Understanding the role of the Sepsis nurse

Implications for Practice

Professor Mark Radford
Chief Nursing Officer
UHCW

- 1400 beds
  - Two sites

- Regional centre
  - MTC, Cardiac, Neuro, Transplant

- Teaching hospital with Warwick Medical School

- £525m

- Circa 8100 staff
  - 600 Consultants
  - 2800 Nursing staff
UHCW Vital Stats

• Emergencies  185,000
• Surgeries    45,000
• Outpatients  577,548
• Admissions   138,588
• Babies born  6,031
The problem

"Wonderful" Coventry mum died - because hospital forgot antibiotics

Wednesday 21 September 2011

The Telegraph

Girl at £24,000 a year Rugby School dies of meningitis

A 17-year-old girl at £24,000-a-year Rugby School in Warwickshire, one of the UK’s top independent schools, has died of meningitis.

9:41pm BST 08 May 2009

Health News

The teenager, who has not been named, collapsed at the school on Wednesday afternoon and was rushed to hospital but died hours later.

She was studying her A-Levels at the school, which has 1,136 pupils aged 11-18.

Patrick Derham, headmaster at the school, said: "It is with great sadness that we have to report the death of a pupil from meningococcal septicaemia.

We are extremely sad and shocked by the loss of one of our pupils. Our thoughts and prayers are with her family and friends.

She was in the final year at the School, full of energy and life with much to look forward to. A lovely friend and highly regarded member of the school community, her loss will be felt by us all."

He added that the school was open as normal and pupils who had come into contact with the girl were being treated with antibiotics.

Earlier this month Sebastian Coe attended the school and unveiled a plaque to honour former headmaster Thomas Arnold who played an important role in creating the Olympics.

Last year Prince Edward also visited the school to open a refurbished science block.
Management of Sepsis

Sepsis is the body’s response to infection. Normally, the body’s own defence system fights infection, but in severe sepsis, the body’s normal reaction goes into overdrive, setting off a cascade of events that can lead to widespread inflammation and blood clotting in tiny vessels throughout the body. Sepsis can have a devastating outcome for patients and their families and carers, it is vital that we heighten awareness of the signs and symptoms of sepsis and continue to aid the clinical staff in recognising and managing the septic patient.

Why is it a priority?

The Trust had a serious incident that went to the Coroner’s Court in 2010; following this the Trust undertook a major review of its processes for the management of sepsis. Whilst there is an established, appropriate Trust clinical guideline it was clear from the evidence that a campaign was required to really embed the principles into the organisation.

What improvements will we make?

- Make the sepsis pathway documentation more readily available and easier to file within the health records.
- Develop the process for timely communication of results from Pathology to Doctors and Nurses.
- Develop clearer lines of responsibility for patients who are released from the resuscitation area.
- Introduction of the use of “score to door” times. These may be useful to measure response times when patients trigger parameters that suggest severe infections. Once this information is collected regularly the data can be used to assess the impact of further initiatives and changes in practice and delivery of care.

Where can I get further information?

UHCW Clinical Leads: Duncan.Watson@uhcw.nhs.uk, Kieran.Flanghan@uhcw.nhs.uk

Surviving Sepsis campaign website; http://www.survivingsepsis.org
The sepsis six and the severe sepsis resuscitation bundle: a prospective observational cohort study

Ron Daniels,¹ Tim Nutbeam,² Georgina McNamara,¹ Clare Galvin¹

ABSTRACT
Background Severe sepsis is likely to account for around 37,000 deaths annually in the UK. Five years after the international Surviving Sepsis Campaign (SSC) care bundles were published, care standards in the management of patients with severe sepsis are achieved in fewer than one in seven patients.

Methods This was a prospective observational cohort study across a 500-bed acute general hospital, to assess the delivery and impact of two interventions: the SSC resuscitation bundle and a new intervention designed to facilitate delivery, the sepsis six. Process measures included compliance with the bundle and the sepsis six; the outcome measure was mortality at hospital discharge.

In recognition of poor compliance, we developed an operational solution reflective of NHS practice to improve delivery of the bundle. The ‘sepsis six’, ⁸ (box 2) is designed to facilitate early intervention with three diagnostic and three therapeutic steps to be delivered by staff within 1 h. The tasks were identified from those poorly performed in our initial gap analysis. After the accompanying education programme, survive sepsis, ¹⁰ reinforces that failure of a patient to respond to the sepsis six (persistent evidence of hypoperfusion) mandates immediate referral to critical care to complete the remaining elements of the resuscitation bundle (ie, EGDT).

The sepsis six, endorsed by SSC, has been widely implemented.
Methodology

- Ethnography
- Peripheral membership role.
- Artefacts
- Process

- 29 ANP, 49 Drs (7 Teams)
- Observation (150 hours)
- Interviews 21 (15 hours)
- Artefacts (99 Documents)

- Three Hospitals
  - District
    - 500 bed DGH
  - Urban
    - 1000+ bed inner city teaching trust
  - Metropolitan
    - 1000+ bed University Teaching Trust
Data Management

Interviews
- 35 – 60 mins
- 3-5000 words per transcript
- 3 – 8 interviews
Changed relationship

- Primarily between Consultant and Junior
  - Service drivers and target culture of NHS
  - Societal position of medicine
  - Changes to the training of Junior Doctors

- Impact on Nursing
  - Development of the ANP role
  - Expectation transfer from Junior Doctor to ANP
Drivers for Change

Medical & Nursing

• Nursing Changes
• Medical Changes
• Experience
• Service Delivery models

‘in the early '80s when I qualified there was already push for change and that the nurses were beginning to say there's more to this than just bed pans ........ the nursing structure in the '70s and '80s was still very rigid ........I think, a lot of intelligent nurses began to ask questions and when people start questioning the structure begin to break down.’

Consultant Surgeon, Interview
Changed relationship

“Do you think the outreach nurses are primarily a replacement for the house officers then?” He smiles and turns to me and says, “Primarily, yes”. To which Nurse B responds, “Bloody House Officer, I think I am more like a registrar.”

– Observation Conversation – consultant Anaesthetist & Outreach Nurse
A new model of interaction
The Division of labour

Micro Division of Labour

- Practitioner
  - Hierarchical/family codes
    - Artefacts
    - Care model
    - Clinical Care
    - Decision making
    - Labour
    - Skills

- Teacher
  - Hierarchical/family codes
    - Artefacts
    - Clinical Care
    - Decision making
    - Knowledge
    - Teaching
    - Skills

- Leader/Follower
  - Hierarchical/family codes
    - Artefacts
    - Care Model
    - Clinical Care
    - Decision making
    - Delegation
    - Labour
    - The team

Medical | Nursing | Tasks | Knowledge | Resources | Process

University Hospitals Coventry and Warwickshire NHS Trust
<table>
<thead>
<tr>
<th>Delegated Task</th>
<th>Descriptor</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Redundant Medical</strong></td>
<td>Redundant tasks were those no longer seen as valuable to the doctor to perform as they were classed as lower order. These were the tasks most often performed by the junior doctors.</td>
<td>Examples include cannulation, venepuncture and catheterisation</td>
</tr>
<tr>
<td><strong>Technical Medical</strong></td>
<td>Technical tasks were those of a higher skilled nature, and valued by the nurse as they supported their position within the team (compared to junior doctors who were unable to perform them). They were often taught to them by the consultants.</td>
<td>Examples include PIC, CVP, arterial lines. Ultrasound scanning.</td>
</tr>
<tr>
<td><strong>Adapted Medical</strong></td>
<td>Adapted Medical were broader responsibilities that were conducted by all members of the clinical team. However, they were adapted from traditional medical practice to form a core function of the specialist nurse.</td>
<td>Examples include history taking, examination, diagnosis and ordering tests and investigations such as radiology tests</td>
</tr>
<tr>
<td><strong>Professional Medical</strong></td>
<td>Professional tasks, were those which crossed the traditional professional role.</td>
<td>Examples would include conducting assessments on junior doctors, conducting audit on the medical process or outcomes. Clinically, they would also include elements of care that would be the domain of the doctor patient relationship such as giving diagnosis, prognosis and referral.</td>
</tr>
</tbody>
</table>
ANP Credibility

• Nurses have to ‘prove’ their knowledge and skill through:
  • Advising and supporting in clinical practice
  • Challenging in clinical scenarios
  • Regular feature each 4 – 6 months

• Nurses find this frustrating but accept the position
• Complicit behaviours of Consultants
  • Let the conflict play out
  • Establishing territory and domain
ANP Credibility

• ‘you think to yourself, hang on a minute, he’s right, why the hell do I have to prove myself to them, when actually I’ve got more knowledge than they have! [Laughs] But I still do it, but I think it possibly is because I’ve no badge that says doctor.’

• - Interview Nurse Practitioner
Expectation of the teaching role

- Both informal and formal
  - Bedside
  - Classroom (inc Development & delivery)
  - Assessment of competence

‘you are quite often [teaching] in the ward environment, you are teaching them [Dr’s] informally in why you are doing things and maybe blood gases and care of central lines, sometimes we get called to help with things that they have no experience with.’

Interview Critical Care Outreach nurse
Expectation of the teaching role

• Both informal and formal
  • Bedside
  • Classroom (inc Development & delivery)
  • Assessment of competence

• Explicit in Job descriptions
• Differences between grades of Doctor
• ‘Medical gaze’
  • Controlling the ‘quality’ or regime
  • Delivering productivity and performance of junior medical staff.
Expectation of the teaching role

• ‘I mean, I think, when they first come to A&E as an junior doctor, they want to learn, so they’re all really like, yes, we’re going to listen and they’re told by the consultants, this is X the nurse practitioner, if you want to know anything, you should just go and ask and he’ll try to do it.’

• Interview Nurse Practitioner
Task vs Theoretical teaching

- Consultants see nurses as task-orientated, therefore:
  - Good on skills transfer
  - Protocol supported practice
  - Tasks no longer seen as ‘medical’

‘I think one of the ideas we have … I suppose to get used to working with nurses as opposed to doctors is nurses tend to work much … or feel much more comfortable with protocols and guidelines.’

Interview Consultant Surgeon
Task vs Theoretical teaching

• Consultants see nurses as task-orientated, therefore:
  • Good on skills transfer
  • Protocol supported practice
  • Tasks no longer seen as ‘medical’

• Informal teaching labelled as ‘advice’
  • Maintain the medical veto
  • An acceptable form of ‘teaching’ without upsetting the natural order

• Paradoxical medical frustrations with specialist nurses
Task vs Theoretical teaching

- ‘I think they're quite clear and may write in their notes what they think you should do, but they always… it's up to you whether you follow their advice or not.’
  - Interview FY1

- ‘that's one of the frustrations that doctors have with nurses, is where to draw the line between the edge of the guideline and when it gets fuzzy. And then the guidelines are interpreted as rules that can't be broken, that when you can get conflicts.’
  - Interview Consultant
Credibility

- Nurses have to ‘prove’ their knowledge and skill through:
  - Advising and supporting in clinical practice
  - Challenging in clinical scenarios
  - Regular feature each 4 – 6 months with Junior doctor rotation
Conflicts & Challenges

- Credibility and ‘usefulness’ of the specialist role to junior doctor
  - Access to knowledge, skills and seniors

- Specialist Nurses utilise clinical experience and up to date knowledge from Consultants –
  - Brings its own challenges of acceptance by juniors.
Conflicts & Challenges

‘So we get … the change happens every four months now, you get often very inexperienced trainees coming into this set up and, I think, we're getting more used to it now, but, we often found it quite difficult.

I know we had a Reg a few years ago, he really was uncomfortable with the idea, in a sense, that these nurse specialists knew more than he did. And so they were treated in a more responsible way.’

– Interview Consultant
Conflicts & Challenges

• Acceptance by Juniors

‘[Following advice from CNS]… you're just coming in and writing it out and you're not taking it in rather than if you had to think about it and look things up yourself and talk to patients yourself you would probably get more experience’

– Interview FY1
Conflicts & Challenges

• Decision making

‘…….yes conflicts do occur, ‘decisions are made by me and some junior doctors do not like it. Others are very good and support both me and my decision. ‘ Observation Discussion with Practitioner

• ‘Easy life’

‘I mean they're better at it because they're experienced and they can draw the patient out and make sure they find out all of their worries and concerns, but I think that's something that we should maybe be learning to do.’ – Interview FY1
INTENTION
• Knowledge
• Decision
• Decision confirmation
• Challenge
• Political
• Social
• Delegation
• Referral

Approach Method
• Proxy
• Team/Group
• Individual

Context
• Problem complexity
• Space / Domain
• Profession expectation
• Rules

Transactions Types
• Verbal
• Non verbal
• Written
• Electronic

Influences
• Organisational Culture
• Previous experience
• Personality
• Emotion
• Status

Transactions Types
• Verbal
• Non verbal
• Written
• Electronic

1o
2o
3o

Influences
• Organisational Culture
• Previous experience
• Personality
• Emotion
• Status

Context
• Problem complexity
• Space / Domain
• Profession expectation
• Rules

Approach Method
• Proxy
• Team/Group
• Individual

Outcomes

Pre Game
Intra Game
Post Game

University Hospitals
Coventry and Warwickshire
NHS Trust

Together Towards Worldclass
Intention [knowledge & confirmation - duality]

‘a junior doctor (SHO) walks in with a set of patient notes and offers a drug chart to Nurse A and says “What about the treatment?” [shows him part of the drug chart which is actually blank.]

Nurse A then goes through the drug chart listing each individual drug and the doses and then explains in some detail why he does not think a beta-blocker is helpful.

Researcher Observation
‘….. at 10.45 the medical doctor (SHO) arrives. Nurse A then describes the three patients that are in the department and identifies “Can you clerk these patients, as I’ve got another one to see?”.

Researcher Observation
Approach Style [Proxy]

They’d call the Consultant a bit like calling daddy in to tell the child off, that happens a bit. Which is fine but it’s interesting that they’re… it’s almost as if, if you don’t do as you're told, I’ll get the Consultant in to tell you off.

Consultant Interview
...kind of get round it just by, again, playing stupid, play a bit innocent and do it that way.’

CNS interview
Pre Game Strategy

‘I’m aware that I’m not confident they do sometimes, even now, still make me feel a little bit intimidated.

………. I kind of go with that and then I’ll think so what will his response be, so I’m kind of almost ready to have whatever thrown at me…

CNS Interview
Game Play

‘I always think if you act a bit kind of like …..‘oh I’m really struggling, could you just help me out’ and I do play terribly on the ‘I’m so sorry to disturb you’ ………..

CNS Interview

Transactions Types
- Verbal
- Non verbal
- Written
- Electronic

Pre Interaction Rehearsal → Interaction → Outcomes

1o
2o
3o

Intra Game

Post Game
I could see how some [nurses] would feel more comfortable in a hierarchical situation because they will... they always know where to go to in the event of... or there’s a responsibility issue in terms of, you know, the buck stops with the Consultant, type of thing.
Transactions [Written]

• ‘I think they write quite a lot and it’s a mixture of feelings and information to back up why they feel that way, rather than this is my opinion which is... I think it’s very reasonable. I don’t think it’s a bad thing.’

Consultant Interview
Interpreting ANP Knowledge

Nursing Knowledge

Novice
Scientific knowledge
Experiential Learning
Personal knowledge
Expert
Interpreting ANP Knowledge

- Sociology
- Psychology
- Nursing
- Biomedical

- Medical Knowledge
- Core Nursing Knowledge
- ANP Knowledge
Questions
Contact details:

Professor Mark Radford
Chief Nursing Officer
University Hospital Coventry & Warwickshire NHS Trust
Clifford Bridge Road
Coventry
CV2 2DX

Email : mark.radford@uhcw.nhs.uk
Tel: 024 7696 4000

UHCW_ChiefNurse