ACAP
Acute Care
Advanced Practitioners

The Advanced Nurse Practitioner

The journal for members of ACAP

Issue 7
March 2013

Registered charity SCO42116

Produced in association with
Skills4Nurses

Scotland Leading the way for Acute Care Practitioners

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

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

Acute care practitioners in Scotland have never had until now:

- The privilege of having an arena to showcase areas of good practice,
- The opportunity to bench mark other practices throughout Scotland,
- A national opportunity for education
- And most importantly have their voice heard.

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

Mission Statement

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

ACAP Scotland Leading the way

Support given by:
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CS MEN

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

Thanks

ACAP would thank all who contributed to the success of our 3rd national conference event, held at the Lighthouse Glasgow. The day was eventful, educational and provided ideal networking opportunities. The evaluations from the day can be found within this journal.

Next Event

Then next event looks set to be in October 2013. The committee are already looking at venues, speakers and sponsors. We recognise that it is sometimes difficult for ACAP members to get time to attend the events, especially for those travelling distances. Therefore to address this we have attempted to leave sufficient time between dates. We would welcome your comments on the decision to reduce the events from bi annually to annually. You can contact us either through the ACAP website: ascapscotland.org or by emailing either Julie at julessmith69@hotmail.com or Elaine at Elaine.headley@gmail.com

Due to the rising cost of putting on events, ACAP has to raise the attendance fee from £30 to £35. We are sure you will all agree that this is still excellent value for money. Look forward to seeing you all in October.

Practitioner Development

The ACAP OSCE sheets are indeed underway, however there has been a bit of a delay in compiling these. We would like to thank Mhairi Paton, from NHS Grampian for her idea. Due to work commitment Mhairi is unable to continue with this, but the committee will continue with the design and implementation of this very worthwhile resource. If any of our members/journal readers would like to contribute please get in touch.

Wikipedia

ACAP is currently looking at compiling a Wikipedia page. To achieve this we would like to ask you for your help. ACAP is your organisation; therefore you have a right to say what you would like to have published on Wikipedia. Again please get in touch with Julie or Elaine with your suggestions.

Website

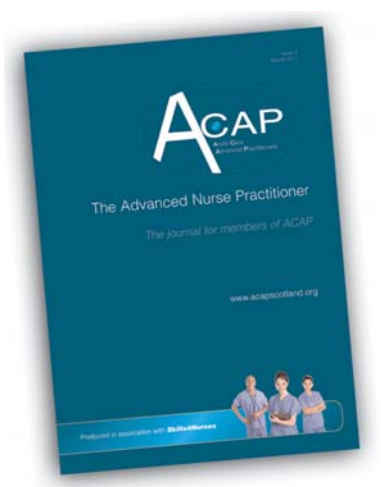
David Watson, ACAP committee member, has suggested the use of Drop Box as a resource to share and store files in the ACAP site. The work for this will be carried out by David Watson & David McDermott, ACAP web manager

Skills4Nurses Recruitment Events

Skills4Nurses are pleased to announce their forthcoming Nursing & Midwifery Recruitment events for 2013. We will be staging our first expo of the year in Belfast within the Europa Hotel on Tuesday 23rd April 2013 and then were heading south to Dublin to the D4 Berkeley Hotel to hold our next event on Thursday 25th April 2013, we then come back to Glasgow for our final event on Wednesday 9th October in the Grand Central Hotel which proved to be a great venue for 2012. Log on to: www.skills4nurses.com for further details or email: shona@gmexpos.com

Get Involved

We would welcome any articles, case studies or any news of service innovations within your area. Additionally, we would like to ask for any comments or suggestions you may have, as ACAP is about practitioners for practitioners, again please contact Elaine or Julie.



NEWS....NEWS..

Development from a Medical Support Nurse Service to a Cardiothoracic Advanced Nurse Practitioner Service; The first 10 years.

Karen Kindness MA, RGN, BA Nursing, MN (Critical Care & Trauma), Nurse Independent Prescriber

Background - The Early Years

As with many other non traditional nursing roles, the Medical Support Nurse (MSN) role in cardiothoracic surgery in Aberdeen was initiated to aid junior doctor compliance with the European Early Working Times directive. The earliest incumbents were appointed in November 2002. They were highly experienced cardiac intensive care nurses and the intention was that they would support the foundation year 1 (FY1) doctors on the ward and the high dependency unit. However, by the time the first MSNs were employed, the deanery had withdrawn the FY1s.

As these roles were the first of their kind in the acute sector of NHS Grampian, pre-dating both night nurse practitioners and out of hour services, they lacked any formal training or structure (Gibb 2007). To address this short fall advice was sought from other cardiothoracic units where similar fledgling services had commenced in Glasgow.

By November 2007, the MSN role was an embedded provision for the cardiothoracic services, at this time there were 3 full time MSNs in post, however there were still gaps in structured training or educational targets. Addressing the educational needs of the practitioners the MSNs undertook Advanced Clinical Examination (ACE) by means of the medical school. Employed from Monday to Friday the MSNs performed most of the duties of the FY2, with the exception of prescribing and ordering investigations out-with their authority (such as computerised tomography (CT) scans). The areas of most positive impact were in continuity of care and organisation – systems had been instituted to manage the patient journey. These systems were mostly just structuring the workload (eg night person orders blood for the next day, orders post-op ECHOs; having designated work areas – either HDU/Ward) and instituting a formal structured patient by patient handover. That is, introducing the type of structured work that was already integral to nursing into the medical service. This was particularly helpful when the FY2s started to rotate every 4 months (Gibb 2007).

By 2009 the cardiothoracic unit (CTU) had lost three of the six FY2 doctors, recognising a service provision gap it was agreed the MSNs would cover nights and weekends for the ward and HDU. This was structured on rotational basis with the remaining FY2s. Senior cover was provided by the medical registrar in the cardiac intensive care unit (CITU). This change in service demands initiated an additional educational development for the MSN, by which each had to successfully complete non medical prescribing (NMP).

On completion of NMP, the cardiothoracic practitioners pioneered the service to work autonomously at advanced level equivalent to FY2 doctors.

Despite all of this development the title and job description did not fully reflect the reality of the role. Further educational development was agreed and recruitment began for additional MSNs, which was necessary to ensure appropriate cover for the expanding service, additionally, Surgical Support Practitioner (SSP) Trainees for theatre were recruited to take over vein harvesting, and assisting in theatre.

November 2010 saw a further two new MSNs being appointed, bringing the ward and HDU staff complement to a total of seven whole time equivalents (WTE), each new team member bringing a different set of skills and experience to the role. Currently both the job description and the future team structure is under review as further service led development is anticipated shortly.

The current role – 24/7

Broadly, the role can be subdivided into the following areas of activities:

Preparing for and clerking admissions (elective and emergency):

- liaising with consultants with regard to pre-operative tests and investigations, fitness for surgery
- preparation for theatre (for example the detailed management of patients with Type 1 Diabetes or other significant co-morbidities).

Post-operative assessments and reviews of patients' following arrival from theatre or CITU, which involves:

- Review of patients following a change in condition.
- assessments and reviews require diagnostic skill,
- request or perform appropriate tests (bloods, xrays, ECGs)
- interpreting results of tests
- prescribe appropriately.

Participation in daily ward rounds which are led by the surgical registrar or consultant surgeon:

- following up on the generated jobs which include:
- ordering investigations/tests
- referrals
- Discharge planning and discharge documentation.

Multi-disciplinary teaching:

- orientation of new FY2s/medical students/
- new CTU nursing staff
- visiting practitioners.

Audit:
- collecting appropriate data to the national cardiac surgery database (TOMCAT);
- in-house quality audit which includes prescribing audits

Involvement in service development:
- Such as being proactive in planning for anticipated changes in service provision.
- Participation in the unit Morbidity and Mortality meetings (M&Ms).
- Participation at the Society of Cardiothoracic Surgery (SCTS).

Part of the value of having a dedicated ward and HDU team working closely with the junior medical staff is that the highly specialised knowledge and expertise of the nurse practitioners allows for effective monitoring and treatment with early detection and prompt safe management of post-operative complications.

Some potential complications of Cardiac/Thoracic Surgery
- Cardiovascular - hypotension, which can be due to one or more of the following – haemorrhage, haematomas, pericardial tamponade, dysrhythmias , or myocardial ischaemia resulting in impaired contractility and subsequent loss of cardiac output.
- Respiratory - atelectasis, chest infection/pneumonia, Acute Respiratory Distress Syndrome (ARDS), pleural effusions, pulmonary emboli, pneumothorax, persistent air leak or empyema (following lung surgery).
- Renal – acute or acute on chronic renal failure
- Gastro-Intestinal – Ulcers, paralytic ileus
- Genito-Urinary – urinary tract infection
- Nervous system – Stroke, cognitive deficit delirium, local neuropathy (pressure/emboli)
- Integumentary - Wound infections (Chikwe, Beddow and Glenville (2006).

Although most of these potential complications of cardiothoracic surgery are also risks for any surgery, there are particular factors in terms of likelihood and management which warrant specialist management: *see box 1*

Risks of particular note post cardiac surgery
Prevention is obviously better than cure however, and both experience and vigilance are required to keep these risks to a minimum, often early detection and prompt effective management will prevent potentially more serious sequelae, therefore patients are actively monitored for complications i.e. high index of suspicion for common ones. Early involvement of speciality expertise facilitates optimum management, the most common of these are referrals to: cardiology and/or renal teams, microbiology, diabetic team, and the general surgeons.

Patient demographics and implications for future practice
Currently the majority of the MSNs work involves cardiac surgery patients. The SCTS 6th National Adult Cardiac Surgical Database Report (2008) identified an increase in the mean age for most categories of surgery. Patients older than 75 years of age account for more than 20% of all cardiac surgery cases. 25% of patients for coronary artery bypass grafts (CABG) alone were more than 75 years old, this change in the demographic towards older patients, with potentially more co-morbidities, can result in more complicated and consequently longer procedures (SCTS 2008). How does

How does Aberdeen compare to the National averages ?
(see box 2)
These figures are more recent than those last published by SCTS. Aberdeen currently shows a similar trend in terms of the percentage of patients over 75 years having CABG alone, but the mean age of patients is no longer rising. It will be interesting to see whether this is also demonstrated in the next national audit which is due to be published this year. In Aberdeen the number of cardiac surgery cases is decreasing year on year, but the unit activity level remains much the same, due to the longer average length of stay and a gradual increase in the number of thoracic cases.

Risk	Incidence
Stroke	2-3% if coronary artery bypass used during surgery Rises to 5% if replacement of calcified aortic valve or previous stroke *NB thrombolysis not an option*
Resternotomy	2-3% often carried out as an emergency procedure, in CITU/HDU
Arrhythmias	30% – most commonly atrial fibrillation
Need for Permanent Pace Maker	1-2% following Aortic Valve Replacement
Deep sternal wound infections	0.5% routine risk, with 3% suffering from diabetes Effective management is often difficult, costly and extremely time consuming
Superficial wound infections	10%
Ulcers	1-2%
AKI	1% requiring dialysis if no previous deficit
Prosthesis failure	Multifactorial, general percentage not available.

- Box 1 Chikwe, Beddow and Glenville (2006).

Year (Apr-Mar)	Cardiac Sx cases	Mean age (SD)	CABG alone	Pts >75yrs	% Pts >75yrs
2007-08	619	**67.1** (10.72)	392	101	25.76%
2008-09	608	**66.7** (10.42)	365	71	19.45%
2009-10	596	**67.2** (10.53)	362	89	24.58%
2010-11	531	**67.1** (11.25)	335	91	27.16%
2011-12	501	**67.5** (10.84)	284	77	27.11%
2007-2012	**2855**	**67.1**	**1738**	**429**	**24.68**

Box 2

There is usually only one thoracic list per week with other cases on an ad hoc basis. There tends to be a greater age range in thoracic patients: from the young individual requiring correction of chest deformity or pleurodesis following multiple spontaneous pneumothoraces, to the older patients with lung or mediastinal masses requiring removal. Ten years ago the work of the MSN was a rather routine role, with specific pre and post operative checks on specified days. While these are still carried out, the management of complications and co-morbidities has become an ever increasing part of the role as it transitioned from MSN to practitioner. It is anticipated that the team will continue to develop to meet these challenges both through formal learning and through consultation with the relevant speciality teams.

Where are we now?

In terms of staffing with nurse practitioners there are:

7 WTE MSNs

- Cardiothoracic Advanced Nurse Practitioner on the new job description, 3 with Masters degrees, 2 with bachelor degrees, 2 with on the job training and specific courses such as ACE and NMP only

6 WTE SSPs

- 1 trained, with the others at various stages in training. There is the likely imminent loss of onsite surgical registrars from the OOH rota with the suggestion that they will provide an on call service from home. To address this change the SSPs will cover CITU OOH, however, the SSPs have no experience of managing ward/HDU patients, and most have minimal CITU experience. To ensure these practitioners are prepared to undertake these responsibilities and have the necessary skills and experience, ongoing training and competency development will be achieved prior to implementation of this new way of working. Nanjaiah, Skinner, Jutley et al. (2011) demonstrated that this has worked successfully in their unit in Nottingham, with no deterioration in patient outcomes.

The future?

The educational target is Advanced Practice at Masters level for all incumbents. Other necessary skills and training identified are:

- Insertion of arterial lines/suturing
- ALS/ IMPACT/ CALS/ Nurse authorisation of blood and blood products

Succession Planning:

- Recruitment has become more difficult due to the highly specialised nature of the work and the level of responsibility. It is anticipated that the structure of the team may have to change so that there is an entry level practitioner/trainee who will only become autonomous upon completion of an agreed set of competencies.

Currently there is no team leader, which can at times lead to a lack of cohesion and focus in how the team works. Although there is a nurse manager responsible for the team, she is not a physical presence on the unit, additionally she is not a nurse practitioner and her managerial remit is not solely the cardiothoracic unit, these factors dilute her ability to resolve the issues which face the team.

Conclusions

It is a tribute to the hard work and dedication of the initial MSNs that their support service has evolved into the effective practitioner service it is today. As the healthcare needs of today's patients are more complex than ever, so must nurses and nurse practitioners at all levels continue to develop the knowledge and skills they need to provide a safe and effective care and treatment.

References

Chikwe, J., Beddow, E., Glenville, B. (2006) Cardiothoracic Surgery, Oxford University Press: Oxford.

Gibb, I. (2007) Cardiothoracic Medical Support Nurse ARI – 5 years on. Local document available Ward 50 ARI: Aberdeen.

Nanjaiah, P., Skinner, H., Jutley, R.S., Mitchell, I.M., McCartney, S., Richens, D. (2011), Nurse Practitioners Can Safely Provide Sole Resident Cover For Cardiac Intensive Care Units. Trent Cardiac Centre: Nottingham [http://www.scts.org/profession-als/nurses_meetings.aspx]

SCTS 2008 Sixth National Adult Cardiac Surgical Database Report Accessed 13/01/2013 http://www.scts.org/_userfiles/resources/SixthNACSDreport2008withcovers.pdf

Shared Involvement in Giving - A Relatives E

Pat Whelan has kindly shared his recent experience (as a joint guardian), whilst his sister was in hospital. Pat has shared these experiences not to complain but to remind us all, as healthcare providers in busy ward environments, that it remains essential that we take time out to reflect on patient/carers views and experiences. Merkouris et al (1999) advise that patients respond better to treatment when they feel their expectations of care are being met, and conversely become frustrated and stressed when these expectations are not met. Additionally Patel (2010) reports that high quality care is directly linked with patient satisfaction, further suggesting that in establishing patient satisfaction/quality healthcare, the patients themselves are the best authority to determine if their needs are being addressed. This suggests it is essential that healthcare professionals continually evaluate their service provision and patient satisfaction through the process of research or audit.

Over the last decade there has been a significant shift from the traditional paternalistic role within healthcare towards shared decision making (Kon 2010, Young 2009). Indeed The Department of Health (2009) maintain that fundamental to good practice is the provision for patients and clients to be involved in the decisions which affect their health. But what is shared decision making and is it applied in clinical practice?

Kon (2010) suggests that rather than meaning the same thing to all situations, there is a continuum, at one end of the spectrum is paternalism, whereby the physician explains all the options and ultimately makes the decision, at the other end of the spectrum is autonomy, in which the physician presents all the options and the patient ultimately makes the decision, along the continuum, is shared decision making where the physician and patient work together to reach a mutual decision.

Both Quality Improvement Scotland (2005) and The Department of Health (2009) have issued documents advocating that patients are empowered by shared involvement in the decision making which affects the care they receive. The National Health Service, as the largest healthcare provider in the United Kingdom (UK) is close to the hearts and minds of voting public; as such it is a subject of constant change and reform. In the current climate of accelerated healthcare costs and strict budgetary control, the Government is challenged to deliver high quality patient care whilst ensuring value for money (Sturgeon 2008).

Margaret's Story

Pat Whelan

Purpose – to let you know what happened when my sister Margaret was a patient in a district general hospital (DGH) within NHS Lanarkshire.

Both our parents died in this district general hospital and in the lead up to their deaths, my dad and then my mum were provided with the highest quality of care, treatment and compassion by nursing staff, ancillary staff and doctors.

Margaret is 56 years old and the youngest of 4 children. Margaret has an older brother, and two older sisters. After Margaret was born, my mother began to notice that she wasn't developing as well as she should have been. Doctors and health visitors told her she was just a hysterical mother. When Margaret was diagnosed with Downs Syndrome, my mother was told to "Take her home and look after her – she'll die in her teens"

We have always been a close family and tried to ensure that Margaret's learning disability never became a handicap. Margaret enjoyed a full and active life – she had a large circle of friends, went on holidays with family and with others, loved to dance and sing and was well known within her community.

As a family we were constantly forward planning, thinking of the future for Margaret. Following the death of her father Margaret's brother and sister applied to the Court and were successful in becoming Margaret's Legal Guardians. She lives in the house she was born in and has independent living arrangements following the death of her parents. Unfortunately, Margaret experienced a rapid onset of Dementia following the death of our mother (often a trigger for people with Downs Syndrome). Her health deteriorated. She had poor mobility, poor speech, epilepsy, Coeliacs Disease and required 24 hour care. Her family tried to ensure that Margaret stayed in her own home where she was comfortable and felt secure until such time that it became no longer an option.

We were advised by Health and Social Work to provide information about Margaret in the form of a Health Passport for those occasions when she might be admitted to hospital. This included information about her background, medication, times of medication and her likes and dislikes. The passport provided information about Margaret's health - she had Coeliacs Disease, epilepsy, was on a soft palate diet, what she was comfortable with, what made her anxious, her home circumstances, family, carers and other background information. After all this work we had real difficulty in getting health staff to read it.

The following is a brief record of a recent visit to the same DGH hospital that cared for my parents. On arrival at A&E Margaret was put into a cubicle, examined and x-rays were requested. Margaret and my sister were left alone for ages. A porter passed by on 4 occasions, eventually my sister asked if he was looking for Margaret. Margaret was taken to X-ray and when the staff were informed of the delay, my sister was advised, "If that happens again, just come round yourself. Don't wait." In the Emergency Receiving Unit, there was a member of staff who was constantly shouting. (If you were elderly, anxious, suffering from Dementia – how would you cope with that type of behaviour?) My sister stayed in the hospital that night with Margaret and slept on chair at her bedside. During the night, no nursing staff made any contact to see if Margaret was well.

Decision Making/Care Experience

Margaret was on a gluten free diet because of her Coeliacs Disease. This information was passed to nursing staff and we were informed that it had been passed to catering. She was given a baguette for one of her meals. Margaret is unable to feed herself and on occasion her food was placed out of reach or no food was offered. She was given no assistance with eating. One morning when Margaret's support staff came on duty, they found her bed was wet. Her support staff gave Margaret a shower and requested sheets. They were told by a nursing auxiliary that it was not her job to provide sheets or change the bed. However, she did bring some sheets and left them on the bed.

Margaret's medication had been carefully monitored over a number of years to maximise impact. We had a major problem in that hospital staff were not providing Margaret with her medication. The family had to discuss medication arrangements with ward staff and agree a way forward. Blood samples were taken for testing to identify the cause of her illness. After 5 days, when family asked for info about the results, we were told the samples had been lost. No-one had checked her charts to look for the results and no-one had pursued the delay.

Since that was why she was in hospital care, we were also concerned that further samples had not been taken. My sister was asked by a consultant if she had considered end of life care for Margaret - Margaret was in hospital with a urine infection that was treatable with antibiotics. Would this conversation have taken place in relation to someone who did not have a learning disability and suffering from Dementia?

This was our sister, someone that my mother and father, my sisters and now our families had cared for, all her life. This was a woman who was ill, scared, and who didn't know or understand what was happening around her. As a family, we were all concerned about poor quality care and treatment for Margaret in hospital. When I asked to speak to someone to discuss my concerns, I was directed towards the path of formal complaint. I refused this process because I wanted to discuss how things could be better for Margaret in the future.

Eventually, I met with the Assistant Director of Nursing who asked if I would make a presentation to ward staff about our experience. The presentation was delivered on two occasions to the hospital nursing staff. I was then asked to make the presentation at the recent ACAP conference and also at the Lanarkshire NMAHP Symposium held at UWS Hamilton.

(Margaret died peacefully at home, in the house in which she was born, on 17th Dec. 2012. Margaret's family were all present at the time of her death).

ACAP would like to express their condolences to Pat and his family, and thanks for sharing this frank and thought provoking experience particularly at this most difficult time.

References

Department of Health (2009), Helping the NHS put patients at the heart of care: The patient and public engagement support programme 2009 – 2010, Department of Health: London

Kon, A.A. (2010) "The Shared Decision-Making Continuum", JAMA: The Journal of the American Medical Association", Vol. 304, no. 8, pp. 903 – 904

Merkouris, A., Ifantopoulos, J., Lanara, V., Lemonidou, C. (1999) "Patient Satisfaction: A key concept for evaluating and improving nursing services", Journal of Nursing Management, Vol. 7, no. 1, pp. 19 – 28

Patel, S. (2010) "Achieving quality assurance through clinical audit", Nursing Management, Vol. 17, no. 3, pp. 28 – 34.

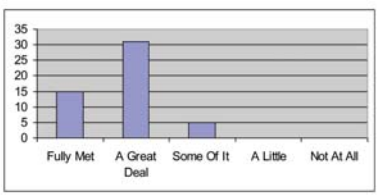
Young, A. (2009) "Review: the legal duty of care for nurses and other healthcare professionals", Journal of Clinical Nursing, Vol. 18, no. 22, pp. 3071 – 3078.

Sturgeon, D. (2008) "Advanced nursing practice and Newton's three laws of motion", British Journal of Nursing, Vol. 17, no. 11, pp. 706 - 710.

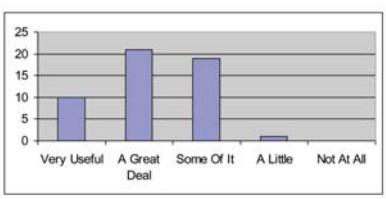
Evaluation of ACAP 3rd Forum Event

– Lighthouse Glasgow 02/11/12 ACAP held its 3rd forum event at The Lighthouse in Glasgow. As always we value your comments and aim to tailor future events to practitioners needs. There were 92 present at the event, including speakers and reps. The following is how you as practitioners rated the day:

Has today raised your awareness and improved your understanding of the issues discussed and demonstrated?

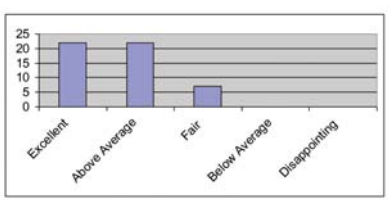


Did you find the poster presentation and stands useful and interesting?



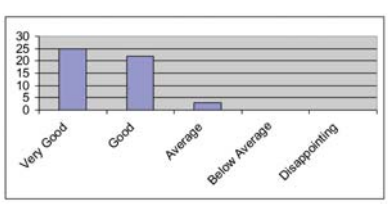
Comments: Over 2 floors, not conducive to viewing posters, a little out of the way

How did you find the venue?



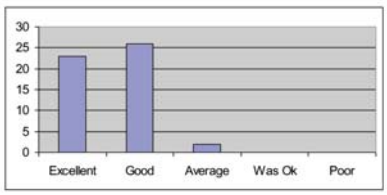
Comments – View of speakers and projector screen limited on floor 3

How was the catering?

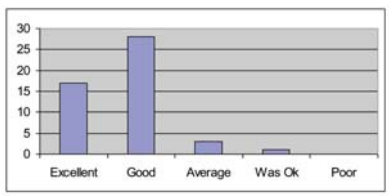


Comments – a lot of wastage; very noisy in the kitchen after last coffee break making it difficult to hear afternoon speakers.

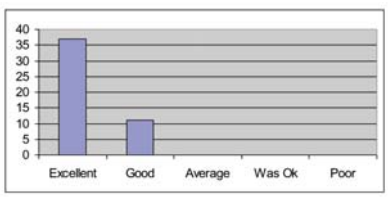
Feedback on the Speakers
Kevin Rooney – Sepsis & VTE



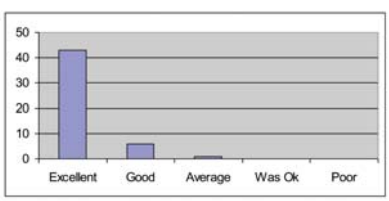
Dennis Purcell – Minor Injuries



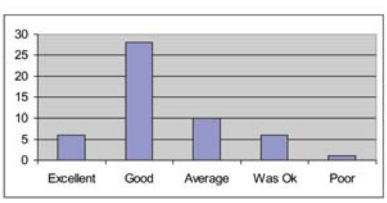
Irwin Turbitt – Leadership



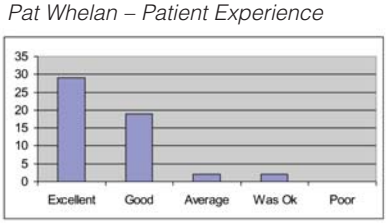
Laura Harvey – Implementing HEWS in MDHU



David Watson – Thesis Proposal

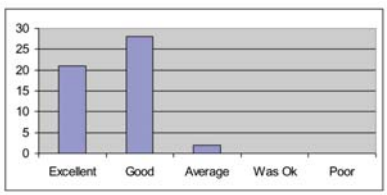


Pat Whelan – Patient Experience

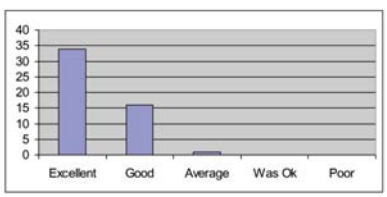


Comments – very powerful in highlighting the need for healthcare professionals to review and develop their treatment of patients; good to have patient side representative

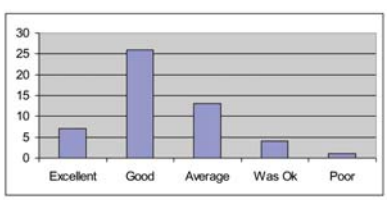
David Fitzpatrick & Dr. Edward Duncan – COPD Research



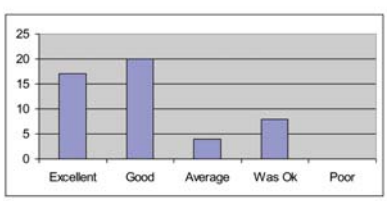
Dr. Pete Thompson – Fluids & Electrolytes



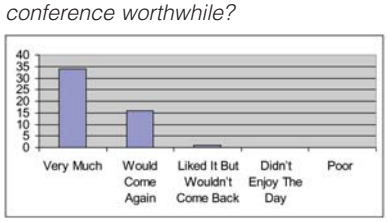
Masterclasses Karen Kindness – Cardithoracic ANP



Irwin Turbitt – Leadership



Overall did you find the forum conference worthwhile?



Suggestions from evaluations for future events:
- More clinical topics/updates
- Diabetes
- Septic shock

Comments – Very worthwhile; very relevant topics, very imformative in a relaxed manner; although based in the community setting this conference was valuable to our development and clinical practice in order to achieve patient outcomes, we would embrace any further education and training; fantastic, educational and insightful day; made some good connections; Look forward to your next event; excellent day very relevant; excellently organised day; particularly enjoyed the clinical based scenarios; of great benefit; wide range of very interesting speakers; Speakers need to speak in front of the microphone so everyone can hear well; very secondary care focused, did not even acknowledge that non secondary care practitioners work in and see acute presentations that don't necessarily reach secondary care.

Advanced Practice Word Search

P R E S C R I B I N G L C E P
T N E M S S E S S A K A A G H
P A M S G N I S R U N C N X L
I I E C P O E X I N A I D A E
H N R T I I X C U P K N C D B
S O G E L T R L I R X I G E O
R M E A Z A A A O T G L N V T
E U N M E T N W T O C C I E O
D E C W I N T I L O H A N L M
A N Y O W E W O M K R D R O Y
E P N R N M R E L O R Y A P M
L F O K I U P K N D D M E M O
E L G D E C N A V D A B L E D
U M A N T O O L K I T C A N E
Q B B Y E D U C A T I O N T L

ABDOMINAL, ACAP, ADVANCED, ASSESSMENT, CANNULATION, CLINICAL
DEVELOPMENT, DOCUMENTATION, EDUCATION, EMERGENCY, LEADERSHIP
LEARNING, MODEL, NETWORKING, NEUROLOGICAL
NURSING, PHLEBOTOMY, PNEUMONIA, PRACTICE
PRESCRIBING, RESPIRATORY, ROLE, TEAMWORK,
TOOLKIT

Dealing with a sick child; Cor
legal and prescribing issues

Lynn Deremiens, Advanced Nurse Practitioner, Lanarkshire

Introduction

The following case study discusses and highlights some of the potential issues that nurse practitioners must consider in their daily line of work. It discusses the approaches that should be considered when giving care to both a child and parent. To maintain confidentiality all names used in this reflection are fictitious.

Karen, a 10 year old young girl and her mother arrived at the OOH (out of hours) for assessment and treatment with the nurse practitioner (NP). The assessment of this child began before she entered the room with mum. While in the waiting area Karen was clearly distressed and maintained a close affinity to her mother. As part of the clinical history taking of children it is essential to ascertain the reason that prompted a visit to OOH team.

The Scottish Executive (2003), in the light of some high profile cases of child neglect, produced 'Getting our Priorities Right: Policy and Practice Guidelines for Working with Children and Families Affected by drug use' in an attempt to recognise and provide a safety mechanism for vulnerable children. Subsequently this recognition highlighted the importance of interfacing agencies such as schools, health care agencies, and nurseries. These agencies play a crucial role in data that may be held on vulnerable children and can provide a multidisciplinary approach with social services providing a comprehensive profile on children at risk. Subsequently in 2004 the Scottish Executive provided further clarity in the way professional agencies protect children, by providing clear standards and guidelines (Scottish Executive 2004). This provided vital guidance on how information was collected and shared. The OOH computer system identifies each visit made by an individual in their event section. Therefore, if a child is a habitual attendee at OOH, as opposed to their own General Practitioner (GP), this could be a significant piece of information worth sharing with a health visitor or GP.

Karen and her mother were a single parent family and as the parent, the mother worked, making visits to her own GP difficult. Therefore attending the OOH service was her only alternative. Karen had a painful right ear and despite being given paracetamol 250mg suspension every six hours, the pain was now escalating and difficult to control.

As they entered the room, the NP introduced herself and spoke directly to Karen. The NP was attempting to gain several things: firstly, Karen's permission to treat her and secondly, her trust. By engaging directly with Karen and involving her, it allowed Karen to participate in the consultation additionally it allowed the NP to gauge Karen's level of understanding and level of competence. This is essential when it comes to adopting the complicated issues around legal consent (Barnes 2007). In Scotland the legal age for consent is 16 years of age, although younger children may be judged Gillick competent by medical staff (Medical Protection Society 2009). To be determined as Gillick competent the child must be able to prove that they have sufficient understanding and intelligence to fully understand the treatment, and the likely outcomes of either accepting or refusing the treatment. Additionally once a child has been found Gillick competent, the parents no longer have the power to exercise their consent on behalf of their child. However, due to Karen's young age her mother was asked to recap, with the view that this would provide a much more detailed and comprehensive clinical history.

After establishing Karen's details were correct, the NP explained that she needed more information to build a more detailed history, before undertaking a physical examination, to formulate a diagnosis. Karen smiled, through tears and nodded in agreement. This was taken as an acknowledgement of consent. However, if Karen had disagreed and the parent consented, it would have to be established that Karen was incompetent to consent to treatment. Children under the age of 16, have the legal right to decline or agree to any medical or dental procedure, provided the medical practitioner deems they understand the implications what they are consenting to or the implications of declining treatment (DOH 2001). However, the Scottish Executive (2005) issued a clear statement on this subject, emphasising the importance that the child must clearly understand the issues and complications surrounding these decisions. So careful communication in language tailored to meet the child's need must be adopted. The NP, established, that Karen had pain relief 3 hours prior to attending OOH and she indicated on the pain scale it was 3 out of 4. Karen struggled to describe the pain at its worst. A practical limitation for the NP was the absence of a child friendly pain scoring chart. Barnes (2007) recognises that children require a child friendly, safe area, adapted to suits their need with toys and distractions. However, Karen, being a little older did not require to be continuously observed nor did she require distraction techniques. To accurately assess pain a valid and reliable pain assessment tool is a useful resource, especially when assessing pain in children (Franck et al 2000, Gaffney et al 2003). The reality, however is that most nurses do not use pain assessment tools when assessing children's pain (Clarke et al 1996, Jacob & Puntillo 1999). However this is extremely important when younger children find it difficult to communicate appropriately these signs.

Nevertheless the NP formulated the child's history as a 2 day history of right earache, initially resolving with analgesia which now had minimal effect. No rashes or abdominal pain. Karen was reluctant for solids but drinking fluids well. At times, her temperature at home was 39.4. The child's pain was now increasing and the mother was concerned.

nsideration of some of the

Karen allowed the NP to examine her and the following are the findings recorded. She was slightly distressed and crying with discomfort, but essentially bright and interactive. Her temperature 37.4, pulse 96, respiratory rate 20, O2 saturations 100% room air, all essentially normal vital signs (Trigg et al 2006). However, the slight sign of dyspnoea, was thought to be related to anxiety, rather than the possible physiological effects of developing sepsis, but SIRS was considered as part of the NP differential diagnosis, which would influence the decision making process. As the child's earache may have caused the most distress during the assessment, it was left until the last part of the clinical exam (Barnes 2007). General appearance was healthy. Her mouth was moist, tongue pink and moist, dentition healthy, and throat pink, nil exudates present and no uvular deviation.

There was no lymphadenopathy, no rashes or meningism and no photophobia. Air entry was vesicular with nil added. Bowel sounds normal, abdomen soft nil acute on palpation. Capillary refill time < 2 seconds and skin turgor elastic. Mentation normal. Left ear was not painful, no redness, pain outside to the tragus or mastoid areas, external canal normal and tympanic membrane intact, translucent in colour and bony landmarks visible. The right ear was not red externally or painful at the tragus or mastoid areas, the external canal was red, inflamed and the tympanic membrane although intact, appeared to be bulging, fiery red with no clear visible cone of light and bony landmarks were not visible. The NP, made a clinical diagnosis of Acute Otitis Media (AOM) of the right ear using the guidelines produced by the Scottish Intercollegiate Guidelines for otitis media (SIGN 2003). (Table 1)

AOM ,is a generic term used for inflammation of the middle ear and earache is one of the most important symptoms in diagnosis (SIGN 2003) Usually AOM is preceded by a runny nose, cough or simple upper respiratory infection (Sign 2003).The most common causes are; streptococcus pneumoniae, haemophilus influenza and morexalla catarrhalus (Barnes 2007, SIGN 2003). There are disputed theories on whether to treat or not with antibiotics. In the Netherlands antibiotics are used much less frequently than in the United Kingdom and there is no increase in the worrying complications of mastoiditis or meningitis (Froom et al., 1999). Ear pain and fever along with an abnormal tympanic membrane are suggestive in the diagnosis when deciding to treat with antibiotic therapy. Although, it is worth considering that others still feel antibiotic use is of little value in AOM and the symptoms would resolve spontaneously without their use (Fahey et al, 1998).

Based on the clinical history and e xamination findings both Karen and her mother were told that she had an ear infection and an antibiotic would be prescribed. However, it was important to ensure regular analgesia was given to keep her comfortable. Amoxicillin 250/5mls, 5ml three times a day for five days was prescribed (SIGN 2003). The analgesia agreed was paracetamol 250mgs/5ml and she would give 10ml every 6 hours as needed, not exceeding 4 doses in 24 hours (BNF for children 2008).

Of note, children are not little adults, nor should they be considered so when prescribing medication for them (Barnes, 2007) The pharmacokinetics of drug metabolism can be very different in children to that of adults. Interestingly 40% of medications actually given to children are not licensed for the reasons actually prescribed. The Nursing and Midwifery Council (NMC) in 2007 issued guidelines for non medical prescribers that indicated that when prescribing for children the clinician should have some accredited background deeming them competent in decision making in the process of diagnosing and prescribing medications for children (NMC 2007).

	Earache Fever Irritability	Middle ear effusion	Opaque drum	Bulging drum	Impaired drum mobility	Hearing loss
Acute Otitis Media	present	present	present	may be present	present	present
Otitis Media with Effusion	usually absent	present	may be absent	usually absent	present	usually present

Table 1. Sign 2003 – Diagnostic Features

Karen and her mother were advised to follow up at their own GP practice over the next 2 weeks as long as symptoms resolved. However, if there was no improvement over 48-72 hours further reassessment should be taken (Sign 2003).

Conclusion

As nurse practitioners continue to push the boundaries of their clinical practice it should be remembered that patient safety is paramount. This is none more so when it involves younger adults and children, who by nature of their youth are potentially much more vulnerable. Providing person centred care is the aim of all practitioners & clinicians alike. However knowledge, skills and competency of those providing this care must be an ongoing development, ensuring holistic care can become the gold standard of practice.

References

Barnes, K. (2007) Paediatrics. A Clinical Guide for Nurse Practitioners. Butterworth: Heinemann.

BNF for Children (2008). British National Formulary for Children. London. British Medical Association and Royal Pharmaceutical Society of Great Britain.

Clarke, E. B., French, B., Bilodeau, M. L., Capasso, V. C., Edwards, A., & Empoliti, J. (1996). 'Pain Management,Knowledge, Attitudes and Clinical Practice ; The impact of nurses . Charachteristics and education.' *Journal of pain & symptom management,* 11 (1) pp 18-31.

Department of Health (2001). Seeking consent: working with children. Department of health. The Stationary Office . London.

Fahey, T., Stocks, N., Thomas, T., (1998) Systemic review of the treatment of upper respiratory track infection. *Archives of Disease in Childhood.* Vol 13 (79), pp. 317-321.

Franck, L. S., Greenberg, C. S., & Stevens, B. (2000). ' Pain assessment in infants and children ', *Paediatric Clinics of north America,* 47 (3), pp 487-512.

Froom, J., Culpepper, L., Grob, P., Bartelds, A., Bowers, P., Bridges-Webb, C., et al. Diagnosis and antibiotic treatment of acute otitis media : report from International Primary Care Network. *British Medical Journal*, (1990) ; pp 300-582 (6)

Gaffney, A., McGrath, P.J., & Dick, B., (2003) 'Measuring pain in children: Developmental and Instrumental issues'. In Schechter, N. L., Berdec, B., & Yaster, M., (eds) *Pain in infants and children and adolescents.* (2nd edition) pp 128-141. Lippincott, Williams and Wilkins. Philadelphia.

Jacob, E., & Puntillo, K.A., (1999). ' A survey of nursing practice in the assessment and management of pain in children.' *Paediatric Nursing,* 25 (3), pp 278-286.

Medical Protection Society factsheet, (2009) Consent – the basics. http://www.medicalprotection.org. [online] available [accessed] 2010-10-01
Nursing and Midwifery Council (NMC) (2007). 'Prescribing for Children and Young people. London. NMC.

Report of health coalition Initiative/Action research Workshop. Action Research. (2001). PAEDIATRIC PRESCRIBING Children are not little Adults. Page 1 (online). Available URL: http://www.action.org.uk/news_media/downloads/drik_report.pdf Accessed 6/01/2009.

Scottish Executive (2003). Getting our Priorities Right: Policy and Practice Guidelines for Working with Children and Families Affected by drug use. Edinburgh. Scottish Executive.

Scottish Executive (2004) Protecting Children and Young people-Framework for Standard. Edinburgh. Scottish executive.

Scottish Executive (2005). A Good Practice Guide on Consent for health Professionals in NHS Scotland. Edinburgh. Scottish Executive.

SIGN (2003). Diagnosis and Management of Childhood Otitis Media in Primary Care. Report No 66. Scottish Intercollegiate Guidelines Network.

Trigg, E., Mohammed, T.A. (2006). Practices in Children's Nursing Guidelines for Hospital and Community. 2nd edition. Edinburgh: Churchill Livingston elsevier.

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