

In this article...

- Benefits of the presence of an advanced nurse practitioner in a care home
- Shared care model between an advanced nurse practitioner and GPs
- Role of nurses in recognising deterioration in care home residents

Employing an advanced nurse practitioner in a care home

Key points

There are growing numbers of advanced nurse practitioners (ANPs) in the UK but, so far, none has been employed by a care home

Employing an ANP helps provide more timely treatment to residents

Other advantages are continuity of care and on-hand resident follow-up

An ANP works in a shared-care model with GPs as expert generalists

The ANP relies on nursing skills in recognising residents whose condition is deteriorating

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Abstract Advanced nursing practice has developed in the UK since the late 1980s and there is a growing number of these nurses in various healthcare settings – so far, however, none is employed directly by a care home. In 2017, the Scottish veterans' charity Erskine appointed an advanced nursing practitioner (ANP) for two of its care homes. The ANP works in partnership with the homes' nurses and the local GP practice, treating and assessing some without GP input. The model is that of shared care, with GPs focusing on their role as expert generalists. Having an ANP on site speeds up residents' assessment and treatment. This article describes the initiative, its aims, processes and outcomes so far.

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In 2017, Erskine, a veterans' charity in Scotland, recruited an advanced nurse practitioner (ANP) for two of its care homes with the aim of providing a rapid on-site response to residents' health problems. This article reports on the initiative, describing its aims, processes and outcomes so far.

Advanced practice

Advanced nursing practice has existed in the UK for over 30 years (Halliday et al, 2018; Gilfedder et al, 2010; Elliott, 1995). An ANP is a nurse with extended clinical knowledge and skills – the role however is not registered with the Nursing and Midwifery Council. In many settings, ANPs deliver 24-hour care, sometimes replacing junior doctors (Halliday et al, 2018; Gilfedder et al, 2010). The opportunities for advanced nursing practice are growing (Barton et al, 2012; Pearson, 2011).

In Scotland, the vision for ANPs was set out in a strategic paper on transforming nursing roles (Scottish Government 2017),

which specifies that “advanced practice represents a level of practice rather than being related to a specific area of clinical practice”. It defines ANPs as “experienced and highly educated registered nurses who manage the complete clinical care of their patients, not focusing on any sole condition” (Scottish Government, 2017).

Appointing an ANP at Erskine

Erskine provides care to 339 veterans and their spouses in four purpose-built care homes. Two of them, Erskine Home (180 residents) and Erskine Park Home (40 residents), are located on a single site in Bishopton, Renfrewshire.

The 220 residents of the two Bishopton homes are supported and cared for by nursing and care staff who are present 24 hours a day, seven days a week. Residents receive both short- and long-term nursing care (including dementia care) and residential care. Erskine Park Home cares exclusively for residents who have dementia.



In 2017, after having researched areas in the NHS where ANPs are employed, Erskine decided to recruit an ANP for its two Bishopton homes. The appointed ANP, Jennifer Boyd (lead author of this article), has been a district nurse, a care home liaison nurse and a house manager at Erskine. She is also an experienced non-medical prescriber (NMP). Through a search of the nursing literature and enquiries to Scottish Care and Care England, we found evidence of ANPs employed by GP practices or trusts whose role includes visiting care homes, but no evidence of ANPs directly employed by a care home anywhere in the UK. In that respect, Erskine seems to be unique.

“At a time when there is concern regarding GP workload, employing ANPs in care homes could be part of the solution”

Shared care

Recognising a resident who is deteriorating and assessing them quickly is crucial in providing timely treatment and potentially avoiding an unnecessary admission to hospital. The aim of having an ANP on site is to ensure residents are assessed and treated more promptly.

The idea is not to replace GPs or stop involving them in the care of residents but, in some cases, the ANP assesses and treats patients without any GP input. The underlying philosophy is that of shared care: the ANP supports the nursing and care teams and, wherever possible, provides higher-level assessments and interventions; the GP, as the expert generalist, provides input into complex cases.

Other advantages of having an ANP on site is continuity of care for residents and continuity of support for staff. The ANP can follow up residents and ensure recommended treatments or interventions are correctly delivered and adhered to.

How does it work in practice?

One of the roles of the nurses at the care homes is to assess residents to determine whether they need medical care. Before the appointment of the ANP, if nurses found that a resident needed medical care, they would fill in a GP referral form and either:

- Add the person to the list of those scheduled to be seen by the GP at their next planned visit;
- Alert the surgery to request a doctor's visit if they thought the resident needed

more-urgent attention – this visit would usually happen within four hours.

In the new system, every morning at 8am, the ANP triages GP referral forms, deciding whether the residents:

- Can be assessed and treated by the ANP without GP input;
- Need a joint visit from the ANP and GP;
- Need to be referred directly to the GP (these referral forms are sent to the surgery at 8.45am).

Box 1 features a case study illustrating how the ANP's input can improve residents' medical care.

New referral forms

In collaboration with nursing staff in both homes, the ANP has developed a new GP referral form that uses the 'situation, background, assessment and recommendation' (SBAR) framework; this helps to clearly explain an individual's health problems and treatment needs to a third party.

Previously, GP referral forms were filled in inconsistently, with varying amounts

and quality of information. Some forms were completed extremely well, giving a clear clinical picture of the presenting symptoms and circumstances but others were rather patchy or vague. The SBAR method prompts nurses to provide adequate information and make recommendations about what they think the resident needs. This helps the ANP decide on the best course of action.

The ANP role is not designed to replace that of the registered nurse. Registered nurses still need to be able to make accurate and timely observations, assessments and decisions. Their role in recognising a resident who is deteriorating remains fundamental.

Training and supervision

The ANP role is managed by Derek Barron, director of care at Erskine (co-author of this article), who ensures policy and clinical standards are met. The two Bishopton care homes are covered medically by the same GP practice and the GPs have allowed

Box 1. Case study

Nursing staff at The Erskine Home are concerned about Bill Fraser,* a resident aged 83, who has become 'out of sorts' over the last 24 hours, having being seen by a GP and put on oral antibiotics for a suspected chest infection. One of the nurses assesses Mr Fraser and records mild tachycardia (100bpm), hypotension (110/65) and pyrexia (38°C). He has also started having rigors. That evening, the nurse submits a new GP referral form for the ANP to review.

The following morning, the ANP reviews the referral form and reads Mr Fraser's notes on the care home's online system. His care plan specifies that he has said he wants to be transferred to hospital if required (unlike many residents who do not wish to go to hospital). From the latest notes, she also sees that Mr Fraser has continued to deteriorate overnight.

The ANP arrives at Mr Fraser's bedside within 20 minutes of reading the referral form and his notes; she finds him sweating, hot to touch, confused and very drowsy. On assessment he is tachycardic (128bpm), hypotensive (97/58) and, despite having been given 1g of paracetamol one hour earlier, pyrexia (38.7°C). At that stage, the diagnosis is suspected sepsis.

The ANP takes blood samples to check infection markers and discusses different options with the nurse in charge and Mr Fraser's family; this includes emergency admission to hospital but the ANP thinks Mr Fraser should be seen by the GP. The GP is telephoned and after a discussion with the ANP, the decision is made to keep Mr Fraser at the care home until the blood test results come through, to ensure he is not admitted unnecessarily.

Two hours later, the local hospital gives the blood test results to the GP by telephone. Inflammation markers are high, so Mr Fraser is taken to hospital by ambulance as an emergency. He is treated with intravenous antibiotics and fluids for urosepsis. After three days on an acute medical ward, he returns to the care home, where he remains on oral antibiotics for a further five days.

Before the ANP was in post, the GP would have visited Mr Fraser at the care home, requested blood tests for the next day and then arranged for transfer to hospital. The ANP's input has resulted in Mr Fraser being admitted and treated much earlier than would otherwise have been the case and, consequently, he was able to return home more quickly.

*The resident's name has been changed.

Clinical Practice Innovation

Table 1. GP referral forms ($n = 1,070$) and ANP activity data

Health professional	Referrals dealt with, n	Actual outcome	Potential outcome
ANP	245	11 were passed on to the GP due to prescribing limitations	
GP and ANP	512		499 could have been dealt with by the ANP if there had been no prescribing limitations
GP	313		37 could have been dealt with by the ANP if there had been no prescribing limitations

^aFebruary–November 2017. The data has been collated and analysed with help from the Information and Statistics Division of NHS Scotland

the ANP to shadow them during their visits, enabling her to develop her skills, knowledge and expertise.

NHS Ayrshire and Arran plays an important part in supporting and developing the role, giving the ANP access to education, training and networking opportunities. She has attended a regional induction course for ANPs, is in contact with a number of ANP colleagues in the region and has spent time at University Hospital Ayr's emergency department and East Ayrshire Community Hospital. Crucially, the ANP receives ongoing support and supervision from Laura Maule, nurse consultant at NHS Ayrshire and Arran (co-author of this article).

“Having an ANP on site benefits residents”

With funding from the Scottish Government, Jennifer Boyd has undertaken an MSc in advanced practice. Here, again, the input from Laura Maule and NHS Ayrshire and Arran is invaluable: Jennifer Boyd spends some of her assessed ‘clinical hours’ in Ayrshire, with the remainder assessed by Derek Barron at Erskine.

Prescribing issues

Although Jennifer Boyd is an experienced NMP, she cannot currently use her full prescribing skills. This is because the new role has created a problem for the local GP practice regarding indemnity insurance. The practice and its insurer were concerned about accountability, as the ANP was using a prescription pad with its practice number on it. Although the ANP has remained unable to prescribe, Erskine was able to source its own indemnity insurance if the issuing of a prescription pad could be resolved.

QUICK FACT
234 Cases dealt with by the ANP without GP input in a 10-month period

A pragmatic approach to prescribing was adopted, which involved developing a restricted medicines formulary upon which all could agree. For example, common medications such as amoxicillin, lactulose and co-codamol were included in the ‘green’ area and could be prescribed without consultation with another health professional, whereas hyoscine butylbromide (Buscopan), oral morphine and midazolam were in the ‘amber’ area, meaning they were only available after discussion with a GP. The purpose of this approach is that when a resident needs a drug that the ANP cannot prescribe, the case will be passed on to the GP, either immediately after triage or after the resident has been seen by the ANP.

Outcomes

Data on the involvement of the ANP in residents’ medical care is being continuously collected and reviewed. Table 1 shows what actually happened and the potential future outcomes if the ANP is enabled to prescribe. It summarises data for 10 months (February–November 2017) when the ANP was still unable to prescribe. In that period:

- 1,070 GP referral forms were submitted to the ANP for triage;
- The ANP dealt with 245 cases in the first instance, of which 11 had to be passed on to the GP due to the ANP’s limited prescribing rights – as such, 234 cases were dealt with by the ANP without GP input;
- In 512 cases, the ANP and GP did joint

visits; however, if the ANP had been able to prescribe independently, she could have dealt with 499 of these cases without GP input;

- The GP dealt with 313 cases; however, if the ANP had been able to prescribe independently, she could have dealt with 37 of these without GP input.

The issue of the ANP being unable to prescribe has been resolved by the local health and social care partnership (rather than the GP practice) issuing a prescription pad.

Conclusion

The ANP is not designed to replace the GP, who retains a critical role in residents’ care. There is little doubt, however, that having an ANP on site benefits residents, as they have more-rapid access to higher-level assessment and decision making, as well as better continuity of care and follow-up. It is also clear that the current ANP, now that she is able to use the full extent of her prescribing abilities, further reduce the reliance on GP visits, thereby freeing up time for GPs to focus on more-complex cases, therefore fulfilling their expert generalist role. At a time when there is a great deal of concern about GP workload, our experience suggests that employing ANPs in care homes could be part of the solution. **NT**

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