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ACAP
Acute Care
Advanced Practitioners

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The Advanced Nurse Practitioner

The journal for members of ACAP

Produced in association with
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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.

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Contents.....

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

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

New Advanced Practice Book

New book on advanced practice released August 2015. Edited by David Barton and Scotland's own (and ACAP supporter) Douglas Allan. It's on amazon if you search for advanced practice Barton and Allan.

Advanced neonatal & paediatric decision making course

Type: Stand-alone module 20 credits at Masters level 11 - Advanced neonatal and paediatric decision making - mix of blended learning (online materials and 2 blocks of 4 day attendance Required - 1 week in February 2016, and 1 week in March 2016. Where: University of the West of Scotland (Hamilton campus for classroom attendance days) Start date: End of January 2016 Duration:12 weeks in total Cost: £570. Entry requirements: Registered nurses or allied health professionals who work in an environment where they regularly come into contact with neonates/children, and require the skills and confidence to undertake an assessment and clinical examination of the neonate/child. There will be a mixture of qualified neonatal/paediatric staff and adult trained staff who work in such environments (such as Out of Hours services or Accident and Emergency).

A pre-course work booklet on the physiology of the neonate and child requires to be completed which ensures the student has the appropriate knowledge to enable them to fully participate in the module and undertake clinical examinations. Contact **mandy.allen@uws.ac.uk**

New Mobile Skills Unit (MSU) Faculty Development Course Datesk

CSMEN are delighted to announce the dates for the 2015/16 MSU Faculty Development Courses.
They are:- 3 & 4 December 2015
4 & 5 February 2016
18 & 19 February 2016
24 & 25 March 2016
For a registration form or for more details see the Faculty Development Course page of the website. For more information contact **lynn.hardie@nes.scot.nhs.uk** or call **01382 425735**

AANPE.. Name Change! Forward from Evelyn McElhinney

The Association of Advanced Nurse Practice Educators (AANPE) have made a slight change to their name to reflect the advancement of practice by other disciplines, mainly AHPs. I am on the national committee and as School we are members, however you can also join as an individual. One of the recent changes is that students can now join for a small fee. Additionally, the old website has been given a facelift http://aape.org.uk so please spread the word and encourage your student to join. There is also a national conference and details of this are on the website. There is also lots of info on revalidation and many other policy etc where AAPEUK (as we are now know) have influenced the development. So please spread the word, follow us on twitter @aapeuk or follow us on Facebook and if you wish more info let me know. Regards Evelyn McElhinney MSc, BSc, RN, RLPE, FHEA Lecturer Advanced Practice Programme Lead MSc Nursing: Advancing Professional Practice Module Leader Non-Medical Prescribing/History Taking & Physical Examination/WBL Room A516 Department of Nursing & Community Health School of Health and Life Sciences. Glasgow Caledonian University is a registered Scottish charity, number SC021474

Congratulations

ACAP would like to congratulate the Senior Advanced Practice Team in Ayrshire & Arran on jointly winning the Ayrshire Achieves Award for Team of The Year. ACAP would like to congratulate committee members Fiona Buchan and Hazel Beveridge on achieving their Post Grad Diplomas in Advanced Practice

Articles/News

ACAP are always looking for articles and news from all areas of advanced practice, If you would like to contribute please contact Julie on **julessmith69@hotmail.com**
Additionally, if you are interested in becoming a member of the committee please contact Julie for details

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

6th NATIONAL CONFERENCE EVENT

ACAP Scotland
SC042116

ACAP IS DELIGHTED TO ANNOUNCE IT'S 6TH NATIONAL CONFERENCE EVENT

The theme of this event:

Developing the Possibilities – Advancing the Boundaries

The hot topics/speakers will include:

Professor Fiona McQueen –
Chief Nursing Officer for Scotland

Remote and Rural Advanced Practice –
Mr Eddie Docherty

ABG Analysis –
Mr. Jacques Kerr

Patient/Carer experiences –
Tommy Whitelaw

A day/night in the life of .... 3 ANP perspectives

Delirium –
Prof MacLullich

Mental Health masterclass

In response to much of the requests from previous evaluations ACAP now have more interactive workshops as part of the master-classes.

For further information contact:

julessmith69@hotmail.com
david.hunter@aaaht.scot.nhs.uk

Venue: The Carlton Hotel, Edinburgh

Date: November 6th 2015

Programme: To be finalised

Cost: £40 per head.

Includes: tea/coffee/snacks on arrival, mid morning & mid afternoon and buffet lunch

Also includes delegate packs and the latest hard copy issue of
THE ADVANCED NURSE PRACTITIONER

REDUCING TRANSFERS BETWEEN COMMUNITY AND ACUTE HOSPITALS – INTRODUCTION OF AN IV SERVICE

Nicola McInroy ANP Ayrshire & Arran

Kirklandside is a small community hospital with 25 beds caring for the frail elderly population with no rehabilitation potential. The patients are either NHS long term care or are awaiting single shared assessment and Nursing Home placement. The Advanced Nurse Practitioner (ANP) covers from Monday – Friday from 9.00am till 5.00 pm and NHS 24 provide cover out of hours. Previously, the consultant from the acute hospital offered daily medical cover but this service was initially reduced to 1 day per week in 2012 and finally discontinued in 2014. The consultants are still on hand for advice and will attend when required to do so by the ANP on duty.

As a Care of the Older Adult ANP working in Kirklandside Hospital, I helped to fill a gap left by consultant when the medical cover was reduced to the hospital. Initially this was on a random basis and the same ANP was only there for a few days at a time. I felt that we were only touching the surface of what was required for our older population but "went with the flow" and dealt with day to day problems and issues.

A few months later a pilot scheme was introduced where the ANPs within the team were asked if they would like to cover Kirklandside for two weeks per month and therefore introduce some continuity to staff, patients and relatives alike. I volunteered for this role and started to look at things on a bigger scale. I got to know the patients and relatives well, and built up relationships with all members of staff. The nursing care was (and still is) of a high standard, but I noted very quickly that when the patients became unwell it was very limited in what could be done at Kirklandside. There was no ability to treat sepsis or deranged U&Es with IV antibiotics or IV fluids. Patients and relatives were given the option for ceiling of treatment at Kirklandside which would include oral antibiotics and medications and subcutaneous fluid administration, or transfer to an acute hospital for IV therapies.

Therefore "to transfer or not to transfer?" was the question that I had to answer. Transferring would mean major upset to namely the patient but also relatives who had become very comfortable with life in Kirklandside Hospital. There are massive risks associated with transferring to an acute hospital. A high percentage of the elderly population have dementia or ongoing delirium and the fast pace of an acute hospital stay has a negative effect on these patients and increases their fear, agitation and confusion. This in itself is detrimental as they are then prescribed antipsychotic medications and sedatives which further exacerbates the situation. They are also at greater risk of developing a hospital acquired infection and increased stress in both patients and relatives.

Surely the question we really had to answer was "Do we transfer for evidence-based, best practice or do we settle for second best?"

In my mind, I was thinking how I would be able to introduce a new service that would be best practice and mentioned it one day when attending a CPD study day to my manager. She informed me of the local Improvement Science Fundamentals course that was being held within the organisation and encouraged me to attend the study days. I attended this course in April 2014 with a head full of excitement and ideas about how we could introduce a new Intravenous Administration service, which would allow us to treat patients on site without the disruption of transfer to another hospital.

I was taught how to develop a new service using Improvement methodology and was fortunate to have an improvement lead to assist and guide me through the process. My initial aims included reducing the number of patients transferred from Kirklandside Hospital, due to medical conditions requiring IV therapy, by 50% by December 2014 I planned for patients to be treated with IV drugs and fluids administered by competent, registered nurses and for the reduction of exposure to risks associated with transfer to an acute site, by providing basic treatment on site, and promoting a person-centred approach in the frail elderly group.

Primary drivers included reducing the risk of developing HAI, reducing the risk of developing/ worsening delirium in an already high risk group and reduction of patient and relative stress. Secondary drivers were implemented by commencing staff training in IV drug administration for registered nurses, cannulation and venepuncture skills were encouraged and competencies had to be completed.

I planned an initiation date of 1st July 2014 and started working towards commencement of an IV service on this date. I liaised with pharmacy, infection control nurses and training educators so that the nurses could be trained in the safe, aseptic, effective and timely administration of IV therapies. It was agreed that competencies could be made relevant to Kirklandside and therefore we aimed to achieve competencies surrounding "adding to bags" (as most intravenous antibiotics could be administered this way). We agreed it would be unachievable to do bolus injections so therefore this part was omitted from the competency bundle. Any boluses required would be administered by the ANP on duty (i.e., Furosemide, Gentamicin).

PRIOR TO NEW SERVICE	**AFTER INITIATION OF NEW SERVICE**
23% of nurses trained in IV administration	92% of nurses trained in IV administration
85% of nurses trained in venepuncture	85% of nurses trained in venepuncture
31% of nurses trained in cannulation	31% of nurses trained in cannulation
11% of nursing auxiliaries trained in venepuncture	11% of nursing auxiliaries trained in venepuncture

The new service was eventually commenced on 1st August 2014 and to date has been a huge success.

PRIOR TO NEW SERVICE 1st February – 31st July 2014		**AFTER INITIATION OF NEW SERVICE** 1st August 2014 – 31st January 2015	
TRANSFERRED	19 (100%)	TRANSFERRED	8
TREATED WITH IV AB'S	0	TREATED WITH IV AB'S	17
TREATED WITH IV FLUIDS	0	TREATED WITH IV FLUIDS	3
TRANSFERRED OOH		TRANSFERRED OOH TRANSFERRED BY ANP (1 X ?#NOF / 1 x CCF)	6 2
		PREVENTED TRANSFER BY TREATING AT KIRKLANDSIDE	20 (72%)

From the 1st of February 2015 until 31st July 2015, 25 patients have been treated with IV fluids / antibiotics therefore preventing their transfer to an acute hospital.

Initial verbal feedback from relatives, patients, staff and consultants include:-

"…. it's good to be able to have the antibiotics given quickly without having to transfer to Crosshouse and go through the whole admission process… we know that mum is getting the best of care available where she feels safe"

"….. I like how we were able to change from oral antibiotics to IV when she didn't respond to treatment….it was important for her to make that decision herself without the hassle of transfer"

".....well done, keep up the good work"

"....excellent development.....avoid the inherent resultant delays"

".....avoid running the gauntlet.....to receive standard fluids and antibiotics"

".....looks good, thanks for initiating this service"

Having developed a successful service, I would like to further develop this service to include out of hours when patients are reviewed by ADOC. The future developments include ensuring that all staff are competent in cannulation so that when ADOC visit overnight, empirical guidelines can be followed and patients can be treated with IV antibiotics on site without the need for transfer. Sepsis six guidelines can be implemented out of hours and patients are therefore given the same survival chances that they would encounter in an acute hospital setting, without the need for the evident delay by transferring from a community hospital via ambulance transport to and A&E setting.

ADVANCED CRITICAL CARE PRACTITIONERS in the UK: an Update

Over the last five years plus training programmes for Advanced Critical Care Practitioners have been created in various places across the United Kingdom. Colleagues in Exeter, Lothian, Middlesborough and Newcastle led these and have been instrumental in the UK ACCP development. These intensive care specialists are advanced practitioners with expertise in this context and specialism, and come mainly from a critical care and acute care nursing background. Key domains of their day to day working include:

- Patient assessment and care planning
- Prescription of drugs and authorisation of blood products
- Resuscitation
- Advanced physiological monitoring
- Provision of advanced organ support (often multiple)
- Diagnosis and disease management in the context of the most gravely ill patients in the hospital
- Requesting investigations including radiology
- Provision of symptom control
- Management and support of the family of the critically ill patient
- End of life care including care of the potential organ donor
- Collaborating in the intensive care team
- Coordination of specialist and multi-specialty input to complicated clinical cases in the unique context of intensive care.

These specialists are located in Intensive Care Units [ICUs] although their range of referral includes much of the acute hospital. Within a single shift ACCPs may find themselves involved in the care of patients ranging from the young adult to the very elderly; in varied locations such as the Emergency Department and Acute Admissions Units, as well as in Critical Care.

In professional terms they remain accountable to their core organisations eg NMC, but in clinical, training and educational terms they are now affiliated to the Faculty of Intensive Care Medicine (as are their medical counterparts). Publication of the ACCP curriculum under the banner of the Faculty profers great progress in standardisation of the training, education and assessment required to meet the standards of the role. This has led to agreement via FICM Board, that those having met the knowledge, skills and competencies commensurate with the FICM and key stakeholders Curriculum 2015 are eligible for FICM Associate status by Assessment.

The Faculty of Intensive Care Medicine (FICM) Advanced Critical Care Practitioner (ACCP) Curriculum 2015 was published in June 2015. The FICM Board has subsequently set up an ACCP Advisory Group. The involvement of many Critical Care Networks including the National Nurse Leads (CC3N) and British Association of Critical Care Nurses (BACCN) in this development was pivotal to its success. Their positivity during this process, and of the role development, has been very much appreciated. The support of these two organisations, given that the principle pool of applicants to become ACCPs are from the critical care nursing background, is fundamental in helping to cement the ACCP role as a workforce and career option for staff supporting patients and intensive care in the UK. The curriculum and syllabus documents form the integral cornerstone defining the ACCP role. They will ensure standardisation of knowledge, skills, competence and capability commensurate with this new role in advanced clinical practice.

Education

Education of this nature, and at this level, brings with it challenges of the involvement of multiple higher educational institutions with differing views . The majority of education providers delivering ACCP MSc level training are from the nursing universities as the majority of entrants to training continues to be from critical care nursing. We are also seeing increasing numbers of physiotherapists who wish to extend their clinical knowledge and skills in this way. The ideal would, of course, be a national course delivered in exactly the same way in every centre. In the absence of this the National ACCP curriculum proffers a clear structure and roadmap through the required academic and clinical elements towards FICM Associate status for those who meet the requirements. The ultimate goal is the development of a National ACCP exam through FICM, with all of the commensurate benefits for the role, the practitioners and our patients.

Establishment and recognition of this quality standard has led to successful implementation of FICM Associate Member status for those ACCPs who meet the stipulated requirements. We have already had a steady stream of successful applicants for this from trained ACCPs who are working in clinical practice at this level. It is recognised that protection of the title ACCP may not be possible, so FICM Associate Membership status provides us with a very effective benchmark in setting the quality standard. This is integral not only for protection of the role, but also provides key quality assurance and governance for hospitals, trusts and health boards and for the quality of care delivery for our patients.

The 3rd National ACCP Conference was held in July 2015 (hosted at Churchill House and coordinated by FICM). The selection of eminent speakers including Professor Mervyn Singer, Professor Rupert Pearse and Dr Carl Waldmann ensured that it was a sell out. The conference faculty delivered a lively programme of clinical debate for ACCPs both trained and in training. These sessions were again coupled with the popular workshops for clinicians and senior nursing teams planning to implement the role locally in their own units.

Dr. Carol Boulanger
(Royal Devon and Exeter NHS Foundation Trust)
Joint chair of the FICM ACCP Advisory Group

Dr. Graham R Nimmo
MD edD, FRCP (Edin) FFARCSI, FFICM
President Scottish Intensive Care Society

The National Association of Advanced Critical Care Practitioners enjoys increasing membership and is proving to be an effective network of communication and support. The National Association of ACCPs (NAACCP) uses social media for communication, education and information to all its members The NAACCP again held their annual AGM at this meeting providing ACCPs from around the UK with an opportunity to have a voice in future developments. The NAACCP has an expanding, and evolving, voluntary database of trained and in training ACCPs. However this is likely to be an underestimate of the range of ACCP activity or projected activity across the UK. FICMACCPAG is conducting a census with the support of the ICM Regional Advisors to ‘map’ activity.

The FICM ACCP Advisory Group has key items on the agenda for the next steps forward: The ACCP website, via the FICM homepage, currently displays useful information about the role, units and HEIs involved in development of the role. The intention is to extend this information to include toolkits for Trusts, units and clinicians around the set up of the role, from creating a business case to work in practice. CPD for those trained ACCPs is a clear work stream for the group. The aim is to provide guidance around CPD for the role and how to meet the requirements for organisational performance appraisal processes. This is important for trained ACCPs in this new role to ensure the process effectively ensures the maintenance of the quality standard whilst guiding further development. All ACCPs currently have to maintain registration with their professional body the Nursing & Midwifery Council (NMC) for nurses and the Health and Care Professions Council for physiotherapists. With the introduction of revalidation the FICM ACCPAG aims to provide CPD guidance on this.

The sustained future of the ACCP role as a quality workforce solution for Intensive care is looking increasingly bright. This role offers the opportunity for recognition of clinical practice at a higher level for nurses and AHP s in the interests of providing consistent high quality care to our patients and their families, and keeps experienced clinical healthcare professionals in the front line of patient care.

The Adoption of The Advanced Practice Toolkit as a Model for Safer Aesthetic Practice

Elaine Headley MSc Pgdip. BA hons, NMP ,RGN. Advanced Aesthetic Nurse Consultant,
Company Director of EL Medical Aesthetics Ltd.

I would like to acknowledge and say 'Thanks' to Robert Benjamin (South Africa), for his help in editing this article.

Introduction

In 2013 the Keogh report was commissioned as a result of poor practices within the aesthetic/cosmetic industry following the Poly Implant Prosthesis (PIP) breast implant scandal in 2010. The 2013 report highlighted the use of unsafe practice and misrepresentation among some practitioners. It helped to identify a highly fragmented industry with regards to training for, and competencies in non-surgical aesthetics. To this day this industry essentially remains unregulated. That is why the Department of Health commissioned and published the 'Review of the Regulations of Cosmetic Interventions' in 2013, which was chaired by Professor Sir Bruce Keogh, (herein also referred to as the Keogh Report).

Despite, there being general consensus among many aesthetic professionals about how services should be delivered, there was no common ground about who should actually be delivering the services. Further, no agreed model existed that could be utilised to provide guidelines for improving practices within this growth industry. Presently, this gap in the industry still has not been filled. To this effect, I propose adopting the Advanced Practice Toolkit (2008) as a standard model of practice. It would be highly advantageous to the industry to standarise and to provide a regulatory safety net for all conscientious practitioners and their non-surgical aesthetic clients. For the purpose of promoting the adoption of the Advance Practice Toolkit (2008), this article will only consider the toolkit as a method of improving safety. It would not attempt to engage with, or examine the issues around those who currently practice in the field of non- surgical aesthetics.

MAIN

Advanced practice is now well embedded into the current culture of health care. Stemming from the very early days, where the United Kingdom (UK) adopted similar developments that were already established in the United States, such as that of physician's assistants and clinical nurse specialists (Mantzoukas 2007, Mc Gee & Castledine 2003). As a result of the European Working Time Directives, (EWTD), and the changes this brought to the reduction in junior doctors' working hours (British Medical Association 2004), the doors opened to facilitate changes in nursing practice Modernising Nursing Career, (Scottish Executive 2006). However since 2004, and as precursor to these changes, Scotland pioneered the role of advanced nurse practitioners (ANPs), delivering care to patients as first responders to acutely unwell adults, in the manner that was once only delivered by doctors (Carberry. 2006). These changes were clearly set to stay, with the need for nurses to continually push their own boundaries as suggested earlier by Masterson (2003). The on-going development of these nurses took a new direction when it became possible for them to take additional training and educate as independent nurse prescribers/non medical prescribers (INP/NMP). This new role gave ANP's a new sense of autonomy and facilitated a completeness in the care they were delivering to their patients. Now as an INP/NMP, the advanced practitioner could ensure prescriptions could be written and administered in a timely manner. This supported medical staff, who often could find it difficult to free up time to complete these important jobs.

It was this development that undoubtedly led to more autonomy in practice for ANP. As a result of this, nurses, and in particular ANP's,could work in complete autonomy, could hold their own clinics, have their own patients, carry out essential physical assessment, prescribe the most appropriate treatment and ensure safe , timely , person -centered care. You would almost think that, the latter section of this statement was straight out of the Scottish Government's 2020 vision (2014). Well it could easily be argued that it was. The area of practice I am referring to is the field of non-surgical aesthetic practice.

There has been a great deal of controversy over this area of practice since the Keogh report was published in 2013 (DoH, 2013). The report aimed to provide suitable recommendations for improving safety in cosmetic interventions. In the UK, one million people use healthcare services every 36 hours and most receive high quality care, but, things can, and do, go wrong (DoH, 2010). In spite of this, and to date, there has been no research done regarding safety and efficacy within aesthetic practice. Further, a profound lack of research exists into the experiences of those working in this area.

It should be noted at this point how the focus of this article is in essence only concerned with those in the medical profession, i.e., doctors, nurses and dentists. In an a attempt to make it safer for practitioners and clients, the 2013 Keogh report produced recommendations for improving this largely unregulated industry. None of these recommendations more so, than the requirement for appropriate training that aesthetic practitioners should be undergoing (DoH,2013).

This article has generally been inspired by the similarities that appear to lie between those nurses who endeavour along the pathway of advanced nursing practice (ANP) and those nurses who also endeavour along the pathway of aesthetic nursing. But in particular it was deeply inspired by nurses following the pathway that amalgamates both the ANP (who is also an INP/NMP) and the aesthetic nurse aesthetic practitioner. The overall impact of the 2013 Keogh report has inspired the need to ascertain models of practice that could be utilised for ensuring the safety of the cosmetic client and the aesthetic practitioner. Furthermore,the recommendations of the 2013 Keogh report prompted changes to remote prescribing rules. Even further still the Nursing & Midwifery Council (NMC, 2008) encouraged all aesthetic nurses to complete a V300 Non-Medical Prescribing course. The Advanced Practice Toolkit (2008) recognises that advanced nursing practice is a 'level' of practice rather than a particular role. It aims to move towards the position of advanced practice via a portfolio of learning and competence assessment. This would represent a consistent level that would reflect both the breadth of clinical expertise and the professional settings within which they can be demonstrated.

Further, the Advance Practice Toolkit (2008) recognises the combination of the necessary level of education and practical expertise needed for in- depth knowledge and correct clinical decisions. Accurate decision making would only become possible via the application of high levels of analysis and critical thinking (2008). To this effect the Advanced Practice Toolkit (2008) advocates a framework of four underpinning themes that encapsulates all the necessary elements to ensure that ANP's meet the recommendations to uphold the title and level of practice required. In addition the Advanced Practice Toolkit (2008) aims to use the emerging consensus around advanced practice to integrate educational, operational and organisational streams into providing clarity and consistency in client support (2008). This support would make headway in advancing safety within the unregulated, fragmented cosmetic industry. This would also satisfy a need, which was recognised by the 2013 Keogh report. The critical goal

of advancing safety in practice would be achievable by establishing a developmental pathway through which existing and new practitioners would work in synergy with their managers and service leads to:

- benchmark their competence
- identify developmental needs
- demonstrate the accepted and recognised attributes of advanced practitioners. (The Advanced Practice toolkit 2008)

Conclusion:

By carrying out any aesthetic treatment, (non- surgical or otherwise), one is carrying out a clinical procedure. Therefore, it is my belief that it should be carried out by an aesthetic clinician, who exhibits the following qualities:

1. Is appropriately trained.
2. Is competent in analysing individual facial structures, muscles, blood and nerve supply that lies beneath the skin.
3. Is competent in analysing the colour, texture and integrity of the skin itself.
4. Have an understanding of the psychological impact that non surgical aesthetic treatments can have on the client's body image and self esteem.
5. Have an expert understanding of pharmacology and pharmakinetics, for both the aesthetic prescriptions to be issued and any established medication the client may already be using.
6. Has proficiency in managing anaphylactic shock, should a severe allergic reaction occur.

Note: Where the clinician is also an ANP, these assessment skills and knowledge base will already exist as areas of competency. Further, in the case of an ANP who undertakes aesthetic practice, the required 'level' would already be established. The adoption of the Advanced Practice Toolkit (2008) would ensure aesthetic practitioners meet, or were working towards meeting the required, underlying recommendations, which would provide for a much safer and robust clinical care for aesthetic clients. It is worth recognising that presently there are post graduate level courses being developed to address the issues raised in the 2013 Keogh Report.

However, it would still be a while before such skills would become available to the industry. Until then, the hole would persist and would need plugging. For example, Northumbria University is one such establishment that has endorsed the 2013 Keogh recommendations (Health Education England 2014). In addition, the Scottish Government have established an expert group in 2014 to explore the need for introducing regulation to cosmetic procedures (Scottish Cosmetic Intervention Expert Group 2014). The ethos of the Scottish Cosmetic Intervention Expert Group (SCIEG) is to ensure that those who choose to seek cosmetic interventions can do so with the fair knowledge that providers are delivering services, which meet certain , basic standards of training.

However, neither of these progressive steps in policy were acknowledged as progress in the development of 'levels' of practice. More is needed then. We need to now show more measurable progress. Adopting the Advanced Practice Toolkit (2008) would be such a step, in the right direction, Viewing aesthetic practice as a 'level' of practice, not a role, with the objectives of improving practitioner education, clinical analysis and decision making, leadership and robust unbiased research, seems the most logical way forward.

References

Advanced Practice Toolkit (2008) [online] available http://www.advancedpractice.scot.nhs.uk [accessed]21/8/2015

British Medical Association (2004) New Deal for Doctors http://www.bma.org.uk [online] available [accessed] 21/8/2015

Carberry M, (2006) Hospital emergency care teams: our solution to out of hours emergency care Nurs Crit Care. 2006 Jul-Aug;11(4):177-87

Department of Health (2013) Review of the regulations into cosmetic intervention : Final Report [online] available http://www.gov.uk/dh [accessed] 19/3/2015 Health Education England (2014) Qualification Requirements for Cosmetic Procedures : Stakeholder consultation document

Mantzoukas, S. (2007) “Review of advanced nursing practice: the international literature and developing the generic features”, Journal of Clinical Nursing, Vol. 16, no.1, pp. 28 – 37

McGee, P., Castledine, G. (2003) Advanced Nursing Practice, 2nd edn., Blackwell Publishing: Singapore.

The Scottish Executive (2006) Modernising Nursing Careers: Setting the Direction. [online] available http://www.gov.scot [accessed]21/8/2015

The Scottish Government (2014) The Scottish Cosmetics Interventions Expert Group [online] available http://www.gov.scot [accessed] 21/8/2015

The Scottish Government (2014) 2020 Vision in health and Social Care [online] available http://www.gov.scot [accessed]21/8/2015

The Sir Bruce Keogh Report (2103) The Keogh Mortality Review [online] available http://www.nhs.uk/NHSEngland/bruce-keogh-review [accessed] 21/8/2015

Some images taken from last years event, our 5th Annual Conference in Edinburgh.

*We look forward to another successful event in **November 2015** and welcome you all to attend.*

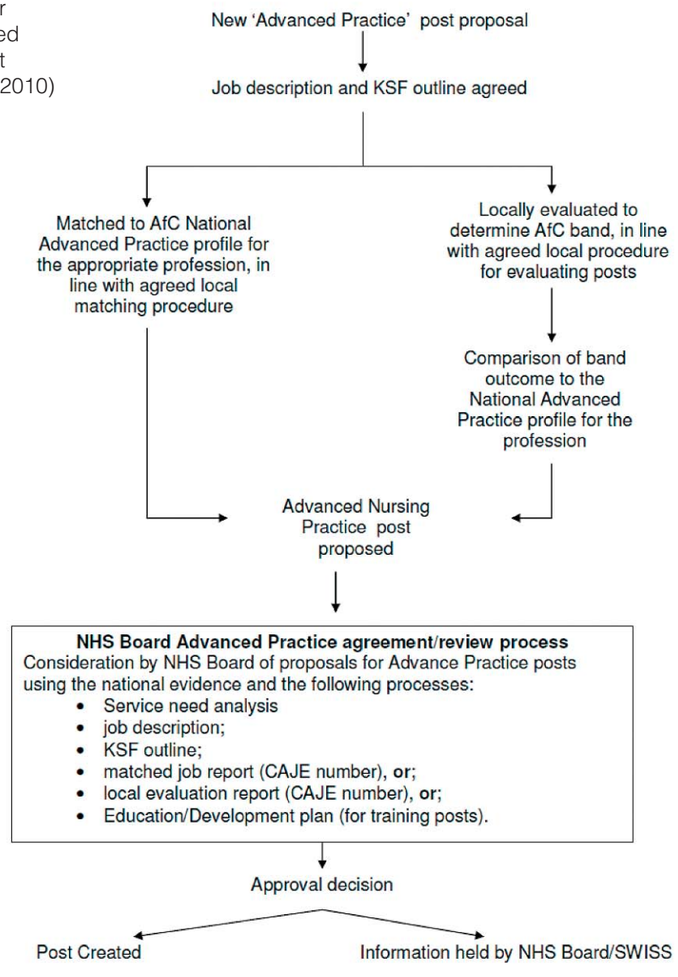
Advanced Nurse Practitioners in NHS Scotland: national data

In March 2010 the Scottish Government published guidance on Advanced Nursing Practice Roles for Health Boards (Scottish Government 2010). The guidance made it clear that NHS Boards should maintain appropriate records of their ANPs and these should be linked to the national Scottish Workforce Information Standard System (SWISS) data.

In effect this means that there is a national dataset of Advanced Nurse Practitioners working in the NHS in Scotland. This data is gathered by the Information and Statistics Division (ISD) which is a division of National Services Scotland, and is part of NHS Scotland. ISD gathers data and provides health information, health intelligence, statistical services and advice that support robust planning and decision making within the NHS in Scotland. ISD publish health data on their website www.isdscotland.scot.nhs.uk

Each Health Board will have its own process to identify and record Advanced Nurse Practitioners. The 2010 Scottish Government guidance outlines the general procedure (see diagram below).

Figure 1: Procedure for identifying an Advanced Nurse Practitioner post (Scottish Government 2010)



In practice this means that an authorised group or individual will review the Job Description and Job Match Report for any existing or proposed ANP role and determine that it meets the requirements for an ANP role, as detailed in the 2010 guidance.

- Posts should be Band 7 (or above)
- Posts should be matched, or band matched, to the Agenda for Change national profile for nurse advanced
- Individuals working at an advanced practice level should be able to show evidence of Master's level learning
- Post will be structured around four central themes: advanced clinical practice, clinical/professional leadership, facilitating learning, and research and development.
- Advanced Clinical Practice includes, amongst other things:
  - o Assessment, diagnosis, referral and discharge
  - o Prescribing (where required)
  - o Managing complexity
  - o Critical thinking and analytical skills incorporating critical reflection
  - o Decision making/clinical judgement and problem solving
  - o Developing higher levels of autonomy

In NHS Greater Glasgow and Clyde, the NHSGGC Advanced Practice Group acts as a gatekeeper to identifying and recording ANP roles within the Board (NHSGGC 2010). In this Board this is a two step process. First the Job Description and Job Match report are reviewed by the Group. The Group ensures that the post:

- Is Band 7 or above
- Has been Job Matched or Band Matched to the Agenda for Change National Profile for the Nurse Advanced or exceeds this
- Job Description describes an Advanced Nurse Practitioner. This Group looks for evidence that the NMC definition of an Advanced Nurse Practitioner (NMC 2005) has been met. This includes looking for evidence of advanced clinical practice, clinical/professional leadership, facilitating learning, and research and development.

If these criteria are met the post is recognised as an Advanced Nurse Practitioner post. This , however, doesn't mean the post-holder is an Advanced Nurse Practitioner. The second part of the process, is the confirmation by the line manager that the post-holder has completed all the required training (as set out in the job description) and is currently practising in the role. Once this has been determined the post-holder receives a letter from their Chief Nurse notifying them of the decision and authorising use of the title 'Advanced Nurse Practitioner' whilst they remain in that post. Workforce Information is informed and the post-holders SWISS entry is amended to record their Advanced Practice status. Other Boards in Scotland will have their own processes in place.

If you are an Advanced Nurse Practitioner working in NHS Scotland, ask your line manager if you are recorded as an ANP on SWISS.

References:

Scottish Government (2010) Advanced Nursing Practice Roles: Guidance for NHS Boards. Scottish Government, Edinburgh.

NHS Greater Glasgow and Clyde (2010) Advanced Nursing Practice Strategy 2010-2015. NHSGGC, Glasgow.

Nursing and Midwifery Council (2005) NMC Council Agendum 27.1 December 2005/c/05/160

Dr Mark Cooper

Chair, NHSGGC Advanced Practice Group

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