Empowering advanced practitioners to set up nurse led clinics for improved outpatient care

One stop outpatient clinics led by nurse practitioners have a positive impact on care. A hospital urology department encouraged nurses to take initiatives forward with the support of urology consultants, hospital matrons and business managers. Working collectively as a team, we introduce changes in practice.

INTRODUCTION
Nurse practitioner led outpatient care has a positive impact on quality of care (Loftus and Weston, 2001), improves patient experience and offers role development for nurses.

Nurses working in nurse led clinics are called upon to demonstrate elements of advanced practice, carrying out detailed physiological assessment, care planning and medicines management, as well as delivering treatments and monitoring patients’ conditions (Hatchett, 2003).

Lipley (2001) found that nurse led clinics provide more efficient outpatient care while cutting waiting times. It is not surprising that this method of organising care is now accepted by medical staff and managers as an alternative to traditional consultant led systems of care.

THE PROCESS
Queens Hospital opened a designated urology department in 2001. At that time the majority of work in the department was consultant led.

Over the past eight years, we have implemented changes to meet the constant challenges of ensuring patients are assessed, diagnosed and treated within specified waiting times. These targets appear to have developed into an evaluation tool for measuring individual hospital performance in the NHS (DH, 2009; 2007a).

It has become essential to empower appropriately qualified nurses to undertake a wider variety of clinical tasks to make the department a predominantly nurse led service. This enables a sustained improvement in nurse practitioners’ (ANp) skills, which then frees up time for the urological consultants to meet clinical demand and provide medical expertise in other areas of complex patient diagnosis/treatment.

New ways of working are discussed at monthly urology team meetings, and senior nurses in the department take initiatives forward with the support of urology consultants, hospital matrons and business managers. Working collectively as a team, we introduce changes in practice.

Within the urology department is a facility for postoperative urology/gynaecology patients who are deemed medically fit for discharge to undergo trial without catheters (TWOC) before going home. This has helped to free up inpatient beds, resulting in a reduction in cancelled operations.

As part of the service redesign, we have redefined the ANp role to include the following diagnostic interventions:
- Performing prostate biopsies;
- Ordering diagnostic and staging radiological investigations;
- Consent for certain diagnostic procedures;
- Independent nurse prescribing.

Implementing the nurse-led clinic has been an ongoing process that has met numerous challenges along the way, such as writing business cases.

Throughout the process, we have networked with urology colleagues across the country to find evidence that nurse led services are successful, benefit hospitals financially and provide a more streamlined service for patients (James and McPhail, 2008; Lipley, 2001).

TRAINING
The Nursing Midwifery Council (2005) stated that “advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist”.

Throughout the process of developing nurse led services, it has been necessary to review the skills and knowledge of all nursing staff and to develop these skills according to the department’s needs.

This has involved developing training packages that are competency based and signed off by a designated mentor; for all ANP training, a urology consultant has acted as mentor. This has enabled us to achieve a high standard of safe practice.

Primary responsibility for the governance of new roles designed to meet the needs of service provision should rest with employers and commissioners; this is to ensure robust organisational governance arrangements to monitor clinical practice (Council for Healthcare Regulatory Excellence, 2009). This process has been adopted at Queens Hospital, where all advanced nursing practice must be authorised by the nursing professional forum committee, executive management team and trust board.

Cancer referrals
It became apparent that we were experiencing problems with meeting waiting time targets for patients referred with suspected prostate cancer. Working with the cancer service improvement team, we looked at ways of solving this problem.

We decided to implement a one stop suspected prostate cancer clinic, which meant that the two urology ANPs had to be trained and deemed competent to trunsrectal...
ultrasound sonography and prostate biopsy. Part of the training included visiting other urology departments that had already implemented such a service.

AUDIT
We have completed two audits: a patient satisfaction survey; and a comparison of the results of prostate biopsies taken by a urology consultant with those taken by the urology ANPs.

The clinical audit manager reviewed the audit/patient satisfaction survey details from an ethical perspective and felt it did not require research ethical committee approval. Clinical governance issues were also addressed; the professional forum committee discussed and approved all documentation.

The results demonstrate that both the ANPs’ outcomes are equal to those of their medical colleagues.

After the audit and patient satisfaction survey were presented, further discussions took place. It was decided that a multidisciplinary approach would be the most appropriate way to deal with our particular care pathway issues, in terms of reducing waiting times and meeting cancer target treatment times.

We have achieved this by running two clinics on the same day, the one stop prostate specific antigen clinic run by a urology consultant, and the nurse led prostate biopsy clinic (patients attending this clinic have already been seen by a urologist).

The setting up of these two clinics was an operational decision and the patient satisfaction survey focused solely on those who attended the one stop PSA clinic. Our intention was to gain opinions of the new clinic from the men who used the service.

The one stop clinic has been running since April 2009 and more than 120 patients have attended. A patient satisfaction survey showed extremely positive results.

We wanted to gain specific information on the experience and health outcomes. Some examples of survey results and patient comments are given below:

- Ninety-five per cent said they were completely prepared for the biopsy in terms of information provided at the consultation;
- Ninety per cent rated the quality of the one stop PSA clinic as excellent.

Patient comments included the following:

“Still staff very friendly – helpful and very courteous and very caring. Couldn’t have been better.”

“Excellent one stop prostate biopsy clinic is an excellent procedure. It saves extra appointments and gives immediate treatment when required.”

We all received some negative comments, which all focused on the environment, for example:

“The downside to my four visits was that I had to spend much time sitting in the passage which has to double as a waiting room.”

The survey has demonstrated patients who have attended this clinic feel we are delivering a high quality service.

THE FUTURE
To continue to achieve high levels of patient satisfaction, the team realise we need to run a successful, viable, cost-effective unit that provides high standards of care, responding to challenges and opportunities in the health service.

This can be achieved by reflecting on practice and looking at where improvements can be made (DH, 2008). However, this requires knowledge of commissioning to ensure we meet patients’ needs and treatment trends.

To achieve the above, nurses need to receive adequate continuing professional development opportunities and support from both senior nursing and medical colleagues. Looking forward, the urology team plans to introduce a training programme later this year so the two urology ANPs can learn how to perform flexible cystoscopies. At a number of hospitals, both locally and nationally, this has proved to be an effective and efficient use of the urology ANP role and will help us to meet the increasing number of patients needing this procedure.

A further project is based on the DH (2007b) initiative on implementing care closer to home, which will help reduce waits and delays and contribute to our meeting the 18 week pathway.

Our urology/gynaecology department has already successfully implemented a care pathway between primary and acute care for women with continence problems. We are engaging with business managers and primary care, looking at other clinics that could be taken out into the community. These could include:

- Lower urinary tract assessment clinic;
- Psychosexual counselling clinic;
- Prostate biopsy clinic.

The two urology ANPs have demonstrated that they can deliver an optimal service for patients in terms of better resource use, provide high quality care, shorter waiting lists for diagnosis and treatment, and fewer hospital visits, resulting in improved patient experience and health outcomes.

REFERENCES


