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The Advanced Nurse Practitioner

The journal for members of ACAP

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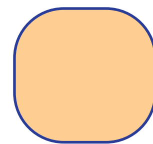
Skills4Nurses

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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Author: Joanne Lawley (2014).
ASSET Team NHS Lanarkshire
Acknowledgement: Our thanks to Rosemary Robertson, Development Manager, Wishaw Locality. NHS Lanarkshire, for her support.

Page 14 **It has been a pleasure**
Elaine Headley

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NEWS....NEWS....NEWS....

ACAP Acute Care Advanced Practitioners

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

Well done

ACAP would like to say a massive well done to Paul Gilmour, Brian Lennon, Derek Pettigrew 3 Mental Health ANPs from Ayrshire & Arran and Derek Cobb, DCN following their ten day challenge to cycle The Rhine's 1300km in early September (childhood cancer awareness month) of this year, combined with 'oordaniels dinner dance' held in October at the Park Hotel, Kilmarnock a total in the region of £16,000 is now expected. A more in depth article can be found in this journal.

Link/Steering Group Members

ACAP would like to invite practitioners to become either link practitioners or even to join the steering group. So, if you have time, commitment and the drive to contributing to leading Advanced Practice forward, please contact Julessmith69@hotmail.com or Elaine.headley@gmail.com

Articles

Many practitioners are now keen to have their work published. ACAP is delighted by this, as it's important to encourage writers to have their work put into print, and a fantastic opportunity to share best practices. Please continue to send your articles to us and we will endeavour to get them published for you.

Send articles to julessmith69@hotmail.com or Elaine.headley@gmail.com

News

ACAP are keen to share local events, nationally. We would like to hear if there is anything going on in your area which you would like to share with other Advanced Practitioners.

Best Wishes

Elaine Headley the co founder and co chair of ACAP is retiring from the NHS this year, and will be stepping down as co chair of ACAP, but has kindly agreed to stay on the committee as a non executive member. Julie and the rest of the ACAP team would like to take this opportunity to say a massive thank you for all her tireless and extraordinary contributions to not only the health service but to ACAP. We would all like to wish her the very best for her retirement.

Main Sponsor

ACAP would like to once again thank Atrium/Marquet for their continued sponsorship and as the main sponsor for the ACAP events. This is essentially down to the ongoing support from Amy Drewery

AGM

Date of next ACAP AGM – Friday 21st November, 10.00am at Newhouse Hotel, Edinburgh Road, Newhouse, Motherwell ML1 5SY. All Welcome.

Life after Sepsis: an international survey

After surviving an acute phase of sepsis, a patient may continue to struggle with a long list of serious symptoms. The extent of these complications varies… … depending on the severity of sepsis and the length of treatment in an intensive care unit and hospital. Such complications may persist for years after a sepsis episode, often having far-reaching effects on a survivor's quality of life. The lack of specific, standardised rehabilitation programs for sepsis patients further slows or hinders full recovery. For full detials visit www.worldsepsis.org

Fireworks night can be a fabulous , family thrilled night,with incredible colours and designs that light up the night sky. Guy Fox night is almost here again. So here a few tips to avoid unnecessary injuries, so you and you families can enjoy the spectacles fireworks can bring.

Follow the Fireworks Code.

- Keep fireworks in a closed box
- Follow the instructions on each firework
- Light all fireworks at arms length
- Stand well back
- Never go back to a lit firework
- Never put fireworks in your pocket
- Never throw fireworks
- Keep Pets indoors

Use only BS 7114 Fireworks

- Check this when you are buying. All reputable dealers will only sell fireworks to this standard and if you are ever offered any others leave them alone!

Take special care with sparklers

- Sparklers can be beautiful and enjoyable for young children but adults must be aware of their potential. Sparklers are the cause of a disproportionate number of injuries but only a few simple precautions are necessary.
- Always supervise children with sparklers.
- Teach them to hold the sparkler at arms length, but not near anyone else
- Sparklers are not for the under 5s.

They will be labeled as such and it is your responsibility.

- Have a container of water handy, big enough for the spent sparkler. Dump the sparkler in it as soon as it goes out.

NEWS....NEWS....NEWS....

Mental Health Advanced Nurse Practitioners-An Evolutionary Process

Lorna Bruce, Senior Nurse for Mental Health NHS Lanarkshire

In recent years NHS Ayrshire and Arran Mental Health Services have undergone a period of extensive service redesign through the Mind Your Heath process. They were forward thinking in their response to Modernising Nursing Careers and having to respond to the requirements of the European Working Time Directive (EWTD) in relation to the reduction of Junior Doctors working hours. They were required to be creative to reconfigure existing services with a view to commissioning and implementing new services which will appropriately meet the challenges of modern mental health care provision in a manner, which will ensure safety, high quality and continuity of care for service users. The creation of the Mental Health Advanced Nurse Practitioner (MHANP) Service was in response to these factors and to other national drivers including the Chief Nursing Officers Review of Mental Health Nursing and Rights, Relationships and Recovery (RRR) 2006. They identify the creation of new and specialised roles as both a necessary and logical evolution for mental health nursing practice. NHS Ayrshire & Arran was the first health board in Scotland to introduce the Mental Health Advanced Nurse Practitioner (MHANP). This MHANP Service was seen as both an innovative and specialised role in developing Mental Health Nursing (MHN) practice as following an extensive literature review no similar service could found.

The Main Drivers

As mentioned there were three main drivers – Modernising Nursing Careers, Modernising Medical Careers and the change to European Working Time Directives for medics. Cognisance of the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 are also supported through this service: the service is non discriminatory – providing care across the full range of mental ill health/distress, including people presenting who have a learning disability and the full age range from adolescents to elderly mental health. It adopts the principle of least restriction and as the MHANPs have significantly more experience than the previous junior doctor service and they are more able to consider appropriate alternatives to inpatient care; additionally they actively encourage the participation of service users, and where appropriate their carers, in the outcomes of assessments and decisions around care planning. Providing this service is the core role and function of the MHANP service. The MHANP service supports the principles of RRR (2006) which supports team work consistent with the 10 Essential Shared Capabilities for mental health practice, working in partnership with people presenting to the service, respecting the diversity of people who are referred to the service, practicing ethically and challenging inequality. The service promotes an ethos of recovery and provides person-centered care. The MHANPs make a difference to the lives of people referred to the service; they make a difference to the skills and knowledge base across the whole hospital and due to their significant experience of working within mental health they are more comfortable in promoting safety and positive risk taking. RRR (2006 - Action 8) (2010 – Action 4) also encourages adopting a whole system approach to delivering care as the MHANPs deliver a whole system approach across mental health inpatient and community services as well as across mental health and general hospital services. Action 13 (RRR 2006) advocates that a MHN contribution to non medical prescribing should be developed; therefore, the MHANP team have all undertaken a non medical prescribing course. Action 21 (2006) (Action 11 – 2010) of RRR promotes the leadership role within MHNs in Scotland. The MHANP service adds a new dimension to the development of the nursing profession and professional leadership nationally as they have expanded the field of practice and competency of the mental health nurse, consistent with the NES Advanced Nurse Practice Toolkit 2008. Action 22 (2006) (Action 12 – 2010) highlights the requirement of MHNs to be involved in regular clinical supervision and the MHANP Service are exemplars of this. Clinical supervision is provided for the MHANPs by a consultant psychiatrist in both acute and elderly mental health and managerial supervision from a senior nurse in mental health.

Phase 1

The initial Mental Health ANP Service began in February 2009 within University Hospital, Crosshouse, near Kilmarnock, with integration into the existing Hospital at Night (H@N) Acute Service and the potential for development of Mental Health Hospital at Day (H@D) Service allowing interface with all clinical areas of practice. A joint assessment model at Accident & Emergency was employed along with the Ayrshire Crisis Resolution and Home Treatment Team (ACRHTT) to permit appropriate admission, discharge and signposting of service users. The service comprised initially of six Whole Time Equivalent (WTE) band seven mental health nurses, covering the University Hospital, Crosshouse site. These MHANPs completed an intense six months training programme of advanced mental health assessment covering all areas of mental health services (adult, elderly, learning disabilities, Children and Adolescence Mental Health Services (CAMHS) and addictions). Additionally to work as part of the Hospital at Night (H@N) team the MHANPs were required to develop skills related to physical health beyond that which would routinely be required by MHNs. They were required to maintain a portfolio of competencies for review to ensure ongoing development and competencies of their practice in all areas. This training programme was therefore robust, comprehensive and protracted. As a MHANP there is an ongoing requirement to demonstrate a high level of skill in relation to mental health assessment, differential diagnosis, formulation and initiation of treatment plans. The competency framework encompasses all areas of practice - mental health and general (1 novice – 5 expert) utilising Benners model (1984), with the expectation to achieve a minimum of level 5 in mental health and level 3 in acute care after two years with an annual review thereafter.

Attendance at formal Continuing Professional Development (CPD) sessions in both mental health and physical health care were encouraged as part of in house training. The MHANPs also completed non medical prescribing modules at University of the West of Scotland as a core component of their role and are registered with the Nursing & Midwifery Council (NMC) as Nurse Independent Prescribers. They are committed to further modules including clinical assessment working towards an MSc level qualification and a commitment to lifelong learning. In general referrals have been received from A&E, medical, surgical and maternity wards. A primary role is to provide mental health assessment, to formulate an immediate clinical management plan to provide safe effective input. This is essentially carried out autonomously with supervision from on call consultant psychiatrist at home on nightshift as required. This is a unique nursing service; it is fully integrated into the whole hospital at night and MHANPs work with a high skill level of intervention and critical decision making ability reflecting values based practice.

Phase 2

Three years on, the MHANPs are now number eight WTE nurses, developing a role 9am to 5pm providing an advanced practice role to the two mental health acute admission wards in University Hospital, Crosshouse and extending to Ayrshire Central Hospital old age mental health wards 9pm to 9am. MHANPs aim to offer a service working collaboratively with ward nurses and doctors on a day to day basis.

There are several key areas of service provision-

- H@N (A&E/ psychiatric inpatients/ emergency psychiatric referrals from the General Hospital wards/ H@N/elderly mental health wards off site)
- H@D (9-5pm mental health inpatients)
- Clinical Leadership Role
- Professional Development

These are activities which are central to the role of the MHANP and include provision for professional leadership, education and research.

Other MHANP activities include:

- Continuing Professional Development/ maintaining professional competence/ Lifelong Learning.
- Attending Non Medical Prescribing CPD Days.
- Teaching both at university level and training to MHNs in NHS Ayrshire & Arran.
- Audit & evaluation of practice; gathering of quantitative and qualitative statistical data evidencing a positive impact on care and treatment.
- Research & development.
- Contributions to service management and planning with attendance at steering groups, driving improvement and clinical governance.
- Writing guidelines and Protocols.
- Any other supporting professional activity, locally or nationally making presentations and attending individual interest functions.

The MHANP essentially provides an advanced practice role to enhance the service users experience and facilitate best nursing practice.

Key Aspects of the role include:

- Completing an advanced mental health assessment and review of ward patients.
- Joint and collaborative work within ward teams avoiding unnecessary repetition of work and multiple assessments.
- Enhancing continuity of contact and care of the patient throughout their healthcare journey, ultimately reducing length of inpatient stay.
- Augmenting training provision for ward staff.
- Ongoing audit and evaluation of the MHANP service.
- Clinical Supervision for Mental Health Nurses.

Phase 3

After five years the MHANP service continues to develop. Further expansion involved piloting and establishing a service within Ailsa Hospital in Ayr. From April 2013 a MHANP was available 9am to 5pm Monday to Friday to offer an enhanced service to five of the Elderly Mental Health wards on the Ailsa site. This was borne from a deficit of junior doctors and at the request of the consultant cohort. This development provided more opportunities to augment the support for MHN staff, improve quality and values based care for inpatients and provide both a timely and effective service.

Conclusion

The development of the Mental Health Advanced Nurse Practitioner role has and will continue to improve services for patients with mental health issues who present at local general hospitals out of hours and in patients in mental health wards. The MHANPs provide a safe, more effective, timely and person-centered service to patients who have mental health needs. The MHANP role on nightshift continues to be core work, while the role on dayshift is developing and it is hoped that MHANPs will become fundamental and present in all areas of MHN practice offering clear and professional leadership, knowledge and experience to colleagues whilst enhancing the patient journey through hospital to community to independent living and wellbeing. With this ethos in mind it is now NHS Lanarkshire who have recruited and currently training six MHANPs to function in a similar model as NHS Ayrshire & Arran. Recognising these previous experiences and understanding how advanced practice can be applied to mental health there is no doubt that the MHANPs in NHS Lanarkshire will achieve similar success.

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Neuroblastoma

Paul Gilmour – Mental Health ANP – NHS Ayrshire & Arran

Neuroblastoma is an aggressive form of childhood cancer, and is the most common solid cancer diagnosed in infancy. A cancer of the nervous system, which often occurs in the abdomen, usually from the adrenal glands, Neuroblastoma, is also commonly found in the neck or chest area. The disease can spread rapidly to almost all other parts of the body, including the bones, bone marrow and the brain.

With over 100 children diagnosed in the UK each year statistically Neuroblastoma is the second biggest killer in children outside of domestic accidents.

Neuroblastoma is almost symptomless. Symptoms that are present are usually dismissed as being something minor. Often, it is not until the tumours are so large that they are pressing on organs, nerves or pathways and causing physical problems such as walking or going to the toilet, that the disease is detected. Around two thirds of children diagnosed will already be at stage 4 (High Risk). Around half of those children will carry the MYC-N gene. This means that the majority of children diagnosed with Neuroblastoma will be in the High Risk (HR), which has an unfavourable prognosis with less than 20% of these children surviving for more than 5 years with most succumbing to the disease within two years. In an effort for survival these children undergo uncompromising and intensive multi-modal therapies which will almost certainly include chemotherapy, surgery, high-dose chemotherapy with stem cell support, radiotherapy and Monoclonial antibody therapy over an 18 month protocol.

Conversely, Neuroblastoma is one of the few human malignancies known to demonstrate spontaneous regression from an undifferentiated state to a completely benign cellular appearance, complicating the provision of any screening programmes which have existed in countries such as Japan. Who, similarly to Canada, Austria and Germany routinely screened asymptomatic infants at three weeks, six months, and one year since the 1980's.However, in 2004 after Canadian and German studies showed no reduction in deaths due to Neuroblastoma screening, but rather it caused an increase in diagnoses that would have disappeared without treatment, subjecting those infants to unnecessary surgery and chemotherapy, routine screening halted.

Three of our NHS Ayrshire & Arran Mental Health ANP's, Paul Gilmour, Brian Lennon, Derek Pettigrew & DCN Derek Cobb (perfectly captured in this caricature by their colleague Ruth Gilmour) recently completed a ten day challenge to cycle The Rhine's 1300km in early September (childhood cancer awareness month) of this year.

Starting from the source of the Rhine in Switzerland the guys made their way through the alps into Austria, Liechtenstein, Germany, France, back to Germany then on up in to Holland till they reached the north sea. For the more dedicated and fitter of cyclist it can take around 14 days to do these miles, so for this motley crew to complete this well trodden path in 10 days whilst carrying their entire kit, tents etc, was no mean feat but a challenge worthy of the cause.

Paul and his partner Fiona sadly lost their son Daniel Gilmour to the childhood cancer Neuroblastoma last year, aged four. During their battle with the disease they were supported by the events chosen charities, CLIC Sargent and North Ayrshire Cancer Care and The Neuroblastoma Society, who fund research in to newer, more effective and less brutal treatments.

As these services need to be paid for, Daniels family and friends wanted to help secure these resources for others in the future and since Daniel got sick just under £20,000 had been raised. Keen to continue with this, they again this year embarked on raising much needed funds and raising awareness of Neuroblastoma, its prevalence and other childhood cancers.

Although still awaiting the final total, it's looking like the charity cycle has raised in the region of £7000, which combined with 'oordaniels dinner dance' held in October at the Park Hotel, Kilmarnock a total in the region of £16000 is now expected.

The guys can be contacted and the challenge can be followed on FACEBOOK @ 'oordanielscharitycycle' page and any donations can be made directly to the charities at www.justgiving.com/teams/oordanielscharitycycle

Delivering advanced, urgent care in community settings: A new approach to healthcare delivery.

Author: Joanne Lawley (2014). ASSET Team NHS Lanarkshire
Acknowledgement: Our thanks to Rosemary Robertson, Development Manager, Wishaw Locality. NHS Lanarkshire, for her support.

In recent years, the National Health Service (NHS) has undergone an unprecedented pace of change, providing both healthcare leaders and nurses alike with both challenges and opportunities. The emergence of policies, (Wanless 2007, DoH 2008,) and subsequent reviews and recommendations for future plans for the NHS, (Scottish Government 2009, 2014) mean that this trend is likely to continue and gain pace (Kleinpell, 2013). In addition, The Queens Nursing Institute (QNI) (2012) cautioned that the population demographics and health problems facing society are changing rapidly. In agreement, The SEHD (2005) highlight that Scotland has a declining but ageing population, which NHS Scotland (2010) caution has led to patients with more complex, and with more frequently changing, health and social care needs. The QNI (2012) added that these facts, when accompanied with rising healthcare costs, technological advances, fewer hospital bed spaces and higher patient expectations, demand that healthcare providers develop and implement a more proactive, planned, and co-ordinated approach to meeting patients healthcare needs. Furthermore, the Scottish Government (2010) argue that healthcare should be delivered, where possible, closer to people's home, within the community setting.NHS Lanarkshire (NHSL) strives to continuously improve the delivery and quality of its care (NHS Lanarkshire, 2012a). However, they are aware, as is the rest of the United Kingdom (UK), that to do this, they need to ensure health and social care delivery is fit for purpose and can meet the challenges facing them, at present, and in the future (Scottish Government, 2009). Despite the challenges within Lanarkshire, in particular, the high levels of deprivation , increasing health inequalities and environment related problems , NHSL (2012a) have responded with a number of initiatives, aimed at shifting the focus from reactive, episodic, unplanned hospital based care to an integrated, preventative, anticipatory and supportive self management, community approach.

Indeed, as advocated by NHS Scotland (2010), there is significant work ongoing in NHSL by management leaders in the long term conditions collaborative, whereby the identification of the workforce, skill mix, skill levels and disciplines of nursing required to safely and competently make this shift are being investigated (McElholm and Thomson, 2014). Furthermore, NHSL are planning and developing their model further. Their aim being the identification, development and implementation of the enhanced skills required to support more acutely unwell patients in their own home. According to McElholm and Thomson (2014) the ultimate goal for NHSL is the implementation of a more proactive, integrated model of health care, which should ensure, where possible, that if urgent care is required, this should be delivered at home by appropriately trained healthcare staff with the appropriate advanced skills. As the SEHD (2005) advocates, patients should be seen at the right time, in the right place, by the right person.

In support, Purdy (2010) claims that avoiding unplanned/ emergency hospital admissions is a major concern and essential goal for the NHS. These concerns involve not only due to the rising costs, when compared with other forms of care delivery, and lack of bed numbers, but also due to the disruption it causes to elective admissions, evident in the increasing numbers on waiting lists and failures in meeting waiting time initiatives. However, McElholme and Thomson (2014) concede that although maintaining people within their own home is NHSLs key priority focus, they accept that at times hospital admissions cannot be avoided, therefore, as recommended by NHS Scotland (2014) they suggest that the identified team within the developed model should be strongly involved, where appropriate, in managing hospital admissions, supporting patients to return home direct from A&E, ECU or GP assessment units and perhaps, planning and managing complex discharges from hospital. According to SEHD (2005) the development of strong links and partnerships between the primary and acute sectors is vital, if safe, effective and sustainable healthcare is to be achieved.

However, as highlighted by QNI (2012) the importance of active risk management is recognised, whereby any practice that is risk averse is avoided. Nevertheless, in support, according to Bryant-Lukosius (2004) there is significant evidence that nurses with advanced skills contribute significantly to healthcare delivery. Lowe (2010) suggests that due to an increasingly demanding economic climate whereby timely, cost effective healthcare is essential, advanced practitioners can assist in providing a more cost effective but excellent standard of care. In agreement, Gardner et al (2007) highlight that nurses with advanced roles and skills have become an integral part of patient care, whereby, the development and extension of new and more advanced roles has seen an improvement in access to and quality of healthcare for patients. In addition, although perhaps controversial, Schrober (2014) argues that with mounting costs, limited resources and increasing health challenges, coupled with ever increasing public expectations for healthcare, the government have been encouraged to accept that access to healthcare and adequate coverage are more important than who provides them.

Hinchcliff and Rogers (2008) concur, suggesting that there are significant gaps in the NHS workforce available to meet patient needs, and question the sustainability of the current pattern of healthcare. However, McKenna et al (2009) suggest that nurses with advanced roles have been recognised as playing a prominent role in building workforce capacity, and as such have been identified in key policy documents, (Department of Health (DoH), 2002, SEHD, 2005) as being central to furthering reform and cost effectiveness. In response, NHSL has actively encouraged staff to participate in developing their skills through further study and practice, such as the MINTS course (Minor/Major Injury/Illness Nurse Treatment Service), Urgent Care Course and Advanced Practice Certificate Course, resulting in the development of new and exciting roles for nurses, in both primary and secondary care (NHSL, 2014).Within NSHL a number of initiatives have proven to be effective in reducing the numbers of patients admitted to hospital, in particular, the Aged Specialist Services Emergency Team (ASSET), established to respond rapidly to the needs of frail, elderly patients identified by their GP as requiring emergency care.

Following identification and inclusion, depending on clinical criteria, if appropriate, these patients have their acute hospital care provided at home, involving an advanced, comprehensive assessment, diagnostic investigations, differential diagnoses and management plan. Initial assessment is carried out by an appropriate trained nurse or allied health professional (AHP) and followed up with consultant review. Early analysis of the data has shown a high percentage of patients were successfully treated and maintained at home (NHSL, 2013). However, although the author acknowledges that the ASSET pilot was a success and NHSL demonstrated that advanced practice interventions proved effective in maintaining older adults at home, and resulted in increased levels of patient and carer satisfaction, (NHSL, 2013) the question of cost, transferability and sustainability is a concern. Indeed, the author notes that complete funding was made available for ASSET through Reshaping Care for Older People. This leads the author to question how, in an already demanding economic climate, can Wishaw, in the North Lanarkshire locality locate the funds required to fund a separate ASSET type team? Indeed, the NHS Confederation (2012) in fact highlight that due to exceptional financial challenges, exacerbated by increasing demands for healthcare, a reduction of 4% spending is required yearly. The author would suggest that it may be more appropriate, cost effective and sustainable to integrate staff with advanced practice skills into existing community and acute teams. In agreement, Burgener and Moore (2002) argue that nurses with advanced practice skills often collaborate with a variety of care providers and health and social organisations to offer the optimum scope of services necessary to deliver comprehensive care, often at a lower cost than present, traditional health care services.

Rosemary Robertson, Service Development Manager at Wishaw Locality is passionate about improving the quality of care provided by NHSL long term conditions, with a particular interest in improving patient outcomes, delivered with a person centred, safe and effective approach. However, Wishaw Locality is one of Lanarkshire's most underserved populations, and as such has multiple, complex health, social and environment related problems, requiring in depth care (NHSL, 2012). Furthermore, NHSL (2012b) add that health care providers require to competently and effectively, provide primary prevention as well as disease management in an area with high levels of deprivation, known for high numbers of addictive behaviours, and high numbers of multiple chronic illnesses, in both the young and old population. Nevertheless, according to Burgener and Moore (2002) nurses with advanced skills, in collaboration with the multidisciplinary team, are in an ideal position to provide care for these persons. In addition, Kleinpell (2013) suggests that care provided by advanced practicing nurses has been shown to improve patient outcomes, and is safe, acceptable and cost effective. In agreement, Begley et al (2010) argues that advanced practice has been found to improve symptom management, prevent complications and improve the appropriateness of medication regimes.

Whilst Kleinpell (2013) highlights a reduction in exacerbations of conditions, improvements in educating patient and family on self management strategies, and an improvement in the patients adherence to treatment plans. With these points in mind, Rosemary Robertson, with the approval of senior management, has appointed a member of her staff, who has been educated to advanced practice level, to undertake two small pilots within Wishaw Locality. It is hoped that in the future these initiatives can be incorporated into the existing long term conditions teams.

Identifying patients at risk of readmission

According to the Scottish Government (2009) one of the first steps is to stratify the local population, with regards to their pattern, seriousness and complexity of long term conditions in order to identify those patients most at risk of future crisis. The SEHD (2010) suggest that an appropriate starting point in identifying those individuals at high risk requiring complex care is the use of national prediction tools, and as such, advocate use of the Scottish Patients At Risk of Readmission and Admission (SPARRA) predictor tool. According to the Scottish Government (2009) the SPARRA list is an effective way of identifying those individuals at greater risk of requiring emergency admission to hospital within the next year, using demographic data, SIMD deciles for deprivation and disease coding. To further identify those at greatest risk, a frailty score was included with a further nine independent predictors, including age, gender, 3+ medications, co-morbidities, ADL disability, low physical activity, sensory deficits, increased calf circumference and problems with gait and balance(NHS Scotland, 2010).

It is anticipated that the use of the SPARRA lists will support the health care team in targeting those individuals at greater risk of admission, which should ensure that the most appropriate patients receive an advanced, comprehensive, holistic assessment. In addition, due to the disproportionate high numbers of emergency admissions to hospital in the Wishaw Locality of patients with exacerbations of respiratory disorders, in particular chronic obstructive pulmonary disease (COPD) (NHSL, 2010) it was decided that those patients presenting with COPD, would initially be further targeted. Anasari et al (2009) describe COPD a slowly progressive disease, mainly caused by cigarette smoking, and highlight that as the disease progresses, exacerbations become more burdensome.

However, Anasari et al (2009) adds that with prompt treatment and intervention the severity of an exacerbation can be substantially reduced, reducing the need for admission to hospital. To compliment the use of the SPARRA data, appropriate patients would also be identified through interacting with the Respiratory Nurses at WGH and A&E department to identify those patients who frequently attend the emergency department. Pilot of effectiveness of MUST tool in the community MUST (Malnutrition Universal Screening Tool) is a validated tool, used nationally, to help identify nutritional risk in groups of people who may be at risk of nutritional problems (NHSL. 2012). The development, and subsequent use of the MUST tool was originally prompted by the publication of the document Essence of Care (NHS Modernisation Agency, 2003), which highlighted the importance of maintaining and enhancing the fundamentals of care, in particular nutrition and food.

Following this, further publications such as, Nutritional Care Standards (NHS Quality Improvement Scotland, 2003) and Nutrition Support in Adults (NICE, 2006), identified gaps and failings in the NHS's nutritional care delivered to their patient population, prompting publication of recommendations and guidelines (NICE, 2006). Indeed, according to Brotherton and Simmons (2010) malnutrition problems are often not recognised and therefore under treated, highlighting that there are as many as 3 million people at any one time in the UK who are malnourished, which NHSL (2012) recognise is to the detriment and cost not only to the individual patient, but also the health service, social care and society as a whole.

Brotherton and Simmons (2010) caution that as many as 30% of people admitted to hospitals and nursing homes are at risk of malnutrition when screened using MUST criteria, whilst, 14% of the elderly at home or in care environments are at risk, as well as 10-14% in sheltered housing. Furthermore, Brotherton and Simmons (2010) caution that 5% of the elderly, living within the general population, are underweight, which NICE (2006) highlights increases to 9% in the presence of chronic diseases. According to NIPEC (2013) these numbers of underweight and malnourished individuals are set to rise, markedly, as the population ages and the prevalence of chronic diseases increases, which Brotherton and Simmons (2010) caution leads to further vulnerability to illness, clinical complications and unfortunately, sometimes death.

However, according to Bapen (2003) if MUST screening is used appropriately, in both community and acute settings, in identifying those at risk of nutrition problems and early nutritional interventions are carried out, patient outcomes are improved, with reductions in GP visits and fewer hospital admissions with complications associated with malnutrition, and indeed, fewer complications whilst inpatients. Indeed, following a pilot on the use of MUST in the community by Wirrell Community Trust NHS (2008,) the tool was found to not only reduce unplanned admissions to hospital but also helped in identifying those individuals at risk in the underserved populations.

Furthermore, such was the pilot's success, MUST screening is now best practice within Wirrell Trust NHS. However, Wirrell Trust NHS (2009) highlight that it is a screening tool and must not replace clinical judgement, but rather compliment it. It is hoped that these interventions within NHS Lanarkshire will prove successful in supporting both NHS Scotland and the Scottish Government's vision, that by 2020 everyone will be able to live longer, healthier lives at home, or in a homely environment (NHSL, 2012). Following a period of implementing and evaluating the pilots, a further paper will be completed, which will highlight the outcomes from this piece of work. It is anticipated this evaluation will identify either the benefits or limitations to the new service and any changes required for improvement, or indeed if the service is viable.

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It has been a pleasure....

Throughout life we are confronted with so many different things. Some we want to share, some we want to keep to ourselves, some we do alone,and some we do with others. I have been part of a profession that I am immensely proud of, it's a profession that has allowed me to share, be alone, be part of a team, allowed me to help those less fortunate than myself and let me step into their lives even for the briefest of time.

I don't know the impact I have made on these countless people over the past 3 decades of my life, but they have all made an impact on me. In the last one of those 3 decades I found myself in a role where I was privileged to work with some of the brightest people within NHS Lanarkshire. The development of Scotland's first advanced practice team saw the cream of Scotland's nurses taking on new roles and responsibilities. Facing the challenges that theses roles brought was interesting, overcoming them is what made it meaningful. The discipline to the success of these roles was going beyond what was expected of you as a nurse.

However, as more advanced practice teams developed over the rest of Scotland, it became clear that unity of these teams was the next logical step. So a group of people throughout 6 areas in Scotland got together to help improve what advanced practice could do for the patient, for the profession and for ourselves. Did we know whether it would work? Simple answer is 'No'. But in order to succeed in something the desire for success has to overcome the fear of failure. This group of people overcame that fear.

ACAP Scotland is now embedded into the ethos of advanced practice and once again I have been honoured to have been part of that. Time has outrun me however, and I am now leaving this *family* we call the NHS, this *family* we call nursing, this *family* that has become advanced practice and ACAP. I feel like a mother letting go of a child who is leaving home for the first time, proud but with a heavy heart. But ACAP is growing with more groups now part of the original group. Paediatrics, Mental Health & ASSET: so the *family* is growing! In the words of Helen Keller, 'Optimism is the faith that leads to achievement....'

My most sincere thanks to all I have worked with in so many different ways. It has been my pleasure and a privilege.

Elaine Headley

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