National Clinical Programme for Emergency Medicine

A Guide to Enhance Advanced Nurse Practitioner Services across Emergency Care Networks in Ireland

June 2013

Foreword

Registered Advanced Nurse Practitioners (RANPs) play a vital role as members of Emergency Department (ED) and Local Injury Unit (LIU) multidisciplinary emergency care teams. Research demonstrates that RANP-provided emergency care is highly-regarded by patients and colleagues.

This Guide to Enhance Advanced Nurse Practitioner (ANP) Services across Emergency Care Networks in Ireland ('The Guide') is presented by the National Clinical Programme for Emergency Medicine (EMP) and the Office of the Nursing and Midwifery Services (ONMSD) as a capacity building strategy to further increase the contribution of RANPs to the provision of emergency care in Ireland. The Guide augments the recommendations of the *National Emergency Medicine Programme Report* (HSE 2012*), Securing the Future of Smaller Hospitals: A framework for Development* (DoH 2013) and the *EMP Guidance Document for LIU Staffing* (HSE 2013) with specific detail relating to:

- current capacity of RANP services
- ANP role development and
- a pragmatic strategy to optimise RANP-delivered patient care across the national emergency care system.

'The Guide' is proposed against a backdrop of radical reorganisation in the way acute health services are planned and delivered in Ireland. It is consistent with the vision of the National Clinical Programmes to improve quality, access and value across the health system. It is presented in two main sections. The main section profiles the status of the service in 2012 with regards ANP capacity, role development and service activity in Emergency Departments (EDs) in Ireland. This information was ascertained through a national survey of EDs with ANP services and through HSE regional consultation workshops. The next main section outlines the strategic direction that is required to develop ANP services to support the workforce planning recommendations of the National Emergency Medicine Programme Report 2012 (p215).

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- The National Emergency Medicine Programme Working Group;
- The National Emergency Medicine Programme Emergency Nursing Interest Group (ENIG); ANP Sub-group;
- The Directors of Nursing and Midwifery Advisory Reference Group (National Clinical Programmes);
- The Area Directors and Directors of the Nursing and Midwifery Planning and Development (NMPD), HSE;
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Glossary of Terms

ANP Advanced Nurse Practitioner

RANP Registered Advanced Nurse Practitioner
The title of Registered Advanced Nurse Practitioner is a protected title and a nurse may only use the title when he/she has fulfilled the criteria and standards for the role and his/her name is entered onto the Register of Advanced Nurse/Midwife Practitioners (ABA 2010). A nurse or midwife whose name is entered on this register is therefore titled Registered Advanced Nurse/Midwife Practitioner (RANP, RAMP)

ANP/RANP Note: In this document, the term ANP/RANP is used when referring to advanced practice practitioners in emergency care. Specifically ANP is used when referring to advanced practice in general or advance nurse practitioner posts but not the post holders. The term RANP is used when referring specifically to the approved post holder who is entered on the NMBI Register.

ANP (C) Advanced Nurse Practitioner Candidate
The title of Advanced Nurse Practitioner Candidate (ANPC) was developed by The National Council for the Professional Development of Nursing and Midwifery in order to identify nurses/midwives who were progressing along a career pathway towards RANP/RAMP. Currently the designation of a nurse/midwife as an ANP (C) is used at the discretion of an employer / line manager through local arrangement.

ANP Forum
The ANP (Emergency) Forum is a recently established national group for RANPS and ANP Candidates to network, and support the workforce planning and professional development of ANPs and ANP services across the system.

ECN Emergency Care Network
Emergency Care Networks are coordinated systems of care that include Pre-hospital care, Emergency Department (EDs), Local Injury Units (LIUs) and other emergency settings, supporting acute hospital services and have links with Primary Care and voluntary emergency care providers.

EMP National Clinical Programme for Emergency Medicine

EMP Working Group
The working group of the EMP consists of Consultants in Emergency Medicine representing each of the four administrative areas of HSE, representatives of Emergency Nursing, the Therapies Professionals, Pre-hospital and GP/Primary Care representatives.

ENIG Emergency Nursing Interest Group
Emergency Nursing Interest Group is a forum of emergency nurses and service managers brought together by the EMP nursing leads to provide a direct link between the EMP and clinical staff and to support implementation of the recommendations of the 'A Strategy to Improve Safety, Quality, Access and Value within Emergency Medicine in Ireland' (the National EMP Report, HSE 2012).

HIQA The Health Information Quality Authority
HIQA is a statutory, government-funded agency in Ireland which monitors the safety and quality of healthcare in hospitals and the social care system. HIQA received its powers and mandate in May 2007 under the Health Act 2007. The Authority also exercises functions under the Child Care Act 1991, and the Children Act 2001.

LIU Local Injury Units
Local injury units provide care to defined patient groups e.g. patients with non-life or limb threatening injury.

Middle Grade Doctor
Registrar, Specialist Registrar or Staff Grade/Associate Specialist

NCNM National Council for the Professional Development of Nursing and Midwifery (now dissolved)

NMBI Nursing and Midwifery Board of Ireland
Following the signing of Commencement Order S.I. No. 385 of 2012 the name of An Bord Altranais changed to Bord Altranais agus Cnaimhseachnais na hEireann, or Nursing and Midwifery Board of Ireland.

NQAI National Qualifications Authority of Ireland

Scope of Nursing Practice
A nurse's scope of practice is defined as 'the range of roles, functions, responsibilities and activities which a registered nurse is educated, competent and has authority to perform'(An Bord Altranais 2000).

SDU The Special Delivery Unit
The SDU was established by the Department of Health in 2011 to unblock access to acute services by improving the flow of patients through the system. The SDU is working closely with key teams in the HSE and the NTPF, building on initiatives already underway including the clinical programmes.

Executive Summary

National and international studies provide evidence to support the development of the role of Registered Advanced Nurse Practitioners (RANP)[1] and have identified these practitioners as being safe, effective clinical decision makers who contribute to service delivery and improve patient outcomes. RANPs interface with nursing and medical staff at all levels and participate in a wide range of clinical and non-clinical activities.

A *Guide to Enhance Advanced Nurse Practitioner Services across Emergency Care Networks (ECNs) in Ireland* (The Guide) aim is to increase the RANP capacity across ECNs to support improvements in the quality and timeliness of care for patients attending Emergency Departments (EDs) and Local Injury Units (LIUs) across the country. In addition this document provides direction and support for continuing professional development of RANPs and supports career planning opportunities for emergency nurses wishing to pursue a career pathway in advanced practice in emergency care.

The Guide proposes a four-year plan to meet the projected ANP workforce requirements. The Guide is one element of the National Clinical Programme for Emergency Medicine (EMP) workforce planning strategy.

Workforce planning for nursing in EDs/LIUs across ECNs should be linked and integrated with workforce planning for other members of the ED/LIU multidisciplinary team. The recommendations of this Guide should be viewed in the context of the current moratorium on recruitment in the public service, the HSE employment control framework and Future Health - A Strategic Framework for Reform of the Health Service 2012-2015 (DoH 2012).

This document intends to support the emergency care system nationally to respond to relevant ANP aspects of *The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts* (DoH 2013a) and the *Securing the Future of Smaller Hospitals: A Framework for Development* (DoH 2013b).

A Guide to Enhance Advanced Nurse Practitioner Services across Emergency Care Networks in Ireland makes recommendations on:

1. Workforce Planning – current resource and projected requirements
2. National ANP Job Descriptions
3. Introduction and Establishment of ANP Posts
4. Education Preparation
5. Continuing Professional Development
6. Research and Audit
7. Career and Succession Planning
8. Implementation of the recommendations in this Guide.

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[1] **ANP/RANP Note**: In this document, the term ANP is used when referring to advanced practice in emergency nursing in general or advance nurse practitioner posts but not post holders. The term RANP is a protected title and only used when referring specifically to an approved post holder who is entered on the NMBI Register.

Recommendations

1. Workforce Planning - Current resource and projected requirements

- All ECNs should establish an ANP service that is available between the core hours of 08.00 and 20.00 hrs over 7 days/week (i.e. a 12/7 service).
- The hours of opening for the ANP service and the number of RANPs required for each ECN (to include EDs/LIUs) should be agreed locally. This will vary according to service need and should be influenced by the number of new patient attendances, patient acuity, staff mix, skill mix in EDs/LIUs, ED/LIU environment.
- Based on current service needs/activity, it is estimated 147 WTE RANPs are required nationally to provide a 12-hour RANP service across current ECNs. With 43.3 WTE RANPs currently in post, the shortfall over the next four years in 103.7 WTEs. These projections are based on a requirement of one RANP on duty in LIU 12/7. When LIUs are established and attendance patterns become clear, the number of senior clinical decision makers required on duty will be reviewed as per *EMP Guidance Document for LIU Staffing* (HSE June 2013).
- The RANP staffing model should be reviewed in each ECN after an initial period of 6 months and thereafter annually to assess it's suitability for each individual emergency setting and ECN. This review should involve robust service planning and service needs analysis that includes review of ED/LIU activity/general demand and capacity, number and acuity of patients seen by RANP and other contextual factors influencing workforce planning in EDs/LIUs e.g. staffing levels, skill mix and unit layout. From a workforce planning perspective it is recommended that the profile of the medical workforce be reviewed as a result of introducing /increasing RANP roles in EDs/LIUs.
- The report recommends a four-year plan for phased implementation of approved ANP posts and RANPs to reach the capacity required as identified in Table 8. This can be achieved incrementally as suggested below.

Year	2013	2014	2015	2016	Total
ANP WTEs required	19.5*	26	58.2		103.7
*Identified in local service plans and the HSE (2013) National Operational Plan p44.					

2. National ANP Job Descriptions

- There is a need for national job descriptions for RANPs and ANP Candidates. Standardised job descriptions (including role competencies) for RANPs and ANP Candidates across the National Emergency Care System will support a cohesive approach to the establishment of RANPs across the country and prevent repetition and duplication of effort in developing job descriptions within each hospital and ECN.
- National job descriptions (including role competencies) should support consideration of site-specific service needs and the development of bespoke roles where there is an identified service need and/or new service provision.
- The national job description for an ANP Candidate should identify the specific clinical competencies, education and academic requirements for nurses following a career path towards RANP. The duration and type of supervised clinical practice will be addressed by the Nursing and Midwifery Board of Ireland (NMBI) when

NMBI develop requirements and standards for education programmes for advanced practice.

- The development of a specific grade code for an ANP Candidate will assist with appointment of suitable nurses onto an ANP career pathway while supporting workforce planning by allowing calculation of the numbers of nurses in the system working towards registration as ANP.

3. Introduction and Establishment of ANPs

- A standardised approach to the selection and appointment of ANP candidates/RANPs across HSE Statutory and Voluntary funded organisations is required. This will be supported by a nationally agreed job description; and the development of a grade code specifically for ANP Candidates.
- ANP post development should continue to be in line with criteria set in 2008 by the National Council for the Professional Development of Nursing and Midwifery NCNM (now dissolved) and as per Statutory Instrument No 3 of 2010 until full enactment of the Nurses and Midwives Act 2011.
- ANP post development should occur on an ECN basis and incorporate flexible working arrangements to allow for movement of staff to occur across EDs / LIUs within the ECN.
- It is recommended that a standard national template document is developed for submission of ANP site approval to NMBI for the remaining EDs/LIUs without post approval based on their designation as an ED or LIU.
- The submission of these documents to the NMBI requires a co-ordinated approach from service providers and the ONMSD / NMPDU with a commitment and approval of financial support from the appropriate funding stream of the HSE, Hospital/Hospital Group or Trust to fund the posts.

4. Education Preparation for RANP Practice

- The ONMSD and EMP should engage with the Nursing and Midwifery Board (NMBI) when the NMBI are developing requirements and standards for education programmes for advanced practice.
- Education programmes should include theoretical and clinical content specific to the RANP's caseload of undiagnosed, undifferentiated clinical conditions in EDs/LIUs.
- Education preparation for ANP practice should meet the service needs of each ED/LIU and provide the skills and competencies required to safely meet the patient needs within the ANP clinical caseload.
- Ionising Radiation and Medicinal Product Prescribing should be incorporated into RANP education preparation and ANP education programmes to provide a seamless, integrated educational experience for the candidate and a more cost-efficient programme for the system.
- There should be two-way communication between EDs/LIUs (i.e. clinical partners) and the third level colleges (i.e. academic partners) in order to support the clinical supervision requirements of ANP Candidates.

5. Continuing Professional Development (CPD) of RANPs

- There should be standardised minimum number of hours allocated to CPD of RANPs that facilitates regulatory requirements and service level demands of RANPs. This should be standard across the system and these hours should be built into the service roster.
- There should be clear governance structures to support regular organised Clinical Supervision and peer review for RANPs within each ECN.
- Standardised scope of practice of an RANP should outline the core competencies required of the person undertaking an advanced practice role. Specific competencies relating to the caseload should further define CPD requirements of the RANP.
- There should be a nationally agreed framework for role expansion that service managers along with RANPs can use to plan for future service needs within an ED/LIU or ECN.
- Appropriate and relevant education modules should be agreed nationally to support RANP CPD requirements and the development of a standard scope of practice of RANPs. Existing educational and training resources could be utilised to provide web-based tutorials, facilitate workshops and units of learning. Master classes could also facilitate the education needs of ECNs on a national basis.
- The ONMSD, EMP and the recently established ANP (Emergency) Forum should develop the RANP CPD frameworks and education materials.

6. Research and Audit

- RANPs are required to initiate and coordinate nursing audit and research as a core concept of their role and as a requirement for continued registration with NMBI. It is essential therefore that there are a standardised minimum number of hours allocated to research and audit for RANPs across the system.
- The Clinical Operations Group in each ED/LIU should support and encourage integrated multidisciplinary audit in order to prioritise quality improvement initiatives in line with National EMP Report (2012).
- Clinical and academic partnerships should be encouraged between third level colleges and ECNs in order to support the research agenda of RANPs and the multidisciplinary team with particular emphasis on contributing to the body of national and international literature related to emergency care.

7. Career Pathway and Succession Planning

- The Clinical Operations Group in each ED should agree how to align Personal Development Planning (PDP) for the multidisciplinary team with the strategic needs of the ED/LIU and ECN. PDP can facilitate nurse managers and ED/LIU nursing staff to carefully consider the clinical experience required to support the development of competencies of the individual. PDP can identify the optimum education required to support the individual whilst meeting ED/LIU service demands.
- It is recommended that the EMP facilitate the dissemination of career guidance information using a variety of fora.
- Succession planning is required to sustain ANP services over time. ECN workforce planning should include a succession plan for ED/LIU nurses in order to

promote clinical and management career pathways to support the future Clinical Nurse Manager and RANP roles in the medium and longer term.

8. Implementation of the recommendations of this Guide

- Implementation of this Guide for should occur in collaboration with the ONMSD, HSE, EMP and the Department of Health. This requires the support of national key stakeholders such as the HSE Integrated Services Directorate, Acute Hospitals Directorate, the Clinical Strategy and Programmes Directorate, National Recruitment Services, Special Delivery Unit, the Nursing and Midwifery Board of Ireland (NMBI), and Higher Education Institutions (HEIs).
- At clinical programme level, the EMP Working Group, Advisory Group, Regional Leads, Emergency Nursing Interest Group (ENIG) and the Directors of Nursing and Midwifery Reference Group play an important role in the dissemination of this Guide and championing implementation of its recommendations across the hospital system. An EMP Advanced Nurse Practitioner Forum, recently established, should provide a means whereby RANPs and ANP Candidates working in EDs/LIUs can contribute to the implementation of recommendations outlined in this Guide.
- At service level, support is required from the ED Clinical Operations Group, and hospital/hospital groups/trust executive management teams. Suitably experienced and qualified ED nurses should be identified to undertake appropriate education and training. This needs to occur in 2013 in preparation for registration as an RANP in 2014-2016; 2014 for 2015/16 and so on.
- The introduction of quality improvement methodology (e.g. Clinical Microsystems Coaching) as an approach to implementing the recommendations of National EMP Report (HSE 2012) should also support the implementation of the recommendations within this Guide.

Conclusion

Coordinated approaches to education and preparation, service planning, selection and appointment of RANPs/ANP Candidates, CPD and role expansion are required to enhance ANP services in ECNs nationally. Such coordination of effort to implement the recommendations in this Guide will contribute to the workforce planning agenda for the HSE, the National Clinical Programme for Emergency Medicine and the Department of Health. The benefits of realising the recommendations in this Guide include the RANP-led delivery of safe, appropriate, timely care; the enhancement of services being delivered EDs and LIUs nationally and the implementation of health policy regarding the establishment of hospital groups and the development of smaller hospitals (DoH 2013 a & b).

Introduction

This Guide to enhance Advanced Nurse Practitioner (ANP) services across Emergency Care Networks (ECNs) in Ireland has been prepared against the backdrop of a radical reorganisation of the way in which health services in Ireland are planned and delivered. The implementation of the National Clinical Programmes is a major change initiative introduced by the Health Service Executive (HSE) in 2010. The National Clinical Programme for Emergency Medicine (EMP) published '*A Strategy to Improve Safety, Quality, Access and Value within Emergency Medicine in Ireland*' (the National EMP Report, HSE 2012). This National EMP Report is a seminal document and a blueprint for how emergency services will be developed and delivered over the coming years. The EMP Report outlines how emergency nursing and the multi-disciplinary team contribute to the implementation of the programme. It provides a comprehensive outline of nursing roles and clinical skills particular to the specialist area of emergency nursing practice. The role of the ANP is also outlined (HSE 2012, p238) and the development of ANPs is considered essential to implementing the EMP strategy at national level. The Minister for Health published '*Future Health: A Strategic Framework for Reform of the Health Services 2012 – 2015*' (DoH 2012). This framework describes the vision for the future configuration of health services, outlining four pillars of reform and specific strategic goals for reforming the service delivery system to include hospital reforms and tackling the capacity deficit. In addition, the Minister for Health recently published two key documents to support Hospital System Reform: *The Establishment of Hospital Groups as a transition to Independent Hospital Trusts (DoH 2013a)* the *Securing the Future of Smaller Hospitals: A Framework for Development* (DoH 2013b). These DOH documents support the development of services in line with demographic needs and endorse the role of ANPs in relation to service delivery across ECNs.

The Special Delivery Unit (SDU) was established to address long waiting times in EDs (unscheduled care) and waiting lists for scheduled care. Hospitals have been set targets in this regard that are monitored by the SDU on a continual basis. Achievement of these targets requires professionals to adopt new ways of working and the continued roll out of improvement to performance management systems (DoH 2012). The National EMP Strategy (2012) supports the achievement of these targets.

1.1 Vision of the National Clinical Programme for Emergency Medicine

The overarching aim of the National Clinical Programme for Emergency Medicine (EMP) is to improve the safety, quality, access and value within emergency medicine in Ireland whilst reducing waiting times for patients in Emergency Departments (EDs) and Local Injury Units (LIUs) throughout the country.

The development of this *Guide to Enhance ANP Service Across Emergency Care Networks in Ireland* contributes to the workforce planning agenda for the HSE and DoH and assists in realising the specific workforce and nursing recommendations of the National EMP Report (HSE 2012 p230). In addition the Guide provides direction and support for continuing professional development of RANPs and supports career planning opportunities for emergency nurses.

The key objectives of this Guide are to make recommendations regarding the:

- Number and location of RANPs required in EDs/LIUs across ECNs in the future.
- Standardisation of the role and scope of practice of RANP.
- Standardisation of how ANP Candidates are selected, appointed and supported along an educational pathway towards registration as an ANP.
- Promotion of continuous professional development (CPD) and research and audit for RANPs.
- Promotion of enhanced career planning for emergency nurses.
- Sustaining ANP services.

1.2 Background to ANP Role Development

The role of ANP in emergency nursing was developed in 1996 to address a specific service need identified for patients with non-urgent clinical presentations to the ED of St James's Hospital, Dublin. It was the first role of its kind in Ireland and subsequently developed across a broad range of nursing specialist areas such as Diabetes Care, Stroke, Cardiology, Mental Health, Intellectual Disability and Midwifery Care. This development was enabled and supported by the robust national standards framework published by the National Council for the Professional Development of Nursing and Midwifery (NCNM) established in 1999 as a recommendation of *The Report of the Commission on Nursing* (Government of Ireland 1998, NCNM 2008a, b, Begley et al 2010). The NCNM is now dissolved and the application for post approval and registration of an ANP/AMP has transferred to the Nursing and Midwifery Board of Ireland (NMBI, previously titled An Bord Altranais).

Ireland is unique in having established frameworks and standards for the expansion of nursing and midwifery roles. The NCNM accreditation process for the establishment of Advanced Nurse/Midwife Practitioner (ANP/AMP) posts (NCNM 2008a) outlines the preparation of the hospital (organisation) site for the introduction of advanced practice roles. The process specifically emphasises the need to involve all clinicians in the development of an ANP/AMP service and the requirement to demonstrate service need. The NCNM also published criteria and standards required for the accreditation of ANPs/AMPs into approved posts (NCNM 2008b). Therefore, a process of site approval with a declaration of financial support for the ANP/AMP post is required in advance of an individual being registered to function in this post. Since the dissolution of the NCNM in 2010, the application for post approval and registration of an ANP/AMP transferred to the NMBI and the standards for site/post and post holder approval still apply.

1.3 Key Literature Findings regarding Contribution of the ANP to the Health Services

National and international studies have supported the development and expansion of the role of the ANP and have identified these practitioners as safe, effective, clinical decision makers who can contribute to service delivery and improve patient outcomes (Begley et al 2010). Strong support has been demonstrated in a number of Irish studies. *O' Shea* (2008) identified that the medical profession had a positive view of Clinical Nurse/Midwife Specialists and Advanced Nurse/Midwife Practitioners. Doctors believed these nursing roles provided good coordination of care and

welcomed the idea of more nurse and midwife-led services. Similarly the development of ANP roles in Irish health services clearly shows the esteem in which these practitioners are held. Begley et al (2010) undertook the first in-depth evaluation of Advanced Nurse/Midwife Practitioner roles in Ireland. The *Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland* is commonly referred to as the SCAPE report. SCAPE demonstrated conclusively that care provided by Advanced Nurse/Midwife Practitioners improves patient outcomes, is safe and acceptable to patients.

The SCAPE report included an economic analysis of ANP-provided services compared with the traditional medically-delivered service. It made particular reference to ANPs in EDs and demonstrated reduced costs for the cohort of care provided by ANPs managing 'minor injuries' (Begley et al 2010, p43). It recommended the development of Clinical Nurse/Midwife Specialist and Advanced Nurse/Midwife Practitioner posts and included the requirement for extensive dialogue with all clinicians and the need for strong clinical governance and guidelines on collaborative decision making. Previous work demonstrated that good communication with all key parties was essential in the preparation for advanced practice roles (NCNM 2005) and this continues to be vital. It is also reported that ANPs/AMPs demonstrated added value in having the capacity to meet the changing health needs of the population, address patient expectations, contribute to service reconfiguration and provide nursing and midwifery leadership.

1.4 Scope of Practice of RANP

RANPs undertake a process of registration with the Nursing and Midwifery Board of Ireland currently under criteria and standards set out by the NCNM in 2008. RANPs practice at a level above that of a Staff Nurse/Midwife or Clinical Nurse/Midwife Specialist (Begley et al 2010) and they are educated to Masters Degree level (Level 9 NQAI). RANPs manage a caseload of patients and deliver a full episode of care as an autonomous expert practitioner.

The scope of practice of RANPs in emergency care has evolved and expanded over the last 10 years to include a broad range of presentations involving complex conditions. However, the main scope of the role involves the management of non-life, non-limb threatening conditions, often referred to as 'minor injuries'. The range of conditions is comparable to the agreed list of conditions suitable to be treated in Local Injury Units (LIUs) in the National EMP Report (Appendix 1). RANPs also have additional education and competence in the prescribing of medicinal products and ionising radiation. These competencies further enhance the ability of the RANP to deliver a seamless episode of care to patients within their scope of practice and offer additional appropriate clinician capacity at the service level. The research and audit component of the ANP role enables RANPs to contribute to the production and monitoring of key performance indicators (KPIs) and the promotion and implementation of evidence based care within the clinical setting.

1.5 Governance and the ANP role

As previously outlined, there is a robust, strongly endorsed framework (NCNM 2008) in Ireland to guide the establishment of ANP/AMP posts. The ONMSD through the regional Nursing and Midwifery Planning and Development Units (NMPDU) provide

support to the Directors of Nursing/Midwifery when establishing an ANP site and developing an RANP job description. The site, job description, associated supporting material (guidelines, protocols etc) and the individual's education preparation and competencies are subsequently approved by the Nursing and Midwifery Board of Ireland. There are also strong national governance frameworks for the establishment of nurse prescribing of medicinal products and for the prescribing of medical ionising radiation (X-Rays).

Within the ANP Site Preparation document the governance and reporting relationships are outlined explicitly. Directors of Nursing and collaborating clinicians such as Consultants in Emergency Medicine agree the professional and clinical responsibilities and clinical caseload associated with the ANP role. When the caseload managed by an RANP is agreed, the competencies associated with that caseload are outlined and the RANP must demonstrate competence in managing the conditions that fall within it. The Clinical Indemnity Scheme (CIS) also recognises the ANP role and scope of practice within the healthcare organisation and healthcare system in general.

1.6 Current context - European Working Time Directive

The European Working Time Directive (EWTD) sets strict limits on the average working hours permitted for non-consultant hospital doctors (NCHDs). The implementation of the EWTD for NCHDs requires them to work a maximum of a 48-hour week. Recent problems recruiting NCHDs also have had a negative impact on the medical staffing of EDs (National Emergency Medicine Report 2012). The role of ANP in Emergency has the potential to support service delivery by providing a safe and efficient adjunct to NCHD delivered service and care.

1.7 Future context - Smaller Hospitals Framework & Reforming our Hospitals

The future organisation of acute hospitals is a major policy priority for the Department of Health. *Future Health* (DoH 2012) commits the Department of Health, working with the HSE, to drive implementation of programmes to reduce waiting times, to establish hospital groups and later independent hospital trusts. The National EMP Report (HSE 2012), in line with recently published Smaller Hospitals Framework (DoH 2013b), recommends the development of Local Injury Units (LIUs), as part of ECNs, to provide care for patients with non-life threatening or limb threatening injuries in smaller hospitals. This type of patient care and scope of practice is delivered currently by RANPs in many EDs around the country. RANPs will therefore be essential to the future development of LIU services and this is reflected in the proposed EMP Guidance on LIU Staffing (HSE 2013).

Summary

The National EMP Report (HSE 2012) recommends standardised, evidence based processes for patient assessment in all EDs/LIUs with an emphasis on effective patient streaming and minimisation of delays for patients. In addition the National

EMP Report recommends standardised workforce planning and staffing models to ensure equitable and appropriate staffing in all EDs/LIUs and ECNs. With increasing demands on the health system there is a continued requirement for smarter, more efficient, more cost effective methods of care delivery, whilst maintaining the provision of safe quality care to patients. The ANP role has the potential to positively impact meeting these increased healthcare demands. In light of the above, the EMP working group with the support of the ONMSD, commissioned a review and development of this Guide to enhance ANP nursing services across ECNs in Ireland. The following section outlines the current capacity and clinical activity of RANPs in Ireland.

Findings on Advanced Nurse Practitioner Capacity

2.0 Introduction

As with any workforce-planning project it is appropriate to explore current resources before making any workforce recommendations for the future. This section describes the background and methodology used to investigate the current capacity of ANP services in emergency departments in Ireland and the key issues that relate to ANP role development across the country.

Key Findings

- There are 45 (43.3 WTE) Registered ANPs in EDs in Ireland - 41 (38.8 WTE) are x-ray prescribers, 36 (35.2 WTE) are registered nurse prescribers.
- An additional 28 (27.8 WTE) ED nurses are at various stages of education and training working towards ANP. (16 WTE are Candidate ANPs, 8 WTE ED nurses have completed ANP education and training but are not in an ANP post and 4 (3.8 WTE) are undertaking ANP education but are not in candidate positions).
- 22 Emergency Departments have an established ANP service.
- 30 Emergency Departments have ANP Site Approval from the Nursing and Midwifery Board of Ireland.
- Almost 60,000 Patients had an episode of care delivered by an RANP across 21 EDs in 2011.
- The caseload of RANPs is primarily non-life, non-limb threatening injury and illness.
- A number of EDs have RANP-led or RANP-supported review clinics.
- Research, audit and continuing professional development arrangements for RANPs vary across organisations.

2.1 Methodology

Two methods of investigation were used to gather specific information profiling the current situation regarding ANP capacity, role development and service activity in EDs in Ireland. These were the:

1. Emergency Department National ANP Survey
2. HSE Regional Consultation Workshops.

2.2 Emergency Department National ANP Survey

The aim of the survey was to capture information regarding the current RANP capacity, ANP service and relevant service planning activity in all EDs in the country at a point in time (Appendix 2). The survey reflects the position as of 21st March 2012.

The objectives of the survey were to:

- Establish the current RANP resource in EDs in Ireland;
- Establish the level of educational preparation of other emergency nurses to scope future potential for the ANP resource development;

- Gather information on the ANP service planning activity for EDs;
- Review hours of service and service activity in all established ANP services;
- Establish the age profile of patients managed by RANPs;
- Review the current scope of practice and clinical caseload in all established ANP services;
- Gather information regarding organisational support for RANP activities e.g. audit/research and continuing professional development;
- Gather information regarding other RANP roles within organisations supporting ED activity.

2.2.1 Design
A customised survey (Appendix 2) to capture the data was developed by the EMP service planner and ANP advisor.

2.2.2 Sample
The survey was distributed to every Director of Nursing in the country where there was an ED within their Hospital. A cover letter explaining the rationale for the survey accompanied the proforma (Appendix 2). The survey information was gathered between April to June 2012.

2.3 ANP Survey Findings and Analysis

Survey data returned was entered into a secure Excel spreadsheet to support analysis. The survey findings were as follows.

2.3.1 Survey Response

There are thirty-eight EDs and LIUs in the country. Thirty-three (33) units (87%) completed and returned the survey. Twenty-one have an established functioning ANP service (totalling 44 RANPs). Thirty have approval from the National Council / NMBI as an ANP site. Eleven units do not have an established ANP service but completed the relevant parts of the survey. The five units who did not complete the survey were followed up by email and direct contact. None of these had an established ANP service. The reason given for not completing the survey was that there was no ANP service anticipated for that unit in the immediate future.

Since completion of the survey one department commenced an ANP service in September 2012, bringing the total of RANPs to 45 in 22 EDs nationally.

2.3.2 ANP Resource

The survey sought information on the numbers of RANPs in post, the numbers of ANP Candidates in post, the number of RANPs with additional registerable qualifications and education in prescribing medicinal products (registration as an RNP) and in prescribing ionising radiation (X-Ray). Questions relating to the ED nursing resource that had MSc level education and service planning were also included.

2.3.2.1 Registered ANP

There are forty-five registered ANPs (43.3 WTEs) in post in twenty-two established ANP services in Ireland.

2.3.2.1 ANP Candidates

There are sixteen (16) ANP Candidates at various levels of education and clinical preparation in departments around the country. These candidates should be ready for registration in 2013 or 2014

Table 1: Registered and Candidate ANPs in emergency units nationally, March 2012

	In post		Registered Nurse Prescriber (RNP)		Authorised to prescribe ionising radiation	
	Head count	WTE	Head count	WTE	Head count	WTE
1.1) Number of Registered ANPs	45	43.3	36	35.2	41	38.8
1.2) Number of nurses in ANP Candidate position	16	16	7	7	6	6

2.3.2.2 ED nurses completed ANP Education but NOT in Candidate Position

Eight WTE nurses (Table 2) have successfully completed education programmes and have demonstrated competence in clinical practice at the level of ANP but are not currently in an ANP Candidate position. (There is no local post approved).

2.3.2.3 ED nurses undertaking MSc ANP education but NOT in candidate position

There are four (WTE 3.8) nurses (Table 2) undertaking an M.Sc. in Advanced Practice at present who are not in an ANP Candidate position.

Table 2: ED Nursing staff who have commenced education preparation: March 2012

	In post		Registered Nurse Prescriber (RNP)		Authorised to prescribe ionising radiation	
	Head count	WTE	Head count	WTE	Head count	WTE
1.3) Number of nurses who have successfully completed MSc ANP education but are NOT in ANP Candidate positions	8	8	1	1	0	0
1.4) Number of nurses currently undertaking MSc ANP education but are NOT in ANP Candidate positions	4	3.8	2	1.8	0	0

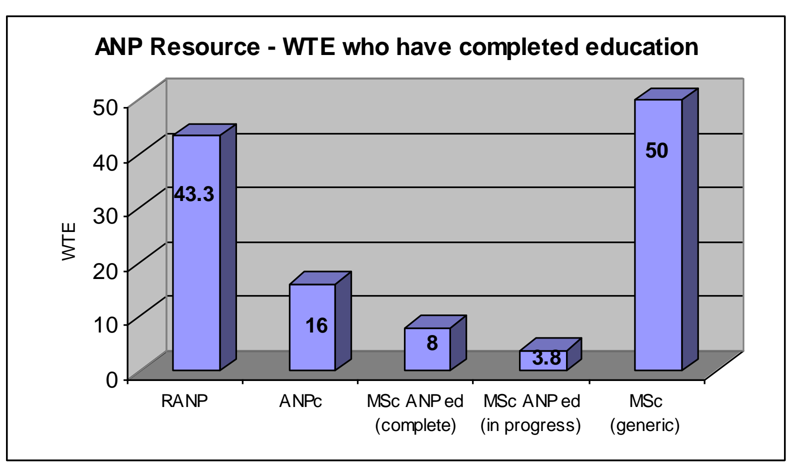
2.3.2.4 ED nurses who hold an MSc. in Nursing not currently undertaking ANP pathway

Table 3: ED nurses who hold an MSc in Nursing but not currently on an ANP pathway, March 2012						
	In post		Registered Nurse Prescriber (RNP)		Authorised to prescribe ionising radiation	
	Head count	WTE	Head count	WTE	Head count	WTE
1.5) Number of nurses who hold an MSc in Nursing NOT currently on an ANP career pathway	51	50	1	1	1	1

Fifty one (WTE 50) nurses in units around the country have achieved an M.Sc. in Nursing (table 3). These nurses are in addition to the RANPs and ANP Candidates who hold or are working toward a Master's degree. Whilst many of these nurses may not be on a clinical career pathway toward ANP, some may be considered as potential for future ANP posts and having already completed part of the educational requirement for registration as an ANP their educational preparation to ANP level may be accelerated.

Figure 1 below gives a breakdown of data collected in the ANP resource section of the survey

Figure 1:



2.4 ANP Service Planning

Information regarding service planning, career planning strategy and post approval was gathered to ascertain the level of planning conducted by individual services.

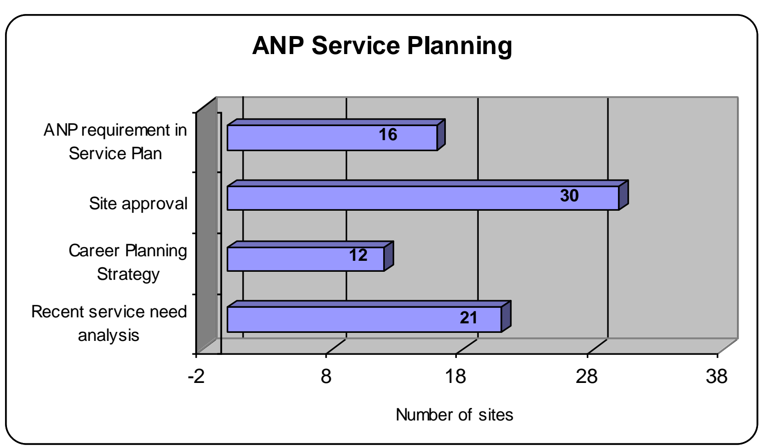
2.4.1 Recent service needs analyses were carried out in 21 departments – 64% of responding departments.

2.4.2 Services were asked if they had a career planning strategy within their unit identifying suitable nurses to be supported towards ANP. The findings reveal that a career planning strategy is in place in 12 departments (36%).

2.4.3 Site approval has been obtained under current NCNM/ABA criteria and standards for 30 emergency departments (91%).

2.4.4 Respondents were asked if the requirement for ANP posts for their unit had been included in the Unit/Organisation Service Plan 2012/2013. The findings confirmed that the requirement for ANP posts was included in service plan 2012/2013 in sixteen departments (48%).

Figure 2:



2.5 ANP Service Activity

Each site with an established ANP service was asked to submit details regarding caseload and activity. Information regarding the triage category of patients and review clinic arrangements was also requested.

2.5.1 Yearly total attendances including scheduled returns

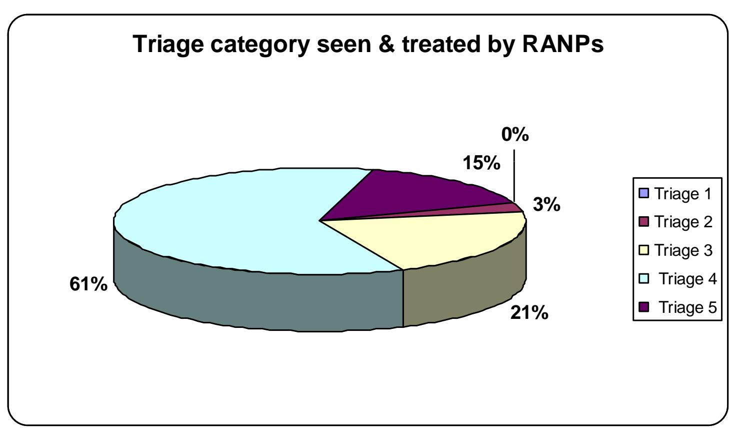
Twenty-one departments with an established ANP service returned activity data for 2011. Just over 7,840 children had an episode of care provided by RANPs across the three children's EDs. In mixed departments 24,907 adults and children were managed and in adult only departments 26,594 patients had an RANP-delivered episode of care. The total number of patients who had completed episodes of care by RANPs for 2011 was 59,341 (combined new and review patients). This equates to 1,370 patients seen and treated by each ANP WTE. Some units have only one RANP in their service which restricts weekly hours of service. Others have a number of RANPs - up to six WTEs - delivering a service over a twelve hour day, seven days per week.

Some units were unable to provide a breakdown of new and return attendances due to lack of an electronic information system.

2.5.2 New ED attendances per triage category

Eight (8) units were able to provide the breakdown of attendances seen and treated by RANPs by triage category. For the remaining 13 the triage category of patients was predominately Manchester Triage System (MTS) Triage 4 (61%). However a number of ANP services managed patients from Triage 1, Triage 2 (3%), Triage 3 (21%) and Triage 5 (15%) categories. Some units were unable to report this information due to lack of an electronic information system.

Figure 3:



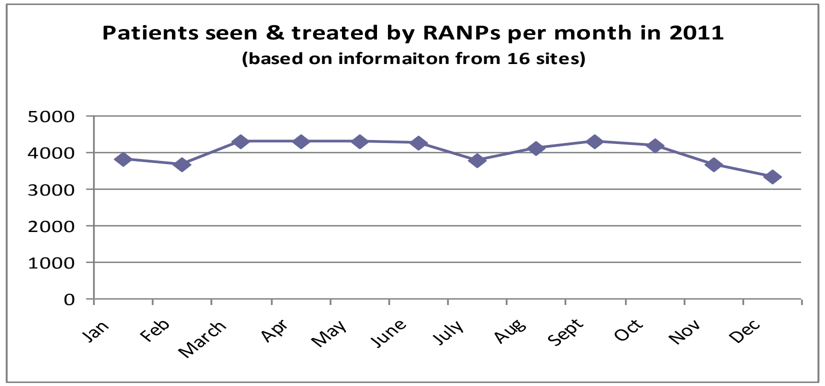
2.5.3 RANP-led review clinics

Eighteen out of twenty-one units have a review clinic that involves RANP reviews. Eleven have an established RANP-led review clinic and seven departments report that RANPs participate in a Consultant-led review clinic. Review clinics are predominantly held in the morning and patients were generally seen by appointment only. Two services report an ad-hoc arrangement for small numbers of RANP-treated patients requiring review.

2.5.4 Attendances per month

Sixteen out of the twenty-one sites were able to provide patient attendance breakdown per month. These are presented in the graph below. The number of patients seen and treated by RANPs in 2011 was reasonably consistent throughout the year.

Figure 4:



2.5.5 Age Profile of Patients

The age profile of patients managed by RANPs was also investigated. In departments with mixed Adult and Children's services the age range of children varied from 18 months to 16 years (15 sites). Children-only RANP Service (three sites) varied from birth to 16 years. Adult-only sites varied from 14 years and upwards (5 sites) to 16 years and upwards (5 sites).

2.6 RANP Scope of Practice

A review of the caseload of the 21 ANP services was also carried out with regard to the list of clinical conditions being managed in the service. The range of conditions was similar across 20 established ANP services and included predominantly non-life, non-limb threatening musculoskeletal conditions. A number of services had a more expanded list of conditions that included dental conditions, eye conditions, maxillofacial injuries, shoulder dislocation and isolated rib injuries. Closer examination of the ANP services with a more expanded scope of practice revealed that each had at least three RANPs in their service and the service had been established for more than five years.

One ANP service had a scope of practice that manages a cohort of patients with medical and surgical presentations as part of a Rapid Assessment and Treatment system of streaming patients through an ambulatory care pathway within the ED (Appendix 3). This service has been established with strong support from Consultants in EM and Diagnostic Imaging. The service operates during daytime hours and there is a middle grade doctor present. The RANP practices as part of a team approach to streaming the specific cohort of patients. The RANP has the authority to refer patients for a range of investigations and based on the results of these can discharge or refer patients to other clinicians for continuing care.

2.7 Audit / Research and Continuing Professional Development (CPD)

There was a variety of audit / research and CPD arrangements reported. These ranged from *ad hoc* or no rostered hours arrangements to 16 hours protected time per month. In general, it was noted that there was no rostered period of time allowed and/or that clinical demands were such that there was little or no time for this activity.

2.8 Other RANP services supporting ED

Six departments reported having support from RANPs with condition-specific scope of practice such as ANP (Emergency Cardiology), ANP (Liaison Psychiatry) and ANP (Stroke Care). In four (4) EDs these RANPs were part of the ED staffing establishment with ANP (Emergency Cardiology) accounting for two such posts.

2.9 Survey Summary

The survey results, demonstrate that there has been significant capacity established in emergency units to date. Thirty (30) out of thirty-eight (38) units have site approval for ANP posts from NMBI (Appendix 4). There are twenty-one (21) EDs with an established ANP service. There are 45 RANPs (43.3 WTEs) with a further twenty eight nurses at various stages of education and training for ANP practice. Eight nurses have successfully completed Advanced Practice education programmes and

have demonstrated competence in clinical practice at the level of an RANP. Sixteen departments have funding for ANP posts included in their hospital service plan submissions for 2013.

Almost 60,000 patients have had an episode of care provided by an RANP in Ireland in 2011. A number of departments have either an RANP-led review clinic or Consultant in EM-led clinic supported by an RANP.

The age profile of patients within RANP caseload ranges from birth to 16 years. The RANPs in paediatric EDs are the only RANPs who see children from birth.

The management of non-life, non-limb threatening conditions is the most common caseload in units with an established ANP service. Only one service reported a cohort of patients managed within an RANP-delivered/led Rapid Assessment and Treatment service with clinical presentations of a surgical and medical nature.

Research, audit and continuing professional development arrangements for registered ANPs vary across organisations. The time allocated to these activities ranges from no formally agreed hours to 16 hours per month with ad-hoc arrangements in the majority of hospitals. Some respondents, mainly in single-handed RANP services, cited demand from clinical caseload as leaving little or no time for CPD, audit or research activities.

Regional Consultation Workshops – Focus Group

Regional Consultation Workshops were conducted in the four HSE Regions (HSE Dublin North East, HSE Dublin Mid-Leinster, HSE South and HSE West) over a two-week period in July 2012.

2.10.1 Purpose of Focus Group

The aim of the workshops was to consult with Directors of Nursing, relevant nurse leaders, ED nurse managers, RANPs and ANP Candidates to gather in-depth information relating to ANP services from those closest to ANP role development and service delivery. Meeting colleagues face to face assisted in validating information gathered through the ANP survey. The key objectives of the workshops were to gain insight and relevant information regarding the following themes that were circulated to participants and colleagues for consideration in advance of the workshop:

Table 4: Consultation Workshop themes

Theme 1 - Workforce Planning (Resource - Current and Potential)
How do RANPs contribute to service delivery (Quality, Access and Value & Cost)? What are the issues to be considered in developing an ANP service? What are the issues (challenges) for approved ANP sites? What is the impact of RANPs on the required numbers of other staff groups?

Theme 2 - Education for ANP Practice
What are the key priorities in relation to educational preparation of ANPs? What are the key factors when determining the Scope of Practice of RANPs? What are the key priorities in relation to competency development of RANPs? What other factors need to be considered?

Theme 3 - Continuous Professional Development (CPD) for RANPs
What are the challenges for maintenance of competencies? What are the key factors in achieving competency maintenance? How can CPD for RANPs be optimally managed?

Theme 4 - Career Guidance for ED Nurses
What is the value of succession planning for nursing in EDs? How can succession planning be optimally achieved? Who is responsible for implementing these initiatives?

Theme 5 - Communication with Key stakeholders
What are the key internal and external influences in the development of ANPs? Who are the key stakeholders in the development and delivery of ANP service? How should communication with these key stakeholders be managed?

2.10.2 Focus Group Participants

Participants were recruited with the assistance of regional Nursing and Midwifery Planning and Development Units (NMPDU) and Directors of Nursing throughout the country. The focus group sessions were arranged and facilitated by the NMPDUs in each HSE region. Directors of Nursing participated in these sessions and also nominated relevant groups of nurses pertinent to EDs to participate.

2.10.3 Focus Group Design

In order to maximise the information gathered and ideas that people could contribute in the course of the workshop, participants were emailed the list of five themes (Table 4) in advance and asked to consider and discuss these themes with colleagues in clinical practice.

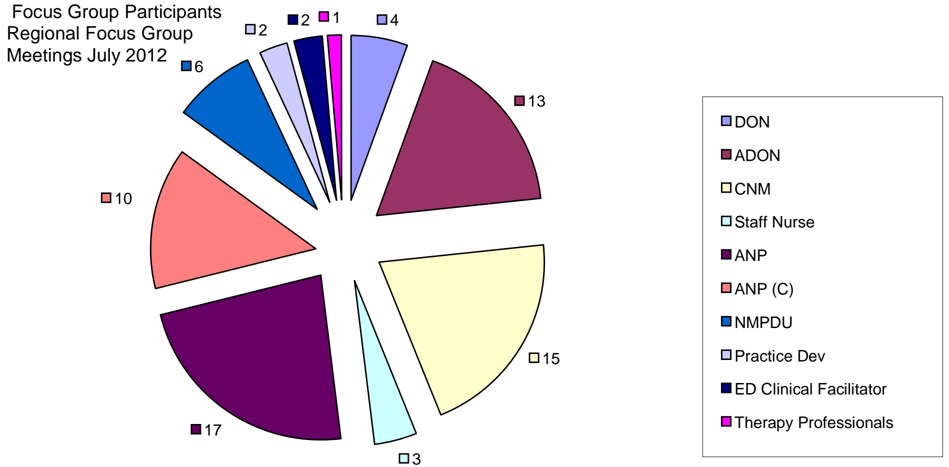
The workshops were conducted in a structured format by experienced facilitators. The EMP Service Planner and ANP Advisor attended each workshop. Staff who were unable to attend were invited to contribute, by submitting comments via email. Comments were submitted by email by two RANPs and these were incorporated into the relevant theme results.

2.11 Focus Group Results

A total of seventy-three (73) participants attended the workshops representing Directors of Nursing, Assistant Directors of Nursing, ED Clinical Nurse Managers (2&3), RANPs, ANP Candidates, ED Staff Nurses, Nurse Practice Development Co-ordinator, ED Clinical Facilitator, NMPDU and Therapy Professionals (Graph 1). Generally there was enthusiasm for the development of a guide to enhance ANP services in ECNs, with many participants paying tribute to the contribution that RANPs make to the day-to-day functioning of EDs. The contribution of ANPs is seen as providing a 'one stop shop' service to patients which results in improved patient experience and satisfaction. Participants felt that RANPs provide a positive role model for all members of the multidisciplinary team. There was full acknowledgement of the contribution made by the National Council in developing the ANP Establishment Framework. This framework has given, and continued to give, clear direction regarding criteria and standards for post development and educational preparation for RANPs nationally.

It was generally acknowledged that a cohort of expert, highly skilled RANPs now existed in many ED's in all regions around the country.

Figure 5:



2.11.0 Focus Group Key Themes

The following is a synopsis of the issues raised and comments made during the workshops under the five key themes.

2.11.1 Workforce Planning (Resource - Current and Potential)

Participants were asked to consider a number of workforce planning issues, both current and potential, regarding ANP role development. The initial question related to how RANPs contribute to service delivery with a focus on the key elements of the EMP strategy to improve 'quality, access and value' for patients. The responses were recorded under the following headings:

Quality

- *RANPs reduce waiting times for patients - participants cited audits from their service that demonstrated improvements of 20% in the total patient experience time.*
- *RANPs facilitate patient streaming through efficient and improved patient flow*
- *RANPs have demonstrated competence in clinical assessment and management of the patient caseload through formal education programmes and through locally agreed clinical supervision arrangements with Consultants in EM.*

Access

- *RANPs improve patient access to a specific service for non-life threatening injuries. Service needs analyses carried out by approved ANP sites as part of the site approval process reviewed patient attendances by triage category and complaint and identified that in excess of 66% of all ED attendances were suitable to be managed by an RANP.*
- *Working towards achieving the national six-hour target was reported as an enabler to ANP service development while improving the patient experience.*

Value and Cost

- *As experienced members of the multidisciplinary team, RANPs act as a resource and support to the team. They provide formal and informal education and clinically supervise members of the team on an ongoing basis.*
- *RANPs were described as being cost effective in terms of added value to the patient experience – "less recalls for missed fractures", "improving provision of patient information resulting in less unplanned re-attendances".*

Issues to be considered in developing an ANP Service (approving sites and developing role)

An overwhelming concern expressed by participants was the continued effect of the moratorium on recruitment and securing whole time equivalent (WTE) funding for ANP posts.

Other issues identified included:

- *Absence of a single central reference point (agency) to support ANP role development. The dissolution of the National Council was cited as negatively impacting on the speed and coherence of role development across the system;*
- *Senior management support was cited as essential for service development and thus ANP role development. The current climate of fiscal constraints and the moratorium on recruitment were seen as negatively impacting on managers' ability to support;*
- *Lack of suitably qualified and educated nurses willing to undertake the additional education and training necessary for ANP pathway were some of the reasons offered for not filling approved ANP posts in some EDs;*
- *Lack of understanding of the role and the scope of practice by senior nursing management also made it difficult for RANPs in single-handed services to make the case for additional RANPs.*

What are the challenges for approved ANP Sites?

There were a number of challenges for sites which have an established ANP service including funding additional numbers of RANPs and the lack of a formal capacity building and succession planning strategy. Limitations to the current scope of practice and inability to expand the scope to manage other clinical conditions were mainly attributed to time constraints on further education and competency development. Other issues highlighted included:

- *Workforce planning not currently including review of MDT workforce and not developing integrated plans in response to service needs;*
- *Sustaining/maintaining Consultant in EM participation in ongoing clinical supervision being difficult due to conflicting work demands;*
- *Inability to expand RANP scope of practice due to lack of formal CPD for RANPs;*
- *Lack of a nationally agreed process for assessing the requirement for ANP staffing in EDs and networks;*
- *Inability to prescribe ionising radiation (X-Ray) for children in mixed departments and children only departments causing inequity in service, time delays and disruption of the patient flow through the episode of care.*

What is the impact of an RANP on other staff groups?

Overall there was agreement that an ANP service was beneficial to other staff groups, in particular junior doctors and ED nurses.

- *ANP service positively releases other staff- ED nurses, NCHDs - to manage the more complex injured and ill patients;*
- *RANPs contribute to education of MDT and provide clinical supervision of junior staff grades in the management of wounds and minor injuries;*
- *One concern noted was the loss of experienced ED nursing staff 'from the ED floor' when recruited into ANP posts.*

2.11.2 Education for ANP Practice

What are the key priorities regarding the educational preparation of RANPs?

There was unanimous agreement that education programmes should include a clinical module specific to the specialty. A national approach to planning ANP educational preparation should be adopted which incorporates a plan for supervised clinical practice in a similar way to Specialist Registrar (SpR) training in Emergency Medicine. In addition, participants suggested the following areas should be addressed:

- *Consistency across the system for release of nurses/ ANP Candidates to undertake the required educational programme and gain the experience in managing clinical caseload relevant to service need;*
- *Creation of practice development supports and links with third level colleges;*
- *Increased flexibility in the delivery of educational modules to support the scope of RANP's practice in response to service needs. A process to revisit competency attainment was necessary;*
- *Delay in the approval process for ANP candidates that result in individuals requiring to up-skill or revisit competencies. There is no provision for this up-skilling or approval currently;*
- *The inclusion of nurse prescribing of medicinal products and ionising radiation (to include children) in advanced practice education programmes in a standardised manner.*

What are the key factors when determining the Scope of Practice of RANPs?

There was general agreement that scope of practice should be developed in order match service need, demographics and geography of the network/region. Key factors reported included:

- *Patient and service needs;*
- *Current health and nursing strategies and policies;*
- *National model / framework for scope of practice with guidance from the Nursing and Midwifery Board of Ireland;*
- *Involvement in a network of hospitals to allow movement of ANPs across the network to support services as dictated by service needs;*
- *Scope being kept broad to allow for expansion;*
- *Standardised job description / specification;*
- *A capacity to change scope when service needs change- responsiveness to service change.*

What are the key priorities in relation to competency development for RANPs?

A number of issues were raised including:

- *Line manager, senior management and senior clinical support in the organisation (DON, CEO, Consultant in EM) which were considered essential;*
- *RANP self-motivation to maintain and develop new competencies;*
- *Sharing and linking with departments with established ANP services in the network or region creating an opportunity to share best practice;*
- *Monitoring of the other strands of RANP role such as audit and research as these may be neglected due to the demands incurred achieving clinical competence;*
- *Development of ANP (Emergency) Forum facilitated by the EMP.*

2.11.3 Continuous Professional Development for Registered ANPs - challenges in maintaining competencies

There was unanimous agreement that the main challenges for registered ANPs in relation to CPD were 'time' based. The key issues raised were as follows

- *CPD being limited by service demand with little time for audit, research or clinical supervision/peer review;*
- *Up skilling affected by constraints on time, resources, lack of co-ordination and training plan;*
- *The need for adequate clinical exposure to maintain competence in practice – this may require off-site development (e.g. with another established ANP service) – which can be difficult to arrange due to time constraints;*
- *Absence of formal educational courses / units of learning beyond MSc for registered ANPs;*
- *Need for a department /network approach to research and audit.*

How can CPD for RANPs be managed?

There was overall agreement that CPD for RANPs could be managed by utilising the MDT to facilitate education and skills training.

- *Coordination of CPD - perhaps through an ANP forum facilitated by the EMP;.*
- *Requirement for a formal structure - annual outputs such as audits should guide CPD requirements of individual RANPs and scope of practice required by service;*
- *Allocation of a standardised minimum number of hours to CPD across system and built into roster;*
- *Integration of CPD across MDT - linked to departmental / network education and research priorities;*
- *Standardisation of clinical logbook for ANP Candidates with sign off after achievement of designated clinical hours;*
- *Use of existing ED expertise and resources e.g. delivery of tutorials, workshops, units of learning, master classes facilitated through network, region;*
- *Facilitation of integrated / shared learning /study hub using EMP website.*

2.11.4 Career Guidance for ED Nurses / Succession Planning

It is generally accepted that succession planning is required to maintain the quality and level of service within the system. Succession planning will:

- *Encourage new graduates to view advanced practice as a viable career pathway without creating false expectations;*
- *Build a service / system / structure to develop skills, knowledge and competence for the succession line - protecting costly investment of time and money in establishing a service;*
- *Facilitate staff retention;*
- *Provide a career pathway in clinical practice for those not wishing to move into a management or educational pathway.*

How can succession planning be optimally achieved?

A clear understanding of the benefits of workforce planning, coupled with a strategic approach to education and recruitment were the key solutions identified by participants to successfully future-proof ANP roles. Specific factors identified included:

- *Starting succession planning with student nurses on clinical placement;*
- *Introducing National / regional / Network / local integrated service planning;*
- *Pro-active management with clearly defined role, career pathway and anticipated ANP post numbers;*
- *Developing a career guidance pack supported by EMP;*
- *A shadowing or 'Buddy' system to promote the role as a career option - grow people from within the ED or network;*
- *Regular staff performance review and personal development planning (PDP) to identify talent early in order to facilitate identification of appropriate educational track;*
- *RANP input at senior management level - involvement in selection of suitable ANP Candidates;*
- *Transparency in selection process with a standard approach to selection and appointment of ANP Candidates;*
- *Identification of supports in advance through a standard job description for ANP Candidates;*
- *Development of a repository of education programmes, relevant short courses, ED specific case studies, teaching aids etc. using the EMP website.*

2.11.5 Communication with Key Stakeholders

How should communication with key stakeholders be managed?

The following suggestions were put forward:

- *The ED Nurse manager to co-ordinate audit data to support business case for role development;*
- *Regular face-to-face update meetings with Director of Nursing / practice development;*
- *Formal arrangement with clinical supervisor for regular clinical supervision of RANPs;*
- *Establishment of Key Performance Indicators (KPIs) for service / network/ region;*
- *Sharing of KPI results with key stakeholders and annual publication of results;*
- *Provision of formal Emergency Medicine Programme support.*

2.12 Analysis and Discussion of Findings

It is clear from the information gathered that RANPs are recognised as a valuable nursing resource that contributes positively to the patient's journey through the ED or Local Injury Unit. The current embargo on recruitment and lack of funding for the development of new posts is cited as the greatest challenge to a national strategy for ANP development/capacity building.

The positive benefits to other members of the MDT in terms of education and role modelling were also highlighted. The challenges involved in developing new and additional ANP services were seen as mainly financial but concerns were also expressed about diminution of the pool of skilled experienced ED nurses in order to train as RANPs. This development therefore needs a staged approach to ensure adequate numbers of competent clinical nurses continue in post to address core ED activities.

There were strong views expressed in relation to educational preparation of ANP candidates and it was emphasised by many that the content of the curriculum should be specifically linked to the caseload and scope of practice of an RANP in emergency care. The curriculum should also incorporate nurse prescribing of medicinal products and ionising radiation and clinical partners should be involved in the delivery of the content.

The role of the RANP in relation to research and audit were considered but it was acknowledged that this was often neglected due to lack of time due to the demands of delivering a service and the lack of formal structures within the ED to support the RANP such as the provision of protected time on the duty roster.

Difficulties with ongoing CPD and skills maintenance for RANPs were raised by many RANPs. It was suggested that a co-ordinated approach was needed to address specific educational needs of this group and that judicious use of current resources could facilitate units of learning being developed to assist individuals who had particular educational needs.

The majority of participants acknowledged that career guidance and succession planning required attention if an ANP service was to be maintained into the future. It was agreed that profiling and personal development planning was required at local level to encourage junior ED nurses to consider their career pathway and prepare for either a management or a clinical route. Positive role modelling and mentorship of junior staff by RANPs was seen as a natural method of generating interest in this role as a career option. Communication with key stakeholders was also seen as a crucial element in successful ANP role development.

Ensuring a good understanding of the benefits that the development of such roles can bring to patients and the organisation was seen as a priority. Sharing results of key performance indicators and audits of patient outcomes was seen as a very important means of highlighting important quality aspects of the role.

2.13 Summary

The information gathered through the national ANP survey along with the views and experiences of the participants of the regional consultation workshops provide valuable information regarding the current situation of ANP services in Ireland. The findings from both sources have informed the development of the guidance and recommendations presented in next section of this Guide.

A Guide to Enhance Advanced Nurse Practitioner Services across Emergency Care Networks in Ireland

3.0 Introduction

This section outlines the strategic direction which is required to develop ANP services to support the workforce planning agenda of the National EMP Report (2012) The Guide makes recommendations to enhance ANP services across ECNs and has been informed by the findings outlined in Section A.

3.1 Aim and Objectives

The aim of the Guide is to increase the capacity of Registered Advanced Nurse Practitioners (RANPs) in the national emergency care system to support the improvements in quality and in timely access to care for patients attending EDs and LIUs.

The key objectives of this Guide are to make recommendations regarding the:

- Number and location of RANPs required in EDs/ LIUs across ECNs in the future.
- Standardisation of the role and scope of practice of RANP
- Standardisation of how ANP Candidates are selected, appointed and supported along an educational pathway towards registration as an ANP.
- Promotion of continuous professional development (CPD) and research and audit for RANPs, as well as enhanced career planning for emergency nurses.
- Sustaining ANP services.

3.2 Advanced Nurse Practitioners current resource and projected requirements

The projected requirements are based on feedback on service requirements analyses in various departments where RANPs currently exist and by units that are exploring the development of these roles. The service planning process involves examination of the caseload of patients attending EDs and matching this to the scope of practice of RANPs – similar to the agreed list of conditions suitable for Local Injury Units (Appendix 1).

3.2.1 Hours of Service

Results of audits to date indicate that the majority of patients seen and treated by RANPs attend EDs during daytime hours. Six EDs carried out this exercise and validated the findings where up to 75% of patients with non-complex, non-life, non-limb threatening conditions attend EDs between the hours of 08.00 and 20.00 hours. **It is therefore recommended that an RANP-led service is available between 08.00 and 20.00 hours 7days a week**. This can be adjusted locally to reflect trends in presentations to the ED e.g. RANPs may not be required to start until 10.00 or 11.00 and may be required to provide a service up until 22.00 or 23.00 hours. The

service requirement can be established through audits reviewing current presentations (type, time etc.) to the ED.

3.2.2 RANP Hours and WTE requirement

One WTE RANP is available to provide clinical care 1,460 hours per annum (Table 5). The RANP role has additional responsibilities such as clinical audit, implementing evidence based research, education of the MDT, mentoring and clinical leadership. These activities should be accounted for in staffing calculations. A minimum of 100 hours per annum is recommended to be included for these purposes and has been factored into the calculations below. Additional support and facilitation to support the CPD requirements of the RANP will be required locally. This should be agreed locally and reviewed annually with the Director of Nursing, ED nurse manager and RANP.

Table 5: ANP availability incorporating 20% time-out				
Grade	**Working hours/week**	**Working hours/year**	**20% time out**	**Available Working hours/year**
ANP	**37.5 hours**	**1,950 hours**	**390 hours time out**	**1,560 hours – 100 hours pa approx. for CPD = 1460 hours**

3.2.3 RANP Projected WTE Requirement

The service planning initiatives conducted in various EDs where RANPs are established revealed that there are 2 RANPs on duty in larger EDs and 1 RANP on duty in smaller units. Based on the WTE calculation as described in table 5 above, this translates to a requirement for 6 WTE in larger EDs and 3 WTE in EDs with less activity and LIUs.

The EMP Guidance on Local Injury Unit (LIU) Staffing (HSE 2013) recommend that one senior clinical decision maker, is on duty to cover the hours of opening of an LIU. A Senior Clinical Decision Maker is defined as an RANP, a Middle Grade Doctor (Registrar, SpR or Staff Grade/Associate Specialist) or a Consultant in Emergency Medicine. The guidance document states that "*Currently, Senior Clinical Decision Maker roles in established LIUs are fulfilled either by doctors only (Consultants/Middle Grades) or by both doctors and RANPs as all LIUs are required to have a Middle Grade doctor present at all times. The potential for LIU staffing to migrate to a predominantly RANP-provided service is recognised"* (HSE 2013).

The projected requirements based on service needs analyses are outlined in Table 6. For the purposes of this report these projections are guided by activity/attendance data and are in line with feedback and data received from established ANP services. The projected requirements for RANPs in LIUs are to fulfil the vision of migrating to a predominately RANP-provided service. These projections are based on a requirement for one RANP on duty in LIU 12/7. When LIUs are established and attendance patterns become clear, the number of senior clinical decision makers required on duty will be reviewed (HSE 2013).

The actual requirement for RANP numbers should be based on local service demand/activity and will be influenced by the number of new patient attendances,

patient acuity, staff mix, skill mix, scope of practice of the RANP and the unit environment. Other factors will need to be considered in the future such as hospital groups and geographical location of services.

The projections based on current service need to provide 12 hour RANP-led services across current ECNs indicate that 147 WTE RANPs are required nationally (Table 6).

Table 6: Projected requirements based on service needs analysis			
24/7 ED Attendance > 37,500	**24/7 ED Attendance < 37,500**	**LIU**	**Paediatric EDs**
2 RANP on duty (6WTE)	**1 RANP on duty (3 WTE)**	**1 RANP on duty (3 WTE)**	**1 RANP on duty (3WTE)**
10 sites	15 sites	11 sites	3 sites
60	**45**	**33**	**9**
Total 147			

3.2.4 Supply and Demand Gap analysis

Based on the information collected in Section A and comparing this supply with projected requirements in Table 6, the deficit is identified for each region and presented in Table 7. The ANP Survey results show that there are 20 ANP Candidates in post while other EDs have reported that 4 nurses have commenced ANP education programmes in September 2012. Service Planning information in the survey indicates that 16 ANP posts (in total) are included in individual hospital service plans for 2012. This suggests an anomaly in relation to service planning and funding for ANP posts which requires further investigation and clarification by the executive management teams of hospital / hospital groups or Trusts.

Table 7: ANP Supply & Demand Gap analysis				
ANP Resource June 2012 & Workforce Planning Projected Numbers per geographical region				
Region	Sites	Registered ANP's (WTE)	Projected required number of RANP's	Deficit
North East	**4 sites**	**7.75**	**15**	**7.25**
Dublin North	**3 sites**	**11**	**15**	**4**
Dublin South	**6 sites**	**7.2**	**27**	**19.8**
Midlands	**3 sites**	**2**	**9**	**7**
South East	**4 sites**	**5**	**15**	**10**
South	**6 sites**	**4.88**	**21**	**16.12**
West	**4 sites**	**1.5**	**15**	**13.5**
Mid West	**4 sites**	**0**	**15**	**15**
North West	**2 sites**	**1**	**6**	**5**
Children's Hospitals	**3 sites**	**3**	**9**	**6**
Overall Total		**43.3**	**147**	**103.7**

3.2.5 Capacity Building Plan

Table 8 outlines a four-year plan for phased implementation of approved ANP posts and RANPs to reach the numbers identified in Table 7.

This plan does not reflect priority for service development but instead is based on current preparedness of ED nursing staff to move into an ANP post as identified in ANP survey 2012. Table 8 outlines the deficit of RANPs following gap analysis. The table includes ANP Candidates already in post or ED nurses who currently have or are working towards a Master's degree relevant to the area of practice.

The projected number of 19.5 RANP WTEs for 2013 is derived from the number of ANP Candidates who currently fulfil or will meet the requirements and standards for registration during 2013.

Projections for 2014, 2015 and 2016 are made on the assumption that there are no candidates in post at present therefore nurses potentially selected in 2013 and 2014 for ANP Candidate positions will require a lead in period of one to two years to undertake the educational programme and progress to meet the requirements for registration.

It is recognised that this resource development may occur over a different timescale in different regions therefore 58.2 WTE may be delivered in either 2015 or 2016 depending on local ability to support or availability of suitable nurses and resources for development.

Table 8. A Four Year Plan for phased implementation of RANPs

Region	Deficit (See Table 3)	2013	2014	2015	2016
North East	7.25	3	1	3.25	
Dublin North	4	1	3		
Dublin South	19.8	2	6	11.8	
Midlands	7	2	1	4	
South East	10	1	4	5	
South	16.12	1	3	12.12	
West	13.5	4.5	1	8	
Mid West	15	3	4	8	
North West	5	1	2	2	
Childrens Hospital	6	1	1	4	
	103.7	19.5	26	58.2	

3.2.6 Service Needs Analysis / Service Planning

It is recommended that the ANP staffing model should be reviewed in each ECN after an initial period of 6 months and thereafter annually. This will assess it's suitability for each individual emergency setting/ECN. Annual service planning to review demand for RANP-led services and to determine the future scope of practice for RANPs will be encouraged and supported by the ONMSD and the EMP.

The impact of the introduction/enhancement of RANP-led service on patient experiences and the ED team as a whole should also be evaluated. From a workforce planning perspective it is recommended that the profile of the medical workforce be reviewed as a result of introducing /increasing RANP roles in the ED.

Workforce Planning Recommendations

- All ECNs should establish an ANP service that is available between the core hours of 08.00 and 20.00 hrs over 7 days/week (i.e. a 12/7 service).
- The hours of opening for the ANP service and the number of ANPS required for each ECN (to include EDs/LIUs) should be agreed locally. This will vary according to service need and should be influenced by the number of new patient attendances, patient acuity, staff mix, skill mix in EDs/LIUs, ED/LIU environment.
- Based on current service needs/activity, it is estimated 147 WTE RANPs are required nationally to provide a 12-hour RANP service across current ECNs. With 43.3 WTE RANPs currently in post, the shortfall over the next four years in 103.7 WTEs. These projections are based on a requirement of one RANP on duty in LIU 12/7. When LIUs are established and attendance patterns become clear, the number of senior clinical decision makers required on duty will be reviewed as per *EMP Guidance on LIU Staffing* (HSE 2013).
- The RANP staffing model should be reviewed in each ECN after an initial period of 6 months and thereafter annually to assess it's suitability for each individual emergency setting and ECN. This review should involve robust service planning and service needs analysis that includes review of ED/LIU activity/general demand and capacity, number and acuity of patients seen by RANP and other contextual factors influencing workforce planning in EDs/LIUs e.g. staffing levels, skill mix and unit layout. From a workforce planning perspective it is recommended that the profile of the medical workforce be reviewed as a result of introducing /increasing RANP roles in EDs/LIUs.
- The Guide recommends a four-year plan for phased implementation of approved ANP posts and RANPs to reach the capacity required as identified in Table 8. This can be achieved incrementally.

Year	**2013**	**2014**	**2015**	**2016**	**Total**
ANP WTEs required	**19.5***	**26**	**58.2**		103.7
*Identified in local service plans and the HSE (2013) National Operational Plan p44.					

3.3 Registered ANP Role and Job Description

Standardising job descriptions and role profiles for RANPs and ANP Candidates across all types of services within EDs/LIUs will support a cohesive approach to the selection and appointment of RANPs across the country and avoid repetition and duplication of effort within each hospital and ECN in developing job profiles.

3.3.1 Scope of Practice

The RANP role was originally developed to manage a cohort of patients (adult and children) with non-life/limb threatening injuries and conditions. More recently RANP roles have been developed to manage other categories of patients within the ED/LIU setting. RANP roles in Emergency Cardiology and Rapid Assessment and Treatment were introduced to support streaming patients into these two specific pathways of care. The number of RANPs undertaking these roles presently is small (3 in total) however some consideration should be given to the development of such roles where there is an identified service need and/or new service provision. Standardising the role profile of an RANP will outline the broad competencies required of the person undertaking an advanced practice role and specific competencies relating to the

caseload will then further explicitly define the population / service need that the RANP will manage. There should be provision within the job description to facilitate expansion of the scope of practice to incorporate additional clinical conditions and patient pathway options to respond to service need. The education and competency development requirements associated with expanding the range of conditions should be addressed through formal CPD planning at ED/LIU and ECN level. The Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Patient Care (DOH 2011) outlines how nursing can contribute to the service agenda through expanding roles and scope of practice parameters Research has demonstrated that the RANPs provide evidence-based clinical care and they contribute to the delivery of more efficient services to groups of patients in our healthcare system.

3.3.2 ANP Candidate Role and Job Description

The development of a standardised role profile and job description for ANP candidate will guide the identification of the specific education and training requirements for nurses undertaking a career pathway towards RANP. It will outline the competencies and milestones that are required to be achieved by the ANP candidate to demonstrate their progression along the education pathway. This approach will further support the clinical training needs of ANP candidates with provision of designated supervised clinical practice hours within a network/region. The duration and type of supervised clinical practice will likely be addressed by the Nursing and Midwifery Board when they develop the requirements and standards for education programmes for advanced practice.

Recommendations

- There is a need for national job descriptions for RANPs and ANP Candidates. Standardised job descriptions (including role competencies) for RANPs and ANP Candidates across the national emergency care system will support a cohesive approach to the establishment of RANPs across the country and prevent repetition and duplication of effort in developing job descriptions within each hospital and ECN.
- National job descriptions (including role competencies) should support consideration of site-specific service needs and the development of bespoke roles where there is an identified service need and/or new service provision.
- The national job description for an ANP Candidate should identify the specific clinical competencies, education and academic requirements for nurses following a career path towards RANP. The duration and type of supervised clinical practice will be addressed by the Nursing and Midwifery Board of Ireland (NMBI) when NMBI develop requirements and standards for education programmes for advanced practice'.
- The development of a specific grade code for an ANP Candidate will assist with appointment of suitable nurses onto an ANP career pathway while supporting workforce planning by allowing calculation of the numbers of nurses in the system working towards registration as ANP.

3.4 Introduction and Establishment of ANP Roles

A coordinated, staged approach is needed to build the number of new posts required for ECNs. The capacity building plan outlined in 3.2.5 does not take into account the possibility that positions could be advertised outside individual organisations and candidates recruited from external pools such that preparedness for post may not need to be considered (i.e. a registered ANP moving from abroad or relocating to an organisation or a region within the country). The plan does not give cognisance to the fact that within some services financial approval has been obtained and the ANP post has previously been included in the service plan locally. It is known through the ED Staffing survey that 505 ED nurses hold a Postgraduate Diploma in ED nursing (NQAI Level 8) which is the minimum entry requirement for MSc Advanced Practice educational programmes.

Thirty out of thirty-eight EDs and LIUs have ANP post approval under criteria and standards of either NCNM or the Nursing and Midwifery Board. Three units are currently developing their site preparation documentation for submission to the NMBI in the coming months. The remaining units will be required to develop their site preparation documents in preparation for ANP service development in line with the capacity building strategy (Appendix 4). Currently ANP posts must be approved by NMBI before an RANP can be registered to practice in that post resulting in a lead-in time in this process.

Recommendations

- A standardised approach to the selection and appointment of ANP Candidates/RANPs across HSE Statutory and Voluntary funded organisations is required. This is supported by a nationally agreed job description; and the development of a grade code specifically for ANP Candidates.
- ANP post development should continue to be in line with criteria set in 2008 by the National Council for the Professional Development of Nursing and Midwifery NCNM (now dissolved) and as per Statutory Instrument No 3 of 2010 until full enactment of the Nurses and Midwives Act 2011.
- ANP post development should occur on an ECN basis and incorporate flexible working arrangements to allow for movement of staff to occur across EDs/LIUs within the ECN.
- It is recommended that a standard national template document is developed for submission of ANP site approval to NMBI for the remaining departments without post approval based on their designation as an ED or LIU.
- The submission of these documents to the NMBI requires a co-ordinated approach through the ONMSD / NMPDU with a commitment of financial support to fund the posts from HSE, Hospital/Hospital Group or Trust.

3.*5 Education Preparation for ANP/Advanced Practice*

The clinical caseload of an RANP requires extensive knowledge and clinical skills in all aspects of emergency care and development of the critical thinking skills and competencies needed for the assessment and diagnosis of patients with undifferentiated and undiagnosed conditions. A minimum of a Postgraduate Diploma (NQAI Level 8 equivalent) in Specialist Nursing (ED) is expected of ED nurses

wishing to pursue a career as RANP. Seven years post registration experience (five in the specialist area of practice) is the minimum required by NMBI for registration as ANP. The minimum educational level for an ANP is a Masters Degree (NQAI Level 9) with a substantial clinical component that relates to the specialist area of practice (NCNM 2008, ABA 2011).

There are a number of MSc (Advanced Practice), Postgraduate Diploma (Advanced Practice) and Graduate Certificate (Advanced Practice) education programmes on offer in third level institutions around the country. These programmes offer education to nurses who are selected to embark on a clinical career pathway towards RANP. The scope of practice of an RANP includes comprehensive patient assessment and investigation in order to conclude a full episode of care thus the competencies to prescribe medicinal products and ionising radiation (X-Ray) are also required as part of the educational preparation of ANP candidates. Many colleges have integrated medicinal prescribing and ionising radiation into their postgraduate and masters programmes however not all have these components incorporated at present. The following table outlines the type of programmes on offer, their broad content and their duration.

Table No 9: Masters in Nursing (Advanced Practice)

College	Type of Programme	Relevant Content	Duration
RCSI	MSc Advanced Practice	Advanced Practice module (Generic) Ionising Radiation Medicinal Prescribing	2 years part-time
UCD	MSc Advanced Practice	Advanced Practice module (Generic) Ionising Radiation Medicinal Prescribing	2 years part-time
NUIG	MSc Advanced Practice	Advanced Practice module (Generic) Medicinal Prescribing	2-3 years part-time
TCD	MSc Advanced Practice (Emergency)	Advanced Practice module (ED specific) Ionising Radiation Medicinal Prescribing	2 years part-time 1st yr front-loaded clinical + prescribing 2nd yr research
UCC	MSc in Nursing	ED specific education module as required	2 years part-time

The following programmes are available for nurses who have completed an MSc in Nursing (or relevant Masters) who wish to pursue a clinical pathway towards RANP.

UCD	Graduate Certificate Advanced Practice	Advanced clinical assessment (generic)	1year part-time
TCD	Postgraduate Diploma (Advanced Practice Emergency)	Advanced clinical assessment (ED specific) **Ionising radiation** **Medicinal Prescribing**	1year part-time

Graduate certificate courses in Advanced Practice in the School of Nursing, UCD do not include medicinal prescribing or ionising radiation, however these programmes can be taken as stand alone courses in addition to the post-graduate programme.

UCD	Prof Diploma	Prescription of Ionising Radiation
	Prof Diploma	Prescription of Medication
	Prof Diploma	Prescription of Ionising Radiation & Medication
	Prof Certificate	Prescription of Medication
	Prof Certificate	Prescription of Ionising Radiation

Nurse Prescribing of Medicinal Products education programmes leading to an award of a professional certificate are available as standalone courses from RCSI, UCC, UL, UCD TCD, NUIG, DCU and WIT.

The Centres of Nursing and Midwifery Education (CNME) in the Midlands Regional Hospital, Tullamore and The Connolly Hospital, Blanchardstown offer a HETAC approved stand alone course in Nurse Prescribing Ionising Radiation (X-ray).

A number of ED nurses have already undertaken courses supported by their organisations in nurse prescribing of medicinal products and ionising radiation as an initiative to enhance service delivery or in preparation for undertaking an advanced practice pathway.

Concern has been raised by service providers that X-Ray prescribing for children is not currently an approved component of the educational programmes on offer. This matter is being addressed through the ONMSD Advisory Committee for Nurse Prescribing of Ionising Radiation (X-Ray) and a resolution is anticipated in the near future.

The education of ED nurses as RANPs requires a cohesive approach involving the ONMSD and the National Emergency Medicine Programme engaging with the Nursing and Midwifery Board regarding *Requirements and Standards for Education Programmes* and the approval of ANP Posts. There is also a need to strengthen the links between EDs / ECNs as clinical partners and the education providers / third level colleges to support the education of ANP Candidates in order provide the skills and competencies required to meet the service needs of the clinical caseload of the emergency care system.

Recommendations

- The ONMSD and EMP should engage with the Nursing and Midwifery Board (NMBI) when the NMBI are developing requirements and standards for education programmes for advanced practice'.
- Education programmes should include theoretical and clinical content specific to the RANP's caseload of undiagnosed, undifferentiated clinical conditions in emergency care.
- Education preparation for ANP practice should meet the service needs of each ED/LIU and provide the skills and competencies required to safely meet the patient needs within the ANP clinical caseload.
- Ionising Radiation and Medicinal Product Prescribing should be incorporated into RANP education preparation and ANP education programmes to provide a seamless, integrated educational experience for the candidate and a more cost-efficient programme for the system.

- There should be two-way communication between EDs/LIUs (i.e. clinical partners) and the third level colleges (i.e. academic partners) in order to support the clinical supervision requirements of ANP Candidates.

3.6 Continuing Professional Development of Registered ANP

Continuing professional development (CPD) is an expectation of all professionals working within the healthcare environment (Government of Ireland 2008). Under the Nurses and Midwives Act, (Government of Ireland 2011) CPD has become mandatory for all nurses. Part 11 of this legislation places responsibilities on registrants, the Board and employers in relation to the maintenance of professional competence (NMBI 2013). CPD for RANPs is especially important for maintaining competence in clinical practice whilst also enabling the development of new skills to meet identified service needs of the ED/LIU/ECN. CPD for RANPs occurs through a variety of activities and includes formal and informal education and skills education and training. Clinical supervision and peer review also contribute to the CPD activities of RANPs however many undertake these on an ad hoc basis due to the competing nature of clinical service need and other manpower issues.

The ANP survey and focus group discussions identified the lack of formal educational programmes or specific education modules for RANPs in EDs in Ireland. This results in many RANPs seeking units of learning, such as specific clinical skills workshops and formal education courses abroad. The ANP survey results suggest also that there is no standard number of CPD hours afforded to RANPs across the country although RANPs report that they undertake CPD at times when the clinical load is light or in their own time.

From a regulatory perspective the Nursing and Midwifery Board of Ireland requirements and standards for registration as an ANP (based on NCNM criteria and standards 2008) require that RANPs demonstrate evidence of ongoing CPD through the submission of a professional portfolio every five years. CPD will form part of the professional competence schemes that the Board will be required to develop as part of its function under the Nurses and Midwives Act 2011 (NMBI 2013). Currently, validation of and continued registration as an Advanced Practitioner is dependent on meeting the criteria and standards (NCNM 2008) thus both the employer and the RANP have a responsibility in relation to meeting regulatory CPD requirements.

Recommendations

- There should be standardised minimum number of hours allocated to CPD of RANPs that will facilitate regulatory requirements and service level demands of RANPs. This should be standard across the system and these hours should be built into the service roster.
- There should be clear governance structures to support regular organised Clinical Supervision and peer review for RANPs within each ECN.
- Standardised scope of practice of an RANP should outline the broad core competencies required of the person undertaking an advanced practice role. Specific competencies relating to the caseload should further define CPD requirements of the RANP.

- There should be a nationally agreed framework for role expansion that service managers along with RANPs can use to plan for future service needs within an ED/LIU in the ECN.
- Appropriate and relevant education modules should be agreed nationally to support RANP CPD requirements and the development of a standard scope of practice of RANPs. Existing educational and training resources could be utilised to provide web-based tutorials, facilitate workshops and units of learning. Master classes could also facilitate the education needs of ECNs on a national basis.
- The ONMSD, EMP and the recently established ANP (Emergency) Forum should develop the RANP CPD frameworks and education materials.

3.7 Research and Audit

A core component of the role of Advanced Nurse/Midwife Practitioners is:

- audit of practice and
- the undertaking of research related to the clinical area of practice.

This is also a requirement for continuing registration as an RANP. Focus group discussions with RANPs identifies that RANPs in established services in Ireland are experiencing difficulties fulfilling this requirement. A system wide standard approach within a clear governance framework supporting this key activity is required.

Recommendations

- RANPs are required to initiate and coordinate nursing audit and research as a core concept of their role and as a requirement for continued registration with NMBI. It is essential therefore that there are a standardised minimum number of hours allocated to research and audit for RANPs across the system.
- The Clinical Operations Group in each ED should support and encourage integrated audit across the multidisciplinary team in order to prioritise quality improvement initiatives in line with the National EMP Report (HSE 2012).
- Clinical and academic partnerships should be encouraged between the third level colleges and ECN in order to support the research agenda of RANPs and the multidisciplinary team, with particular emphasis on contributing to the body of national and international literature related to emergency care.

3.8 Career Pathway and Succession Planning

In line with the *Scope of Nursing and Midwifery Practice Framework* (ABA 2000) nurses develop competencies through experience and skills development under the supervision of senior nurses or other appropriate healthcare professionals. Preceptorship and mentorship initiatives are in place in many EDs and these facilitate the structured development of specific competencies relevant to the area of practice. This type of local arrangement allows for individual nurses to gain the specific competence and confidence required for enhanced roles e.g. cannulation and phlebotomy, medication management, history taking, physical assessment and prescribing.

Personal Development Planning (PDP) can facilitate Nurse Managers and ED nursing staff to carefully consider the clinical experience required to support the

development of competencies of the individual and identify the optimum education required to support the individual whilst meeting ED service demands (NCNM 2008). The Clinical Operations Group in each ED should decide on how to align PDP for the MDT with the strategic needs of the ED/ECN.

Recommendations

- The Clinical Operations Group in each ED should agree how to align Personal Development Planning (PDP) for the multidisciplinary team with the strategic needs of the ED/LIU and ECN. PDP can facilitate nurse managers and ED/LIU nursing staff to carefully consider the clinical experience required to support the development of competencies of the individual. PDP can identify the optimum education required to support the individual whilst matching ED/LIU service demands.
- It is recommended that the EMP facilitate the dissemination of career guidance information using a variety of fora.
- Succession planning is required to sustain ANP services over time. ECN workforce planning should include a succession plan for ED/LIU nurses in order to promote clinical and management career pathways to support the future Clinical Nurse Manager and RANP roles for the medium and long term.

3.10 Implementation

The implementation of this document - A *Guide to Enhance Advanced Nurse Practitioner Services across Emergency Care Networks in Ireland* - will contribute to the workforce planning agenda for the DoH, HSE and the EMP. Implementation of the elements of this Guide requires collaborative working by the ONMSD, HSE, EMP and the Department of Health. The support of key stakeholders such as the Special Delivery Unit, the Clinical Strategy and Programmes Directorate, HSE Integrated Services Directorate, Acute Hospital Directorate, National Recruitment Services, RDOs, Hospital CEOs/Group/Trust Executive Management, the Nursing and Midwifery Board of Ireland (NMBI) and Higher Education Institutes (HEIs) is also essential.

At Clinical Programme level, the EMP Working Group, Advisory Group, Regional Leads, Emergency Nursing Interest Group (ENIG) and the Directors of Nursing and Midwifery Reference Group play an important role in the dissemination of this Guide and championing implementation of its recommendations across the hospital system. An EMP Advanced Nurse Practitioner Forum is established to provide a means whereby ANPs working in EDs/LIUs can contribute to the implementation of recommendations outlined in this Guide.

At service level, support is required from the ED Clinical Operations Group, ED/LIU nursing management and hospital/Hospital Groups/Trusts executive management teams. The introduction of quality improvement across ECNs as an approach to implementing the National EMP Report (HSE 2012) also supports the implementation of the recommendations within this Guide.

Coordinated approaches to the education and preparation of ANPs, service planning, selection and appointment, CPD, role expansion and succession planning are required to enhance ANP services in ECNs nationally. Suitably experienced and qualified ED nurses need to be identified to undertake appropriate education and training. This needs to occur in 2013 in preparation for registration as an RANP in 2014-2016; 2014 for 2015/16 and so on.

Recommendations

- Implementation of this Guide for should occur in collaboration with the ONMSD, HSE, EMP and the Department of Health. This requires the support of national key stakeholders such as the HSE Integrated Services Directorate, Acute Hospitals Directorate, the Clinical Strategy and Programmes Directorate, National Recruitment Services, Special Delivery Unit, the Nursing and Midwifery Board of Ireland (NMBI), and Higher Education Institutions (HEIs).
- At clinical programme level, the EMP Working Group, Advisory Group, Regional Leads, Emergency Nursing Interest Group (ENIG) and the Directors of Nursing and Midwifery Reference Group play an important role in the dissemination of this Guide and championing implementation of its recommendations across the hospital system. An EMP Advanced Nurse Practitioner Forum, recently established, should provide a means whereby RANPs and ANP Candidates working in EDs/LIUs can contribute to the implementation of recommendations outlined in this Guide.
- At service level, support is required from the ED Clinical Operations Group, and hospital/hospital groups/trust executive management teams. Suitably experienced and qualified ED nurses should be identified to undertake appropriate education and training. This needs to occur in 2013 in preparation for registration as an RANP in 2014-2016; 2014 for 2015/16 and so on.
- The introduction of quality improvement methodology (e.g. Clinical Microsystems Coaching) as an approach to implementing the recommendations of National EMP Report (HSE 2012) should also support the implementation of the recommendations within this Guide.

3.11 Summary

National and international research has demonstrated that the RANPs provide evidence-based clinical care and they contribute to the delivery of more efficient services to groups of patients in our healthcare system. The role of RANP is well established and has a proven track record in improving access and quality for ED patients without adversely affecting cost of care (Begley et al 2010).

A robust regulatory framework supporting the registration of advanced practitioners and expansion of RANP's scope of practice to prescribe medication and ionising radiation equips the RANP with the additional skills and competence needed to deliver a seamless episode of care leading to improved patient satisfaction. Demonstrating recent clinical practice and patient focused outcomes through audit and original research supports the CPD and regulatory requirements for RANPs.

The recommendations in this Guide must be implemented while taking account of the moratorium on recruitment in the public service and the current HSE employment control framework. The focus of the Guide is to increase the capacity of RANPs to support the improvements in quality and timely access to care for patients attending EDs and LIUs throughout the country.

Coordination of effort to implement these recommendations will contribute to the workforce planning agenda for the HSE, the National Clinical Programme for Emergency Medicine and the Department of Health. The outcomes will include the delivery of safe, appropriate, timely care; enhancement of services being delivered in EDs and LIUs nationally. It will also support the implementation of national health policy regarding the establishment of hospital groups and the development of smaller hospitals (DoH 2013 a & b).

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Appendix 1: List of Conditions LIU

National Emergency Medicine Programme

Conditions Suitable and Unsuitable for care in a Local Injury Unit.

Overview:

Local Injury Units will treat patients with injuries that are not life-threatening and are unlikely to result in serious long-term disability. Local Injury Units (LIUs) will not treat medical conditions, pregnancy-related or gynaecological problems, injuries to the chest, abdomen or pelvis and serious head and spine injuries. Lists are provided to try to direct patients with single, isolated and uncomplicated injuries to these units. These are not exhaustive lists and patients should be advised to contact their Local Injury Unit or General Practitioner for guidance if they are uncertain whether or not to attend a Local Injury Unit or Emergency Department.

Notes:

1. These attendance protocols are intended for use in Local Injury Units, linked to Emergency Departments and operating within the governance of an Emergency Care Network.
2. The protocols are intended as guidance to lead Consultants in Emergency Medicine for LIUs and should be adapted for local use. Patient information leaflets produced on the basis of these protocols should use patient-appropriate language.
3. There should be transfer protocols in place for patients who inadvertently attend LIUs though their care needs cannot be met in this clinical environment.
4. The protocols should be supported by network and national clinical guidelines. Doctors, Advanced Nurse Practitioners and Nurses working in Local Injury Units should have direct access to clinical advice from a Consultant in Emergency Medicine from the lead network ED.
5. The appropriate age for Paediatric LIU attendances may be determined by the Emergency Care Network Lead/Paediatric Emergency Medicine Lead depending on local practice but should not be younger than 5 years.
6. Audit of patient outcomes and monitoring of LIU workload will indicate the need for review of these lists, as part of the governance function of the network.

Adult Patients: Conditions Suitable and Unsuitable for Care in a Local Injury Unit

What the Local Injury Unit does treat	What the Local Injury Unit does not treat
✓ Suspected broken bones to legs from knees to toes ✓ Suspected broken bones to arms from collar bone (clavicle) to finger tips ✓ All sprains and strains ✓ Minor facial injuries (including oral, dental and nasal injuries) ✓ Minor scalds and burns ✓ Wounds, bites, cuts, grazes and scalp lacerations ✓ Small abscesses and boils ✓ Splinters and fish hooks ✓ Foreign bodies in eyes/ears/nose ✓ Minor head injury (fully conscious patients who did <u>not</u> experience loss of consciousness nor have more than one episode of vomiting after the head injury)	✗ Conditions due to "Medical" illness e.g. fever, seizures, headache. ✗ Suspected serious injury or unable to walk following a fall from a height or a motor vehicle collision. Patients with neck pain or back pain that started on the day of injury should attend an ED rather than a Local Injury Unit. ✗ Injury causing chest pain, abdominal pain or shortness of breath ✗ Serious head injury ✗ Chest pain ✗ Respiratory conditions ✗ Abdominal pain ✗ Gynaecological problems ✗ Neck/back pain ✗ Pregnancy related conditions ✗ Pelvis or hip fractures ✗ Injuries due to self-harm

Paediatric Patients: Conditions Suitable and Unsuitable for Care in a Local Injury Unit

<table>
<tr><th>What the Local Injury Unit does treat</th><th>What the Local Injury Unit does not treat</th></tr>
<tr><td>

Any child aged 5 years or older with:

- ✓ Suspected broken bones to legs from knees to toes
- ✓ Suspected broken bones to arms from collar bone (clavicle) to finger tips
- ✓ Any sprain or strain
- ✓ Minor facial injuries (including oral, dental and nasal injuries)
- ✓ Minor scalds and burns
- ✓ Wounds, bites, cuts, grazes and scalp lacerations
- ✓ Splinters and fish hooks
- ✓ Foreign bodies in eyes/ears/nose
- ✓ Minor head injury (fully conscious children, who did not experience loss of consciousness or vomit after the head injury)

</td><td>

- x **Any child of any age with a “Medical” Illness e.g. fever, seizures, respiratory symptoms**
- x **Any child younger than 5 years**
- x **Any child aged 5 years or older with:**
  - x Non-traumatic limp or non-use of a limb
  - x Injuries following a fall from a height or a motor vehicle collision
  - x Serious head injuries
  - x Abdominal pain
  - x Gynaecological problems
  - x Injuries due to self-harm
  - x Neck pain or back pain

</td></tr>
</table>

Appendix 2: National ED ANP Survey

National ED ANP Survey – March 2012

The information collected in this survey will inform the development of a Capacity Building Strategy for ANPs for the Emergency Medicine Programme.

Name of Hospital ______________________________

1.0 ANP Resource						
Please provide head count and whole time equivalent (WTE) data for the staff categories described below						
	In post 31/03/2012		Registered Nurse Prescriber (RNP)		Authorised to prescribe ionising radiation	
	Head count	**WTE**	**Head count**	**WTE**	**Head count**	**WTE**
Number of Registered ANPs (Emergency) in your ED						
Number of nurses in ANP Candidate (Emergency) position						
Number of nurses who have successfully completed MSc ANP education but are NOT in ANP Candidate position						
Number of nurses currently undertaking **MSc ANP education** NOT in ANP Candidate position						
Number of nurses who hold an **MSc in Nursing** NOT currently undertaking an ANP career pathway						

2.0 ANP Service Planning				
	Yes	No	If yes, what is the number of WTE ANPs required?	
Have you carried out a recent service need analysis to determine the requirement for ANP(s) in your ED?			WTE	
	Yes	No	If yes, what is the number of nurses identified?	
Have you a career planning strategy within your ED identifying suitable nurses to be supported towards ANP?			Head count	WTE
	Yes	No	If yes, what is the number of Posts approved?	
Has your organisation obtained site approval under ABA/NCNM Criteria and Standards			WTE	
	Yes	No	Numbers of WTE ANP posts identified in Service Plan	
Has the requirement for ANP posts for your ED been included in the ED/Organisation Service Plan 2012/2013				

3.0 ANP Activity statistics	
	Total attendances seen by ANP in 2011
Please identify the total number of patients seen and treated by ANP(s) in your ED in **2011**	

If you have these attendances broken down by triage category please identify

	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
Total 2011 ED attendances seen by ANP(s)					
What % of the total hospital ED attendances does this represent?					
What % (or number) of these attendances were review/returns?					

If you have attendance data (seen and treated by ANP) **per month** please provide the details here:

Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec

4.0 ANP Scope of Practice

To gain insight into the scope of practice of the ANP service your ED provides please review the current list of conditions and tick the appropriate box

	Yes	No
Abrasions		
Abscess		
Achilles tendon injury		
Animal/insect bite		
Ankle injury		

Bursitis		
Calcaneal injury		
Cellulitis		
Clavicular injury		
Dental injury		
Dental pain		
Ear injury		
Ear pain		
Elbow injury		
Epistaxis		
Eye conditions		
Eye injury		
Facial injury		
Foot conditions		
Foot injury		
Foreign bodies ENT		
Forearm injury		
Hand Injury		
Human bites		
Humeral injury		
Infected sebaceous cyst		
Ingrown Toenail		
Knee conditions		
Knee injury		
Mallet deformity		
Mandible injury		
Minor head injury		
Minor burns		
Nail bed injury		
Paronychia		
Pulled Elbow (Children)		
Shoulder dislocation		
Soft Tissue Infection		
Vaginal foreign body		
Wounds		
Wrist injury		
Other conditions (please list)		

5.0 Patient AGE Profile of ANP Service	
If your ANP service is Adult ONLY, what is the **minimum** age profile of the patient you see and treat (14 or 16)?	
If your ANP service is Adult and Children what is the **minimum** age you see and treat children (18months, 2years, 5years etc)?	
If your ANP service is children ONLY, what is the **minimum** age you see and treat children (e.g. 6 weeks, 3 months, 6 months etc)?	

6.0 Other ANP Service supporting your ED		
Are there any other ANPs directly supporting your ED e.g. ANP Cardiology	Yes❒	
ANP title	**Head count**	**WTE**
Are these ANPs part of the ED Establishment?	Yes❒	

Please feel free to tell us more about your service and if you wish and share any other relevant information regarding your ANP service such as Business Case Reports, Service Needs Analysis, Audits or Service Plans.

Please send the completed survey to and any additional information to:
Susanna Byrne EMP Service Planner at susanna.byrne1@hse.ie
or post to Susanna Byrne at NMPD, HSE, Mill Lane, Palmerstown, Dublin 20

Thank you for completing this survey

Appendix 3: List of Conditions RAT

ANP Scope of Practice- St Vincent's University Hospital				
To gain insight into the caseload of the ANP service your ED provides please review the current list of conditions and tick the appropriate box				
** ANP does not lead a Minor Injury Unit – We have a fully medically staffed stand alone Minor Injury Unit. It has been agreed that the role would be quite limiting from a nursing capacity perspective.	**Adult**		**Childre n**	
	Yes	No	Yes	No
Abrasions				
Abscess				
Achilles tendon injury				
Animal/insect bite				
Ankle injury				
Bursitis				
Calcaneal injury				
Cellulitis	X			
Clavicular injury				
Dental injury				
Dental pain				
Ear injury				
Ear pain				
Elbow injury				
Epistaxis	X			
Eye conditions				
Eye injury				
Facial injury				
Foot conditions				
Foot injury				
Foreign bodies ENT				
Forearm injury				
Hand Injury				
Human bites				
Humeral injury				
Infected sebaceous cyst				
Ingrown Toenail				
Knee conditions				
Knee injury				
Mallet deformity				
Mandible injury				
Minor head injury				
Minor burns				
Nail bed injury				
Paronychia				

Pulled Elbow (Children)				
Shoulder dislocation				
Soft Tissue Infection				
Vaginal foreign body				
Wounds				
Wrist injury				
Other conditions (please list)				
Shortness of breath / Pleuritic chest pain – Possible pneumothorax				
Shortness of breath / Pleuritic chest pain – Possible pneumonia				
Shortness of breath / Pleuritic chest pain – Possible musculoskeletal injury				
Shortness of breath / Pleuritic chest pain – Possible heart failure				
Shortness of breath / Pleuritic chest pain – Possible PE				
Shortness of breath / Pleuritic chest pain – Possible asthma exacerbation				
Abdominal Pain – Possible appendicitis				
Abdominal Pain – Possible cholecystitis				
Abdominal Pain – Possible cholelithiasis				
Abdominal Pain – Possible diverticulitis				
Abdominal Pain – Possible pregnancy /ectopic pregnancy				
Abdominal Pain – Possible ovarian cyst				
Abdominal Pain – Possible urinary tract infection				
Abdominal Pain – Possible urinary retention				
Abdominal Pain – Possible blocked urinary catheter				
Abdominal Pain – Possible constipation				
Abdominal Pain – Possible gastritis / PUD				
Abdominal Pain – Possible GI bleed				
Abdominal Pain – Possible bowel obstruction				
Flank pain – Possible renal stone				
Flank pain – Possible pyelonephritis				
Flank pain – Possible renal trauma				
A possible DVT				
A possible bakers cyst				
A possible fractured neck or femur				
Sore throat – Possible tonsillitis				
Sore throat – Possible Quinsy				
Sore throat – Possible glandular fever				
Mental health complaints – depression				

Appendix 4: ANP Posts Approved per ED (2012)

The following table details:
EDs with post approval and an established ANP service;
EDs with post approval with only ANP Candidates in place;
EDs with approved posts and no ANPs and EDs without approved posts.

Table 10: ANP posts approved in EDs					
Region	Hospital	Site approved	RANP in post	Post approved	Candidate ANP in post
North East	OLOL Hospital, Drogheda	√	√	√	?
	Our Lady's Hospital, Navan	√	√	√	√
	Cavan General Hospital Monaghan General Hospital	√ √	√ In Cavan	√ √	√
	Louth County, Dundalk				
Dublin North	Connolly Hospital	√	√	√	
	Beaumont Hospital	√	√	√	
	Mater Misericordiae Hospital	√	√	√	√
Dublin South	St. James's Hospital	√	√	√	
	Tallaght Hospital	√	√	√	
	Naas General Hospital	√		√	√
	St. Vincent's Hospital	√	√	√	
	St.Columcille's, Loughlinstown				
	St Michaels Hosp, D'laoire				
Midlands	Midlands R H, Tullamore				√
	Midlands R H, Portlaoise				√
	Midlands R H, Mullingar	√	√	√	
South East	Wexford General Hospital	√	√	√	√
	Waterford Regional Hospital	√	√	√	
	South Tipperary, Clonmel	√	√	√	(1 Apt pending)
	St Luke's Hospital, Kilkenny				
South	Cork University Hospital	√	√	√	
	Mercy University Hospital North Cork MUCC	√	√	√	
	Mallow General Hospital	√		√	
	Bantry General Hospital				
	Kerry General Hospital	√	√	√	√
West	University Hospital Galway	√	√	√	(2 Apt pending)
	Portiuncula Hospital	√		√	√
	Co. Hospital, Roscommon				
	Mayo General Hospital	√	√	√	
Mid West	Midwestern R H, Limerick	√		√	√
	Midwestern R H, Ennis	√		√	√
	Midwestern R H, Nenagh	√		√	√
	St John's Hospital	√		√	
North West	Sligo Regional Hospital	√		√	?
	Letterkenny Gen Hospital	√	√	√	(1 Apt pending)
Children's Hospitals	O L C Hospital, Crumlin	√	√	√	
	Children's U H, Temple St	√	√	√	√
	NCH, Tallaght	√	√	√	

Apt = appointment