Case Study – Advanced Clinical Practitioner

British Thoracic Society

ACPs are an intrinsic part of many respiratory multi-professional teams and here we meet **Padma Parthasarathy.** Padma works at University Hospital Leicester mainly in the cardiorespiratory admission unit along with her colleague **Samuele Boschi**.

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 nursing degree in India, then moved to England in 2000. Initially, I was not aware of the career pathways available for nurses in England, but I always wanted to have a role which would have direct patient care as the main focus along, with career progression.

For nearly 16 years, I worked in several roles & different specialities. Among all those, my role as nurse practitioner in critical care outreach team / out of hours offered me a great deal of job satisfaction due to its degree of autonomy. However, this role also had its drawbacks; I was only allowed to assess patients and make treatment suggestions, not prescribe (my job description did not support the prescribing qualification) which felt like I was doing a half job. Therefore, I started looking for a role which will allow me to complete the whole patient journey (assess, diagnose, treat, discharge/refer) and the ACP role felt like a good fit.

In 2016, I completed the MSc in Advanced Clinical Practice from Leeds Beckett University and secured my current job in Leicester. Since then, I never looked back.

How long have you been working in respiratory medicine? What drew you to respiratory?

I have been working respiratory medicine since 2016. I developed an interest in the speciality following my intensive care job and critical care outreach/out of hours job. During my job in the intensive care unit, I had a special interest in ventilation & weaning. In my critical care outreach / out of hours job, I had the opportunity to deal with a lot of acutely unwell respiratory patients. I also found that the respiratory team is very supportive and respects the view of their Multi-Disciplinary Team (MDT) colleagues. Further, during my ACP training, we had a rotation that included the emergency department, acute medical unit, surgical admission unit & care of the elderly, and I found managing respiratory patients is more interesting and challenging due to the complexity of these patients. In respiratory medicine, we also have the opportunity to work with both acute & chronic patients. As the speciality provides with endless opportunities, when I was presented with an opportunity, I grabbed it without a second thought.

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

We really enjoy being part of the respiratory team at University Hospital Leicester due to their ongoing support and their recognition towards advanced clinical practice. When I say we, it is me and my colleague Sam I am talking about. we work closely with all members of the MDT – nurses, clinical nurse specialists, physiotherapists, respiratory physiologists, consultants, and junior doctors.

Our main role is to provide direct patient care, which involves:

- Assessing, diagnosing, and treating patients in the admission unit
- supporting the consultant during the ward round by preparing the notes and accurate documentation of the plans
- implementing the ward round plans
- completing the timely discharge summaries with accurate information
- requesting and interpreting the investigations

- undertaking diagnostic and therapeutic pleural procedures under supervision
- referring patients to other specialities
- being a key member of departmental strategic meetings
- providing teaching sessions for junior doctors and nursing staff.
- We both work one day a week in the ambulatory clinic where we assess, diagnose, treat/refer and discharge respiratory patients independently.

Clinical audits & quality improvement projects also form part of the role. I have undertaken a quality improvement project to improve the triage process to increase the patient intake into ambulatory clinic by implementing a scoring system (GAP score). We are currently undertaking a quality improvement project to improve the oxygen prescribing, administering, and monitoring practice.

I am one of the oxygen champions of the trust and my main role is to ensure the trust oxygen administration, prescribing & monitoring policy is up to date, and any national alerts are disseminated to appropriate clinical group.

The major highlight of our work during the pandemic is, becoming the part of 'acute respiratory response team' (ARRT) which was put together by our lead ventilation physiotherapist. The team included respiratory ACPs, ventilation team, physiotherapists, respiratory physiologists, and specialist nurses. We actively tracked COVID patients who were deteriorating in acute respiratory wards and moved them to a respiratory support unit if needed, where the patients were started on high flow nasal oxygen or CPAP. The team worked very closely with critical care outreach team, intensive care unit doctors, respiratory consultants & nursing team. The team helped to provide high dependency care to a large volume of patients outside the intensive care which reduced the pressure on ITU beds in our hospital.

Can you share your experience with a particular patient?

I talked earlier about how my role allows me to see the whole patient journey. A good example of this was the care of a patient transferred to our admission unit from ED. I was involved in the following:

Initial assessment. As the patient was found to be drowsy, Completed an A-E assessment. Reviewed the ED notes, patient's chest X-ray, blood results and the treatment received in ED quickly.

- **Treatment** There was a blood gas results in the notes suggesting the patient was in decompensated type-II respiratory failure. As soon as I saw these results, immediately titrated the oxygen to aim target saturation of 88-92%. Commenced the patient on non-invasive ventilation. Informed the on call respiratory consultant. Patient started to become alert. The chest X-ray showed pneumonic changes and the blood results confirmed the infection. Therefore, I prescribed the appropriate antibiotics.
- **History taking**. A full history was obtained from the patient including his baseline mobility, health statues etc which helped to plan the care of the patient further.
- **Care planning**. Although there was some improvement, as the patient needed continuous NIV for 24 hours and plan for ongoing management, patient was referred to out ventilation team. After discussion with the patient, it was agreed that intensive care treatment would not be appropriate, and a Respect form completed regarding the level of care. Then, I arranged a bed on our ventilation ward and co-ordinated handover.

This patient journey explains how an ACP in respiratory medicine can holistically manage the patient.

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

There are around 30 qualified ACPs and around 20 trainee ACPs (A survey has been undertaken recently).

How do you see the profession developing?

In recent years, there has been mounting interest in developing ACP roles both in primary and secondary care to meet the growing service needs. The respiratory community has embraced these roles, as the ACPs bring their own professional experience, knowledge, and skills along with their newly learnt advanced clinical practice which enhances patient care. The ACP role provides continuity of care, improves team working, enhances communication among MDT members and provides the opportunity for the junior doctors to involve in other training activities by releasing them from the clinical areas. I am sure the role will continue to evolve as the NHS 10-year plan prioritises respiratory care and places more emphasis on a multi-professional approach and new ways of working. If we can develop a more structured approach to developing the role along with clear career progression opportunities, the ACP role in respiratory will be more appealing for both employers & employees.

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

An ACP role in respiratory is very exciting and rewarding. If you want to further you career in the NHS, without having to compromise your interest in direct patient care, this is a great opportunity. More universities are providing ACP training in apprenticeship models which I would recommend. This is also an exciting time to become an ACP, as Health Education England is working with the Royal College of Physicians to provide a clear pathway for each speciality-based ACP training. I would say to anyone who wants to become an ACP in respiratory medicine, the training period could feel like being on a roller coaster with lots of ups and downs, and it can take over your life. Hence, take it seriously. Be prepared for lifelong learning as the learning continuous beyond your training period. But this is the most rewarding job anyone can aspire to.

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??

A framework for respiratory ACP
E-portfolio opportunities
Networking opportunities
Teaching events suitable for ACPs
Opportunities for ACPs to Involve in BTS committees

Contact details

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