

The specialist nurse consultation nursing essay



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As a clinical haematology nurse specialist I review patients in the out – patient setting alongside consultant haematologists. The majority of patients have chronic and incurable haematological conditions; many of the patients have a variety of malignant and non-malignant conditions, which require periods of cytoreductive therapy. The case load is increasing due to patients living longer as discussed by van Olman et al (2011) especially with developments in treatment modalities. From my personal experiences seeing follow up patients in clinic, patients often vocally complain in private that they have inconsistent experiences regarding medical clinical consultations. Patients have expressed that they have had too many clinicians involved in their care journey. Lots of patients would rather be seen by fewer healthcare professionals, thereby improving the continuity and quality of care and communication.

My rationale is to identify patient experience and satisfaction from nurse led interaction in a face to face follow up consultation. This will provide evidence needed in order to influence the development and implement a nurse led follow-up clinic to improve and enhance patient experience and haematology service.

BACKGROUND

The Primary Care Act of (DoH 1997) influenced the development of nurse led pilot schemes in primary care (Moore 1999) and (Lewis 2001). Nurse led clinics have continued to expand for a variety of needs and challenges, be it the European working directive , to reduce junior doctors working, gaps in practice, locally driven, a cost effective way for patients with stable non-complex needs to be monitored and reviewed.

National strategic drivers, Making a Difference (DoH 1999), NHS Moderation Agency (DoH 2004), Cancer Plan (DoH 2000), the White Paper Equity and Excellence: Liberating the NHS (DoH 2012)) and the Excellence in Cancer Nursing (DoH 2012) supports the development of nurse led services, especially as the evidence now strongly points towards a comparable service provided by medical clinicians demonstrated in a quick guide for commissioners by the National Prescribing Centre (2010).

In the realm of cancer care nurse led clinics the research from Corner (2003), Wells et al (2008), Cox et al (2006), Moore et al (2006) Wilkinson and Sloan (2009) and Krishnasamy et al (2007) has demonstrated successful nurse led clinics. Certainly the advantage of non-medical prescribing has influenced the development of nurse led clinic for patients having ease of access to medications (Extending Independent Nurse Prescribing within the NHS 2002).

There are two opposing arguments, that the nurse led development is usually locally driven by a clinical nurse specialist (Hutchinson 2011) who identifies a gap in clinical practice that has created a need or a change that cannot be filled by a medical colleague. Hatchett (2006) disagrees and argues that it is National driven targets that have influenced the development. The Nursing Midwifery Council offers no specific professional guidance nurse led services, other than the established code of professional conduct (NMC 2008).

LITERATURE SEARCH

Defining the term nurse led follow up, depends on the specific aims and outcomes of that specific clinic (Hatchett 2008), it will certainly be defined by the academic qualifications and the level of autonomy.

This literature review plans to scrutinise the body of evidence surrounding the subject of nurse led review in clinics, and whether or not they ensure patient safety, valued by patients in the outcomes and provide value for money in the fiscal reducing time in the National Health Service. Searches were conducted using 5 data bases: Internurse, CINAHL, Medline (PubMed), Cochrane and Proquest. (See appendix 1 for table of results) The evidence selected features recent publications and older empirical evidence, that continues to add value to the debate in nurse led clinic development. The key words used in the literature search where nurse led consultation, patient experience and haematology dated from 2000-2012. Hatchett (2006) clearly states that it is difficult to locate supporting literature prior to 2000.

There is considerable debate a strong body of evidence stating and supporting the progressive development of nurse led clinics especially in oncology against the call for ceasing follow up consultations in oncology as they see little value at identifying reoccurrences of tumour (Francken et al 2005, Collins et al 2004, Botteman et al 2003, Rojas et al 2000) and the only significant is to the value gained by the patient is psychological support. Haematological changes of recurrence can be observed in the blood parameters and through specific clinical enquiry at follow up, this is supported by Lewis (2010).

It has been clearly stated, that many nurse clinics have and will continue to develop by initiative nurse usually Clinical Nurse Specialists (CNS) (Hutchison 2011). Nowhere in the literature review was it stated that strategic planning as a top down approach to resolving, addressing a clinical need. Yet in the national agenda, Excellence in nursing (2010), it clearly states that the need for nurse led clinics by CNS's to be expanded in a growing diverse range of conditions especially chronic conditions with a population living longer. It is interesting over time how the perception of roles is perceived, Hatchett (2006) believes CNS's where only available to attend and review ward patients and not undertake independent case load monitoring.

Development of nurse led clinics

Nurse led clinics are usually developed by a nurse working single handed (Hatchett 2006) due to staffing costs less than half to function Lewis (2010). Unfortunately none of the research literature reviewed discusses the importance of clinical supervision, peer support of medical leads, case load reviews, I find this somewhat frightening that such a cavalier approach is being adopted and even more so without clinical guidelines and protocols . The NMC (2008) clearly states that a nurse must work with evidence based practice, recognise the limits of competency and most importantly have the knowledge and skills for safe and effective practice when working without direct supervision.

Setting up the service

Within the literature reviewed, only one discussed the role of using clinical algorithm, Mugarza et al (2008), however none of the researchers

undertaking nurse led follow up discussed clinical guidelines or competencies supported by their hospital for vicarious liability NMC (2008). Given the compensation culture individual nurses will require to be fully covered for the work they undertake for their hospitals. Hatchett (2006) discusses the utilising the NHS knowledge, skills, framework to plan the development of levels of competency for practitioners, it was disappointing within the literature review not to read authors use of competencies.

Mugarza et al (2008) conducted a small scale of 71 patients for which only 52 completed the 12 month audit time line, the focus of the study was adhering to a validated clinical algorithm to optimise patient's therapeutic management in a nurse led clinic. It clearly demonstrated a quantitative observed physical improvement due to drug therapy, managed by nurses. They stated that 15-20% of the case load had to be discussed with the medical doctors at the end of clinic. I believe this certainly provided peer support, and ensured patient safety.

Mugarza et al (2008) concluded that the nurse led clinic demonstrated and supported compliance, and implied that such compliance would improve quality of life and a physical wellbeing. I question the reliability of such statement, given the fact that the research was quantitative not qualitative, and had no patient satisfaction element.

Patient satisfaction.

Bhattacharys et al (2007) undertook a small qualitative patient satisfaction non validated questionnaire sent out by post, on a nurse led diabetic clinic, it was very simple in its construction, 91 patients were identified of which 68

replied (75%). Although the results were positive and scored the service highly, the authors concluded that they had detailed knowledge of patients, their lives and family and that it created a long lasting therapeutic relationship, which had a positive outcome on the HbA of 0.8% stating this was due to their frequent contact does improve patient outcomes. This was supported by Mugarza et al (2008) findings in their study, describing it as the “Hawthorne effect” were participant’s try harder when they know they in a trail or experiment (Draper 2002). I question the reliability and validity of these statements for Bhattacharys study given the fact the nurse led clinic was an annual review and small sample, this is supported by Burns and Grove (2007). The authors did acknowledge that the survey was small yet stated that it was random and representative unlike Hicks et al (2012) whose audit of nurse consultant led clinic demonstrated limitations that it was not randomised in however patient response bias is always a risk to the results (Waltz et al 2005.)

Outcomes benefiting the patient

Hatchett (2006) stated that, “there requires to a patient focused and a measurable effective outcome”. However, does a nurse led service compare favourable to that of a medical clinic, which is seen as the gold standard to follow up management. Hatchett (2008) believes that patients will expect a higher standard of care compared to the care offered by our medical counterparts.

Miles et al (2003) undertook a qualitative study with a well-constructed questionnaire demonstrating reliability and elements of validity. 282

participants completed the patient satisfaction questionnaires equally spread between the nursing and medical disciplines with 90% response rate. No significance difference was found measuring interpersonal relationships and patients were satisfied with the level of care received by both groups. These views are supported by the large scale qualitative study of Beaver et al (2010) and Xue (2010) review of effectiveness of cardiac nurse led clinics. It clearly demonstrates that nursing follow up is equally in benefits and care provided to patients that a medical follow up provides, in essence no harm was caused to the patient.

Miles et al (2003) further adds that nursing clinics are a satisfactory substitute to the present model of medical led clinics. Supporting this view is the work of Sanne et al (2010) with their quantitative study comparing nursing and medical follow ups working in the HIV setting, clearly demonstrated that the measured therapeutic outcomes equalled that of the doctors, however control of illness could lead to and be interpreted as an improvement of quality of life, however this is a subjective view by interpreting the qualitative and quantitative studies together.

Lewis (2010) in undertaking a review of effectiveness of nurse led clinics determined that there were no statistical differences that were significant to demonstrating increase of survival, reoccurrence rates and psychological morbidity. However Lewis (2010) does concede in the implications for practice that nurse led follow up could potentially benefit the patient in psychological support. I believe that utilising nurse led services for psychological support is a soft and less cost effective way of employing an advanced nurse practitioner, especially in the times of fiscal constraints as <https://assignbuster.com/the-specialist-nurse-consultation-nursing-essay/>

well as purposely assigning the nurse role to an inferior position and devaluing the clinical follow up when reviewing patients compared to medical colleagues.

Patient expectations are entwined with outcomes, Redsell et al (2007) with their qualitative small scale study of patients met and unmet expectations when follow up by a nurse, concluded that most patients were satisfied with the follow up consultations. What concerns me is that the study was extremely small with no validity or reliability, even the author's stated caution interpreting the results.

Summary

It is evident from the literature that researchers have adopted a wide variation of research method, and drawing conclusion can add confusion when trying to link them to other findings. Linked with this was a lack of evidence that demonstrated suitable experience and qualifications to undertake nurse led follow up safely in accordance with the NMC code of professional conduct (2008). It was evident from the literature review that clinical governance issues were not discussed to address patient safety; Hutchinson (2007) has also observed this phenomenon in the body of literature. The nurse led clinic has to more than a hand holding clinic for emotion support, there has to be a therapeutic outcome for the patient, with this there has to an element of role satisfaction, which was not addressed within the literature review.

The study of Redsell (2007) identified from their study that patients believed the nurse to be subordinate to the doctors, and further added they believed <https://assignbuster.com/the-specialist-nurse-consultation-nursing-essay/>

that patient expectations of nurses would increase as the role developed. However role development can only occur with autonomy, Hutchinson (2011) has observed inconsistent levels of autonomy in nurse led practices. Beaver et al (2010) also identified that nurse led follow up created a friendship. My concern is that allowing a friendship to develop is a blurring of professional boundaries, which could lead to an unprofessional balance in the relationship.

It has been concluded that patients are not adversely comprised by nurse follow up; the literature supports that the outcomes and satisfaction are equal to if not better than medical colleagues, especially when combined to quality of life (Xue 2011). To confirm this in any new clinical venture there requires a measured effectiveness through audit (Hatchett 2008).

This literature review found a lack of research based solely on patient experiences when reviewed by nurses in a clinic setting. This demonstrates the need and importance to undertake this research proposal, with main objective to focus on the lived experience of the patient being reviewed by a nurse in clinic. If this potential research proposal is accepted will aid towards the development in setting up a future nurse led clinic.

“ The patient experience following Specialist Nurse consultation review in a follow up clinic.”

Methodology

It is imperative to use the correct methodology to ensure that as a researcher you achieve the best results and for research project to be a success in its aims and objectives (Jasper 1994). The most appropriate

method for this investigation would be to use the qualitative method. The rationale is based on patient experience as discussed by (Robson 2002) quantitative research does not possess the quality material of in depth understanding needed from the patient's perspective which is supported by Sadala and Adorno (2002). Qualitative research findings are formed from actual patient expressions, emotions and most importantly their own personal experiences and their humanistic behaviours (Rossman & Rallis 2003). Following the premise that phenomenology can be easily applied to the development of nursing knowledge and research (Jones 2001, Priest 2002), through describing and interpretation (Taylor 1995) rather than measurement and predictions. This as a qualitative researcher it is important gain knowledge from emotions, personal experiences, personal values and cultural differences and perceptions for this to succeed in a qualitative investigation (Byrne 2001).

Sample

As a qualitative researcher there are various sampling strategies available Patton (1990), Miles and Huberman (1994) and Onwuegbuzie and Leech (2004b). Using a sample strategy in selecting participants is crucial in recruiting the correct participants to explore and compare their experiences needed to answer the investigation as discussed by Lane et al (2001) and Meadows (2003). A purposeful random sampling will be used in this selection process as potential participants for its shared characteristics needed to answer the phenomenon as highlighted by Patton (2002). The criteria for this purposeful random sample selection are as follows:

Inclusion Criteria

Only open to haematology patients under the care of the Trust.

Can only be current haematology patients being monitored in the out-patient clinics.

Must have been reviewed by the clinical haematology nurse specialist previously.

Exclusion Criteria

New Referral

No Consent

Lack of capacity

Sample size is debateable, according to Onwuegbuzie and Collins (2007) too big a sample would be too difficult to extract all the data, however (Flick, 1998; Morse, 1995) disagree that too small is difficult to achieve data saturation. The purposeful random sample selection size required for this potential investigation is 15 participants and this size is supported by (Speziale and Carpenter 2007) stating this number of participants are able to provide rich descriptions of the potential investigation. However there are no rules for the size of samples in qualitative investigations according to Patton (2002), he claims it is about maintaining credibility not representativeness.

How will the participants be recruited into the investigation? This will be with the involvement of the clinical audit department. The clinical audit department will randomly select 30 patients that the haematology nurse

specialist has reviewed in the last 3 months. This will prevent loss of patient recall. (REF)

An information pack approved by the research and development department and the patient information department will be sent out to the 30 potential participants. This pack will enclose a covering letter explaining fully the investigation and offering the opportunity to participate. Enclosed in the pack will be a pre-paid addressed envelope to the clinical audit department and a return reply slip for potential participant to complete indicating yes or no to participate in the phenomenon. The clinical audit department will recruit the first 15 people that reply to participate in the investigation and will have a reserve list if participants change their mind. The clinical audit will have complete control in this part of this process. (REF is audit dept better ???)

This investigation will be conducted utilising one to one interviews as a tool to collect the data.

Data Collection

Not utilising the right data collection tool may hinder acquiring and extracting essential data Emore Weolke (1997). As discussed by Marshall & Rossman (2006) questionnaires and patient documentary diaries are good approaches but only if patients participate, this is confirmed by Hicks et al (2012) only receiving 29% response rate in their retrospective questionnaire audit. Therefore an interview approach will be used as it will provide the highest rate of data collection (Sanderman and Wells 2011 and Beaver et al 2010) and reliability (Bowling 2004).

One to one interviews can be more flexible as discussed by (Kvale 1996) which allows sensitive information being discussed more openly in comparison to a quantitative approach as supported by (Jackson 1998). Using a semi structured approach, where the participant can record their feelings and explore experiences Cormack (2000) describes this as an enlightening process which will allow the researcher the opportunity to identify quality data and themes (Martins 1992).

The interviews will take place over a period of one month at a suitable time for the patients for an one hour interview which will be conducted in a counselling room and not the usual busy out-patient setting to ensure privacy. This will prevent being interrupted as distractions could contribute to a lack of understanding of the questioning (Malik et al 2002) and be unsuccessful in obtaining the right data. Kleiman (2005) states that by using the descriptive phenomenological method, the researcher assumes an attitude of openness and readiness to listen to the descriptions of peoples experiences

Data Analysis

There are more issues in qualitative research analysis in comparison to quantitative due to the complexity of the data for interpretation by the researcher (Patton 2002). Analysing subjective data of words, thoughts, feelings which makes it more complex than deductive numbers expressed in quantitative research (Tollick 2004). Quantitive data is usually collected before the analysis process commences whereas analysis begins as soon as qualitative data is being collected (Burnard 1996). Phenomenology will be the analytic approach in this proposed investigation using this concept as <https://assignbuster.com/the-specialist-nurse-consultation-nursing-essay/>

discussed by (Colazzi 1978) in analysing the data will answer the question in this investigation. This correlates with Moustakas (1994) who describes phenomenology as the study of the shared meaning of experience of a phenomenon for several individuals. As a researcher I find ethnography approach of Straus and Corbin (1990) a workable concept as this uses a questioning approach comparing methods of different groups, cultures and practices. However it is not suitable for this this investigation, this type of analysis would be more conducive if perhaps comparing different speciality nurse led clinics or comparing nurse led clinic to a Doctor led clinic.

Analytical grounded theory as discussed by Morse & Field (1966) would be selected if this patient experience was a new concept which it is not (DOH 2010 and DOH 2012).

It is imperative that the researchers remain unbiased (Polit and Hungler 1995) separating their own views and opinions when interpreting the data (Brink and Wood 1998). By listening to the taped interview and reading the transcript a several times they will gain a sense of the whole interview (Giorgi 1975) and identify themes from the codes utilising Ritchie and Spencer's (1994) five stages of framework analysis. These themes relating to participants feelings, thoughts and experience can subsequently be presented robustly in a table with headed categories and supportive statements.

Reliability Validity and Rigour

Analysis of qualitative data is more subjective and a systemic rigour of data analysis is fundamental and crucial to validate the data ensuring they are trustworthy (Long and Johnson 2000). However this data is only as good as

people give the information which fulfill four key areas of credibility, dependability, confirmability and transferability (Parahoo 1997). This qualitative investigation will meet these four key areas to demonstrate its trustworthiness. To maintain validity and trustworthiness the results will be transcribed and a paper copy of the individual transcript will be sent to the individual participants of the investigation for signing. This follows Colazzi (1978) method and participants should agree that it is a fair or accurate account of their answers and what was discussed. This credibility will be enhanced as the sample selection was undertaken solely by the clinical audit department

Two researchers will be conducting the investigation and as discussed Denzin (2000) this use of investigator triangulation will increase the validity of results of this potential investigation which is also supported by Thurmond (2001). The investigation will be valid as more people in the data collection and analysis process supports' the dependability of the findings (Morse 2010). The findings will not be just one researcher's opinion or interpretation they will be agreed by the research team ensuring the results are not biased or misleading. Agreed themes by the 2 researcher's participant will maintain the confirmability needed in this potential investigation. Any identified interesting themes or raised questions from this investigation could be considered and transferred for further study to benefit patients in the trust.

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ETHICS

As a nurse I have a duty to provide safe quality care to my patients (NMC 2008) and nursing research follows the same ethos it has to be robust ethical and safe (NMC 2012). Ethical approval will have been obtained from the NHS Research Ethics Committee by online application.

This is a legal requirement when conducting research involving NHS patients and staff. Research and Development approval will also be obtained as this phenomenon will take place in a NHS Hospital again using the online application form available at [https://www. myresearchproject. org. uk](https://www.myresearchproject.org.uk).

Integrity of the phenomenon has to be mandatory unlike in the ethnographic research (Ellis 1986) when participants were identified. The researcher will maintain strict participant confidentiality in accordance with Trust, NHS guidelines Caldicott (DOH 1997), and in accordance with the NMC (2008) to protect the phenomenon participants from harm. Kaiser (2009) states that maintaining confidentiality can be challenging whilst presenting this rich detailed data All subjects have the right to privacy and anonymity (Polit and Hungler 1995pg 124) and (Wood and Brink 1998 pg 152) therefore a confidentiality and anonymity agreement will be undertaken by the researchers and the participant prior to conducting each interview. All taped interviews and transcripts will be locked in a secure office to ensure participant's personal data remains confidential.

Informed consent is central to ethics and participants will have been fully informed from the information packs they receive about the phenomenon, allowing free conscious choice (Polit and Hungler 1995), before giving their

consent voluntarily (Royal College of Nursing 2012). Contact details for the lead researcher will be enclosed regarding questions, concerns or withdrawing from the phenomenon as participant can do so at any stage in the phenomenon (Nursing & Midwifery Council, 2008).

Day of interview participant will be asked if they wish to continue in the phenomenon and written consent obtained a copy given to the participant and original kept in research records.

CONCLUSION

Expertise good interviews require expertise in both the subject matter and human interaction as discussed by (Kvale 1998). The researcher acknowledges the researchers are novices in conducting this type of research and her research is not perfect. As a new researcher this I would learn and develop as I continued to conduct them and also participate alongside other researchers in their phenomenon's.

Having a lack of experience in conducting interviews may be a weakness and limit the quality data extracted during this phenomenon. Marshall and Rossman (1995) discuss the relevance in considering other methods for obtaining the quality information needed. During the early stages in the design the researcher did consider a questionnaire as the tool used in this phenomenon sending it out to the potential participants. As discussed by (Quote) using an open ended questionnaire cannot be measured like in quantitative research thus making it a quality phenomenon.

However I felt this approach may hinder good quality information being obtained from the participants and also there may be problems with the

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return of questionnaires (Hicks et al) and the loss of precious quality data. This is why I decided on a semi structured open interview approach is to be used in this phenomenon.

Deciding on the sample selection strategy was more difficult than I thought. I found this to be a problem which initially I thought would quite simple to decide upon. From my interpretation I thought three was applicable for this phenomenon. As a qualitative researcher I struggled to interpret the variety available and what would be the most suitable purposeful strategy. Is this a weakness? It could be if I have used the wrong sample strategy affecting its credibility.

In comparison to other methodologies I agree with Keen (1975) that phenomenology is not like a cookbook with recipes, it is a new approach, with an exploratory stance with a particular set of objectives. Analysing phenomenological data is not straightforward it is very complex and if not interpreted correctly can affect the quality results needed and hinder the aim for the phenomenon.

As a new qualitative researcher new research terminology removes one from their comfort zone when reading the literature and can be difficult to comprehend and understand making it thus difficult to critique. The literature review for this research proposal, could demonstrate a weakness in the critiquing of the literature. (Tarling and Crofts 1998) discuss that literature review and critiquing is nurtured over time.

Time frame when conducting a phenomenon is important as this could be a potential limitation in completion, data becomes old and resources could

disappear. Setting a realistic time frame for its completion is crucial allowing extra time for any unforeseen problems. As a researcher you cannot identify in advance those that lack capacity and vulnerable people who may have been contacted to participate (Lewis & Poret 1994). This can be ethically challenging and time consuming especially when ensuring you adhere to vulnerable adult policies. As their experiences and contribution to any investigation should be represented and not excluded.