The challenge of developing a nurse-led burns clinic

This article looks at the development of a nurse-led burns clinic. Changes in the NHS, such as reduced doctors' hours, have meant that nurse-led clinics have risen ever higher on the political agenda. The increased quality of care and the professional development of the practitioners themselves, demonstrate that there is a need for these clinics, especially in specialised areas such as burns care. The clinics allow nurses to address all of the patient's needs in one visit and although the clinics are run by teams of specialist nurses, they can call on any member of the multidisciplinary team, for example, a surgeon, if reconstruction is being considered.

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KEY WORDS
Burns
Nurse-led clinics
Holistic treatment
Quality of care

A burn can degrade, diminish and disfigure a human being for life (Helm and Walker, 1992) and treatment can be lengthy, painful and fraught with potential setbacks. The resulting disfigurement can be surgically ameliorated, but the scars will be lifelong. For some, life after burns can be entirely successful, whereas for others it can be a struggle (McBride, 1979).

The impact of the burn injury and the associated psychological trauma can be enormous and individuals and their families can experience severe distress (Shakespeare, 1998). A patient's ability to function at a social and vocational level can also be severely impaired. However, there is also strong evidence that these problems respond well to psychological treatments and counselling. This is especially true if the patient is seen soon after the injury (Edhe et al, 1999).

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Background

Wisely and Tarrier (2001) surveyed the need for psychological input in a follow-up service for patients with burn injuries. These patients were compared with a group of other trauma patients being treated in a plastic surgery unit. The patients with burns identified shortcomings in the traditional service, when they were seen in outpatients clinics alongside other types of patients. There was a significantly greater level of emotional disturbance in the patients with burns compared with other trauma patients as well as a lack of accessible specialist burn services for both physical and psychological issues post-discharge. The researchers concluded that patients with burn injuries require a comprehensive follow-up service, which did not then exist.

Van Loey et al (2001) questioned 429 patients with burns 12–24 months post-injury and found that they were still reporting severe physical and psychological problems. In addition, other problems were identified, including social, financial and legal issues. Because of these problems, 68% of respondents stated that they would visit a specific burn outpatient aftercare service if it were available even 1–2 years after their injury.

As a result of increased skill in wound care, surgical techniques and advanced life support systems, 83% of major burn victims now survive (Meyers-Paal et al, 2000). However, less attention has been focused on the quality of that survival and the factors that influence it (Tanttula et al, 1997). The unexpected trauma, the prospect of permanent disfiguration, systemic depletion, multi-system involvement, ongoing pain and discomfort, loss of loved ones, and financial losses can all place great demands on both resources and defence mechanisms (Wisely and Tarrier, 2001).

It is often not until a patient returns home that their problems begin. Patients often find themselves weaker than expected or are pitied and treated as a 'sick' person by friends and family. They are then at risk of succumbing to 'social death' a phenomenon described by Wallace (1988) in which patients disappear from follow-up services because of a desire to hide away their disfigurement.

Treatment

Burns care provides us with a good example of holistic nursing. Good technical care can be accompanied by the provision of humane and life-enhancing treatment. This can then be continued into the patient's own care setting.

Table 1
Referral criteria

Patients with the following types of burns may be referred to the Burns Outreach Service:
- Partial/full thickness burns
- Facial burns
- Chemical burns
- Electrical burns
- Burns over 1% total body surface area
- Burns not healed at two weeks review
- Burns to buttocks and genitalia
- Extensive hand/feet burns

Patients excluded from follow up in the burns clinic include:
- All children (aged below 16 years)
- Patients who require immediate referral to the burns centre
- Patients with superficial non-complicated wounds

The functional aspect of the patient's care is also an issue as many patients do not return to their previous level of functional ability for prolonged periods of time, if at all. This is related to pain, dressings and therapy (Michaels et al, 2000) and can impact hugely on the patient's ability to return to work and a normal social life. Provision of therapy services post-discharge can be problematic and there is often nowhere for the patients to access rehabilitation. Also, local therapy staff often do not have the specialist knowledge to be able to manage these patients at the level of care they require.

Developing the service

When working as a nursing student at University Hospital of South Manchester NHS Foundation Trust the author was shocked to discover that burn patients were often lost to follow-up. Having identified that, according to the study by Wisely and Tarrier (2001), the traditional method of managing the trust's burn patients through a plastic surgery outpatients department might not be meeting all their physical and psychosocial needs, it was decided to develop a nurse-led burns service. The aim of the service was to provide clinics where patients newly referred from A&E, GPs and walk-in services, as well as all those patients who were discharged from the burn centre, could be seen. It was decided to develop this as a nurse-led clinic as although the specialty of burns is multidisciplinary, nurses play a pivotal role and can coordinate all the other disciplines that need to be involved in the patient's care. Jinks and Hope (2000) support this view, stating: 'Nurses are primary co-coordinators of direct and indirect patient care. They are the 'glue' maintaining the holistic overview of care given by all members of the healthcare team.'

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However, while nurses can take on expanded roles and provide basic physiotherapy, scar management and counselling, as well as addressing basic social work issues, many patients with burn injuries have more complex needs. Therefore, patients who are referred to the unit still have access to all the other members of the team whose expertise might be required, for example, therapists, surgeons, social workers, psychologists and pain specialists.

Issues to be considered

There are a number of professional issues that need to be considered when setting up a nurse-led clinic. The level of nurse education, training and experience of the nurses involved is an important factor. Rafferty and Elborn (2002) suggest that an appropriate level of education, clinical expertise and available support is important if the nurse is to exercise informed judgment in clinical decisions. The lead nurse for this project had over 15 years of experience in burns as well as being educated to Masters' level. In addition, she also felt competent fulfilling the expanded roles that would be required. It was also arranged that the early nurse-led clinics would run at the same time as the consultant clinics to aid discussion about clinical management when necessary.

Another issue to be considered is that of responsibility and accountability. Tingle and Cribb (1995) suggest that accountability means taking responsibility for actions, being answerable and making decisions based on knowledge and understanding. As this clinic was designed to cater for both new referrals and patients who had been discharged from the over-arching burns service, it was necessary for protocols to be drawn up. These were agreed with the consultant burns surgeon and they identified those groups of patients that could be admitted into the service. The protocols were ratified by the trusts' Nursing and Midwifery Board and include detailed referral criteria (*Table 1*).

There had to be a great deal of trust in the knowledge level of the nurses involved in the clinic as they would be working autonomously and making diagnoses on issues such as burn depth, severity and the treatment required. Initially the clinics ran with one nurse who was a clinical nurse specialist but the service has gradually expanded to include an additional four trained nurses. One of these nurses rotates with the burn centre so that knowledge and experience is shared between the two areas.

Another issue to be addressed was that of nurse prescribing. The nurses in the clinic needed to be able to prescribe analgesia, dressings and antibiotics rather than waiting for a senior house officer, most of whom are usually in theatre. Patient group directives were considered, but it was

decided that undertaking the nurse prescribing course might be more effective. Shepherd (1998) suggests that nurse prescribing offers nurses positive benefits such as increased control over drug treatment, an opportunity to respond to patients' needs without calling a doctor and advancement in professional status. In the nurse-led burn clinic this has enabled a range of products to be prescribed for a significant number of patients who are of no fixed abode or who have no GP.

The other main issue to be considered was conflict. Traditionally patients with a burn injury had been cared for by the plastic surgery dressings clinic, but issues such as psychological problems, social issues and long-term follow-up had not been addressed. Initially, staff in the plastic surgery dressings clinic felt that they may be de-skilled by the new service, but also admitted that follow-up for this group of patients had been haphazard. This was countered by inviting any member of staff into the burn clinics to retain their skills and develop them further. Some staff did initially rotate into the clinic when the other clinics were quiet and new employees in the plastic surgery dressings clinic still rotate into the clinics, as do new staff at the burns centre.

Process

In order to set up the clinic some practical issues had to be addressed, including identifying clinical space in which to run the clinics. Initially it had to take place one day a week in the plastic surgery dressings clinic and one day a week in the physiotherapy hand room. However, as a new burns and plastic surgery department was opened, clinics were expanded, initially to three times a week and then to the current five. Additional support had to be identified and financed as patients required registration and notes as well as preparation for clinics. Letters also had to be sent out to GPs and community staff.

Initially the clinics were funded from charitable donations, but in order for the trust to consider funding the clinic and to prove its effectiveness, a database was created to collect both the numbers of referrals and also details of where the referrals had originated from. In addition, a mechanism for measuring outcomes needed to be defined.

The outcome measures that the organisers' decided to use were the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983), which measures the levels of anxiety and depression in patients over time, the Impact of Events Scale (Horowitz et al, 1979), which identifies patients with post-traumatic stress disorder, the Short Form-36 (Ware et al, 1993), which is a functional and psychosocial assessment tool, and the Burn Specific Health Score (Munster et al, 1987), which was designed to specifically look at problems burn patients suffered after discharge.

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Measurements were taken before discharge and then regularly for the first 12 months afterwards. This in itself proved difficult as patients were reluctant to complete them and they did not help in validating the service as many patients actually had more problems over a longer time period. This is in common with findings by Edhe et al (1999), who also noted an increase in psychological symptoms three-months post injury. It could be that repeatedly asking patients about the psychological effects of their injury could prevent them from moving on with their lives as they do not then experience closure.

As this was a new initiative, paperwork such as referral forms, assessment forms and care plans had to be devised. The referral guidelines and forms were distributed to A&E departments, walk-in clinics and minor injury units and to community nurses and GPs.

Aims of the clinic

The aims of the clinic were:

- To provide psychological support, wound care and therapy for patients and their carers
- To educate community staff on all aspects of burn wound management
- To educate outlying therapy staff
- To act as a resource for patients, carers and the primary healthcare team
- To accurately validate the efficacy of the service
- To develop outreach clinics within the burns service catchment area
- To develop return-to-work/study programmes with industry, schools and colleges.

Results

Table 2 demonstrates the number of patients seen over the first four years of the clinic. These were new burns patients referred to the system who had not been inpatients in the burn centre. On average, another 250–300 patients discharged from the burn centre were seen in the clinics each year.

Table 2
Number of new referrals

April 2001 – April 2002	148
April 2002 – April 2003	161
April 2003 – April 2004	182
April 2004 – April 2005	226

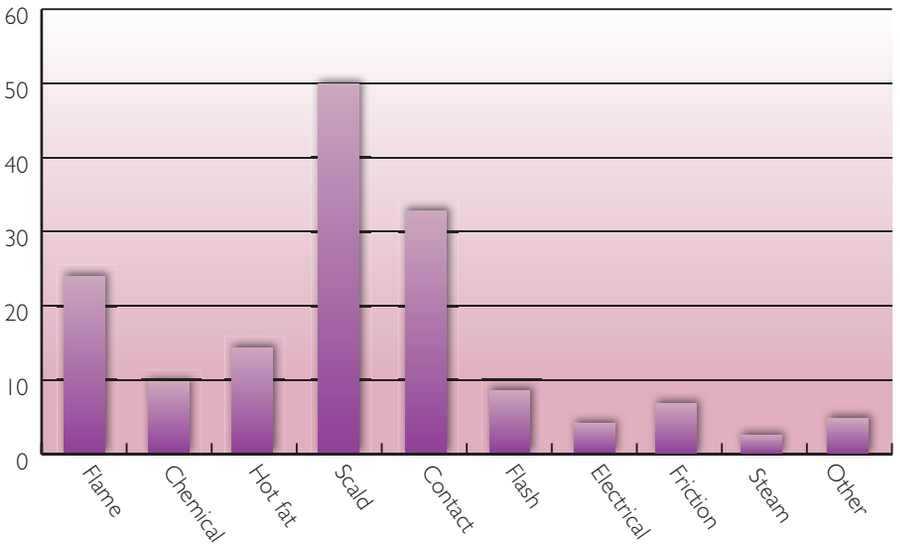

Figure 1. Mechanism of injury of patients seen at the burn clinic.

The predominant mechanism of injury was scald, closely followed by contact and then flame (*Figure 1*). As was expected, the majority of injuries were less than 1% total body surface area, which was in line with the referral criteria identified. Interestingly, more than half the burns were deeper (*Figure 2*), which demonstrates the need for specialist advice to be available at the clinic.

Advantages

A number of advantages to the nurse-led burn clinics became apparent after the service was instigated, for example, the number of non-attendances was down in comparison to the consultant-led burn clinic and fewer patients were being lost to follow-up. This is supported by Denver et al (2003) who suggest that patient education is constantly reinforced in nurse-led clinics and that this could have a positive effect on health as well as increasing concordance. Another advantage, particularly in the elderly population, was a reduction in admissions as specialist advice was more readily available. This reflected Corser and Ebank's (2004) experience where admissions for self-harm were prevented when nurse-led clinics for self-harming patients were developed.

Because the clinic is able to offer patients access to the whole multi-disciplinary team at one visit, this

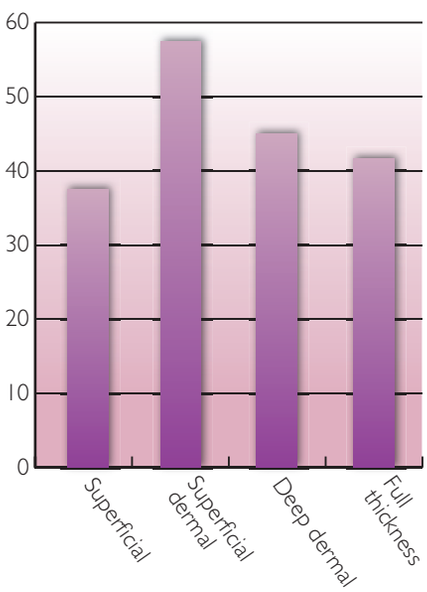

Figure 2. Depths of the burns referred to the clinic

reduces the number of unnecessary outpatient appointments. It also frees up consultant time to see more complex patients and ultimately could help consultants reduce hospital waiting lists, thus making nurse-led clinics a cost-effective option (Uppal et al, 2004).

A number of authors have suggested that nurse-led clinics result in increased patient satisfaction (Hill, 1997) and that they are acceptable alternatives to consultant-led clinics (Miles et al, 2003), and this reflects the author's experience. Patients regularly comment on how informed they are and that they feel that they are being dealt with competently and confidently.

In addition, patient satisfaction questionnaires were sent out and patients were asked a number of questions about their experiences in the nurse-led clinics, in particular whether they felt they would rather have seen a doctor. None of the patients were unhappy at not seeing a doctor and were happy with their ultimate outcome. All of the patients who responded to the questionnaire said they were happy seeing the clinical nurse specialist. Additional questions were asked about how confident patients felt with their diagnosis, treatment plans and the advice they were given by nursing staff and 100% of respondents were happy with all aspects of care. Comments received from patients included:

'The clinics I have attended have been well organised and I have never had to wait long to be seen, which is not always the same in other clinics.'

'From the first cheery "good morning" to leaving with a new appointment written down, your dedication and consultations have been professional and have helped me a lot. I hope that you will continue to help others as you have helped me.'

'Your staff and yourself have been straightforward and honest as well as clinically very professional. I feel that I have been kept informed about the status of my injuries and my progress at every stage.'

Disadvantages

Very few disadvantages to the nurse-led clinics were identified. In fact the main problem was attempting to grow the service to match the demand. The service has grown year-on-year and while it was initially funded by charitable donations, the trust has had to take on the financial responsibility for the service. The numbers of nursing and therapy staff have had to be increased as the service has grown.

An additional problem arose in that many consultants did not want

Key Points

- Burn treatment is lengthy, painful, and fraught with potential setbacks.
- The nurse plays a pivotal role and coordinates all the other disciplines that need to be involved in the patient's care.
- Nurse-led clinics allow patients to have all their physical and psychological needs met through a one-stop approach.
- Nurse-led clinics have led to increased development of nurses' roles, which in turn has led to increased job satisfaction.

to accept referrals from nurses. It has taken a long time for consultants from other disciplines, for example, dermatologists and vascular surgeons, to accept referrals from the team and there are still occasions when the team experience some resistance in this area. This reluctance has gradually lessened as the referrals have been shown to be appropriate.

The nurse-led burn clinics have now been expanded to include outreach home visits for patients who cannot travel to the clinic, for example, older patients, patients with learning disabilities and patients in other care institutions. Training regarding referrals has been developed for all A&E departments and community staff and although this has seen our referrals increase, it means that considerably fewer patients are referred inappropriately.

Conclusion

The development of these clinics has provided a number of advantages, the most important being the ability to provide patients with seamless care through injury to recovery. Patients are able to attend the clinic and have all their physical and psychological needs met through a one-stop approach. The clinics have led to increased development of the nurses' role, which in turn has led to increased job satisfaction.

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Another unexpected benefit has been the improved concordance from patients in terms of their physical care and also in attending the clinics in comparison to consultant-led clinics. Overall, the patients seem to be very happy with the service. It continues to grow and there has been a recent introduction of scar clinics. **WUK**

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