Case Study – Advanced Clinical Practitioner

British Thoracic Society

More and more Advanced Clinical Practitioners (ACPs) are working within the NHS. ACPs are an important part of the workforce and are helping to support innovative ways of delivering hospital-based care.

ACPs are increasingly becoming part of many respiratory multi-professional teams and here we meet **Kirsty Laing**. Kirsty is an Advanced Clinical Practitioner working at Harrogate District and Foundation Hospital within the respiratory team. The team consists of two consultants, two registrars, one Internal Medicine Trainee, one foundation doctor, plus a team of respiratory specialist nurses.

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 2004 in Sheffield and worked for a year on an acute admissions unit seeing a wide and diverse presentation of patients. Even at this point I was keen to upskill so I could do more for my patients such as IVs, cannulas and phlebotomy.

I relocated back to Harrogate working again on medical admissions, but the ward had an integrated coronary care unit. It was pre-PCI so patients were often thrombolysed and could be extremely unstable with potential to deteriorate rapidly. I was encouraged upskill to do bloods/cannulas/male catherization/ALS and any additional courses such as ECG interpretation to improve patients access to care they needed. Having a great mentor encouraged me to assess and anticipate what patients were likely to need and could support the medical team better.

From here I worked within a newly formed critical care outreach team. It was in this role I started my advancing clinical practice journey as I was able to develop my clinical decision-making and diagnostic reasoning skills. This was further supported by my commencement of the MSc in Advanced Practice, however as my skills and knowledge improved, I became frustrated at not being able to initiate the treatment options required for the patients I reviewed and ultimately felt as though it was duplication of the workload when having to call upon the thinly stretched junior doctors prescribe to IV fluids/antibiotics for a patient.

At this point an opportunity arose to help set up a hospital out of hours service at Sheffield Hospitals with study time as an ACP. Great experience to go back where I had started my career.

Despite completing my Non-Medical Prescribing, the distance and travelling were taking its toll and I wanted to work nearer to home.

I started at Airedale hospital in a combined role of CCOT and hospital at night with the knowledge that they were looking to trial the ACP role soon. I officially began my transition to an ACP on a short stay and ambulatory care ward, completing my MSc in 2013. This gave me a wide general medicine experience.

I then relocated to Kingsmill Hospital as a geriatric ACP. Instigating comprehensive geriatric assessment at the front door as part of the MDT. It was during my time here I became aware of Derby hospital and their well-established team of ACPs. I moved to Derby where I had a rotational post through different speciality's which introduced me to respiratory. It enabled me to draw upon and utilise previous experience whilst establishing a passion and interest for pleural work.

Luckily, Harrogate hospital were looking for a respiratory ACP with interest to develop pleural work. This prospect came at a time when I was keen to move back home and have an opportunity to specialise within respiratory medicine. I was successfully appointed and have been here since. My consultant team and

respiratory registrars have been key in supporting my development within this role.

How long have you been working in respiratory medicine?

I have a genuine passion for respiratory medicine and have been predominantly working within this speciality for over 3 years now. It draws upon my previous clinical experiences, such as patients living with frailty and those that have the vulnerability to deteriorate rapidly. It keeps me on my toes providing plenty of variety and clinical challenges.

I thoroughly enjoy working alongside the diversity of the wider respiratory MDT. This can range from therapy teams to lung cancer clinical nurse specialists (CNS), respiratory CNS, palliative care teams and radiology to name a few.

The trust has provided scope and capability to develop a pleural outpatient service which is overseen by a respiratory consultant and supported by establishing a close working relationship with radiology department. This is run jointly with a respiratory registrar and myself. We are now able to provide ambulatory pleural taps/aspirations for symptomatic patients or those requiring diagnosis where historically it has been undertaken as an inpatient.

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

My typical ACP week includes:

- Two Consultant ward rounds
- Three junior ward rounds – ACP will divide with juniors or if no other junior team member, will review patients. Consultants are available to discuss any concerns
- I x pleural clinic
- Lung MDT
- Radiology MDT

Undertaking any pleural procedures which are required.
In addition, I am an Advanced Life Support instructor, recently performed a chest drain audit, implemented and updated our chest drain monitoring chart, and support training for ACP and nursing teams' verification of death.

Can you share your experience with a particular patient?

A patient with learning difficulties presented with an asymptomatic spontaneous primary pneumothorax following a hypoglycaemic episode on background of type 1 diabetes. He was initially conservatively managed and was discharged with follow up in ambulatory care.

At follow up his pneumothorax had progressed. A best interest decision was taken with presence of family and social worker for a therapeutic aspiration. He was discharged with a follow up chest x-ray one week later. This showed reoccurrence of his pneumothorax therefore he was admitted for chest drain insertion which I performed under supervision of Respiratory registrar. This took place on a Friday afternoon but fortunately I was on-call over the weekend and able to provide continuity of specialist care to an otherwise vulnerable patient.

As a small DGH there is often no respiratory cover over the weekend. His lung successfully re-inflated and he was discharged back home.

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 between 25-30, but that is only those who are on social media regularly.

Case Study – Advanced Clinical Practitioner

British Thoracic Society

How do you see the profession developing?

Working in both a teaching hospital and district hospital I have come to realise the role of the respiratory ACP is dependent on the needs of the area they are working within and interests of the consultant team supporting them.

The capability of an ACP can be vast if the appropriate governance and support is available. With this in place a respiratory ACP can become a senior decision maker within the team. This could be around the care of a patient, to develop new services, change/improve clinical practice or as a support network for the education of junior team members. Respiratory ACP's are an integral member of the senior respiratory team.

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

It is a rewarding journey, but the road is bumpy. You must be kind to yourself when you may not feel cut out for the job. Not knowing something is OK, as long as you are prepared to learn. Knowing that the learning process is a continuous part of your journey and everyday there is something new. Put priorities in networking and reach out to colleagues as you are not alone.

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?

- Points of contact
- ACPs with specific areas of interest
- Where there is training opportunities to include if open to ACPs (Please)

Contact details

To get in touch with Kirsty, please email:

k.laing@nhs.net

If would like to share your experience of working as an ACP, please email Louise Preston:
Louise.preston@brit-thoracic.org.uk