Issue 17 : November 2019
Registered charity SCO42116

The Advanced Nurse Practitioner

ACAP
Acute Care
Advanced Practitioners

Produced in association with
Skills4Nurses

The journal for members of ACAP

ACAP Scotland leading the way

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

Members will also be entitled to annual newsletters and unlimited ACAP web site access, as well as the opportunity to share ideas with fellow advanced practitioners via the facebook page.

Advanced 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.

Mission Statement

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

Support given by:
AANPE
CS MEN

Executive committee members:
Julie Smith Chair
Sharon Oswald Vice Chair
Fiona Buchan Treasurer
Lilian Paterson-Murray Vice treasurer
Anne Scott Secretary
Heather Ross Comms
Sarah Lortscher Comms
David Hunter
Kelvin Moran
Aileen Ballantyne
Lynn Scott
Robin Hyde
Karen Kindness
Lisa Fabisak
Elaine Parker
Kirsten Ramsay

Non executive committee Members:
Dr. Mark Cooper
Mr. Eddie Docherty

West Of Scotland Advanced Practice Academy Update

The West of Scotland Advanced Practice Academy has been functioning since 2016. Chaired by Eddie Docherty, the academy has representation from all of the regional health boards for advanced nursing and allied health professional practice from NHS Ayrshire and Arran, Dumfries and Galloway, Lanarkshire, Greater Glasgow and Clyde, Forth Valley, The Golden Jubilee, NHS 24, Scottish Ambulance Service and the HEIs. As an academy we use a shared resource approach and have territorial oversight for all areas of advanced practice either current or in development.

In addition to the 8 CPD events held throughout the region, there has been one event specifically designed around the Allied Health Professions. As well as ongoing support and education for our clinical staff, work in progress includes testing of final sign-off paperwork across the region, developing a regional approach for supervision models including action learning sets and the development of regional standards for competency frameworks

NHS Borders, NHS Fife, NHS Lothian NHS 24, Scottish Ambulance Service Edinburgh Napier University, Queen Margaret University, Edinburgh University

Develop a regional approach to mentorship and supervision for trainee ANP's and develop job plans for qualified ANP's to support protected time for this part of their role. Scoping Advanced Practice roles for other health care professionals, e.g AHP's and paramedics within the region in order to support and develop the governance within these professions. Scoping the research element of those that are working in all advanced practice roles to understand research interests and provide a network of support and information of dissertation topics. Sharing of local ANP CPD events within the academy.

Contents...

• www.acapscotland.org •

The ACAP journal gives practitioners the opportunity to share the valuable work they are doing, either through research, case based discussion or update on individual practitioners role – if you would like to write an article for the journal please get in touch. We have updated the guidelines for publication to make this process easier for practitioners and we are happy to provide guidance/feedback and support.

A day/year in the life of an Advanced Practice Nurse Consultant

When I commenced my nursing career in 1985, I had not the remotest idea where that journey would take me. It has certainly been a bumpy ride at times. From 1985 until 2013 I was either full time or part time working clinically in the wards/units, with my advanced practice journey starting ~2003 in South Africa. Returning to Scotland in 2009 with my newly minted Masters, I still had a few hurdles to clear transitioning from the South African Nursing Council Regulations to NMC/UK legislative requirements. I am sure all of you in the health care professions, and especially those with advanced clinical practice roles, can identify with having to juggle multiple commitments: routine clinical patient care; additional studies; deteriorating patient and emergency clinical patient care, family commitments; more additional studies; CPD; delivering on the "pillars"(not just the day/night clinical role); supporting and mentoring trainees; audit and research; yet more additional studies; teaching; "leadership"; "consultancy"?.... So what is a Nurse/NMAHP Consultant? This was me in early 2017, before I really knew, applying for the job!

Needless to say there is no clear answer as it is both complex and complicated. NHS Education for Scotland (NES) has the pillars of practice[i], which has informed subsequent work by Prof Kim Manley who is leading development of a capability and impact framework for Consultant Practice for Health Education England[ii] using 4+1 pillars which is due to be published shortly:

Advanced Level Practice	Consultant Practice
• Not a substitution role but 'value added' from own profession/field of practice • Shared competences with medicine in some areas as reflected in the HEE levels of practice document • Beginning journey focusing predominantly on client- centred consultancy • Has professional expertise in own professional role and field of practice • Beginning a journey of growing expertise in the other 4 pillars	• Expertise in all the pillars – integrating practice, research and education – Boyer's model with system –wide consultancy • Strong strategic and systems leadership role for field of practice • Flexibility in focusing on the four pillars depending on the need of the system, organisation to meet the needs of people/population • Assumption is that working at advanced level practice or having expertise in field of practice - might look different for different disciplines or contexts

Both these models emphasise the strategic nature of the role, which is important, but in some areas there has been an active choice to maintain a significant direct clinical contribution as would be expected of a medically qualified consultant e.g. the Advanced Critical care Practitioner (ACCP) role accredited by the Faculty of Intensive Care Medicine (FICM) which uses a 50% clinical model[iii]

Bottom line, for me there isn't really a representative day. My remit is notionally split 40% education, 25% clinical (but with no specific clinical area I am aligned to as I cover NHS Grampian), 15% research, which leaves a theoretical 20% to fulfil the leadership/strategic elements. This means I can end up doing pretty much a whole week working clinically on my own in a remote/rural practice, or a full days teaching at University if the Advanced Clinical Practice module is running.

Other days I am in the office writing/chasing Scottish Government statistical reporting data/analysing project data in between meetings haggling for improvements to advanced practice training structures with services/ approval of NHSG advanced practice role guidance at governance meetings, or out on the floor/simulation ward focused on supporting trainees develop their clinical history and examination skills with formulation of appropriate differential diagnoses/problem lists.

Is this the right model for an advanced practice consultant? Honestly I am not sure. It certainly hones your juggling skills with frequent deadlines to meet, and semi- predictable periods of panic calls/mails around portfolio submission time! A real benefit of taking on a new role is the opportunity to help shape and develop it. The risk is that you try and take on too many new projects at once because you want to deliver for the practitioners and services you are supporting.

This is me in 2019, older, wiser, and hanging in there. The work I have helped to deliver for NHS Grampian is encapsulated in the NHS Grampian Board update and associated publications. I am grateful for our new team member who is providing much needed administrative support. I am immensely proud of our Academy Fellows and our "Fast Track" 1 year trainees who are coming to the end of their programme - there have been a few where life has got in the way of them meeting the original timeframe, but we are creating re-configuring pathways to enable completion. #Juggling

@NHSG_ACA
@NurseKindness

NHSG Advanced Care Academy
@NHSGACA

[i] NHS Education for Scotland. Undated webpage. Post Registration Career Development Framework for Nurses, Midwives and Allied Health Professionals in Scotland. [Online]. Available: http://www.careerframework.nes.scot.nhs.uk/media/32227/nesd0057_postregistrationcareerframework_f.pdf

[ii] Manley, K. Undated Webpage. Consultant Practice: Person centred, safe and effective care across systems through the 4+1 pillars. [Online]. Available: https://www.canterbury.ac.uk/health-and-wellbeing/events/documents/KM-Advanced- Practice-Crawley-23-11-18.pdf

[iii] Warwick Medical School. Undated webpage. Interview with Sarah Quinton. Available: https://warwick.ac.uk/fac/sci/ med/study/cpd/critcare/cphc/squinton/

Journal Board Advanced Practice:
NHS Shetland Update

The Advanced Practitioner (AP) workforce within NHS Shetland has until recently been solely employed within GP practices. This service has been an established for the last 5 years following difficulties with recruitment and retention of GPs.

We have a higher ratio of development APs to the low number of qualified APs; NHS Shetland has recently recruited an ANP (Practice Educator).

NHS Shetlands ANP compliment:
Primary Care: GP setting (working across 3 of the 10 GP practices in NHS Shetland)
1 full time ANP (qualified, working in primary care)
6 development ANPs (At different stages of the MSc in Advanced Practice program)

Acute Sector: Gilbert Bain Hospital
1 full time development ANP (Fast track)
We have also just successfully recruited a further full time development ANP to an acute post (not commencing until October 2019)

Practice Education:
1 full time ANP Practice Educator (Credentialed ANP, employed within the acute sector). Working across both primary and secondary care to maintain clinical skills and support the development ANPS)

The practice education post was recruited to just under a year ago. This role was developed to:

- Standardise the recruitment process for advanced practitioners within NHS Shetland
- To oversee and implement comprehensive documentation to ensure practice and governance procedures are adhered to, ie standards for supervision have been implemented in primary care and the acute sector
- To monitor and evaluate clinical practice in a variety of ways, delivering feedback and any learning points (clinical audit, case based discussions, reflections, COTs)
- To facilitate educational sessions for the ANPs, to facilitate continued development
- To liaise with Universities in regards to the MSc program, taking into consideration the remote and rural location of NHS Shetland, to consider different ways of educational delivery, ie VLE.

The next step for NHS Shetland is to work closely with Practice Education colleagues on mainland Scotland and set up a Community of Practice for North of Scotland Advanced Practice. This is in its infancy, but we are very excited to be part of this process.

We are underway carrying out research within NHS Shetland to identify what frontline ANPs would see a digital platform look like and how they would use such a platform, ie, for education, sharing information, networking, links to other sites etc.

We are excited to see the outcome and take this forward to be a worthwhile and user friendly platform for Advanced Practitioners in the north of Scotland.

Kim Anderson ANP (Practice Education) NHS Shetland

Transformational leadership in the GI setting

Marion Clarke, Gastroenterologist ANP
NHS Ayrshire and Arran
(marion.clarke@aapct.scot.nhs.uk)

The Advanced practice toolkit indicates that Advanced Nurse Practitioners (ANPs) have a high level of abilities through the four pillars, clinic practice, facilitation of learning, leadership, and evidence, research and development. Furthermore RCN (2018) shows that the key to improving health and wellbeing across our nation is to develop and innovate through leadership. The RCN (2018) goes on to discuss that within the leadership pillar ANPs should be identifying the requirement for change and leading that change including service development, this often requires the ability to influence and negotiate skills as well as advanced networking and team building.

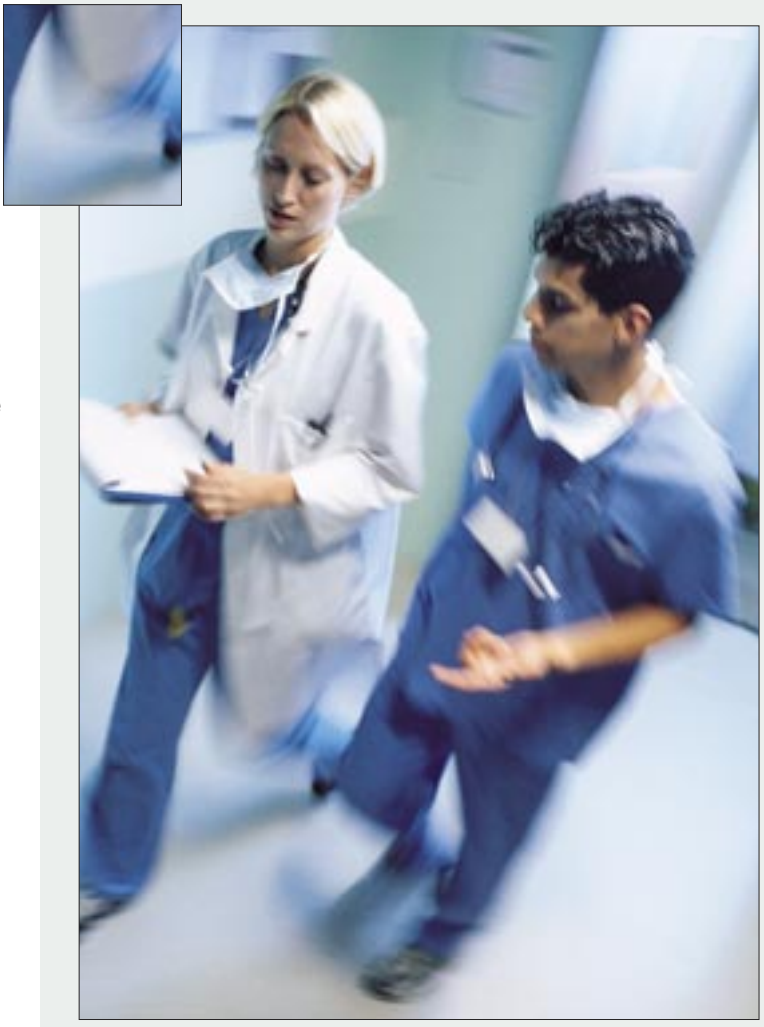
Smith (2011) suggests that due to the continually changing nature of the NHS it is essential for nurse leaders to adopt a transformational leadership style which inspires change. In addition Doody and Doody (2012) show that transformational leadership is viewed as the most effective style of leadership as it satisfies the higher needs of the follower by connecting with the person emotionally and intellectually through recognising the importance of rewards. Furthermore Fischer (2017) links the NMC code of conduct 2015 which states nurses should work with their peers to preserve the safety of those receiving care to improve healthcare outcomes and improve patient safety which can be achieved by effective transformational leadership.

Moreover transformational leadership is a style of leadership which develops the relationship between leader and follower to enable them to achieve results together which meet organizational goals. (Thomson et al 2016). Transformational leaders are able to enthuse their cohorts to change opportunities, perceptions and motivations to come towards a common goal. In contrast Transactional leadership is described by Callaghan (2008) as possibly the style of nursing leadership of the past where managers controlled and maintained the current situation.

ANPs are very well matched for the leadership role as they have completed post graduate education, hold an expert level of knowledge and complex decision-making skills, and have additional obligation for innovation and strategic professional development (Heck et al 2019). Moreover Callaghan (2008) agrees that the features of the ANP role are synonymous with the transformational style of leadership with focus on innovation, vision and change.

Gastroenterology is a diverse speciality which encompasses the diagnosis and management of many conditions from luminal diseases like inflammatory bowel disease and irritable bowel syndrome to gastrointestinal cancers and liver disease. Due to the vast array of conditions managed by this speciality it appeals to the generalists and offers the opportunity to sub specialise. Given the general and holistic training of ANPs this area is an ideal speciality as it covers many elements of general medicine as well as many highly specialised investigations and diagnoses.

The ANP within a GI setting has countless elements to their job role. In the authors area of work a typical week consists of four consultant ward rounds, two GI clinics and independent ward rounds. In addition to this the prescribing of outpatient infusions and responding to concerns from patients and GP's passed on from the IBD helpline is undertaken. The author is also the first port of call for any GI patient attending the medical day case unit. Administration and development time is also required.



Firstly the author provides support and encouragement to trainee doctors on the ward. New junior doctors require maximum reassurance and the author has enabled this through good communication and changing layout of the doctor's room in the ward to facilitate a white board to provide a comprehensive overview of tasks and immediate discharge prescriptions that are required in the ward environment. With this encouragement and leadership in the early stages of training on the ward this motivates the team to provide thorough and organised care. This too inspires nursing staff to think ahead and in turn this enables improved patient safety and a smoother patient journey. By involving others in the process of change, the transformational leader is able to raise the acceptance of new organizational practices, this is an example of intellectual stimulation. (Giddens 2017)

Fischer (2017) suggests idealised influence is a key element of transformational leadership this involves being a role model and having a positive influence on others which subsequently has a significant influence on healthcare services. A further example of this is the re-implementation of criteria led discharges within the authors area of work. This was designed to allow nursing staff to discharge patients without a medical review whilst adhering to strict criteria laid out by a senior doctor or ANP. To do this the author had to inspire a shared vision to improve our discharges, this was a common vision shared by all staff. Information was displayed and members of the team were given information which inspired the author's vision. Together as a team, improved morning and weekend discharges were achieved and this was welcomed by patients, staff and management alike. Giddens (2018) explains that idealised influence is used to build confidence, pride and optimism amongst followers.

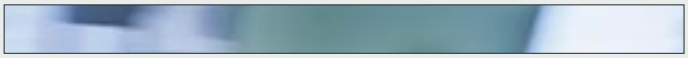
In keeping with the pillar of advanced practice: facilitation of learning, in amongst the busy working day the author also spends time teaching within the ward area, empowering nursing staff to further their confidence and knowledge within a GI ward. ANP education is also given to peers with regards to GI specialist subjects e.g. Upper GI bleeding and decompensation of Liver disease. Medical teaching has also been undertaken for consultants and trainee doctors. The variation in those being taught has led to a variation in teaching styles. This shows that effective communication is essential to the job role, Smith (2011) shows that one of the four elements of transformational leadership is effective communication with the ability to adapt communication styles and approaches to suit the individuals learning style and focus. Furthermore Fischer (2017) describes intellectual stimulation as the leader challenging those around them to think innovatively and creatively, which has been achieved by suggesting in teaching sessions different ways to practice or think about a condition. This approach is paramount to succeeding in improving patient care.

Individual consideration is the process by which strong leaders support and encourage individuals to reach higher levels of achievement. This is primarily done through empowerment, Doody and Doody (2012) suggest this is a fundamental component of transformational leadership. As a GI ANP the author is able to empower many members of the multidisciplinary team as well as peers. As a member of staff with an acute medical nursing background that also works as part of the medical team the author is able to empower nursing and medical staff in achieving goals. Promoting confidence with regular positive feedback and team meetings. In addition Fischer (2017) explains it is often the informal leader who has concern for others and is looked to for explanation of changes from higher management.

Furthermore inspirational motivation is the process where the transformational leader will be able to articulate their vision for the future and how this can positively affect an organization (Doody and Doody 2012). In the authors practice even the smaller changes can produce an improvement and have a positive effect on the daily practices in the hospital. For example in discussing a vision for improved steroid prescriptions, ensuring a reducing course is effectively prescribed the ward consultants and pharmacy team were involved in producing a gastroenterology reducing regime on the electronic prescribing system reducing errors and giving staff the confidence in the patients receiving the correct dosage of steroid at the correct time.

In summary transformational leadership is key in making organisational improvements. In the GI setting it enables small crucial changes to be made which in turn make significant changes within NHS Ayrshire and Arran. The four key elements of transformational leadership have been examined and examples of the authors practice made. Intellectual stimulation is used within teaching sessions and challenging staff on a regular basic to made positive changes and change attitudes.

Furthermore being a role model within a GI setting and having a positive influence on staff and peers is an example of idealised influence. Individual consideration is a way of tailoring teaching and communication to empower members of the team to make improvements. Finally inspirational motivation is used to let followers see and believe in the leader's vision to make improvements within the organisation. Doody and Doody (2012) explain that although these four elements are separate they all must harmonise to produce improvement beyond what is anticipated. In a difficult and ever challenging healthcare system nurses and in particular ANPs are ideal at using transformational leadership to engage and motivate others to make the changes required to improve patient safety and satisfaction.



Transforming Roles in Advanced Practice

Paul Gilmour
ANP Care of the Older Adult NHS Ayrshire and Arran
Paul.Gilmour@aapct.scot.nhs.uk

Having practiced as a Mental Health ANP (MHANP) for over seven years, despite the variety in the role I found myself at a juncture in which I needed to move on but wanted to stay within, develop and experience new challenges in Advanced Practice. Considering my options, 'absolute advanced practice' opportunities were limited, ie advanced practice as I knew and had experienced, formally encapsulating both mental and physical aspects of health and ill health. Looking at my own skill set, knowledge, qualifications, expertise and moreover my deficits and broader areas of clinical interest, I considered my penchant for the general side of nursing. Evident from my time in medical receiving as a student and as an added incentive when applying for my MHANP post, my liking for the assessment and treatment of the physically unwell patient was nurtured. This was further evidenced through my time working with my acute care mentor and subsequent H@N experience.

Given this and the emerging thinking around the concept of transforming nursing roles, the 2030 vision and my own journey as a nurse, I discussed the notion of applying for an Acute Care ANP post within the Older Adult Team, despite my RMN background, with my acute care mentor Kenny Fulton. As an ever present throughout the evolution of the MHANP team, Kenny had a good front line understanding of our team and was, not surprisingly, very supportive of the notion. However, mindful that a chat over a beer was poles apart from overcoming what could well be legitimate governance hurdles my somewhat leftfield application would have to negotiate. I deliberated for a number of months regarding the extent of the challenge that would lay ahead before tentatively penning my email to Barbara Cowley, the CNM for NHS Ayrshire and Arran's Older Adult ANP (OAANP) Service for thoughts and waited.

Since taking a part time job in a nursing home in my late 20's and heading off to college to gain the qualifications needed to pursue a career as a registered Nurse, I had done reasonably well and have been absolutely taken by all things nursing. As an RMN, Mental Health services at that time were working hard to develop care provision, encouraging community focused care and times were a changing with a huge influence being placed on patient recovery and what that required in terms of peoples physical, intellectual and social needs. Having practiced in a number of areas, mainly with patients experiencing acute mental illness, my practice benefited greatly from this experience and I realised the position of ward manger, firstly in an Intensive Psychiatric Care Unit and then Acute Admissions.

Although a hugely satisfying and challenging role, when the MHANP role was established, for me that was an opportunity to develop clinical skills beyond those traditionally considered to be the nursing role, that couldn't be missed.

When established in 2009 the MHANP team worked within an existing hospital at night team based at University Crosshouse Hospital in Ayrshire & Arran. Barron, Docherty and Docherty wrote in their 2010 Nursing Standard article "Developing the role of the advanced nurse practitioners in mental health" that set against the agenda of Modernising Nursing Careers and Modernising Medical Careers, the team came to be in order to replace junior psychiatric doctors in the out-of-hours period. Providing psychiatric expertise to ED for unscheduled Mental Health presentations as well as medical cover to the two mental health in-patient wards on site. The MHANP team also facilitated assessment of any of those patients who became physically unwell, with a view to initiating treatment and/or referring accordingly. In addition to this supporting the wider hospital in their care for individuals with mental health needs whilst being treated for a physiological problem.

To this end, robust governance was ensured to facilitate the expertise required to meet the challenges faced by the developing service to ensure the teams attributes were fit for purpose. Derek Barron, Maria Docherty and Eddie Docherty, as the Clinical Leads in Advanced Practice and Mental Health at the time had the foresight to ensure that in order to provide the best possible care for patients and satisfy corporate and public expectations, beyond attaining the level of expert in the role specific Competency Framework, they insisted MHANP's embrace the same Acute Care Competency Framework as that completed by the already established H@N team, albeit to a lesser degree. However, MHANP's were and are still required to achieve competence at level 3 on a Likert scale as opposed to 'expert' level 5 in their Acute Care Framework and in order to achieve this and satisfy the expectations of the Acute Care Nurse Consultant for sign off, undertake the same training required to effectively identify, assess and treat the sick patient.

Completing further learning in immediate life support, insitu simulation training, CPD, clinical supervision, and further academia at masters level. Modules to be completed included non- medical prescribing, advanced clinical assessment and diagnostic decision making. This would ensure that the team were collectively and individually prepared to function as Advanced Nurse Practitioners.

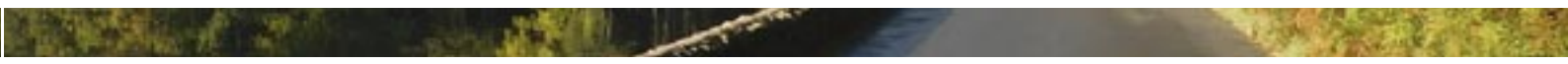
Having since spoken to Nurse Consultant Laura Maule, it is my understanding she and the Senior Management team discussed my query at a regional level through the West of Scotland Advanced Practice Academy under the auspice of transforming roles, and locally with Human Resources. Able to evidence the knowledge, training and experienced required for the role as a qualified ANP through my Competency Framework, albeit as an RMN, I met the criteria and duly applied at the next opportunity. However, with significantf competition, i was unsuccessful in my initial application for a substantive post but offered a secondment opportunity, which thankfully due to my forward thinking and always supportive CNM Julie Barrett, despite staffing challenges within the MHANP team at the time, I was afforded the opportunity to accept the post.

From day one I quickly learned that my understanding of the depth, breadth and demands of the role, were hugely underestimated. Despite spending time previously with H@N and having insight into the level of complex decision making required, the day time role with the OAANP team is very different. Although patient care is Consultant lead, by way of weekly ward reviews, there is, no junior medical cover on site. The title OAANP team in itself is a bit of a misnomer, the team

provide medical cover to Stroke rehab, Neuro rehab for under 65's, medical/ortho rehab for over 65 and complex care areas where people require palliative and end of life care, 24hrs, 7 days a week, 365 days a year.

The decision making is of a high level, autonomous and extremely challenging. We have direct access to University Hospital Crosshouse medics for advice if needed and will assess and treat patients accordingly within the parameters of our collective and individual expertise. Through the night we offer a single ANP H@N type service to both Ayrshire Central/Mental Health Services at Woodland View Hospital and Biggart Hospitals, whilst through the day the team will attend to most matters from patient clerk-ins to whatever may occur thereafter. For example, new strokes, sepsis, acute onset of IECOPD, ACS, decisions regarding patient's end of life care, referring to other disciplines or assessing and making treatment changes in the management of chronic illness. The list is endless and the understanding, knowledge and skill sets within the team are extensive. The team is patient centred and always considers the balance of treating patients in a safe and effective manner versus transfer to a higher care area, whilst also giving cognisance to what an unnecessary transfer would mean for that patient in terms of their journey whether that be eventually to home or possibly to end of life care.

From the outset my new CNM David Hunter was keen that I establish a plan to facilitate my further learning and identified Kirsty Scoular as my mentor. Sitting down with Kirsty we established a structure for supervision that would allow me to attain the skills knowledge and experience needed to practice safely and expertly as an OAANP. Recognising beyond that, as is under the auspice of an ANP in any specialty I would be required to lead by example and be able to confidently advise very experienced ward staff on situations that may arise in areas where they had worked, in some cases, for many years.



As an experienced Medical Receiving Nurse and having worked in Advanced Practice for 8 years, Kirsty was able to advise on skill sets I would quickly need to be competent in and supported a plan of action that annexed my Competency Frameworks. Focusing on skill sets that would generally be the bread and butter of the areas i was now covering and would likely be asked with a degree of expectation, to assist with responsibilities such as the passing NG tubes, difficult male catheterisations, catheter management and having a greater understanding of wound care for example.

'The capacity to learn is a gift: the ability to learn is a skill; the willingness to learn is a choice ' – Brian Herbert

All of which, although not alien to me as an RMN, i think it would be fair to say were not my area of expertise at the time and would generally be more common place within the realms of general nursing. Skills such as venepuncture, administration of IV medications, fluid management etc i was already comfortable with as a MHANP and in today's climate certainly within NHSAAA are actually, contrary to common belief, not that uncommon within areas of inpatient mental health services now, thanks to the service development work facilitated by the MHANP team over the years.

Combined with CPD, Critical Companion, Learnpro, the hell but eloquently delivered ALS teaching and a whole new associated language with terms such as ECMO, Wenckebach, far too many drugs beginning with the letter A, SIMAN with the expectation of expert weighing heavily on my shoulders, some excellent team support and regular supervision I have done ok thus far in meeting and evidencing the standards expected me.

'The capacity to learn is a gift: the ability to learn is a skill; the willingness to learn is a choice '– Brian Herbert
The value of our Competency Framework and the responsibility of the Advanced Nurse Practitioner to make and evidence complex, high level decisions across all pillars of advanced practice, I have come to learn is also fundamental key to transforming roles.

Despite the daily challenges experienced in my own steep learning curve and moments of doubt throughout my time as an ANP, I have been reassured by my self imposed decision making governance and believe that by way of impressing this sense of professional responsibility, Advanced Practice has facilitated a framework where individuals are able to not only collectively support meeting the challenges of future proofing a contemporary health service but also excel as individuals within their chosen specialties. Whilst my secondment was fairly short lived and lead on to successfully attaining a permanent post with the OAANP team, existing roles are evolving day on day, week on week and year on year through Advancing Practice, transforming the diverse nature of health care provision.

With Senior Remote and Rural, Cardiology and Urology ANP's, Mental Health, Orthopaedics, General Practice, Care home ANP's and many more, here in NHSAAA, the evidence suggest Advanced Practice offers the knowledge, skills, attributes and leadership required to support the vision of care being delivered by the right person, in the right place at the right time. Affording continuity of care and standards through robust personal development and clinically supervised governance structures. With the added benefit of being grounded in our nursing profession, allowing us to voice healthy anxieties amongst our ranks, whilst patients, peers, clinical events and self-directed expectations challenge us to be better nurses today than we were yesterday.

NHS Grampian Advanced Practice update for ACAP 2019

NHS Grampian has continued to develop its board level governance arrangements for advanced clinical practice in line with the various transforming roles papers[i] released by Chief Nursing Officer Directorate (CNOD).

The NHSG Advanced Care Academy (ACA), under the guidance of the Advancing Practice Steering Group and the Nurse Consultant (NC) for Advanced Practice, provides learning opportunities and clinical supervision through use of Academy Fellows to support established and developing practitioners in the work place. NHSG links to the regional North of Scotland Advanced Practice Academy (NoSAPA) through NMAHP representatives on the regional steering group.

The ACA resources and NC advice are available to all registered health professionals evolving their clinical contribution at advanced practice level, and to all NHSG services seeking to incorporate advanced practice roles as part of their service delivery.

A brief timeline of progress with the advanced practice agenda within NHSG, since the first guidance[ii] was developed in 2016 follows:

- Initiated the advanced practice steering group, which initially focused entirely on nursing and midwifery roles, but has evolved to have a much broader advanced practice remit.
- Undertaken a board wide review of N&M advancing practice roles.
- Supported two (2-year: 2017-2019) ~ Advanced Practice NC secondments, to support delivery of the transforming roles agenda in NHSG.
- Development and adoption of a generic Advanced Nurse Practitioner (ANP) Job Description.
- Harmonised ANP role titles for appropriately qualified and experienced staff in line with Paper 2.
- Launched our local academy arrangements including the use of Academy Fellows to support trainees in areas with a paucity of other options. Both the NHSG Advanced Care Academy[iii] initiative , the use of Fellows and regional workingiv initiatives have recently been published celebrating development of the Fellow role, the successful retention of GP services in rural Aberdeenshire, and regional collaboration.
- Development of an Advanced Nurse Practitioner 1 year “Fast Track” programme. This commenced November 2018 to support maintenance of service for a District General Hospital and hard to recruit posts in Aberdeen. It is scheduled to complete November this year. The programme is being evaluated and results will be shared.
- Exploration of the implementation of the Advanced District Nurse Role.
- Development of Custody Nurse Practitioners.
- Continued development of Advanced Pharmacist Practitioner (APP) roles within remote and rural areas.
  - o Within GP practices
  - o In the District General Hospital: providing cover in lieu of junior medical staff to obstetrics and gynaecology; scoping the potential contribution of the APP in Out of Hours service.

- Development of multi-professional “Advanced Clinical Practitioner” (ACP) roles modelled on the ANP descriptor as expert autonomous generalists, recruiting from registered professions with potential for independent prescribing.

- Development of an NHSG Advanced Practice portfolio for staff working towards, or working at, advanced practice level – this incorporates the “triangle of capability” as per national directive: Masters level theoretical preparation, appropriate clinical supervision, clinical competency sign-off in practice using the TURAS feedback forms (CEX/DOPS/CbD). It further utilises multi-source feed back, alignment to national competencies and service specific competency frameworks, and a process of board sign-off for newly qualified practitioners parallel to the process developed by colleagues in the West of Scotland Advanced Practice Academy.

- We are commencing work to align Midwives, Physician Associates, Healthcare Scientists, Nurse and AHP Specialists practising at advanced level with local healthcare needs in Grampian and the ongoing Scottish national work with these professional groups.

- There is now one substantive NC post for advanced practice in NHSG, which affects how the role and remit is delivered and is a new journey.

We are always willing to share any of our work, contact: nhsg.aca@nhs.net. We are indebted to the West of Scotland Advanced Practice Academy for advice and support in the early days while NoSAPA got under- weigh. We are confident that the regional and national collaborations in place will enable robust governance for advanced practice in Scotland.

i Key Transforming NMaHP Roles papers

Scottish Government. (2017a). Transforming Nursing, Midwifery and Health Professions’ (NMaHP) Roles: pushing the boundaries to meet health and social care needs in Scotland - Paper 1: Introduction. [Online]. Available: http://www.nes.scot.nhs.uk/media/4031447/cno_paper_1_transforming_nmahp_roles.pdf [Accessed 16/04/2019].

Scottish Government. (2017b). Transforming Nursing, Midwifery and Health Professions’ (NMaHP) Roles: pushing the boundaries to meet health and social care needs in Scotland - Paper 2: Advanced nursing practice. [Online]. Available: http://www.nes.scot.nhs.uk/media/4031450/cno_paper_2_transforming_nmahp_roles.pdf [Accessed 16/04/2019].

Scottish Government. (2017c). Transforming Nursing, Midwifery and Health Professions’ (NMaHP) Roles: pushing the boundaries to meet health and social care needs in Scotland. Paper 3: The district nursing role in integrated community nursing teams. [Online]. Available: http://www.nes.scot.nhs.uk/media/4031453/cno_paper_3_transforming_nmahp_roles.pdf [Accessed 16/04/2019].

Scottish Government. (2018). Transforming Nursing, Midwifery and Health Professions’ (NMaHP) Roles: Paper 5 Transforming education and career development in nursing.

[Online]. Available: https://www.gov.scot/publications/transforming-nmahp-education-career-development-paper-5/ [Accessed 16/04/2019].

ii TRANSFORMING NURSING ROLES DEVELOPING ADVANCED PRACTICE IN NHSSCOTLAND JUNE 2016: SUMMARY AND RECOMMENDATIONS [Online]. Available: http://aape.org.uk/wp- content/uploads/2016/10/Transforming-Roles-Advanced-Practice-Paper-June-2016.pdf [Accessed 16/04/2019].

iii Kindness K, Gray H, Moggach A, Croft A, Hiscox C. (2019) Establishing an advanced care academy and its role in advanced practitioner development. Nursing Management [Online]. Available: https://journals.rcni.com/nursing-management/evidence-and-practice/establishing-an-advanced-care- academy-and-its-role-in-advanced-practitioner-development-nm.2019.e1856/absb [Accessed 04/09/2019].

iv Kindness K, Chalmers A, Watt O, Cameron D, Hall I. (2019) Applying national standards to advanced clinical practice. In Nursing management [Online]. Available: https://rcni.com/nursing- management/features/applying-national-standards-to-advanced-clinical-practice-151456 [Accessed 04/09/2019].

Identification of barriers associated with the activation of Rapid Response Teams

Julie Moran
Senior Advanced Nurse Practitioner Hospital at Night Team/Cumbrae Ayrshire and Arran Health Board.
(Julie.moran@aapct.scot.nhs.uk)

Rapid response teams have been established within Ayrshire and Arran health board since 2012. These teams were implemented predominantly due to an increase in hospital standard mortality ratio data and the success of the surviving sepsis campaign in 2012. This dual response team is comprised of a combination of a Doctor and/or Advanced Nurse Practitioners (ANPs) who have the clinical assessment and technical skills necessary to allow early diagnosis, treatment and, if necessary, escalation of the deteriorating patient. Initially there was improvement in compliance with the activation of the rapid response teams among staff but there are ongoing incidences when rapid response teams are not being activated despite patients fitting the criteria. Downey et al. (2008) illustrate that in-patient mortality can double due to significant delay in rapid response team activation. However it is acknowledged by Ferrer et al. (2008) that there are many challenges associated with sustaining any quality improvement initiatives in the healthcare setting and this initiative is no different. It is suggested by Taylor et al. (2013) that effective quality improvement remains mixed and tends to be effective only in specific settings.

Prior to the implementation of this initiative a structured staff education programme was introduced to both nursing and medical staff. This programme emphasised the significance of prompt early referral to the team. It was recognised that nursing staff are fundamental in success of this improvement as this group are responsible for activating the vast majority of calls to a rapid response team (Massey et al. 2014). Rapid response teams are activated by pre-determined call-out criteria triggered by abnormal physiological parameters or staff concern. Therefore the implementation of call-outs should improve outcomes for deteriorating patients (Jamieson et al. 2008). Bucknall et al. (2012) and Pantazopoulos et al. (2012) studies agree that when there is a failure to activate rapid response teams there is potentially a compromise in patient safety.

The sole function of a rapid response team is to provide a timeous response to the acutely unwell patient by providing expert assessment, early intervention and stabilisation of patients who present with early signs of clinical deterioration (Jamieson et al. 2008). The overall objective of all rapid response teams is to improve both safety and quality of care for patients (Beitler et al. 2011, and Devita et al. 2006). Levy et al. (2010) agreed that by implementing evidence-based guidelines and standardising practice the outcome of the deteriorating patient could be improved.

Even though rapid response has been endorsed worldwide, there remains evidence of under use of this service; a literature search was carried out aimed at identifying barriers to activating a rapid response team for the deteriorating patient. Surprisingly, Astroth et al. (2013) reported the team itself as being a barrier; identifying that where team members were perceived to be abrupt or unsupportive had an impact on the decision to activate rapid response teams, and consequent detrimental effect on staff culture and potential non-activation of the teams. Marshall et al. (2011) agreed that previous experience of interpersonal interactions can affect the activation of rapid response teams in the future. Furthermore Jones et al. (2006) identified that ward staff were reluctant to activate a rapid response team due to the volume of people who arrive and the unclear expectation of their role in the situation.

Another key theme that emerged was unit/ward culture, nurses being fearful of looking incompetent to peers or medical colleagues. Medical hierarchy within the ward area was deemed a barrier to implementing the call-out of rapid response teams (Marshall et al. 2011). Massey et al. (2014) agreed that due to this hierarchical structure nurses feared being reprimanded by medical staff or looking incompetent in front of peers if they activated the team. Staff culture was another barrier, a perceived differing level of co-operation between professional groups combined with culture of the profession leading to rapid response teams not being activated (Marshall et al. 2011).

Jones et al. (2006) indicated that staff were reluctant to activate rapid response teams as it went against senior medical staff wishes and reprisal was feared. Tee et al. (2008) highlighted that many nurses would contact their own ward based medical team rather than activate a rapid response team, due to fear of criticism or negative verbal response from either the rapid response team or ward based medical team. Furthermore Jones et al. (2006) identified that nurses would only consider contacting a rapid response team if their own team did not respond. Interestingly a study carried out by Benin et al. (2012) identified that the introduction of rapid response teams caused conflict between nurses and doctors, as medical staff actively discouraged rapid response team activation, such activation being deemed a failure by medical colleagues, rather than an additional support.

A prevalent causative factor identified by Bucknall et al. (2012) is the lack of recognition of and reaction to abnormal physiological parameters, resulting in under-utilisation of this service. Undeniably if abnormal physiological parameters are left untreated or unrecognised then this may lead to cardiac arrest. It is recognised that patients manifest physiological abnormalities prior to cardiac arrest, sudden death or unexpected ITU admission (Kause et al. 2004). Patient survival is dependent on nursing staff recognising this and responding appropriately (Jones et al. 2009). A systematic review incorporating 42 studies was carried out by Johnston et al. (2017), which identified factors that impacted failure to rescue and escalation: Nurses identified that increased workload and over-confidence in their own ability to manage a situation delayed the activation of rapid response teams with poor interpersonal communication and interactions also identified as common areas that underpinned the failure to activate rapid response teams. Marshall et al. (2011) agreed that inability to recognise the gravity of a situation can affect the course of action taken, since if situational awareness is lacking failure to rescue can occur. Furthermore Marshall et al.

(2011) identified that comprehension and perception of the physiological observations are vital, as staff must be able to recognise and relate the observations to the call-out criteria. Cioffi (2001) emphasised that past clinical experience impacted on a nurse's ability to recognise and respond to physiological deterioration; frequently nurses recognised patterns from past experiences and exposure to similar cases. Jones et al. (2006) agree that nurses often use pattern recognition and intuition rather than following call-out criteria to decide appropriateness of activation. Interestingly Astroth et al. (2013) study identified that nurses with 5 or more years' experience felt that rapid response teams were beneficial only to nurses with limited experience. Tee et al. (2008) agree that expertise of nursing staff tends to have a significant effect on rapid response activation, as expert nurses tend to rely on experience and knowledge to recognise early warning signs of deterioration. Pantazopoulos et al. (2012) study concluded that experienced nurses often attempted to manage the situation independently rather than activate a rapid response team, often to the detriment of the patient. Both Downey et al. (2008) and Quach et al. (2008) agree that delaying rapid response activation significantly increases patient mortality. Johnston et al. (2017) suggested that effective communication and team work can play an important role in preventing delayed escalation of care. Even though there is evidence of communication improvement in clinical areas, activation of a rapid response team remains suboptimal (Bucknall et al. 2012, Bellomo et al. 2014, Johnston et al. 2017).

Within Ayrshire and Arran there are activation guidelines which state that a NEWS score of five or above in any patient should trigger activation of a rapid response team. Activation is the responsibility of any healthcare worker attending to the patient; this is most commonly nursing staff.

Both Jones et al. (2009) and Davies et al. (2014) identified a key barrier to activation of rapid response team as unfamiliarity with the call-out criteria, and it was suggested that an improvement in staff education was essential. These studies are representative of a key theme throughout the literature - the important role of education regarding the function of, and criteria for, rapid response team activation. Education was identified as needing to include: an understanding of the rapid response team's role, response times, and expectations of ward staff involvement. There is a presumption that activation of rapid response teams would be utilised effectively if nurses were educated on the principles, theory and purpose of the team (Hillman et al. 2005). Many nurses in Massey et al. (2014) study acknowledged that activating rapid response team was a last resort, thus misunderstanding the primary function of the team. Both Williams (2011) and Cretikos et al. (2006) agree that nursing lack of knowledge of rapid response is an identifiable barrier and activation is affected significantly if formal education is not provided. Davies et al. (2014) suggested that an ongoing education programme might tackle this barrier. Jones et al. (2006) agree that education of all clinical staff members was paramount in contributing to a sustained and successful cultural change in the activation of rapid response teams.

Conclusions

Rapid response has been embraced as part of the patient safety agenda by leaders and organisations both nationally and internationally, and seems to be considered a popular solution to preventing patient deterioration (NICE, 2007). There are clear challenges in relation to the integration, adoption and activation of rapid response teams. The literature identified a few overarching themes which prevent activation, including: lack of education; fear of repercussion and allegiance to hierarchical traditions; lack of expertise; knowledge of the efficiency of a rapid response team. It is recognised that nursing staff are a vital asset to successful activation of rapid response teams, as they are crucial in identifying, recognising and responding appropriately to the deteriorating patient. Nursing staff are the primary activators, and as such are being empowered to seek help in managing an unwell patient. (Williams et al., 2011). Therefore the provision of staff education is fundamental in the activation, utilisation and sustainability of rapid response teams (Hillman et al., 2005). Sustainability remains an ongoing challenge due to staff turnover; therefore continued education regarding rapid response activation is carried out as the necessity arises. Continuous positive reinforcement is fundamental as staff engagement and motivation is essential in facilitating the sustainability of rapid response team activation for the deteriorating patient.

References

Astroth, K.S.,Woith, W.M.,Stapleton, S.J.,Degitz, R.J., Jenkins, S.H. (2013) Qualitatative exploration of nurses decisions to activate rapid response teams. Journal of Clinical Nursing. Vol.22, pp2876- 2882.

Beitler, J.R., Link, N., Bails, D.B., Hurdle, K., Chong, D.H. (2011) Reduction in Hospital-Wide Mortality After Implementation of a Rapid Response Team: A long term Cohort Study. Critical Care. BioMed central. Vol.15(6). [Online] Available: http://ccforum.com/ content/15/6/R269 [Accessed 10/08/2019].

Bellomo, R., Goldsmith, D., Uchino, S., Buckmaster, J., Hart, G, Opdam, H., Silvster, W., Doolan, L. & Gutteridge, G. (2004) Prospective Controlled Trial of Effect of Medical Emergency Team on Postoperative Morbidity and Mortality Rates. Critical Care Medicine. Vol. 32(32), pp. 916-921.

Benin, A.L., Borgstrom, C.P., Jeng, G.Y., Roumanis, S.A., Horwitz, LI.I. (2012) Defining impact of rapid response teams: a qualitative study with nurses, physicians and hospital administartors. Postgraduate Medicine Journal. Vol. 88(1044), pp. 575-582.

Bucknall, T.K. Jones, D. Bellomo, R. Staples, M. (2012) Responding to medical emergencies: System characteristics under examination (RESCUE). A prospective multi-site pointprevalence study. Resuscitation. [Online]. Available: http://dx.doi.org/10.1016/j. resuscitation2012.06.015. [Accessed 10/08/2019].

Cioffi, J. (2001) A study of the use of past experiences in clinical decision making in emergency situations. International Journal of Nursing Studies. Vol. 38, pp.591-599.

Cretikos, M., Hillman, K. (2003) The medical emergency team: does it really make a difference? Internal Medicine Journal. Vol. 33, pp. 511-514.

Davies, O., Devita, M.A., Ayinla, R., Perez, X. (2014) Barriers to activation of the rapid response system. Resuscitation. Vol. 85, pp.1557-1561.

Devita, M.A., Bellomo, R., Hillman, K., Kellum, J., Rotondi, A., Teres, D., Auerbach, A., Chen, W.J.,Duncan, K., Kenward, G., Bell, M., Buist, M., Chen, J., Bion, J., Kirby, A., Lighthall, G., Ovreveit, J., Braithwaite, S., Gosbee, J., Milbrandt, E., Peberdy, M., Savitz, L., Young, L. & Galhotra, S. (2006) Findings of the First Consensus Conference on Medical Emergency Teams. Critical Care Medicine. Vol. 34(9), pp. 2463-2479.

Downey, A., Quach, J., Haase, M., Haase, A., Jones, D., Bellomo, R. (2008) Characteristics and outcomes of patients receiving medical emergency team review for acute changes in conscious state or arrhythmias. Critical Care Medicine, Vol, 36 (2), pp.477-481.

Ferrer, R., Artigas, A., Levy, M.M., Blanco, J., Gonzalez-Diaz, G., Garnacho-Montero, J., Ibanez, J., Palencia, E., Quintana, M. (2008) Improvement in the process of care and outcome after multicentre severe sepsis education programme in Spain. JAMA. Vol.299, pp2294-2303.

Hillman, K., Chen, J., Cretikos, M., Bellomo, R., Brown, D., Doig, G and Flabouris, A. (2005). Introduction of the medical emergency team (MET) system: a cluster-randomised control trial. Lancet. Vol 18(24), pp2091-2097.

Jamieson, E., Ferrell, C., and Rutledge, D.N. (2008) Medical Emergency Team implementation: Experiences of a Mentor Hospital. MEDSURG Nursing. Vol.17(5), pp312-316.

Johnston, M., Arora, S., King, D., Bouras, G., Almoudrais, A., Davis, R. and Darzi, A. (2017) A systematic review to identify the factors that affect failure to rescue and escalation of care in surgery. Journal of Surgery. Vol. 10, pp752-762.

Jones, D.A., Mitra, B., Barbetti, J., Choate, K., Leong, T., Bellomo, R. (2006) Increasing the use of an existing Medical Emergency Team in a teaching hospital. Anaesthetic Intensive Care. Vol. 34, pp. 731-735.

Jones, L., King, L., Wilson, C. (2009) A literature review: factors that impact on nurses' effective use of the Medical Emergency Team (MET). Journal of Clinical Nursing. Vol. 18, pp. 3379-3390.

Kause, J., Smith, G., Prytherch, D., Parr, M., Flabouris, A., Hillman, K. (2004) A comparison of antecedents to cardiac arrest, deaths and emergency intensive care admissions in Australia and New Zealand and United Kingdom- the ACADEMIA study. Resuscitation. Vol.62, pp. 275-282.

Levy, M.M., Dellinger, R.P.,Townsend, S.R., Linde-Zwirble, W.T., Marshall, J.C., Bion, J., Schorr, C., Artigas, A., Ramsay, G., Beale, R., Parker, M.M., Gerlach, H., Reinhart, K., Silva, E.,Harvey, M., Regan, S. and Angus, D.C. (2010) The surviving Sepsis campaign: results of an international guideline-based performance improvement program targeting severe sepsis. Intensive care Medicine. Vol 36, pp.222.

Marshall, S.D., Kitto, S., Shearer, W., Wilson, S.J., Finnigan, M.A., Sturgess, T., Hore, T., Buist, M.D. (2011) Why don't hospital staff activate the rapid response system. Implementation Science. Vol. 6, pp. 39-40.

Massey, D., Aitken, L.M., Chaboyer, W. (2014) Literature review: do rapid response systems reduce the incidence of major adverse events in the deteriorating ward patient? Journal of Clinical Nursing. Vol.19 (23-24), pp. 3260-3273.

National Institute for Health and Clinical Excellence. (2007) Clinical Guideline 50: Acutely ill patients in hospitals: recognition of and response to acute illness in adults in hospital. [online]. Available: http://nice.org.uk/CG050. [Accessed 26/07/2019].

Pantazopoulos, I., Tsoni, A., Kouskouni, E., Papadimitriou, L., Johnson, E., Xanthos, T. (2012) Factors influencing nurses' decisions to activate medical emergency teams. Journal of Clinical Nursing. Vol. 21, pp. 2668-2678.

Quach, J., Downey, A., Haase, M., Haase, A., Jones, D., Bellomo, R. (2008) Characteristics and outcomes of patients receiving medical emergency team review for acute changes in conscious state or arrhythmias. Journal of Critical Care. Vol 23 (3), pp 325-331

Taylor, M.J., McNicholas, C., Nicolay, C., Darzi, A., Bell, D., Reed, J.E. (2013) Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. BMJ Quality and Safety. Vol. 0, pp1-9.

Tee, A., Calzavecca, P., Licari, E., Goldsmith, D., Bellomo, R. (2008) Bench-to-bedside review: the MET syndrome- the challenges of researching and adopting medical emergency teams. Critical Care. Vol. 12, pp. 205-206.

Williams J. (2011) Research Paradigms and Philosophy. [online]. Available: http://www.howtodo.dissertationhelpservice.com/research-paradigm [Accessed 09/08/2019].

ACAP
Acute Care
Advanced Practitioners

ACAP would like to thank the sponsors of the 2019 conference

Scottish Nursing Guild

eden medical

Royal College of Nursing

EVOLUTION Designs Limited

SKILLS4NURSES

ACAP would like to thank all the sponsors for their contribution towards making this conference possible.

www.acapscotland.org