Case Study – Advanced Clinical Practitioner

ACPs are an intrinsic part of many respiratory multi-professional teams and here we meet **Rebecca Kurylec.** Rebecca works at Nottingham University Hospitals within the respiratory team.

We would be really interested to know more about your path to becoming an ACP. What attracted you to this role in the NHS?

I completed my nurse training in 2011 in Nottingham. I have always worked within respiratory medicine. I find the speciality fascinating and treatments are forever changing and improving. I started as a newly qualified nurse on a respiratory ward. I completed packages to upskill myself including intravenous and catheterisation packages. I also completed courses such as the Advanced Life Support course, mentorship course and Band 5 educational program. I became the resuscitation link nurse for my ward and trained nurses in basic life support, ensured the resuscitation trolley was stocked and worked on resuscitation audits.

I then went on to complete a band 6 development course and progressed to deputy sister on one of our respiratory wards. I was involved in more managerial roles including rostering, managing staffing issues, appraisals, sickness management and benchmarking.
I then went on to become a triage nurse on the respiratory admissions unit, which consisted of taking referral calls from GPs, community respiratory nurses, ambulance crews and the emergency department. We would assess over the phone whether the patient should be admitted to hospital, and if so whether they should come to the respiratory or another part of the hospital depending on their symptoms. The role also included managing bed flow within respiratory medicine to ensure we had beds available for patients coming through the door.

I was then made aware of the Advanced Clinical Practitioner course, which I applied for. The ACP role was very new in respiratory medicine, we had 3 trainees in place prior to my starting of the course. I approached them to discuss the role and how they found the course. It was something I really wanted to do as it would allow me to stay in a clinical post whilst improving my skills further and developing my career.

Once I graduated as an ACP I felt I was able to make a bigger difference within respiratory. I am now able to clerk patients, order and interpret investigations and radiology, prescribe medical treatment and organise follow up for patients on the respiratory assessment unit. We also work as part of the medical team on the Advanced Respiratory Care Unit (ARCU) where we care for patients that need more respiratory support and may be on high flow oxygen and non-invasive ventilation. We are also part of the respiratory referrals team. Clinicians can refer patients to this service when they need non-urgent respiratory advice, we will go to the ward and assess the patients and advise on any care they may need, with consultant support.

How long have you been working in respiratory medicine?

When I was a student nurse in my second year I worked on a respiratory ward. I was really drawn to the speciality, the patients that you looked after and how supportive the team was. I have worked in respiratory medicine for 10 years now.

I thoroughly enjoy working in respiratory medicine as there is so much to learn within the different sub-specialities such as ILD, lung cancer, COPD, CF etc. Being part of a multi-disciplinary team is fantastic as you can help advocate for the patients and ensure their voices are heard.

I see the ACP role as a hybrid role that takes the best parts of being both a nurse and a

doctor. Unfortunately patients with a long-term condition can end up coming into hospital quite frequently. We have the opportunity to create therapeutic relationships with these patients because we are a constant fixture on the respiratory wards, unlike the junior doctors that rotate. We get to know them from a medical and social point of view and can maximise their care. We are seen as a massive asset to respiratory medicine now, especially among the consultants, which is the biggest complement.

Many people will be new to the role of an ACP. Could you outline a typical week?

My typical week as an ACP in Respiratory medicine can fall into three different patterns:

Week 1) would include working on the respiratory assessment unit, clerking and reassessing patients, whilst also taking part in the consultant ward rounds. Utilising many clinical skills such ABGs, venepuncture, cannulation, potentially midline insertion, maybe even pleural aspirates under supervision.

Week 2) working on ARCU, taking part on the ward rounds and involved in assessments of patients needing non-invasive ventilation.

Week 3) working on respiratory referrals giving advice on patients that are currently in-patients not on the respiratory wards. Support others in prescribing home oxygen assessments to allow people to go home. Take part in the teaching/supervising of OSCE's on the ACP course.

Can you share your experience with a particular patient?

A gentleman was admitted to the admission unit via an ambulance crew with a background of COPD. He was admitted with increased shortness of breath and a productive cough. He had desaturated with the crew and needed oxygen to maintain his saturations by the time he came into hospital.

My involvement included:
Assessment
This involved, taking bloods, an ABG and cannulating him. I prescribed treatment, administered by a nurse. I ordered an urgent portable chest x-ray and looked through his past medical history in more depth.

Monitoring/care plan
I reassessed and repeated the ABG and discussed treatment options. We also discussed his resuscitation status as I felt NIV would be his ceiling of treatment, to which he agreed.

Transfer to ward
After review of his CXR I felt NIV and a transfer to ARCU was appropriate. With the consultant on-call, it was decided that NIV and a transfer to ARCU was necessary and a DNACPR form was completed. I started him on NIV with the nurse looking after him and also arranged a bed on ARCU, organised porters for transfer and assisted with the escort. After gaining consent from the patient I updated his wife of his condition and the plan for his care, I also had to update her of his resus status.

You are developing strong relationships with other ACPs. Do you have a sense of how many ACPs are working in respiratory medicine?

A recent survey suggests there are between 25-30 respiratory ACPs not just within the region but nationally. The survey was completed through the use of social media so there may be more that we are not aware of.

How do you see the profession developing?

The ACP community is forever growing and are becoming an integral part of the workforce - the future is very bright for ACPs. Within our

own team, I would like to see the team progressing to clinic work, become senior decision makers on ward rounds, continue to develop skills in pleural procedures and ultrasound.

Do you have any particular advice for someone considering training as an ACP?

Do not go into to it lightly. The course will take over your life; it is a hard course to do and it will take blood, sweat and tears to qualify but qualifying is so satisfying and the most rewarding thing I have ever done. As the course is so intense your ACP peers become like a family and you will support each other through the course and throughout your career.

We are very keen to increase the number of ACPs who become members of BTS. Is there anything we could offer on our website that would be helpful to ACPs who are currently working in respiratory medicine?

- Involve ACPs in training opportunities and courses
- Have a platform for ACP discussions to take place

Contact details

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