise what a duty of care actually means and should we be aware of the relevance on us in both a professional and personal capacity? Stipulation from the Nursing and Midwifery Council (NMC) (2008) highlights that healthcare practitioners have a professional duty to provide care and said care provided would be judged against what could reasonably be expected from someone with your knowledge, skills and abilities when placed in those particular circumstances.' This then begs the question, who will advanced nurse practitioners be judged against - the nursing profession or the medical profession? Jones et al (2007) point out that in a court of law, the skill level of a non-medical professional who undertakes a task which is normally attributed to medical staff will be judged against the usual practice of a medical practitioner. Consequently, it is essential that ANPs work within their own sphere of competence and absolutely must not agree, or be coerced into taking on tasks which fall beyond their competence.

From the discussion above it is clear and unambiguous what a duty of care means, but what then does a breach in duty of care represent? The 'Bolam test' highlights three components that should be shown when there is the possibility of libellous action against a practitioner or a hospital (Shanmugam 2002). The first two of these are essentially to identify a duty of care and to establish whether or not there was a breach in that duty. Shanmugan (2002) argues that identifying a duty of care is easily established, in that the hospital or practitioner owes the patient a duty of care when there is acceptance to treat the patient. However, to establish when a breach of that duty has occurred, it has to be proven that the practitioner/ hospital has been careless when providing treatment for the patient. It must be proven that the practitioner fell below the required standard of care – this is the Bolam test. Although the Bolam test was set in the judiciary of the English High Court, Scottish courts took a comparable decision in Hunter v Hanley (1955 as cited by JL Duncan). The NMC (2008) guidelines would appear to reflect the findings of the Bolam test, in that the practitioner in such cases need not possess the highest expert skill; it is sufficient if he exercises the ordinary skill of an ordinary competent practitioner, exercising that particular skill. However, this becomes significant for practitioners who undertake roles normally attributed to medical staff, in cases of negligence; as previously discussed, ANPs will, in a court of law be judged against their medical colleagues, who typically carry out these skills. Similarly, McHarg (2008) highlights that from a legal perspective when applying a duty of care, a nurse should be able to show that he/she acts in a way that would be approved by a body of fellow professionals. Beauchamp and Childress (2009) identify essential elements in professional duty of care:

1. The professional must have a duty of care to the affected party
2. The professional must not be in breach of that duty
3. The affected party must experience harm
4. The harm must be caused by the breach of duty.

Interestingly, McHarg (2008) proposes that nurses should practise clinical protocols to the letter; in so doing, if called to account they will have nothing to fear from the NMC, the courts or their own conscience. However, this may raise the questions: do ANPs with increasing autonomy always act under the guidance of protocols and follow them to the letter? Is there room for such tight restrictions on this element of rigidity or is protocol guidance merely no more than that? If we as advanced practitioners consider briefly the contrast between policy, protocol and procedure then it could be argued that a policy is a general description of what the organization wants to accomplish.

In comparison a protocol may be described as a step-by-step description of how something should be accomplished and finally a procedure could be considered a protocol, or indeed something less specific; for example, a description of how a task should be accomplished. Such terminology, as suggested by Mann (1996), is often interchangeable and without precise definition. This does nothing more than fuel more ambiguity. Indeed, Mann (1996) highlights that NHS Executives at that time advised against using the term 'protocol' in relation to development or application of clinical guidelines. Subsequently the question should be asked, where does the question of clinical findings at the time of diagnosis fit into this area? Does one size fit all? Can healthcare legislate for every single situation? While judges will favour clinical protocols and guidelines, if a practitioner can prove that a deviation in protocol or guideline driven care is the route that the ordinary competent practitioner would take, then the Bolam test will overrule in cases of clinical negligence.

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How using Action Research resolved communication problems with H@N in BGH

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Introduction
This article will discuss and highlight some of the issues that faced the H@N team at the Borders General when it became obvious there was a problem with the communications between the team and other areas of the hospital. It will accentuate how the team addressed these issues and through reflection and action research, ultimately led to improvement in communication and in service provision.

A subsequent audit result will follow later in 2011 anticipating the benefits of the use of SBAR.

August 2007 saw the inception of the H@N service in the Borders General Hospital. As with any new service there were some teething problems. However evidence stipulates that team work provides effectiveness and greater achievement than staff who work in isolation (Thylefors et al, 2005). This ideology had been effective in other health boards throughout Scotland where H@N teams were already established.

Although H@N in the BGH had been successful and had received a great deal of positive feedback from both nursing and medical colleagues, the team did become aware of a rise in complaints in relation to response times to calls made from ward staff and the accident and emergency department. Reflecting on this we, as a team realised the importance of addressing this situation to improve relationships and communication. Listening to the dissatisfactions that were relayed back to the team was the first and most important step in improving our service provision. Marquis and Huston (2003) identify listening as a crucial and important form of communication. Adair (1998) argues that team or group organisation provides a primary and secondary system of communication that affords options in decision making and problem solving. Moreover communication is accepted as a pinnacle resource within the Scottish Patient Safety Programme (SPSP) (2010).

In view of all of this our H@N team made the decision to carry out action research. Action research can be defined as '…learning by doing - a group of people identify a problem, do something to resolve it, see how successful their efforts were, and if not satisfied, try again' (O'Brien 1998). This simple and straightforward definition highlights exactly what the H@N team managed to do when we became aware of the complaints that came our way.

Fig 1

The diagram displayed in Fig 1 shows just how effective this form of research can be by encasing it in a circular effect, stipulating that whatever the issues are, they can be revisited time and again.

Following a period of reflection on the communication and response time issues, the H@N team made the collaborative decision to carry out a staff survey looking at the service being provided and how best we could improve it. The strategies agreed from the survey results are displayed in

SUPPORT TOOL for calls to H@N

All requests to be communicated using **SBAR** and utilising **SIRS** scoring.

Task Category	Indication for Task	Possible Attendees	Standard Response	Escalation
Crash Call – Call 2222	Arrest – Peri-arrest	Crash Team	Emergency	
Acute review	E.g., Tachyopnoea, fast AF, GI Bleed, Post op haemorrhage.	Any team member	0 - 15 minutes	H@N Team Leader/ Specialty SPR/ Consultant/ ITU SPR/ ITU Consultant.
Prescribe	Patient in acute	Any team	30 mins – 1	H@N Team Leader
Urgent Fluids/ Medications	pain, urgent medications and fluids including analgesia	member	hour	
Admission clerking	Patient admitted to Hospital in overnight period	Any team member	1– 3 hours (dependant on SIRS score)	H@N Team Leader
Follow on Review (patients alerted at handover)	Patient requires on going review in order to maintain condition	Any team member	2 – 3 hours	H@N Team Leader
Fluids/ medications prescription required.	Routine fluids or medications Patient condition stable and uncompromised	Any team member	2 – 3 hours	Co-coordinator will recontact ward if delay anticipated.

Box 1: November 2010.

The operational strategy prior to H@N involved ward and A/E staff calling the patient's doctor directly. When H@N service went live this became a change in the usual practice with the service operational policy that endorsed H@N. The staff had now to speak to the H@N co-ordinator.

The most frequent comment made on the survey was the long delays experienced after the phone call and before the clinician arrived in the ward/department. Previously staff would call a doctor directly for all their jobs: IV Fluids, medicine changes etc. Their doctor would respond to carry out non-urgent jobs as they were on hand most of the time.

Improvements in the response times are highlighted in Figures 2 and 3 when H@N team went live: The survey was anonymous; it asked a total of six questions which were kept brief and unambiguous to prevent non-compliance by staff. The staff were also given the opportunity to make any other comments on the survey. One of the most crucial questions the survey asked was: Do you use SBAR when communicating with the HAN Co-ordinator?

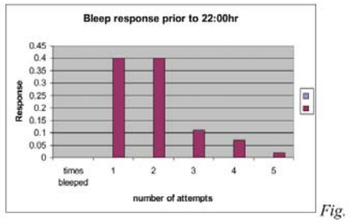

Fig. 2

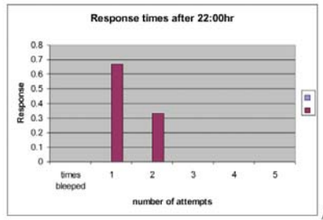

Fig. 3

Only 33% said they used this tool all the time. The team felt this was important and should be highlighted on any communication policy they devised.

The results and comments made from the survey inspired the team to look at ways in which they could alleviate the staff's concerns. White (2004) highlights that a well-designed, comprehensive plan is required for implementation of change. As a team we have come up with a Communication Policy, Support Tool (adapted from NHS Staffordshire H@N team policies), see Appendix 1; and attached to this will be a copy of SBAR, (Situation, Background, Assessment and Recommendation), see Appendix 2. The Communication Policy will be put into place throughout the hospital by April 2011 and the outcome of this tool will be audited later in the year.

The team plan to use this in the medical wards and accident and emergency departments initially from November 2010. Additionally encouragement and support for the night staff to use the tool was provided as well as the necessary teaching required for its implementation. For future audit results and with additional use of Action Research, I will update ACAP with the findings of the ongoing monitoring of the H@N team's progress in this area.

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Appendix 1:

NHS BORDERS

BGH Hospital at Night Communication Policy

This policy seeks to consolidate good practice relating to communication between BGH medical and nursing staff in the overnight period. Co-ordination of the H@N team is fundamental to safe, timely and effective responses to requests relating to patient assessment and treatments, allowing professionals to provide care; limiting unnecessary interruptions; and ensuring the most appropriate member of the team is allocated to the task. All calls to the co-coordinator are prioritised in terms of clinical need.

Medical day teams have a responsibility to ensure that planned tasks are completed (where practicable) prior to H@N handover but on occasion some tasks may remain outstanding. Wards should endeavour to compile a complete list of outstanding tasks (communication between both ends of wards) prior to bleeping the H@N coordinator; this limits duplication of contacts for the same ward/dept.

When contacting the H@N coordinator please use the SBAR tool and ensure that all essential information is to hand. This will enable the H@N coordinator to prioritise the call appropriately.

The attached support tool gives an indication of expected response times to requests. If a delay in response is anticipated, the H@N coordinator will communicate with the ward/dept to receive an update on the patient's condition and to provide an updated expected response time to the request.

June Nelson, Acting Operational Manager, Unscheduled Care
17th November 2010

Calling H@N

Appendix 2

SBAR: Situation, Background, Assessment, Recommendation.

Before calling
1. Assess the patient or patients if calling about multiple issues
2. Have available
3. Case notes
4. Obs chart
5. Kardex
6. Results

DOCUMENT CALL IN CASE NOTES WHEN COMPLETED

Situation:
State your *Name, Ward, Time of call.*
I am calling about: *Patient's name*
The problem I am calling about is: *State the current problem*
I need / don't need you to come to see the patient right away.
Observations: *HR___RR___Temp___BP___Sp02___GCS___Urine output*
SIRS score.
Background:
State the **date of admission** and **admission diagnosis**
State the **pertinent past medical history**
Brief synopsis of treatment to date
Oxygen %/ l/min
IV Fluids
Assessment:
State what you think the problem is
Respiratory/ cardiac/ GI/ GU/ Neurological/ Pain
Examination findings
Current lab results
I believe the problem is:
Recommendation:
Do you think we should: *state what you would like to see done*
I would like you to:
- Come to review the patient
- Advise about further management by telephone
- Refer the patient to ITU
- Arrange analgesia/ other medication/ fluid prescription (s)
- Other suggestion?

Are any other tests needed?
Do you need any other tests now: CXR, ABG, ECG, Bloods
If a change in treatment is suggested:

If the patient does not improve, when would you want us to call you again?

Advanced Nurse Practitioners in Intensive Care - An NHS Lanarkshire Perspective

Martin Carberry Consultant Nurse Critical Care

Background

The scope and potential to develop advanced nursing practice had never been more evident than in the past five years. Advanced nursing roles in ICU are not new indeed they have existed for many years in America and Australia; however they are new to the U.K and had never been used in NHS Scotland. In intensive care the potential impact of Modernising Medical Careers (SEHD 2005) could effectively reduce not only the hours that anesthetic trainees can work in intensive care, but the number of trainees available to them. In an effort to explore a sustainable workforce NHS Lanarkshire examined the outcomes of the Critical Care Practitioner (CCP) pilot in England and Wales (DOH 2008). As a result of extensive research NHS Lanarkshire in 2008 pioneered the development of advanced nursing practice in the Scotland's ICUs via the Advanced Nurse Practitioner Critical Care (ANPCC) programme. Two cohorts of senior critical care nurses were recruited and rotate across three ICUs, two of which are hybrid ICU and HDU facilities. The ANPCCs undertake many of the roles traditionally associated with medical staff trainees in anesthesia and critical care.

Who are the ANPCCs?

Nine experienced critical care nurses from Lanarkshire, Glasgow and Edinburgh were accepted onto the programme. Candidates were expected to have a base degree, a post registration critical care course and five years experience in ICU. The programme consisted of two cohorts of five training band seven nurses in Sep 2008 and four in Sep 2009.

The ANPCC recruitment and selection programme proved to be extremely valuable and well worthy of the comprehensive planning involved. The selection process involved a day of psychometric testing, clinical OSCEs (validated at Glasgow University medical school) and finally a competency based interview. Although a stressful experience for candidates they concurred that the intensity of this type of selection process reinforced the belief that they were the right person for the job. Their training, preparation and role development took full cognisance of the advanced practice guidance for health boards (SGHD 2010).

ANPCC Training and Development

New recruits were afforded the opportunity of supernumerary status for the first two years of the programme. Academic preparation included an initial post graduate certificate in advanced practice and subsequent masters' degree.

A comprehensive competency framework was designed, strongly the influenced by the CCP programme (DOH 2008), anaesthetic training competencies, MMC (SEHD 2005) clinical outcomes and audit of medical trainee activity in the ICU.

The foundation for the ANPCCs development however is the tutorial programme. This programme involves practice based case studies, simulation, problem based learning, OSCEs, site visits and traditional tutorials. This ongoing programme provides an invaluable link with many multidisciplinary staff and outlined the level of knowledge that would be required for the ANPCCs. All ANPCCs have a consultant intensivist as a mentor and are professionally accountable to the nurse consultant. ANPCCs have developed an extensive reflective portfolio with a wide and varied evidence base; this is required in order to progress to a trained ANPCC post at band 8a.

What is their role?

The ANPCCs provide support for the critical care team within and out with the ICU / HDU. The role involves critical assessment of sick patients, treatment planning and procedures such as advanced airway management arterial and central vascular access. The fist cohort of ANPCCs are Non Medical Prescribers (NMP), with the second cohort expected to follow. The integration of NMP into a traditional anaesthetic governed environment presented fresh challenges for clinical and professional governance, namely the prescribing of anaesthetic agents, by law these still require to be prescribed by a medical doctor. Prescribing activity was extensively audited and on the main the ANPCCs prescribe antimicrobials, fluids and electrolytes, with blood and blood products. In addition to this sedation and analgesia are also prescribed.

Evaluation and Governance

The ANPCC programme of assessment is ongoing but has included traditional OSCEs, Multi Source Feedback (multidisciplinary feedback on the practitioners' performance) and DOPS (Direct Observation of Procedural Skills) such as central vascular access and intubation. ANPCCs are now actively engaged in teaching appropriate skills to some junior medical staff in the ICU. Some ANPCCs have now amassed many hours of central vascular access experience, critical assessment and intensive treatment planning skills.

The first cohort of ANPCCs are now actively contributing to the ICU medical rotas, they form a team with the consultant intensivist. A formal evaluation has been completed to assess the impact of the ANPCC role, identify gaps in competency and potential service role in ICU. The evaluation audit is expected to be published in summer 2011.

Next Steps

Further areas for potential exploration for the ANPCC role includes transfer of the intubated critically ill patient and airway lead for cardiac arrest calls. In conjunction with colleagues from clinical pharmacy a medicines reconciliation project is being scheduled for 2011. NHS Lanarkshire is represented on the Royal College of Anesthetists Advanced practice group. Potential developments for advanced practice in critical care include minimum national entry criteria, minimum competency set and a national exam, leading to a nationally recognised transferable qualification.

A grounded theory study has been completed entitled "Steering a course toward advanced nurse practitioner: a critical care perspective". This study used theoretical sampling to explore the experiences of the ANPCCs and subsequently those influencing their development (n=25), namely, consultant intensivists, ANPCCs, senior management, critical care nurses and senior charge nurses. This study will be published in Nursing in Critical Care early in 2011. The conceptual model and emerging themes and experiences may be of interest to ACAP members.

Further information is available from martin.carberry@lanarkshire@scot.nhs.uk

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