

The Advanced Nurse Practitioner



The journal for
members of ACAP

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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 annual forum events. These events will host guest speakers, work shops, master classes and the opportunity for discussion on topical subjects. Most importantly the forum will facilitate educational and professional development.

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

Acute care practitioners in Scotland have never had until now:



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

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

Mission Statement

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

ACAP Scotland Leading the way

Support given by:

AANPE
CS MEN

Executive committee members:

Elaine Headley
Julie Smith
Ednamay Sinclair
Anne Scott
Hazel Beveridge
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David Watson
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Mr. Douglas Allan
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Jill Mundy *Clinical Education and Development*



• www.acapscotland.org •

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Retirements

Ednamay Sinclair HECT Nurse NHS Lanarkshire and ACAP steering group member, and Douglas Allan Senior Lecturer in Advanced Practice Glasgow Caledonian University and ACAP non executive member have both taken their retirement this year. They will be missed in both their substantive posts and for their contributions and support to ACAP over the last 3 years. ACAP would like to take this opportunity to wish them all the best for their future.

welcome some feedback, as to where you would like ACAP to develop and what you would like to see from future events/journals/ web site. Contact Elaine or Julie.

Log on to: www.skills4nurses.com for further details or email: shona@gmexpox.com

Social networking

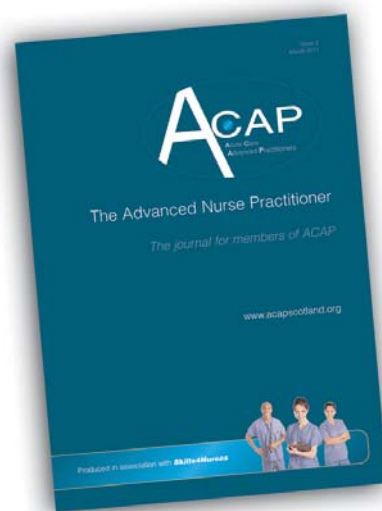
ACAP Scotland now has 270 followers on Twitter and 120 members on its open Facebook page. This is a great way to interact in a very informal manner. Follow us and join the chat.

Congratulations

ACAP would like to congratulate David Watson, HECT nurse NHS Lanarkshire and ACAP steering group member on his recent appointment as ERU manager NHS Lanarkshire

Thanks

ACAP would like to thank Atruim Marquet and EL Medical Aesthetics Ltd for their support in helping with this year's event.



Future Developments

ACAP steering group are currently working on OSCE/ Crib sheets to be made available on the web site. If anyone would like to contribute to this process please contact Julie on julesmith69@hotmail.com The steering group remain committed to delivery and provision of what the members want, therefore we would

Skills4Nurses Recruitment Events 2014

Skills4Nurses are pleased to announce their forthcoming Nursing & Midwifery Recruitment events:

Belfast : Tuesday 22nd April 2014
Dublin : Thursday 24th April 2014
Glasgow : Thursday 9th October



Annual Report From Chairs –September 2013

ACAP Scotland at its inception set the following objectives:
OBJECTIVES:

- To provide a platform for sharing evidenced based practice.
- To provide a link between Acute Care Advanced Practitioners (ACAP'S) and major stakeholders.
- To provide an arena for networking.
- To provide ACAPs with a "voice".
- To provide an opportunity for education

These objectives were constructed from the 4 overarching themes of advanced practice:

- Clinical/professional leadership
- Facilitating Learning
- Research and Development
- Advanced Clinical Practice

In the past year ACAP Scotland has met all the set objectives and has covered the 4 key principles of advanced practice as detailed below:

This has been achieved by way of:

1. Forum conference events
2. Production of "The Advanced Nurse Practitioner" – the ACAP journal
3. Web site, providing education and information availability
4. Links with major stakeholders – NES, Scottish Government and securing a seat on the WoS advanced practice group.

Forum Event

ACAP Scotland 3rd forum event – held on November 2nd 2013 at the Lighthouse Glasgow ; 92 delegates attended a 1 day conference, which included lectures and masterclasses. ANPs were invited to lecture and present posters; additionally this provided an invaluable setting for networking and sharing of best practice. The Lighthouse attracted a number of reps who provided support for ACAP whilst displaying their products.

Journal

ACAP Scotland has produced 3 journals in the past year, incorporating case studies, literature reviews and research based articles. A hard copy of the latest journal is available in each delegate pack at the conference events

Web Site

The ACAP website continues to go from strength to strength. There are now 230 registered members. Additionally ACAP now has a twitter account with 266 followers and 76 on facebook

Further Achievements

- ACAP Scotland continues to have registered charity status. Treasurers report available as a separate document.
- ACAP has now forged links with Advanced Practitioners in AHP sector
- Succession Planning questionnaire completed and analysed – awaiting feedback from non exec members on how to proceed.
- ACAP steering group working on OSCE sheets for the web

AGM – ACAP SCOTLAND INCORPORATING STEERING GROUP MEETING

*Venue: Borders General Hospital
Date & Time: 26.09.2013 10.00am*

Present

Julie Smith, Elaine Headley, David Hunter, Lillian Redman, Hazel Beveridge, Agnes Allan

Apologies

Anne Scott, Lynn Deremeins, Fiona Buchan Mark Cooper

AGM

• Update from chairs 230 members now on ACAP site
266 followers on twitter
76 followers on facebook
ACAP chairs annual update attached

• Update from treasurer - balance £2298
£250 from HMRC (gift aid) included in balance
Accounts have been submitted

• Governance Structure.... updated accordingly

• Terms of Reference.... updated accordingly

• Operational Policy.... updated accordingly

• Office Barriers
Secretary: Anne Scott – proposed Julie Smith seconded Lilian Redman

Vice Secretary: Hazel Beveridge - proposed Julie Smith seconded Agnes Allan

Treasurer: Fiona Buchan - proposed Julie Smith seconded Elaine Headley

Vice Treasurer: Lilian Redman - proposed Julie Smith seconded David Hunter

Sepsis – a personal perspective and an introduction to FEAT

(The Fiona Elizabeth Agnew Trust)

Background

Before the weekend of 23rd – 26th August last year, I had never heard of sepsis. I was living in Edinburgh with my wife, Fiona Agnew and our young 2 year old son, Robert. We were expecting our second child at the end of September and had just recently moved house. I was working for one of the ‘Big Four’ accountancy firms based in Edinburgh and Fiona was a GP retainer working two days a week in Bo’ness. Our life together was full and as hectic as it is for most couples with a young family and both parents working. We were both looking forward to the baby’s arrival to complete our wee family.

This was all to change in the most ghastly and shocking fashion over the course of just 62 hours that weekend.

I am a very lucky man to be alive. I am here and able to write this today because of Fiona’s quick action in getting me to my GP. I had gone home from work on Thursday 23rd August to crawl into my bed and sleep off what I thought was flu. It would have been my final sleep.

In fact, I had a virulent infection which led to cellulitis and sepsis, and by the time I reached A&E at Edinburgh Western, this had become septic shock. Without treatment, I would have been on my way out; I now know that by the time sepsis has reached that stage, the survival rate is only 50%. Thanks to Fiona’s intervention and quick thinking, and the prompt action of my GP and treatment by the medical staff in A&E at Edinburgh Western, my life was saved. I was and am very fortunate: at each stage where things had to happen quickly and go the right way, they did.

I was Fiona’s last patient and I owe my life to her.

Tragically, Fiona herself also became seriously ill just 24 hours later. Fiona was taken to Forth Valley Royal hospital on the evening of Friday 24th after suddenly falling ill. She had been perfectly well up until then and had had an antenatal scan the previous day, at which point both she and the baby were well. Upon admission, she was also diagnosed as having an infection and sepsis, which had also attacked the baby. Treatment was started immediately, but the baby had already died in utero. In the early hours of Saturday 25th, I was discharged from the acute unit at Edinburgh Western to be with them once it became clear how grave the situation was. When I arrived Fiona’s condition was described as critical and unstable. This seemed surreal; she had visited me in hospital on Friday afternoon between 3pm and 4pm and had been fine.

However, the reality was that there was nothing that could be done for either of them. I can say that because I was there. I watched the staff do everything they could to try and save



Fiona – using the latest medical techniques, machines, technology, blood transfusions (some 56 units of blood), antibiotics and three surgical procedures. They tried everything they could – and nothing worked.

Baby Isla was stillborn at 5.10 am on the Saturday morning. We had chosen not to find out whether we were having a wee boy or a wee girl. Now, I held her and named her – alone.

For the remainder of the day and into the night the medical staff worked tirelessly to save Fiona’s life. She remained critical and unstable throughout the day and had continued to bleed following the birth. Her condition gradually deteriorated; she was being ventilated and was on dialysis by this stage.

By around 9pm on the 25th, Fiona’s condition had become more unstable than previously and the doctors still couldn’t get her to stop bleeding.

The medical staff fought to stabilise her so they could attempt a third procedure to try and halt the bleeding. This was the priority, as all that was happening was each time she was given a blood transfusion, she would stabilise for a short while and then gradually become more unstable again – until the next blood transfusion.

By around midnight, she was stable enough for her to be taken to theatre. I told her that I loved her and would see her again soon and then she was wheeled away.

I had continued to be treated for my own infection in A&E throughout the day and was wheeled down to A&E for my final antibiotic treatment of the day at around quarter past midnight.

I was wheeled back upstairs to the relatives waiting room where our family had spent much of the previous 24 hours, at 2.20am. A few minutes later, there was a knock on the door and pretty much the entire medical team who had been treating Fi was lined up outside.

I knew before any of them said anything that we had lost her.

The lead consultant told me that she had arrested whilst in theatre and that they had brought her back twice, but ultimately, the sepsis and septic shock had overwhelmed her body and they had not been able to save her. He said how sorry they all were. The whole family were all left profoundly shocked, devastated and simply bewildered.

I remember asking over and over, ‘What the hell just happened?’ My world had imploded within the space of 62 hours: sepsis had just killed half my family.

Before all this happened, I had known nothing about sepsis. I knew a little about septicaemia and vaguely understood it, but had never heard of sepsis at all. Over the days following Fiona’s death, I was able to ask questions about what had happened and I learned more – much more - about sepsis.

What I found out shocked me to the core and made me realise that there was an urgent need to raise awareness about the condition and to begin tackling the appalling mortality figures.

Hence, the idea for the Trust named after Fiona was formed.

What is sepsis?

Sepsis is a life-threatening condition that arises when the body’s response to an infection injures its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly.

It remains the primary cause of death from infection, despite advances in modern medicine, including vaccines, antibiotics and acute care.

It kills more people in the UK than lung cancer. It claims more lives than breast cancer, bowel cancer and prostate cancer combined.

At least 37,000 people die from sepsis each year in the UK alone, but this number may be a significant underestimate as coding of the condition in hospitals remains piecemeal; the true figure may be as high as 64,000 deaths per annum.

Globally, 20-30 million cases of sepsis occur each year and the incidence is increasing dramatically.

At least 8 million people per year worldwide die from the condition - and if you have severe sepsis, the mortality rate is around 40%.

If the 37,000 figure is accurate, it is the UK’s 5th biggest killer condition. If the number is closer to the 64,000 figure, it is the 4th biggest killer.

These numbers are grim and simply unacceptable.

Recognising Sepsis

Sepsis should be suspected if more than one of the following occurs:

- Very high or low temperature, which may be accompanied by chills or shaking, or other flu-like symptoms;
- Difficulty breathing;
- Rapid heart beat;
- Low blood pressure;
- Change in behaviour: slurred speech, confusion, drowsiness or loss of consciousness;

- Changes in skin colour;
- Reduction in the amount of urine passed.

Immediate medical attention should be sought.

Diagnosing and treating sepsis

Sepsis should be treated as a medical emergency. In other words, sepsis should be treated as quickly and efficiently as possible as soon as it has been identified. Research shows early recognition and treatment saves lives. Unfortunately, the diagnosis is often missed or delayed due to multiple factors, including the complexity of sepsis, unspecific and rapid nature of the symptoms, poor awareness or inadequate diagnostic tools.

Evidence-based guidelines are available but are used inconsistently.

If sepsis is treated within the first hour, “The Golden Hour”, the risk of death is halved and survival rates can be more than 80%.

This means rapid administration of antibiotics and fluids. A 2006 study showed that the risk of death from sepsis increases by 7.6% with every hour that passes before treatment begins.

Until a cure for sepsis is found, early detection and treatment is the best hope for improved survival rates.

This rapid treatment will not save everyone who has sepsis, but it is a crucial start in reducing the death toll – a ‘quick win’.

The more difficult cases will require research to more fully understand why some patients do not respond as well to antibiotics and fluids.

FEAT’s aims and objectives

FEAT core and immediate aim is to raise awareness and recognition of sepsis at all levels amongst medical professionals and the public. By doing so, we will help realize the ‘quick win’ of saving between 10-15,000 lives a year through prompt diagnosis and treatment.

Hence our key objective: **Stop Sepsis Now.**

As a first step towards this, we recently held our inaugural sepsis seminar on World Sepsis Day on September 13th. The film of this is at: www.youtube.com/watch?v=Yrrz2UbUuXE

In addition, we are fundraising to support longer-term research into better diagnostic testing and improved treatment, particularly for those who do not currently respond as well to rapid administration of fluids and antibiotics. In order to save more lives, we need to understand why this is so.

Since FEAT was established, we have received a great deal of anecdotal evidence that some 20-30% of sepsis survivors do not make a complete recovery from the condition.

Many are left with organ damage, cognitive problems, difficulties with affected limbs or simply a general feeling of never being well in the way they were before they were ill. This area, the quality of recovery and the after-effects of sepsis, is another area that FEAT will fund research into in due course. We don’t just want people to survive sepsis; we also want to help ensure the best possible quality of life for sepsis survivors.

How you can help

We are asking people to do a ‘feat for FEAT’ to help us raise funds and awareness and there are examples of the feats people have been doing on our website: www.stopsepsis.org.uk - these needn’t be athletic feats, either!

If you are interested in doing a feat for FEAT, then we can help. We can send you literature to pass out to help raise donations as well as t-shirts or running vests and you can also fundraise easily via JustGiving. There are many ways people can undertake a feat for FEAT and feats can take many forms. We have listed some suggestions on the website, but you can be as creative as you like. All of our upcoming feats and events are listed on the website, too, so if you’re stuck for inspiration or want to join in, please look here first. As well as relying on fundraisers volunteering to undertake a feat for FEAT, we will also be organising lectures, receptions and fundraising events to raise sepsis awareness and again details of these will be posted on our website as they are planned. So, however big or small your feat for FEAT, rest assured that anything you are able to do will help us raise funds and awareness and help us Stop Sepsis Now.

Finally

I am very lucky to be alive and also incredibly lucky to have had no after effects from either the septic shock or cellulitis. I know how lucky I am: at every single stage where things had to go right, they did and I rode my luck plenty. I now intend to use my incredible good fortune to do whatever I can help others who have been affected by sepsis and ultimately to stop it.

I was very lucky to be with Fi. We had ten great years together and she was a lovely person, a great mum and a very good doctor. Fi clearly understood that the symptoms I was describing to her that Thursday afternoon were not flu and knowing her well, this is why she insisted I go to the GP immediately. Without her intervention, I would have gone to sleep and likely would not have woken up. Ultimately, I owe my life to her timely intervention, to my GP’s quick actions and to all the doctors in A&E who treated me so promptly. Again, I reiterate that I am very, very lucky to be here.

Ultimately, Fiona saved my life. The tragedy is that her own life and that of Isla could not be saved.

All of this is why FEAT has been established: we want to prevent others from suffering what our family and friends have been through.

This is why we will do all we can to Stop Sepsis Now.

Craig Stobo
Founding Chair
FEAT

Contact & info:
Twitter: [@stopsepsisnow](https://twitter.com/stopsepsisnow)
E-mail: info@featuk.org.uk
Website: www.stopsepsis.org.uk
facebook.com/TheFionaElizabethAgnewTrustFeat
Justgiving.com/feat

‘ Sepsis is one of the leading causes of death around the world ’

‘ an estimated 18 million people contract Sepsis each year ’

Clinical Simulation in Patient Safety – a local perspective

Julie Hannah, Resuscitation Officer, RGN, BSc Health Studies

Simulation based learning (SBL) has been around for much longer than practitioners may imagine. As far back as 17th century France, birthing manikins were known to be used for teaching purposes. (1) For decades simple part task trainers and manikins have been used to teach basic and advanced life support, airway and obstetric skills and drills, amongst other clinical skills. Today, we have reached the point where simulation technology is “now a central thread in the fabric of medical education” (1) Many health service organisations, health care professionals, medical instructors and educational establishments are increasingly utilising simulation training as a means to provide training not only in clinical skills, but for team training, human factors and ergonomics. Increasingly, simulation based learning (SBL) is seen as an integral tool in the drive towards improving quality and patient safety (2). The following article highlights how simulation training has been developed and implemented in NHS Ayrshire & Arran (NHSA&A) and discusses the benefits to staff development and patient safety locally.

BACKGROUND

In 2005, through Additional Contribution to Training (ACT) funding, 2 Laerdal mid fidelity Simman simulators were purchased in NHSA&A – one for each acute hospital site i.e Ayr and Crosshouse. Unlike other centres whereby these expensive manikins were left to gather dust at the back of training rooms and cupboards (3), we committed to utilising these immediately for the training of medical undergraduates. Provision was also made for the appointment of a Resuscitation Officer who would have the responsibility of developing a simulation service across each acute care setting. The latter has been a major challenge and at times daunting. However, with small steps, enthusiasm, determination and support from the Lead Resuscitation Officer, Director of Medical Education and members of the Simulation User Group, one could suggest that NHSA&A is fortunate to have a robust and healthy simulation service. Proof of this has been the funding and design of a designated simulation lab with recording and debriefing facilities at Crosshouse Hospital, installed in 2009, with a similar set up currently being installed in Ayr Hospital. More recently 2 joint Clinical Leads for Simulation have been appointed - from Emergency Medicine and Anaesthetics respectively.

SIMULATION USER GROUP

The Simulation User Group has been central to the continuing support and development of the simulation service; even the name has evolved from that of Simulation Interest to Simulator User Group and has gone from an initial membership of less than 10 clinicians (doctors & nurses) to a healthy membership of around 40. The group has ‘link’ clinicians from various specialties including Emergency Medicine, Anaesthetics, General Medicine and Paediatrics. To ensure quality of service delivery, 24 of the group members have undergone the Faculty Development Course provided by the Scottish National Simulation Centre at Larbert. As a minimum standard, at least one trained faculty member attends each of the simulation sessions provided. Simulation User Group

members work together to provide a variety of SBL opportunities in the simulation lab and in a variety of clinical settings as follows.

FIXED SIMULATION

These are held in the dedicated simulation lab within the Education Centre at Crosshouse Hospital. Our aim is to provide a safe and supportive educational environment for various specialties including, general medicine, paediatrics, emergency medicine, anaesthetics, obstetrics and advanced nursing practitioners (general & mental health). The ethos is to ensure that all learners can practise and develop skills with the understanding that mistakes carry no judgements and harm neither patients nor learners. Errors are seen as a shared opportunity for learning. Indeed, as are the successes! Recording and debrief facilities ensure that participants are able to reflect on their individual and team performance. Educational feedback is facilitated by trained faculty members and it is this feedback that has been identified to be one of the essential features to the success of SBL. (4)(5) To achieve maximum benefit, feedback must be non judgemental or threatening, focus on improvement and ultimately be constructive. As patient care and safety relies on the efforts of the wider team, inter professional (IPL) sessions are supported whenever possible. We have had a variety of disciplines and levels of staff collaborating and learning together in the simulation lab such as, undergraduate nursing and medical students, auxiliary nurses, theatre orderlies, nurses of varying levels of experience and doctors from FY1 through to consultant level. It is recognised that inter professional team based care provision is associated with improved patient outcomes and a reduction in adverse events. (6) It makes sense then to train together rather than training in ‘silos’ and SBL is an ideal means to achieve this. Through IPL we can promote a shared safety culture by creating an environment of equality and openness. Staff can be made aware of their individual and collective value and what these may bring to patient safety. IPL can help to develop leadership and followership skills, develop role clarity, improve communication, improve individual and team performance and reduce stress; all of which can translate to better patient outcomes. (7) For the last 2 years, the fixed simulation facility has also hosted an innovative development in collaboration with NHS Lanarkshire and Glasgow University. All Year 5 Medical Undergraduates now receive SBL 3-4 months prior to appointment as Foundation Year One Trainees (FY1’s). Whilst SBL cannot replace, it can complement traditional training methods in the clinical environment. (4) Particularly, if embedded within the curriculum and integrated with other educational methods. Thus, we set out to ensure that all Glasgow students to be appointed to NHS Ayrshire & Arran as FY1’s were trained locally during their Preparation for Practice block, introducing them to organisational processes and documentation. Scenarios were designed around the Acute Care Competencies within the framework for the Foundation Year Curriculum UK and simulated deteriorating patients that the students would be likely to encounter once appointed as FY1s.

This year, 24 of the students trained, returned to NHSA&A as Foundation Year Trainees. Immediate post course evaluation results indicated that all students felt that the SBL had:

- helped to prepare them for their role as an FY1in Ayrshire & Arran
- helped to inform them of local systems/guidelines/processes

A Survey Monkey questionnaire was sent 10 months post course (7months into trainee post) to establish if attendance at the SBL during Preparation for Practice had continued to have an influence. Almost half of the attendees responded, all with the exception of one, reporting that learning in the simulated environment:

- had been transferred to the clinical area
- had been sustained over time;
- maintained improvement in confidence
- positively influenced practice in dealing with the acutely unwell adult
- complemented learning in the clinical environment

These retrospective evaluations suggest that learning through simulation was achieved and sustained by the students; translating (5) through to their clinical placement as junior doctors, thereby influencing patient safety in a positive way.

IN SITU SIMULATION

Patient safety is influenced not only by individual clinicians or care teams, but also by their physical, cognitive and social/ behavioural interactions with other elements of the system (8). In situ (or immersive) simulation training extends beyond the simulation lab out into the clinical areas to the point of care. The benefits being the delivery of training to inter professional teams on their door step. Evaluations highlight that learners welcome this style of SBL and are keen for further opportunities to learn in this way. Participants consider these training events as being much more realistic than the traditional classroom environment, bringing another dimensions and added value to their learning. Notably, there are 2 well recognised benefits to this style of SBL, both of which has clear potential to influence patient safety:

1. Training in their own environment with their own teams and equipment increases the psychological engagement of the learner, resulting in less ‘disconnects’ and increased engagement of learner (9).
2. Provides opportunities to identify any system incompetence and latent environmental safety threats (9,10).

In NHSA&A, we are providing more and more of this style of SBL and have purchased paediatric and adult ‘wireless’ manikins and mobile recording equipment to facilitate this in various clinical settings including the emergency department (paediatric and resus areas), anaesthetics/theatre, maternity, paediatrics and general ward areas. Some of the benefits of and latent issues identified through immersive SBL have been addressed and are discussed below:

Emergency Department

- The physical arrangement of the paediatric bay in resus has been modified and improved
- Drug calculations are now done at the bed side as opposed to being done at the drug cupboards, which are distant from the patient bays
- Learning from a case review of a real life ‘near miss’ has resulted in a SBL educational programme leading to improvement changes in the management of acute exacerbation of asthma in children

Ward areas

- Team training for nurses as first responders in cardiac arrests highlighted that key performance measures according to Resuscitation Council UK were not always being met, i.e. time to first defibrillation was greater than the recommended 3 minutes in some areas - as a result feedback was provided to the relevant areas and there has been a change in the focus of our resuscitation training updates for nurses to highlight and improve upon this issue
- Identification of latent safety threat in one ward area, which highlighted that the emergency buzzer could not be heard from a specific part of the ward area
- A review of the level of training for mental health nurses to ensure that they will now all receive life support training that includes advisory defibrillator competence – historically the majority of them received basic life support training only
- Reinforcement of the procedure to ensure that the cardiac arrest team gain rapid access to the psychiatric wards at Crosshouse. Under the umbrella of primary care the psychiatry department has separate ID badge access from that used in the main hospital – this is currently being addressed with the redevelopment of the main entry to the psychiatry wards

Paediatrics

- Twice monthly in situ SBL sessions are held. These are open to other specialties such as anaesthetics and emergency department practitioners to encourage collaborative working.
- These sessions have affirmed to all levels of paediatric staff that they each have a responsibility towards patient safety and the value each brings to the team in terms of recognition & management of the deteriorating child. Evaluations have highlighted that nursery nurses and auxiliary nurses are more aware of their important input in this respect.
- More recently, a joint initiative between emergency medicine and paediatrics saw the use of a truly immersive simulation exercise to practise the application of the new paediatric diabetic ketoacidosis protocol. The simulated scenario began with the admission of the sick child to the emergency department and continued with input from both specialties there, through to the transfer of the child and subsequent admission to the paediatric ward. This allowed both teams to train collaboratively and learn from feedback on the technical and non technical aspects of the exercise.

Anaesthetics & Assessment

The use of in situ SBL has been used for assessment purposes for anaesthetic trainees in NHSA&A since 2007, prior to their inclusion on the on call rota. We know that compared to traditional teaching methods, training on a simulator improves performance and skill retention, but its value for assessment purposes is less well documented. The ‘failed intubation drill’ is part of the anaesthetic trainees’ rite of passage as a component of their initial assessment of competency.



Inter Professional learning in the Emergency Department

As a rarely occurring anaesthetic emergency it is difficult for trainees to gain real life experience of this event. A reproducible simulation scenario was seen as a safe and measureable way for trainees to experience this in a controlled environment. Although it could be argued that performance in a simulated environment does not necessarily reflect clinical competence (11), taking Simman into the anaesthetic room has now become accepted practice for trainee assessment in NHSA&A. Previously, the trainees were assessed using a simple part task airway trainer – undoubtedly a training tool with very little realism. The use of in situ SBL in the anaesthetic room has clearly enhanced the environment fidelity, thereby significantly increasing the realism of the failed intubation scenario/drill. Indeed the trainees have reported that the experience feels incredibly life like, not to mention stressful; with witnessed pallor, shaking hands and sweating – as would perhaps be seen in real life! Self reported evaluations from participants; state that they now feel better prepared to manage the situation should it arise during clinical practice. As an added benefit, the inclusion of anaesthetic nurses has meant that they too have been able to reinforce their knowledge, skills and anticipated role within the team during this clinical emergency. It is anticipated that this learning would be translated to clinical practice and have a positive and sustained influence on patient safety.

Testing of protocols & clinical pathways

In situ simulation is also known to be of use in testing the reliance and feasibility of protocols (12) and has been used locally to test the stroke thrombolysis protocol, the major haemorrhage protocol and the anaphylaxis pathway prior to implementation throughout the organisation.

Testing of environments

Again in situ simulation can be of value in the testing of new clinical environments and use of equipment (13). As this is written, preparations are underway to test the recently built Clinical Decisions Unit at Ayr hospital with the aim of helping staff to familiarise themselves with the lay out, the equipment and clinical pathways prior to caring for real patients there. It is anticipated that the use of SBL will help to identify any unanticipated latent safety threats. There is clearly scope to do this kind of SBL in any new clinical environment, making it a safer place for patients and staff to be.

In conclusion, simulation is a realistic and safe method of teaching and learning for the benefit of individuals, teams and patients in the healthcare environment. SBL can identify system and process errors and highlight any latent safety threats within clinical settings. Future efforts for our service delivery will strive towards increasing both the fixed and in situ capabilities that we have currently. In particular towards targeting team training, encouraging collaborative working within varying specialties and a variety of clinical teams from emergency medicine, paediatrics, intensive care, theatre, maternity and radiology to mention just a few. A colleague once told me, “patient safety is the only game in town” and simulation training is the ultimate interactive and immersive teaching and learning tool to help us in our drive towards a safer patient climate.

Acknowledgments

None of the aforementioned developments and achievements would have been possible without the continued support, encouragement, involvement and innovation of the following key people:

Mr. Michael Canavan – Lead Resuscitation Officer
Dr. Julie Mardon, Consultant in Emergency Medicine and

Joint Clinical Lead for Simulation
Dr. Caroline Whymark, Consultant in Anaesthesia and Joint Clinical Lead for Simulation
Dr. Hugh Neill, Consultant in Anaesthesia and Director of Medical Education
Mrs. Dianne Wood, Mrs. Gillian Biggans, Mrs Monica Love, Mr. David Campbell – Resuscitation Officers

Words seem inadequate. Thank you.

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Final Frontier: Offshore Medic

EMERGENCY NURSING BACKGROUND

“Probably the single most important choice I made was to become a registered nurse, but also to continue my education and strive to continually develop my skills. Without this background I would never be able to function in my role as an Offshore Medic “



bank in accident and emergency (A&E) department Wishaw General Hospital. During this I studied for my BSc. in Nursing, successfully completed Major Injuries and Trauma (MINTs) course, which like an advanced nurse practice (ANP) qualification, but was certainly in its infancy when I completed the course. Now it is common place in hospitals in various forms along with hospital emergency care team (HECT) nurses who specialise in acutely unwell adult care. I now had the CV required to work offshore.



When ACAP Member Elaine Headley asked me to write an article on what a remote offshore medic does and the role we play in providing healthcare remotely I had to pause and ask myself

‘How do I begin to explain what we do?’

So now is an opportunity for me to at least give a brief overview of what actually happens when you are responsible for the medical/Health & Safety Executive (HSE)/welfare of fifty crew members on a working seismic survey vessel pretty much anywhere in the world.

BACKGROUND

Working offshore as a remote medic is not generally considered a career aspiration. It’s something that one kind of stumbles upon. I started my Dip HE General Nursing at Paisley University, graduated in September 2001, and then started my first job in Glasgow Royal Infirmary in the Surgical Receiving Unit. I then moved to Monklands hospital to the Emergency Care Unit and finally worked in the nurse



At this time I had come in contact with a colleague in intensive therapy unit (ITU) in Wishaw General who was looking into working offshore as an alternative career. After extensive research I decided that this would be something I would like to pursue. In order to work offshore either on rigs or marine vessels it was a requirement to have an HSE offshore medic certificate which is recognized by Oil and Gas Industry. This consists of a four week intensive in house course in Nottingham Acute NHS Trust which consisted of advanced life support (ALS), Pre Hospital Trauma Life Support, Prolonged Transport Care, ECG, thrombolysis and a two week clinical placement one of which is working in A&E then another in GP placement.

“The 4 week intensive Offshore Medic Course prepares the candidates for life offshore with lectures from industry professionals”

24/7 STANDBY ON CALL

‘You really have to be ready for any eventuality on the vessels. We are autonomous practitioners who do not have the benefit of crash teams, anesthetists, and doctors so its import to be ready and prepared’



After much help and assistance from my unit manager the emergency care unit (ECU) and A&E, I finally left NHS in May 2009, though still working as a bank nurse until I could secure my first assignment. By this time I had completed the four week residential medic course, completed my Offshore Survival BOSIET/HUET (helicopter transfers are standard offshore), this with my acute experience, medic certificate and offshore survival I was ready to go.

FRONTIERMEDEX

FrontierMEDEX were the first provider I contacted and are a Global leader in design and delivery of medical solutions in the world’s most complex and challenging environments. They bring together healthcare professionals, equipment, local knowledge and provide international medical care anywhere in the world.

I submitted my CV to FrontierMEDEX and after a very rigorous recruitment process, which included telephone interviews and face to face interviews with FMX Medical Director Dr Phil Sharples and various personnel staff; I was informed that I would be contacted in due course if an opportunity arose.

FIRST ASSIGNMENT

I was called in August 2009 by FrontierMEDEX to work as a medic on a survey vessel offshore Greenland. This was a seven week job which required very clear objectives. It was a new vessel and the hospital had to be stocked, set up and all medication had to be inventoried. Medical equipment checked and first aid with HSE training for all 35 crew members. This was a learning curve for me as FrontierMEDEX have very specific standard operating procedures which include comprehensive clinical guidelines, equipment, drug

formulary and reporting system. The very nature of working offshore means that topside advice is essential. FrontierMEDEX have an excellent topside doctor service where highly experienced doctors can be contacted at any time for advice on treatments, drug clarification and more complex medical problems, support is always on the end of the phone.

The transition from working in an NHS hospital to be on a vessel in Greenland was challenging and exciting at the same time. The rotations are as such we work five weeks on and five weeks off. It might seem long but in actual fact it the time off is a bonus as you have 'quality' time with family and home life. It was difficult at first but now after four years offshore it's as normal as working a 9 to 5 job. Professionally it was difficult to adjust to the responsibility that you have. But I always say it can't be any more daunting than being responsible for a thirty five bedded receiving unit. Therefore it gave some importance to the perspective of my new working environment.

NHS NURSE TO MARINE OFFSHORE?

'The transition from working in the NHS to working offshore can be daunting but with drive and a clear desire you will be surprise at what you can achieve and how you deal with working in challenging locations'



OFFSHORE LIFE / WHAT WE DO

Currently I now have been contracted to a major client via FrontierMEDEX to provide medical and HSE cover on a seismic survey vessel, the first stage in oil detection and exploration. I have worked for the client for four years and it is stable and challenging. The role of the offshore medic is wide and varying as the expectation of the client should mirror the expectation of the medical provider.

MEDICAL

The primary role is one of the ships medics. You will have an average of fifty plus crew members who will visit your hospital in all weathers which may be 6ft swells or nice calm seas in the Gulf of Mexico. So it certainly has its challenges. Presentations of complaints range from primary care such as, dermatology, cardiac, minor/major trauma and the occasional dental issue.

FrontierMEDEX have very concise clinical guidelines which must be

referred to for all conditions and patient confidentiality is of primary concern. Therefore it is really important for the medic to have a very broad spectrum of knowledge.

Casualty transfer is important and having paramedic or pre-hospital care experience is essential: and if you don't have it you must learn. There are times where crew members must be medically evacuated by helicopter for shore-side consult so thinking on your feet is critical.



'It is important those first aid teams are trained in casualty transfer and first aid in order to assist the medic in all aspects of medical care and medical evacuation transfer to shore'

TRAINING

Training is a very strong offshore requirement and certainly medical first aid is high up in the priority list. It is the medics' role to ensure all crew members are trained in first aid situations such as immediate life support, (ILS) automated electrical defibrillator (AED), trauma management, musculoskeletal trauma, bleeding, burns and the list goes on. This is addition to more in-depth medical training with the first aid team facilitating a safe working environment with the ability to function and provide quality medical care to the crew in the event of any emergency.

Additionally the in house training the medic may be asked to travel to the supply boats to train the crew in the HSE topics specific to clients' requirements. This normally involves a fast response boat transfer which in good weather can be fun but in bad weather is not for the faint hearted.

QUALITY /HEALTH/ SAFETY AND ENVIRONMENT

It is fair to say that working offshore is not like working in A&E, so if you are lucky enough to have a quiet day then the role will change. The medic has a very strong focus on HSE and they are utilised accordingly. We are involved in all matters relating to HSE, client meetings, toolbox talks, active reporting on hazardous situations and loss prevention. So to say we are not busy is a myth; the medics are busy trying to prevent injuries but also treating injuries and learning from incidents.

CONCLUSION

So a very brief story of what we do and our roles within health care away from the busy wards up and down the country. Life here is good and is rewarding in many ways. Being offshore for six months with a crew brings a 'camaraderie' and crew becomes an extended family. The very nature of the job means you get the opportunity to travel pretty much anywhere in the world. Places as diverse as Gulf of Mexico to Equatorial Guinea from Greenland to Australia.

The crew work hard but also there is time for recreation activities such basketball on helideck, deck hockey and circuit training. So there is an incentive to keep healthy and fit. It's the medic's role to use the holistic care approach to everything we do in the remote setting.

FrontierMEDEX have provided me an opportunity to provide quality health care and also to step outside the box and think critically. There was an occasion once when I was home and doing a shift in a local Glasgow hospital I spoke to a student nurse about my job and she asked for advice. I pointed out that completing her degree and becoming a registered nurse will bring many opportunities both in hospital and in primary care but sometimes it's important to step outside the box as you never know what opportunities might be around the corner.

FrontierMEDEX
GO FURTHER. DO MORE.

Steven Kemp has been working for FrontierMEDEX for 4 yrs as a Remote Site Medic /FMX Mentor/HSE Medic /RGN
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