Nursing contribution to Sepsis Management

Mark Radford
Chief Nursing Officer
SAM Event 2013
Simple question

- Can a nurse deliver sepsis management?

Yes / Maybe / No

Over my dead body
Crisis, What Crisis!

- Workforce, Workforce, Workforce!
  - Increase in demand due to increasing medical advancements
  - Increasingly elderly population
  - Significant decrease due to EWTD and early retirements,
  - A small increase in supply from within medical workforce immigration and increased medical student numbers.

- Projected Need:
  - Acute Medicine (similar number??)
Can we have new roles?

- Diagnosis
- Prescribing
- Procedures
- Accountability
- Responsibility

- The question remains from central policy ‘can we’ rather than ‘should we’
- Argument that we are alone is not convincing.
Do Nothing

• Is the status quo an option?
  – Continue with current model, clearly distinct professional and practice boundaries.

• Has it been explored? – Probably not
• Should it be explored?
Task approach

• Specific tasks for specific groups of staff

• Clinical Exam

• Diagnostics

• Prescribing

• Procedures (EG)
  – Epidural/Neuroaxial blocks
  – IV, central and arterial lines placement
Task approach

- Epidural/Neuro-axial blocks
  - Several known examples of pilot sites
  - Early stages
  - ‘It is just a skill’, till something goes wrong.
  - Protocols may not be enough
  - Boredom
Enhanced traditional role

• Fulfilling a service gap left by a whole host of problems
  – Skills, knowledge and manpower

• Critical Care Outreach
• Perioperative Emergency Care
• Acute Medical Practitioners
• ED Practitioners
Challenging the Sacred Cows

Nursing Autonomy in clinical practice alongside Medical accountability

Change in culture to accept this information from a nurse!

Coordinating Medical consultants activity.

Developing a consultancy and collaboration network with Medical Staff
‘The Ideal Nurse’

‘No matter how gifted she may be, she will never become a reliable nurse until she can obey without question. The first and most helpful criticism I ever received from a doctor was when he told me I was supposed to be simply an intelligent machine for the purpose of carrying out his orders’

– SD (1917)
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
Traditional model of care

Early Hospital

- Ordered Relationship
- Gender division
- Patriarchal
Contemporary model of Care

Modern Hospital

- Medical Lead, Senior Nursing support.
- Power delegated to Juniors
- Horizontal interdisciplinary power sharing
- The ‘have nots’
  - HO and Junior Staff Nurse
  - Students
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
“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
The Division of labour

Macro Division of Labour

State
  • Legislation
  • Policy

Profession
  • Licensing
  • Regulation
  • Educational requirements
  • Knowledge and Expertise

Corporate
  • Business model
  • Productivity and Performance
  • Finance
  • Governance (Policy and Procedure)
# The Division of labour

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<td>Redundant Medical</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 task most often performed by the junior doctors.</td>
<td>Examples include cannulation, venepuncture and catheterisation</td>
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<td>Technical Medical</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>
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<td>Adapted Medical</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>
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<tr>
<td>Professional Medical</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>
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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 Emergency Care Nurse Practitioner

• ‘I’ve felt scared sometimes by the fact that they are accepting what I’m saying. [laughing] Because this consultant ‘I am God’ attitude with some people - and here’s me telling this consultant of many years’ training and experience...... . And sometimes I think ‘What way have I got to be telling this man this’ - you know, ......- and then I think - ‘But that’s why I’m here.’ – Interview Vascular Nurse
The Medical Leader

• ‘it's not always easy I have to say because typically, I think, the doctors tend to be very much the ones that try to control the situation, because of their nature, and in a sense yeah that's what, I guess, people doing medicine are supposed to be a team leader.’

• Consultant Surgeon Interview
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.
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 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

• ‘…they may write in their notes what they think you should do, … it's up to you whether you follow their advice or not.’ – Interview FY1
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.

• Competition for experiences
  • The nurse knows their position

• ‘Easy life’
• Boundary blurring and use of knowledge
Conflicts & Challenges

• 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

• ‘sometimes you leave talking about their [patient] cancer to the palliative care nurses to go through, I think maybe that’s probably not so good. 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
Knowledge

• Passing on knowledge
  • Medical – biomedical or modified/mediated?
  • Behaviours – shifting identities?
  • Rules – whose rules? New rules?

• Knowledge Adaptability
  • Perception of differences between doctors and nurses
  • Perceived as a Professional role issue
  • Consultant idea, that ‘character’ dictated role choice and therefore ability to process knowledge.
Knowledge

‘in some people’s eyes might sound a bit bizarre - that a nurse should have more knowledge than the doctor - but hey, that’s life, isn’t it?’ – Interview Vascular Specialist Nurse

‘[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
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 37000 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.
Heart of England Sepsis Screening Tool (wards)

Patient name: ________________________  PID: __________ Date: ___________  Ward: ______

Apply if MEWS is 4 or more, or if infection suspected

Are any 2 of the following SIRS criteria present and new to your patient?

- Temperature <36 or >38.3°C
- Respiratory rate >20/min
- Heart Rate >90 bpm
- Acutely altered mental state
- Blood: WCC < 4 x 10^9/l or > 12 x 10^9/l
- Glucose > 7.7 mmol/l

If patient is neutropenic and any 1 present, follow 'yes' and call Consultant

Patient has SIRS: Think SEPSIS!!!

Is this likely to be due to an infection?

- Cough; sputum; chest pain
- New or worsening infection
- Fever and/or rigors
- Headache with neck stiffness
- Line infection
- Wound infection
- Inflamed or tender joints

This patient has SEPSIS

Ensure Doctor present within 30 mins

Immediately start Sepsis Stx Pathway

Time of SIRS call

Doctor’s name:

Referring staff name:
Compliance at Good Hope Hospital (%)
Compliance and mortality at Good Hope Hospital (%)

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Mortality by Sepsis Six

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<th>Cohort size</th>
<th>Mortality %</th>
<th>RRR</th>
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<tr>
<td>Total</td>
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<td>34.7</td>
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‘Sepsis Six’ : Oxygen therapy
  - Blood culture
  - Antibiotic administration
  - Fluid challenges
  - Lactate and haemoglobin measurement
  - Urine output monitoring… *within one hour*

Resuscitation Bundle: SSC, within 6 hours following recognition
# Mortality by Sepsis Six

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<th>Mortality %</th>
<th>RRR % (NNT)</th>
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<tr>
<td>Total</td>
<td>567 (100)</td>
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<tr>
<td>Sepsis Six ✓</td>
<td>220 (38.8)</td>
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<td>Sepsis Six ✗</td>
<td>347 (61.2)</td>
<td>44.0</td>
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