The respiratory nurse specialist role at a medical assessment unit

The development of new nursing roles such as the nurse practitioner has been driven by the shortage of junior doctors and the initiative that advocates the reduction of junior doctors’ hours (Dowling, 1996). Todd (1997) identified other factors that have also fuelled these initiatives, including:

- The abolition of nursing extended roles in 1992;
- The unmet needs of certain patient groups;
- The pressure to deliver clinically efficient and cost-effective health care;
- A change in the expectations of patients.

The chief nursing officer’s 10 key roles have also enabled nurses to change their practice to undertake advanced skills and provide total patient care (Department of Health, 2000).

Benefits of the nurse practitioner role Much of the research relating to the nurse practitioner role has been conducted in primary care. These studies have demonstrated that nurse practitioners are as cost-effective as GPs (Venning et al, 2000), and the standard of care is at least equal if not better than that of their medical counterparts (Horrocks et al, 2002).

A study conducted in A&E highlighted that nurse practitioners record more comprehensive and holistic medical histories than doctors (Sakr et al, 1999). It was found that the nurses’ examination skills, interpretation of chest X-rays and treatment plans were comparable with the senior house officers assigned to the department.

More recently Sharples et al (2002) established that the role of the nurse practitioner in an outpatient setting was also extremely beneficial. Studies have also demonstrated a higher level of patient satisfaction with the care received from a nurse practitioner (Iliffe, 2000; Kinnersley et al, 2000).

Developing the nurse practitioner role in respiratory care There were 259,000 emergency admissions for respiratory disease in the UK in 1999–2000 (Lung Asthma Information Agency, 2001). Patients with respiratory problems account for 40 per cent of the total number of emergency admissions at Glenfield Hospital, Leicester.

The development of two respiratory nurse practitioner posts for the medical admissions unit was first conceived in May 2001 after it was recognised that patients were not receiving optimum care. It was realised that:

- Patients with respiratory disease were receiving fragmented care;
- Patients were experiencing delays in investigations and treatment;
- Care did not always follow nationally agreed guidelines;
- Patients were not able to access specialist care when they had been inappropriately placed in medical beds.

The nurse practitioner role was established to tackle these shortcomings as well as to help meet government targets to reduce waiting times in A&E as outlined in The NHS Plan (DoH, 2000).

Objectives The aim of the new service was to ensure the highest possible standard of care for patients with respiratory disease.

We anticipated that early triage, assessment, investigation and treatment would ensure high-quality, evidence-based health care. This would improve the patient’s treatment journey and reduce the time spent in hospital. The aims of the respiratory nurse practitioner role are listed in Box 1.

Role of the nurse practitioner The nurse practitioner adopted the title respiratory nurse specialist (RNS). Patients admitted to the medical assessment unit (MAU) with a provisional diagnosis of respiratory disease are now triaged and assessed by the RNS.

Triage involves a thorough, holistic assessment of patient needs, encompassing medical and nursing models. The RNS needed a number of additional skills in order to complete thorough triage (Box 2).

Patients who are previously known to a respiratory consultant or have a confirmed or likely diagnosis of respiratory disease may be fast-tracked to the ward. This allows patients to be moved immediately after assessment by the RNS without the need for further medical review on the MAU.

Developing the nurse practitioner role in respiratory care

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<td>Nurse practitioner</td>
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**Box 1. The Aims of the Respiratory Nurse Practitioner Role**

- Triage and prioritising patients admitted with breathlessness
- Rapid and appropriate assessment of patients admitted with respiratory disease
- Instigation of necessary investigations
- Initiating timely and appropriate treatment, including non-invasive ventilation (NIV)
- Identifying patients for transfer to a respiratory ward or the early discharge team

References

REFERENCES

SUPPLEMENT

RESPIRATORY CARE DEVELOPMENT

EDUCATION AND TRAINING

As with many new roles in nursing, access to clinically credible training is often a problem. Although both RNSs had a wealth of previous respiratory experience they needed to acquire the more specific skills necessary for the post. There was therefore an initial period of training when appropriate policies and guidelines to support clinical practice were developed.

Both nurses felt strongly that all training should be supported by comprehensive teaching packages and competency-based assessment. The nurses therefore wrote all appropriate documentation and spent about three months gaining skills and being assessed. By the time the service began in January 2002 the nurses had developed an extensive repertoire of additional clinical skills. The start date was timed to coincide with a geographical move and expansion of beds on the MAU.

BOX 2. ADDITIONAL SKILLS REQUIRED BY THE NURSE PRACTITIONER

- Venepuncture
- Venous cannulation
- Administration of bronchodilator medication, oxygen, and oral corticosteroids using patient group directions
- Ear lobe capillary/radial artery puncture
- Interpretation of arterial blood gas results, and initiation and titration of appropriate oxygen therapy
- Requesting chest radiography and identification of acute changes on the X-ray
- Spirometry
- Auscultation and chest examination
- Application of non-invasive ventilation and continuous positive airway pressure (CPAP)
- Heaf testing (to diagnose tuberculosis)
- Referral to appropriate services, for example asthma nurse specialists, lung cancer nurse specialists, respiratory early discharge scheme, and pulmonary rehabilitation

Both RNSs maintain a personal portfolio that includes:
- A reflective diary;
- Details of study time and courses attended;
- Policies and competency-based training packages in support of the additional expanded role;
- Records of formal assessment;
- Professional development plans and key objectives that are set at annual appraisals.

OUTCOMES

Initial outcomes for the service have been positive, and a detailed formal study is currently being undertaken. Concurrent audit data collected on a daily basis has demonstrated increased numbers of patients placed in appropriate respiratory beds, more appropriate referral to other respiratory specialists (for example, asthma nurses), more appropriate investigation of patients, and rapid initiation of treatment.

WAITING TIMES

The average time taken to be seen by an RNS was 14 minutes with the majority of patients being seen within 10 minutes of arrival. This is in contrast with the average time to be seen by a senior house officer (SHO) of one hour 10 minutes, with the majority of patients waiting a minimum of two hours to be seen.

BENEFITS TO OTHER STAFF

All staff on the unit are happy with the role and the SHOs find it particularly useful when there are many patients to be seen.

BENEFITS TO PATIENTS

Patients seen by an RNS receive care that is based on nationally recognised guidelines. Respiratory consultants have reported that patients receive optimal treatment and care.

Although this is a relatively new role there already appears to be a positive response from patients regarding their treatment journey. Qualitative data from patient interviews supports this. Patients felt they received more rapid and appropriate care from the nurse specialists. They described increased confidence in the skills and knowledge of the nurse specialists, they felt more able to express concerns and fears, and they felt that they received better understanding and empathy for their condition.

CONCLUSION

Patients are seen more rapidly and receive timely and optimal treatment. The RNS is able to spend more time with the patients to answer specific questions related to respiratory disease, lifestyle management, and ways to cope with chronic illness. There is a marked improvement in the patients’ treatment pathway, while also providing better utilisation of acute medical beds.