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EDITORIAL COMMENT

Re: Advanced care nurse practitioners can safely provide sole resident cover for level three patients: impact on outcomes, cost and work patterns in a cardiac surgery programme

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The pressure to challenge the traditional models of the cardiothoracic service provision has never been greater than now. The need to develop a workforce more suited to the future of cardiothoracic service delivery has been pushed to the forefront of organizational structures by a number of factors.

Within Europe, the traditional plethora of junior doctors is threatened by the implementation of the European Working Time Directive [1]. The work from Nottingham Hospital is ground-breaking within the UK and Ireland [2]. It sets the context for new ways of working that meet the need of modern training of the junior medical staff and underpins excellence in delivery for patients [3]. Additional driving factors of reduced number of suitable candidates to fill non-deanery training positions from within the UK and Ireland, the difficulties recruiting overseas doctors and the increasing reliance on locum staff that are expensive and of uncertain standards, have focused on the development of other members of the multidisciplinary team.

Planning for the deficit in service provision focused work within the Society for Cardiothoracic Surgery (SCTS) in Great Britain and Ireland as early as 2005, when joint work was undertaken with the Department of Health [4] and subsequently in 2007 with a national benchmarking survey documenting current and future policy for workforce development within the Cardiothoracic Speciality. It examined the practice implications for the strategic future of cardiothoracic surgical provision and sought the views of all professions involved in service delivery. Each unit within the UK and Ireland was asked to document their existing surgical, nursing and allied health professional (AHP) staffing structure and describes the roles of the AHP workforce involved in all clinical areas throughout the patient pathway. In a small number of units, the Advanced Nurse Practitioner role was being developed in the critical setting. Nottingham led the way. This development has been well received within the cardiothoracic speciality.

The survey aimed to reveal the range of solutions that had been adopted in 2007 and to help inform the speciality about how the service may be delivered in the future.

The conclusions suggested that service delivery demanded an expansion in the number of nurse practitioners who hold a qualification for non-medical prescribing, health assessment, patient examination and critical decision-making. The solution was that practitioners must have the knowledge, experience and decision-making skills to deliver expert care while working within the multi-disciplinary team throughout the patient journey. The vision was to create a seamless patient pathway that delivered care in a timely fashion. Surgeons who spent much of their day in the operating theatre could rely upon a consistent team of educated and experienced practitioners to deliver care throughout the day and release trainees to undertake the clinical experiences as set by the deanery.

The results also suggested that such a workforce would help to address national and local targets for cardiothoracic surgery,
develop a clinical career pathway and as such be a positive indicator for recruitment and retention of staff, which in today's National Health Service is a time-consuming and expensive undertaking [5].

The creation of such a workforce is not without challenges. The survey revealed a number of obstacles that would need to be overcome for the successful implementation both at national and local levels. These include the culture of the team and the institution. Would the workforce deplete the existing nursing cohort? This fear could be considered a threat but should not be a legitimate excuse for halting progress; the development of staff is a prerequisite of career development and a necessary part of our professional lives.

In 2010, a further SCTS survey was undertaken to document the degree to which strategic planning was being realized. It sought to review the number of AHP roles; their impact on the delivery of care and their education and clinical competencies. Sixty-two percent of units responded and the data show that 100% of these units had created a Nurse Practitioner and Surgical Care Practitioner team [6].

The Nottingham model sets the benchmark for the workforce within critical care and there has been an expanse of units with the UK and Ireland who have developed the service in other parts of the patient pathway. What is clear is that while there is a plethora of postgraduate courses for Advanced Practice, the degree to which they cover specialty knowledge and competency is not assured, it is often for the student and individual unit to determine the competence, and much of the work at the local level is of a very high standard. In the UK and Ireland, the SCTS has developed a national course that combines didactic lectures, wet labs and interactive workshops. However, to date, there is no generic cardiothoracic specialist examination to benchmark a standard and demonstrate competence for the individual, the speciality, the hospital and the public. There is a joint venture between the SCTS and the Royal College of Surgeons in progress to address this.

Interestingly the USA, to which Europe often looks, has disparate models of care. Geographical restrictions mean that many critical care units do not have resident surgical cover at night, with AHPs caring for the deteriorating patient with surgeon direction through telephone or video link. Opening the chest in an emergency situation is one necessity that has led to the American Critical Care Association to run the Cardiac Life Support course (www.csu-als.com). The European Resuscitation guidelines have been embraced across USA and within the UK and Ireland. They demonstrate a positive outcome for patients. Coincidentally, anecdotal evidence suggests that there is a reduction in the incidence of open chests and intuitively, an improvement in the care of the deteriorating patient.

It could be asked why a review of the workforce would be necessary in units where surgical cover is plentiful as it still is in some areas of Europe, but the Nottingham data demonstrates that a consistent team, correctly trained, improves outcomes. To those that argue AHPs cannot deliver the care of the cardiothoracic surgical patient, the Nottingham paper and the evidence emerging from the SCTS in the UK and Ireland and the USA would give clear evidence to the contrary.

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