WORKING AS AN NHS RESPIRATORY NURSE IN ENGLAND

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BACKGROUND TO RESPIRATORY NURSING IN THE UK

A "specialist nurse" was described by the Royal College of Nursing (RCN) in 2014 as a nurse who specialises in a specific condition or treatment pathway, providing patient care, clinical expertise and education, as well as leadership and service development. Doctors have traditionally provided management of many aspects of the patient journey; however, with role expansion and the advent of autonomous nursing practice, boundaries between what is medicine and what is nursing have been blurred.

In some ways, the expansion of the nursing role has made defining nursing difficult; however, the RCN defined nursing in 2014 as “The use of clinical judgment in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.”. Furthermore, the International Council of Nurses addressed the autonomy of nursing practice in 2017 stating “Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people.”

These two definitions capture the essential role undertaken by nurses in the care and management of patients with respiratory disease, throughout the natural trajectory of that disease, from diagnosis through to palliative care at the terminal stages.

The role of a clinical nurse specialist (CNS) in the UK requires clinical, research, education and consultation skills. The Nursing and Midwifery Council recommends that specialist practice should require a higher level of judgement, discretion and decision making skill (with a focus on clinical practice, care and programme management, as well as clinical practice development and clinical practice leadership). However, it was argued by Leary et al. in 2008 that the role undertaken by a CNS has a wider remit, including service redesign, coordination of care and ensuring appropriate and timely care. The RCN suggested in 2012 that nurses working in specialist roles should spend around 60% of their time in clinical activity, which has resulted in a reduction in the number of unnecessary hospital admissions, a reduction in waiting times, improved access to care, and improved provision of support to patients in the community. The diversity of the role has been acknowledged by patients in a RCN/National Voices report in 2009, with the CNS being rated higher than any other healthcare professional for understanding patients’ needs, designing and implementing care pathways, obtaining patient feedback, and being transparent and honest.

Respiratory nurse specialists (RNS) have been providing support for patients with respiratory disease since...
recommendations from the Royal College of Physicians in the 1980s. The number of RNS across the UK has grown over the last three decades as a result of changes to medical training, expansion of nursing roles and the need to meet the demands for high quality, cost-effective care for patients with respiratory conditions. The role of the RNS is varied, including the provision of nurse-led services in primary, community and secondary care. Consequently, RNS are now recognised as important members of multidisciplinary teams providing care for patients with chronic obstructive pulmonary disease (COPD), as illustrated in National Institute for Clinical Excellence and Department of Health guidelines in 2010 and 2011, respectively. Work by Forbes in 2008 has also shown that RNS are highly valued by patients and carers.

BACKGROUND TO MY ROLE

The post was one of the first RNS posts to be established in the UK following a public health initiative to "add years to life and life to years" for patients with respiratory conditions, by providing an outreach service to the local community served by St George's Hospital. The project was deemed to be successful, with further funding secured for additional staff which enabled more patients to be supported and cared for outside of hospital. Recognising the importance of a multidisciplinary team I "sacrificed" funding for a third nurse, opting instead for a respiratory physiotherapist, which enabled pulmonary rehabilitation (maybe not as we know it today!) as well as breathing control and sputum clearance techniques to be provided and taught to patients at home. In addition, I was fortunate in being able to establish a strong link with our local hospice to address symptom control in advanced disease. This resulted in additional funding for a year, allowing a palliative care nurse specialist to join our team and to enhance both specialities knowledge and understanding. The service has developed and evolved significantly over the last 20 years, with the creation of community based teams and fully commissioned pulmonary rehabilitation and oxygen assessment services, as well numerous nurse-led clinics for a multitude of respiratory conditions.

My clinical caseload today is mixed but predominantly involves providing care for patients with asthma and COPD, as well as patients requiring ventilatory support in the community. I am a part time PhD student registered at the University of Manchester, where I am developing a nurse-sensitive outcome indicator for patients with COPD. This will hopefully provide a method of measuring the impact of specialist respiratory nursing input on patient experience. I provide leadership and clinical supervision to teams of respiratory nurses and physiotherapists in the acute hospital setting and in two of our local Clinical Commissioning Groups (CCGs). Other aspects of my role include service development and education. I am a trainer for Education For Health, an education charity which provides a wide range of respiratory training packages (as well as for other chronic diseases), from workshops and updates through to diploma, degree and masters level modules.

A WEEK IN MY LIFE

I was originally asked to describe a day in my life as a respiratory nurse. However, this would not demonstrate the diversity of the role and therefore it has been decided that I should share a typical week!

Monday

I start the week with a busy asthma clinic (figure 1). I run the clinic alongside my medical colleagues, sharing the management of patients with difficult and severe asthma. Many patients have significant psychological issues and building a strong relationship is essential in addressing problems with adherence, acceptance of their condition and provision of self-management strategies. We provide a biologic service for patients with severe allergic asthma and refractory eosinophilic asthma. The injections are given by one of my fellow RNS but I am often asked to review patients if they are unwell. Today is no exception as one patient presents as acutely unwell and we need to arrange hospital admission.

The afternoon involves another clinic at another site which is a 30 min drive away. The patients attending this clinic have a mixture of COPD, asthma and bronchiectasis. I will be reviewing their symptoms, titrating medication

Figure 1. A patient being reviewed in the asthma clinic.
and reviewing inhaler technique, as well as providing smoking cessation advice, encouraging exercise, and providing self-management strategies and support for both the patient and their carer(s). I also run the domiciliary non invasive ventilation (NIV) service. This service has approximately 40 patients who are remotely monitored and before I leave for my afternoon clinic I need to check the data on these patients. A typical patient would be one with a neuromuscular condition, e.g. motor neurone disease (MND), who may find it increasingly difficult to attend clinic appointments as their disease progresses. This technology enables us to adjust ventilator settings remotely, to monitor usage, to optimise ventilation and to identify potential issues, e.g. mask leakage.

**Tuesday**

I spend most of Tuesday morning on administrative tasks such as reviewing clinic letters and referring patients from yesterday’s clinic to colleagues. This includes referring patients to the pulmonary rehabilitation team and the smoking cessation team, as well as to the dietician. I am also keen to ensure that a patient with a history of frequent hospital admissions is referred to the community team. They will be able to provide additional support when he is unwell and hopefully manage him at home.

The acute medical team then contacts me requesting that I review a current inpatient with acute respiratory failure. The patient, who has obesity hypoventilation syndrome, is well known to me as she has been struggling with accepting that she requires NIV and will require follow-up in clinic on discharge. While I’m in the acute medical unit I review a patient who has a new diagnosis of asthma and provide guidance on her treatment, check her inhaler technique and provide her with information about asthma. She will need to be reviewed tomorrow by the RNS team to review her progress, provide her with a personal asthma plan before she is discharged and arrange an outpatient review.

I spend the last couple of hours of the afternoon working on a presentation about our local respiratory medicines guidelines for the CCG.

**Wednesday**

I meet with the hospital- and community-based teams for an hour of clinical supervision prior to a busy NIV clinic. Today we discuss a patient who is acutely unwell but is very reluctant to be admitted to hospital. This is not an uncommon problem but is made worse by the fact that he lives alone and is reluctant to have additional support at home. The community team will need to monitor him closely over the next few days and assess if he has the capacity to make the decision to stay at home. We also use this meeting to disseminate information and review and discuss relevant research papers. Today we discuss a recently published paper on inhaler technique errors. The NIV clinic (figure 2) runs smoothly and even the new patient requiring setup is relatively straightforward! We tend to review patients frequently until we have optimised their treatment and then review them every 4–6 months depending on their individual needs.

The afternoon involves reviewing three patients requiring NIV in their homes (all three have MND and find it difficult to attend clinic). The review can include adjusting pressures, trouble-shooting mask fit, monitoring disease progression and discussions around advance care plans. One patient has had a change in her night carers and I need to ensure that they are competent in caring for her. I will need to contact the agency tomorrow to discuss this, as we provide training for informal and formal carers on the application of NIV.

The last visit of the day is to a man with advanced MND who is getting very distressed by excess saliva. He is known to the palliative care team but has not been reviewed by them for a few weeks. He is happy for me to contact them tomorrow.

**Thursday**

I try and keep Thursdays and Fridays free for research but I need to liaise with the palliative care team, and contact the care agency to provide additional
training for staff in the use of NIV, before I can switch from clinical to research mode! As always, this takes longer than expected and it’s nearly the afternoon before I start to analyse data from my research project.

**Friday**

I work from home today and am completely engrossed in analysing my data. I have a meeting with my supervisors in a couple of weeks and would like to be able share the preliminary results with them! Quite a few more hours of data analysis will be required before I am in a position to start writing up the results.

**LOOKING BACK**

As I reflect upon my work week I recognise that I am fortunate to be able to practice autonomously. While I manage a complex caseload of patients I am very aware that I am part of a fantastic multidisciplinary team who provide excellent care to patients with respiratory conditions.

**CONFLICT OF INTEREST**

Ms. Prigmore reports personal fees from Astra Zeneca, personal fees and non-financial support from Chiesi, personal fees from Pfizer, personal fees from Nutricia, personal fees from NAPP, personal fees and non-financial support from TEVA, outside the submitted work.

**RECOMMENDED READING**


