Key issues in setting up and running a nurse-led cardiology clinic


Summary
This article discusses the key issues involved in setting up and running an effective nurse-led cardiology clinic. These include: developing clear aims and objectives for the service, techniques to reduce resistance from colleagues who are affected by the change in service provision, professional development, audit and evaluation.

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Keywords
Cardiac nursing; Cardiology; Nurse-led clinics
These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles and author guidelines visit our online archive at www.nursing-standard.co.uk and search using the keywords.

IN RECENT years there has been a marked increase in the number of nurse-led clinics in a variety of specialties, including cardiology. This has been brought about by, among other factors, advancing and expanding nursing skills – supported by the university sector – the continued reduction in doctor’s working hours (Department of Health (DH) et al 2002, British Medical Association (BMA) 2004), and a need to shorten waiting times for definitive health care. Nurse-led clinics are often the first point of patient contact in both primary and secondary care.

In cardiology, the development of rapid access chest pain clinics is a clear example. The emphasis in government documents, such as the National Service Framework (NSF) for Coronary Heart Disease (DH 2000a) and guidance from the National Institute for Health and Clinical Excellence (NICE) (2005) on providing evidence-based treatments has required that healthcare team resources are pooled to ensure specific clinical targets and best practice are achieved. More recent documents have emphasised healthcare staff working outside traditional roles (DH 2004a, NHS Modernisation Agency 2004), with new plans emerging for a social care model to support those with long-term conditions. For example, community matrons with advanced practice skills will use a case management approach (DH 2005). Such documents may not refer explicitly to nurse-led clinics, but their approach to health care should encourage the innovation and diversity of roles that feed such service provision.

The emphasis on supporting self-care for those with long-term conditions (DH 2005), will hopefully have an impact on the philosophical underpinning of nurse-led clinics in cardiology.

Cardiac services are notable for using nurse-led clinics to improve patient care (Clare and Sandys 2002, Connor et al 2002, Denver et al 2003, Trowbridge et al 2003, Eldh et al 2004). In a recent Scottish study of nurse-led secondary prevention clinics for coronary heart disease, based on a four-year follow up, Raftery et al (2005) concluded that the clinics appeared to be cost effective compared with most interventions in health care. The main benefits were in the number of life years saved, with 28 fewer deaths in the intervention group (n=673) than in the control group (n=670).

As well as increasing access to specific cardiac care for patients with acute conditions, such as newly diagnosed chest pain or following a myocardial infarction, clinics have been used to manage the care of patients with long-term conditions, such as those with chronic heart failure (Gould 2002).

The aim of a nurse-led clinic might, therefore, not be curative, but to allow the monitoring of a patient’s condition to prevent further deterioration and maintain quality of life. Patients with chronic cardiac conditions might not need regular consultations with medical personnel and, because nurse-led clinics often allow the same nurse to see the patient over a prolonged period of time, a highly therapeutic relationship can be offered.

While articles continue to describe the role of various nurse-led clinics in cardiology, few address the key issues underpinning setting up a clinic and achieving a measurably effective service. Beginning with a broad definition of a nurse-led clinic, this article considers some of the key issues.
The definition of a nurse-led clinic (Box 1) is broad because some clinics will offer a service that is valuable, but may not involve skills that can be termed advanced nursing practice, although this term is difficult to define (Cox 2001, Gulland 2002, Hatchett 2003). Others can incorporate this, with detailed physiological assessment, the creation of complex treatment plans and the ability to administer medications based on the nurse’s decision-making skills. Box 2 outlines the roles of a nurse-led cardiology clinic. When these roles are linked to the aspects outlined in the definition (Box 1), it becomes clear that not all clinics will incorporate each of these aspects.

**BOX 1**

**Definition of a nurse-led clinic**

A nurse-led clinic can be defined as a clinic or drop-in service that is run at set times by a registered nurse. This contrasts with other nursing roles, where the nurse can be contacted to visit the patient at different times. This may be visiting the ward when the patient requires a specific nursing skill, perhaps offered by a clinical nurse specialist. The clinic requires the patient to fit into a rigid time slot, often through an appointment system. The nurse has his or her own patient caseload and the clinic involves an increase in autonomy. There is the ability to admit and discharge patients, or to refer to other more appropriate healthcare colleagues, based on the nurse’s assessment. The plethora of nurse titles beyond registration, the variety of roles and varying levels of professional development may make some members of the multidisciplinary team wary of receiving referrals from nurses running the clinics. The move by the Nursing and Midwifery Council (NMC)(2005) to regulate advanced nursing practice, may help to address this issue. (Hatchett 2003)

**BOX 2**

**Roles of a nurse-led cardiology clinic**

- Educating patients.
- Providing psychological support and explanation.
- Monitoring the patient’s condition.
- Conducting physical assessments.
- Ordering appropriate diagnostic investigations and interpretation.
- Creating treatment plans, often involving other members of the multidisciplinary team, such as GPs or primary care colleagues.
- Managing medicines.
- Empowering the patient or carer to achieve greater self-monitoring and/or care.

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**Setting up a nurse-led cardiology clinic**

Some of the main issues to consider when setting up a nurse-led cardiology clinic are listed in Box 3. Many, if not all, of these can be addressed in initial planning, and this will take time. Setting up a nurse-led clinic in any specialty may be perceived as a threat by some healthcare and support staff because it represents a change to the usual pattern of working. Making sure staff affected by the change are kept informed, valuing their opinions, and incorporating suggested ideas can smooth the way for change.

Management techniques, such as performing a force field analysis can be useful in identifying potential resistance to setting up the nurse-led clinic from colleagues and other practical factors. Force field analysis involves group work with those who will be affected by the change. A facilitator identifies the change, and asks the group to consider the factors that will act as driving or restraining forces to that change.

These are listed and the group then rates the strength of each force as high, medium or low. The group and those directly leading the change can plan to lessen restraining forces and strengthen those perceived as driving the change (Cook et al 2004, Pettinger 2004).

**The importance of aims and objectives**

In the initial stages of setting up a clinic, it is vital to state its aims and objectives clearly. This should prevent misunderstanding about what service is being offered and will form part of the publicity for the clinic. Having clear aims and objectives should help to ensure that the correct patients access the service. Patients may become irritated if they are told they cannot be seen because of an inappropriate referral.

The rapid access chest pain clinics that emerged after the NSF (DH 2000a) generally see the patient only once to offer a more definitive diagnosis of coronary heart disease. They provide a service for a specific group of potential cardiac patients that can be open to misuse if the role and access criteria are not clear. There may be occasions when colleagues inappropriately refer patients. This may be because of an inability to deal with the patient’s problem or because they feel that the clinic will address the patient’s needs. Good auditing can identify those who encourage inappropriate referrals, but clear aims and objectives prevent an uneasy situation where the nurse has not been clear about the clinic’s role.

It is valuable to create a business case. This involves documenting what resources, particularly monetary, will be required to set up and run the nurse-led clinic. Patient and economic benefits are identified or predicted. This will include examining...
the referral process and determining which cardiology patients the clinic will treat based on specific admission criteria. Other issues include:

- When the clinic will be held.
- The cost of administrative support.
- Any anticipated education funding to prepare the nurse adequately to offer the service.
- Salary costs.
- The cost and requirement of publicity, offering material to interested parties such as colleagues who may refer patients to the service, managers, and those who will be affected by the setting up of the clinic, such as those performing diagnostic tests.

At an early stage consideration should be given to all those who can offer support, such as secretarial and administrative staff and healthcare colleagues, who can provide valuable professional advice allowing the clinic to function effectively and the nurse to attend to patients. Factors to be addressed include: where the clinic will be held and the facilities available, for example, the waiting area, the size of the room, equipment, storage space, a sink and, if needed, an examination couch. The concept of a nurse-led clinic suggests increased autonomy, but staff should not work in isolation. Liaison with, and support and advice from, other nursing and multidisciplinary colleagues will assist in developing an effective service. When deciding the day that the clinic operates, it is useful to find out which cardiology and administrative colleagues will be available on the day to provide support.

An important area to consider when setting up the clinic is which colleagues will be able to deputise for annual leave, sickness and perhaps maternity or paternity leave. Would this mean that the clinic would not run, or would other colleagues be prepared to see the patients during these times? Other nursing staff may need to be developed in similar roles. Such planning requires consideration.

Professional development

One of the most important objectives of a nurse-led clinic in cardiology – and any other specialty – should be to produce a measurably effective service for patients. The experience, skills and competence of the nurses running the clinics will vary. It is valuable for the nurse to meet a manager and review the job description and the aims and objectives of the clinic. An appraisal leading to a professional development plan can be undertaken to address, monitor and record the development of the nurse’s skills.

This can be linked to the outcomes in the NHS Knowledge and Skills Framework (DH 2004b), if the employer is working for the NHS. This defines and describes the knowledge and skills that NHS staff need to apply in their work to deliver a quality service. The framework can assist in creating an outline of the post, guiding knowledge and skills progression that can be linked to remuneration.

### BOX 3

**Factors to consider when a nurse-led cardiology clinic is set up**

- What is the impetus for setting up the clinic?
- Has a business case been created to consider the full costs, which will include human resource issues such as ongoing professional development and salaries, and other areas such as diagnostic testing?
- What are the aims and objectives of the clinic? Are they clear and specific to patients and to healthcare professionals who will refer patients to it?
- Is the clinic likely to produce resistance, particularly if it is being instigated by management rather than clinical staff?
- What steps are being taken to reduce resistance?
- Where will the clinic be run?
- At what times will the clinic run and how frequently?
- How will patients access the service, for example, through referrals or as drop-in or walk-in service?
- How will the service be publicised to patients and healthcare professionals? Ideas could include posters, presentations and community visits.
- What administrative support is available and can this be accessed easily and regularly? This should include issues such as how appointment bookings will be made, who will deal with correspondence and can Dictaphones be used?
- Who is willing to accept referrals and who is not?
- Is there agreement from other healthcare professionals to perform diagnostic investigations, ranging from blood tests to more complex diagnostic tests? Please note that requests for radiological examinations are regulated by the Ionising Radiation (Medical Exposure) Regulations 2000 (DH 2000b).
- Are you able to interpret or gain access to those who can assist with interpretation of results as required?
- What are the required skills and knowledge base of the nurse running the clinic? How will professional development be planned to meet any deficits in these or changes in the service? Has a personal education portfolio for the nurse been created to plan for this?
- Is clinical supervision available to aid professional development and offer ongoing support?
- How will the service be audited and evaluated to provide evidence of an effective service?
The development plan can contain a job description, and the aims and objectives of the service. It can be used to create an action plan to achieve the necessary competence for the role. Competencies are valuable in setting out what is required to achieve a specific role. An action plan can then be written, outlining the educational methods to achieve the competence and knowledge, and how the nurse will demonstrate these, usually to a competent colleague. For some, these factors may be assured because the evidence is already apparent, for example, through certification for assessed elements of a relevant course, but competence and knowledge may also require updating. Alternatively, or in addition, the competence and knowledge may be gained through certification from the college or university but it is important to remember that professional development is an ongoing process.

**Clinical supervision**

Releasing staff from a nurse-led clinic can be difficult, but the service must run with a commitment to professional development from the start. It can be useful for the nurse to form a supervisory relationship to try to analyse events and patient examples – learning from these through reflection. Clinical supervision has the advantage that it occurs in the work area and can incorporate the environmental and contextual issues that affect service delivery, which may be difficult to consider fully in the classroom setting. Clinical supervision should be allocated protected time and occur periodically, perhaps once a month or every few weeks. It is a formal process of professional support. Butterworth (1998) outlines three main goals based on Platt-Koch’s (1986) work. These are:

- To expand the theorist’s knowledge base.
- To assist in developing clinical proficiency.
- To develop autonomy and self-esteem as a professional.

The process involves spending time with a supervisor who can encourage the nurse to explore and articulate his or her knowledge and compare it with what is needed in practice. The supervisor can help the nurse to consider alternative methods of dealing with a situation and to identify gaps in knowledge, which can become a part of a development plan. Each supervision session needs to be planned carefully. The clinical supervisor should use an open questioning technique that helps the nurse to reflect how he or she can develop critical thinking and problem-solving skills using different strategies. This may involve the application of specific patient questioning as part of physical assessment (Snadden et al 2005), the use of a treatment algorithm or the enhancement of physical assessment skills. Only when the nurse has exhausted these should the supervisor give his or her method to solve the problem. The relationship should not be based on the supervisor telling the supervisee what to do.

It is useful to set ground rules at the beginning, particularly if group supervision is chosen, to ensure that each party understands the process. Ground rules should also include how far issues, such as confidentiality, can extend in areas such as unsafe practice. There is literature available that explores the process in much greater depth (Butterworth 1998, Van Ooijen 2003). Universities also run study days and short courses on clinical supervision. The effect of clinical supervision on patient outcomes requires ongoing research.

**Audit and evaluation**

The need to audit and evaluate a nurse-led cardiology clinic is imperative. Clinical audit seeks to improve the quality and outcome of patient care through systematic and critical analysis reviewed against explicit criteria (Pennery 2003). The process should have clearly defined aims, explicit goals and measurable targets for quality improvement. The process can be closely linked to evaluation, which measures the value, merit or worth of the clinic. Evaluation will help inform the nurse about whether the clinic is influencing patient care positively or negatively. Therefore, audit can be used to collect information to allow evaluation of the service provided. There are four useful and fundamental areas where good auditing can be used to evaluate a nurse-led clinic in cardiology. The four areas are: the overall change in the health status of the patients as a reflection of the care provided; the impact on measures of quality, such as morbidity and mortality; the effects on the physical, functional and psychosocial aspects of the patient’s health status; and patient satisfaction with the service (Pennery 2003).

Box 4 lists the range of research methods that may be required to evaluate the clinic. Each of the questions will require a different form of data collection, ranging from the recording of physiological parameters and patient satisfaction surveys to quality of life measurement tools. Bowling (2004) and O’Connor (2004) offer useful texts that illustrate the variety of scales and tools available to measure quality of life. It may be that specific data have to be collected as part of wider auditing or to demonstrate that certain national
targets are being met. It is advisable to assess what auditing is already in progress and whether there is an audit department that can help in the process.

**Conclusion**

Nurse-led cardiology clinics can be highly challenging, and it is important to seek the support and guidance of colleagues who are experienced in the area. Professional organisations, such as the British Association for Nursing in Cardiac Care, literature searching and the internet are useful starting points. The issue of professional rivalry can be addressed by adopting an open and honest approach to the development of a nurse-led clinic.

The creation of clear aims and objectives, a business case and discussion with those who will use the service and those who can offer support, will highlight potential difficulties at an early stage, allowing time to problem solve. Performing a force field analysis can help to identify the factors that will promote or hamper the setting up of the service. The issue of self-reflection in assessing and achieving competence, underpinning knowledge through ongoing professional development and using audit as part of service evaluation are important aspects in maintaining an effective nurse-led clinic.

**References**


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**BOX 4**

Checklist for evaluating a nurse-led cardiology clinic

- Has the nurse-led clinic improved the care in cardiology as measured by changes in the health status of the patients?
- What impact has the nurse-led clinic had on traditional measures of quality, such as morbidity and mortality in the cardiac care setting?
- Has the physical, functional and/or psychosocial health status of the patients improved as a result of the nurse-led clinic?
- Are the patients satisfied with the care they receive from the nurse-led clinic when compared to alternatives?

(Penney 2003 adapted from Girouard 1996)