Development of an RANP role, Acute Medicine

Emily Bury
RANP, Acute Medicine
Background

2010

National Acute Medicine Programme (NAMP) established in Ireland.

June 2013

Acute Medical Unit/Acute Medical Assessment Unit opened in St. Vincent's University Hospital, Dublin, Ireland.

March 2014

Business plan for ANP post approved and ANP candidate commenced (Graduate Certificate Advanced Nursing Practice). 2 clinical nurse managers appointed.

NAMP recommends the development of ANP posts with emphasis on independent assessment and development of treatment plans.

SVUH business plan which stipulated ANP role, acute medicine.

2015

A need for clinical nursing role models and development of acute medical nursing as speciality.

2017

Business plan for ANP post approved and ED Task force - Development of ANP model of care both in the ED and AMAU to assess.

17 ANP candidates
Change is like a planned journey into uncharted waters on a leaky boat with a mutinous crew.
The Acute Medicine philosophy of care – how does ANP role fit?

RANP can assess and manage an agreed caseload

- Be seen by Senior Doctor within 1 hour
- Reduce trolley waits
- Receive the right treatment, in the right place, without delays
- Multidisciplinary rapid response
- Better communication

RANP can assess and manage an agreed caseload
Where next?

• Collaborative approach
• Local implementation group
• Agree scope of practice/caseload
• Agree appropriate referral pathways
• Clinical supervision arrangements
Local Need

Audit of common presentations to the AMAU/AMU at SVUH

Common Presentations to AMU

- Other
- CCF
- I/E COPD
- Seizure
- Migraine
- UTI
- Pneumonia
- Collapse
- TIA

Number of presentations

0 5 10 15 20 25 30 35 40
Caseload

Winter month

In Depth Analysis

Cardiovascular (CV):

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage of CV conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient Ischaemic attack (TIA)</td>
<td>25%</td>
</tr>
<tr>
<td>Thrombophlebitis and thromboembolism</td>
<td>17%</td>
</tr>
</tbody>
</table>

Total 42%
Inclusion criteria – Symptom based

**RESPIRATORY**
- Acute SOB, Pleuritic chest pain, acute onset of cough

**CARDIO VASCULAR**
- Acute onset of symptoms of focal limb weakness, speech disturbance, visual field defect, unsteady gait and/or dizziness

**COLLAPSE**
- Syncope and falls
Exclusion criteria – Generic and specific

**RESPIRATORY**
RR > 28 RPM, SaO2 < 92% RA, GCS < 14/15

**CARDIO VASCULAR**
- Patients commenced on the stroke pathway in ED and/or NIHSS score greater than 4

**COLLAPSE**
Hemodynamically unstable
**Integrated DVT/AMAU Pathway**

**Confirmed DVT**

**Provoked DVT**
- Known risk factor which will resolve

  - If no contraindications consider Rivaroxaban
    - 15mg BD for 21 days followed by
    - 20mg OD for remainder of 3 months
    + Compression stockings (grade 2) for 2 years

  - If contraindications to Rivaroxaban
    - Warfarin therapy
    - Low molecular weight heparin until therapeutic on Warfarin (consider CIT referral)
    - Referral to Warfarin clinic
    + Compression stockings (grade 2) for 2 years

**Unprovoked DVT**
- No identified risk factor

  - If no contraindications consider Rivaroxaban
    - 15mg BD PO for 21 days followed by
    - 20mg OD PO ongoing
    + Compression stockings (grade 2) for 2 years
    - Thorough history and examination for malignancy – FBC, ESR, U&E, LFTs, Calcium, PSA (men>40), CXR. If abnormal refer for specific investigations
    - Discussion about life-long anticoagulation at this visit or a future OPD visit
    + Compression stockings (grade 2) for 2 years

  - If contraindications to Rivaroxaban commence Warfarin in LMWH
    - Warfarin therapy
    - Low molecular weight heparin until therapeutic on Warfarin (consider CIT referral)
    - Referral to Warfarin clinic
    + Compression stockings (grade 2) for 2 years
    - Thorough history and examination for malignancy – FBC, ESR, U&E, LFTs, Calcium, PSA (men>40), CXR. If abnormal refer for specific investigations
    - Discussion about life-long anticoagulation at this visit or a future OPD visit
    + Compression stockings (grade 2) for 2 years
Syncope algorithm

1. Evaluate Circumstance Prodomes During T-LOC Postdrome
2. Stabilise ABC. Check capillary glucose and reverse hypolycæmia
3. Comprehensive health history/OLD CART
   - Risk factors (CAD, CCF, syncope, valvular disease, family history of SADS, epilepsy)
4. Physical Examination, review of systems
   - ECG, orthostatic BP measurements if tolerated
5. Are there features to suggest a benign aetiology?
   - Lightheadedness upon standing
   - Physical Findings
     - Vital signs: Low BP, sinus bradycardia
     - CVS: HS normal
     - Resp: Clear
     - Neuro: no focal neurology
   - Investigations
     - Labs: FBC, u&es, Orthostatic BP and HR measurements
     - CT Brain*
     - Medication review
     - Neurally mediated syncope
6. Are there features to suggest a structural or arrhythmic cardiac aetiology?
   - Physical Findings
     - signs: ↓ systolic (20mmHg) and/or diastolic BP (10mmHg) on standing, sinus tachycardia on standing
     - CVS: HS normal
     - Resp: Clear
     - Neuro: no focal neurology
   - Investigations
     - Labs: FBC, u&es, Orthostatic BP and HR measurements
     - CT Brain*
     - Medication review
     - Orthostatic Hypotension
   - Physical Findings
     - Vital signs: rapid or slow HR, low or high BP
     - CVS: Added heart sound S3, murmurs, Aortic stenosis. +JVP, ankle oedema
     - Resp: Crackles
     - Neuro: no focal neurology
   - Investigations
     - Labs: FBC, u&es, TnT
     - CXR
     - 24 hour telemetry
     - ECHO
     - EST *
     - CT Brain*
   - Cardiac Syncope
7. Is there evidence to suggest that the T-LOC was a seizure?
   - Physical Findings
     - Vital signs: ↓GCS, normotensive, NSR
     - CVS: HS normal
     - Resp: Clear
     - Neuro: focal neurological signs, diplopia, limb weakness
   - Investigations
     - Labs: FBC, u&es, Ca, glucose
     - VBG: lactate, pH
     - EEG *"*
     - CT Brain +/- MRI
     - Brain *
   - Seizure
Memorandum of Understanding

between

Department of Speech and Language Therapy

and

Registered Advanced Nurse Practitioner Service, Acute Medicine

This Memorandum of Understanding (MOU) sets out for the terms and understanding between the Department of Speech and Language Therapy (SLT) at St. Vincent’s University Hospital, Dublin and the Registered Advanced Nurse Practitioner (RANP) Service, Acute Medicine to refer to the SLT service in the Acute Medical Assessment Unit and Acute Medical Unit within a defined and agreed caseload as outlined in the RANP Acute Medicine Job description.

Purpose:
The RANP Acute Medicine service includes a caseload that requires the input of the SLT service to ensure provision of optimal care and management of patients. This caseload includes patients complaining of respiratory conditions i.e. Pneumonia, COPD; cardiovascular conditions i.e. TIA and minor stroke, falls and collapse, and care of the frail older patient.

Reporting relationships for the RANP Acute Medicine:
The RANP Acute Medicine will be professionally accountable to the Director of Nursing.
The RANP Acute Medicine will be clinically accountable to the Consultants Acute Medicine

Indemnity:
Indemnity arrangements for the post and service are provided by the State Claim Agency’s Clinical Indemnity Scheme; the Registered Advanced Nurse Practitioner, Acute Medicine works within a defined and agreed scope of practice and in accordance with approved protocols, policies, procedures and guidelines (PPPGs) and clinical supervision arrangements.

Head of SLT Department,  
Acute Medical Consultant,  
Interim Director of Nursing,
Virtual clinic

• nurse led AMU virtual clinic
• interpretation of agreed diagnostic tests and acting on results, supported by the AMU consultants.

• Benefits
• safe discharge, reduction in length of stay, re admission avoidance, reduction in outpatient clinic reviews and the improvement in communication with primary care.
Other benefits to ANP service in Acute Medicine?

CLINICAL PRACTICE
- Reduce PET times & trolleyGAR
- Expedite diagnostics and initiation of tx plans
- Initiate safe discharge planning

LEADERSHIP
- Implements change in health service delivery
  - Mentorship, teaching and perceptorship

RESEARCH
Non clinical time for research
-- Audit of clinical practice to shape local service
Figure 1 Key themes and sub-themes.
Key Performance Indicators

- In alignment with NAMP targets
- Including patient satisfaction with RANP Service
COMPETENCY ATTAINMENT

Alas, a perfect portrait of my social calendar as a nurse practitioner student.
Competency attainment

- Clinical attachments in relevant specialities
- Formative case based discussions
- Clinical and professional mentorship
- Academic education and conferences
**Candidate name:** Emily Bury

**Assessor:** DA Oala

**Grade of Assessor:** Conjoint

**Date:** 24/11/16

**Case Discussed (brief description):** Acute confusion in elderly man. 

**Diagnosis:** Delirium secondary to dehydration

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**Please TICK to indicate the standard of the Candidate's performance in each area**

<table>
<thead>
<tr>
<th>Area</th>
<th>Not observed</th>
<th>Further care needed</th>
<th>Demonstrates good practice</th>
<th>Demonstrates excellent practice</th>
<th>Should address learning points highlighted below</th>
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</thead>
<tbody>
<tr>
<td>Record Keeping</td>
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<td></td>
<td></td>
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<tr>
<td>Review of investigations</td>
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<td>Diagnosis</td>
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<td>Treatment</td>
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<td>Patient safety issues</td>
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<tr>
<td>Overall clinical care</td>
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</tbody>
</table>

**Things done particularly well**
- Identifying delivery in context of delirium
- Use of antibiotics as per SGM and microbial guidelines

**Learning points**
- Screening for delirium - 4 AT pathway

**Action points**
- Educate on activity pathway
- Education/review 4 AT pathway for screening delirium in elderly patients

**Assessor Signature:** [Signature]

**Trainee Signature:** [Signature]
National Strategy RANPs, Acute Medicine

• Currently aiming to establish ANP services within AMAUs with 17 candidates commencing posts.

• ANP forum - Establish support network for candidate ANPs and identify learning and service needs.

• AMNIG work closely with ONMSD and DoH and demonstrator sites.

• Vision to create further posts nationally.
SVUH - the future

- 2 candidate ANPs commencing post (+ 1 candidate ANP with defined respiratory caseload)
- Extended working day
- Access (GP referral, pathways from ED)
- Nurse led clinics (ie VTE clinic)
- Protected non clinical days for research/audit/ quality initiatives and continuous review of service needs
APRIL...

NOT SURE IF IT'S A MONTH OR AN ACE INHIBITOR