Getting one's eye in

BY LISETTE BIJMA

Lisette Bijma, Sister in the Eye Emergency Department at John Radcliffe Hospital, explains how COVID-19 provided a 'baptism by fire' and enabled fundamental and positive changes to the running of the department.

Five years ago, I arrived in the UK, a young final year nursing student who needed a change from her home country, the Netherlands. I applied for a six-month internship at the British Language School in Oxford, while I was waiting for my thesis results to come back from the University.

One day, during my lunch break at the now closed Jimbob's, an elderly woman had the misfortune of tripping outside, falling and cutting her forehead open in the process. I finally had a moment, between typing certificates and copying progress reports, to be myself, to be a nurse. It took a very unfortunate incident to make me realise that I chose the right profession and that I could not wait to actively practise nursing.

Four months into my internship, my plans for a temporary stay in the UK were swiftly altered by the fact that I met who is now my long-term partner. Consequently, my nursing career had to be started in the UK, and I applied for my NMC pin number and a job at the John Radcliffe Hospital. I started my first hospital role on the Specialist Surgery Inpatient Ward (SSIP) as a band 3 healthcare assistant awaiting my pin number. From there I rolled into a band 5 registered nurse role and was promoted not long after that to a band 6 deputy sister. The three years I spent there were the most challenging, stressful, tearful, reflective and formative moments of my life in general but also as a young professional. Because of SSIP I had my first exposure to ophthalmology as, along with ear, nose and throat (ENT), maxillofacial (maxfax) and plastics, it is one of the four specialties of the ward.

"Eye" patients

Like my fellow colleagues I was terrified to look after "eye" (this is how we referred to ophthalmology) patients. This was mainly caused by the lack of knowledge about the anatomy and physiology and the poor support and communication from the ophthalmology team. The discussions I have held about the need to answer a bleep, to make sure prescriptions and clinical instructions are written correctly are too many to count. Therefore, I was grateful when my manager at the time asked if I was interested in "doing a course about eyes". I thought it was a good opportunity to manage those fears when working with eye patients and start to learn more about ophthalmology – not realising it was a one-year PGcert level 7 course!

There I was at the induction, listening to the lecturer explaining what we could expect in the upcoming year. I remember him joking around and saying: "Once you understand ophthalmology you are hooked, you don't want any other speciality." He promised we would come and work at the eye hospital after completing the course. My colleagues / fellow students and I laughed very loudly and said that would never happen; one year after graduating from the PGcert I got my first role within the eye hospital as an ophthalmic specialist nurse practitioner (OSNP).

During my first year as an OSNP, I got the opportunity to put the PGcert into practice. I got accustomed to working in an outpatient setting, the different sections of the department: optometry, orthoptics, imaging, clinics, eye emergency department (EED) and admin. I further developed my diagnostic, slit-lamp and clinical skills. I got to know the team and what an amazing group of people they are. I really enjoyed my new place of work; however, it doesn't take long for me to see areas for improvement. Unfortunately, that is just the way I am programmed, I always seem to notice the inefficiencies within my workplace and feel the need to start a quality improvement project for them. Just a couple of months in the job, I was that annoying new person with loads of ideas that ultimately influenced changes in procedures that had been in place for 10+ years!

Tackling inefficiencies

There seemed to be a structural imbalance within the EED. Staff members were frustrated with the set-up, doctors could arrive whenever they wanted, plus there were not enough doctors allocated to cover the sessions. Although optometrists and GPs with a special interest in ophthalmology were allocated with an EED clinical sessions, specialist nurses weren't included. On average around 50+ patients would attend EED, this could be via the walk-in service, the urgent referral email from GPs / optometrists / 111 or main A&E. The urgency of some of the clinical presentations was questionable. The Minor Eye Condition Service (MECS) was implemented in Oxfordshire, allowing us to refer patients meeting the criteria to the community instead. After that, a Telephone Triage (TT) pilot was initiated, covered by one MECS optician, with the aim for patients to call before attending EED, to make sure it was the right service for their symptoms. The initiatives had potential but didn't work in the current setting, as it was only causing yet another stream of patients attending EED.

The drive to tackle this situation was so powerful that I successfully applied for the band 7 sister role for EED. By the time all my paperwork was finalised and I was able to start it was March 2020. Hello COVID-19! Forget the supernumerary period, forget visiting other eye emergency departments in the country to get an impression and experience from others, it was action time. I was surrounded by an amazing team of managers and with the EED consultant, newly hired Locum EED consultant and new optometry lead for EED we have done a great deal of work for the department.

Hello COVID-19

Before the national lockdown we closed our walk-in service. Instead, we asked all patients / professionals to call our TT before attending / sending patients to EED. To meet the volume of phone calls we increased from one MECS operator to eventually three phone lines covered by optometrists and specialist nurses. We closed the door of the department. Instead, two staff members stood outside triaging all patients for COVID-19 symptoms and making sure they had spoken to a member

of staff before allowing them into the department. At no point have patients been refused emergency care.

All junior doctors had to be redeployed, leaving just the consultants, some of whom haven't worked in EED for many years. We developed an EED COVID-19 protocol, explaining the setup of EED, where to find material, what type of pathologies to expect and how to treat them. We set up a line of communication with main A&E, GPs and optometrists to inform them about the changes to the department, the website and automated telephone answering machine were updated. Luckily, the MECS service continued during lockdown, allowing us to refer patients to the community, which has been a massive service to us and the patients.

After the national lockdown we had to decide as a team how we were going to restructure the department under the new 'normal' circumstances. This allowed me to work on the initial identified issues for the department. Therefore, in order to prevent inconsistencies in doctor arrival times, we implemented set times for their sessions and an increase in the number of doctors. We now have at least three doctors allocated plus one optometrist / GP. On SSIP I learned the importance of communication and being available for external areas. The nurse in charge of EED is now wearing a bleep to create a line of contact in case other areas can't get hold of the doctors, with positive effect. We improved the communication towards our team, by giving regular updates, asking for feedback had a good effect on staff morale, as it makes them feel included and part of the team.

I am so proud of our team and everything they have endured and achieved during this period. The resilience and hard work they have shown still continues to impress me every day. Personally, I can't wait for the next opportunity to celebrate our achievements and I strive daily to give them the acknowledgement they deserve. I think COVID-19 is the best baptism by fire I could have received as a new manager and I haven't regretted going for the role once. To some extent, I feel COVID-19 was the reset button the NHS needed. The changes we have made in the last couple of months would have never been possible pre-COVID or would have taken years to be implemented. Although I am nervous about the future and the further development of COVID-19 in society, I am also motivated and feel that as a team and a department, we are ready and will continue to act with the same resilience and teamwork we have been doing so far.

LEARNING POINTS

- Never say no to a new learning opportunity as you never know what doors it might open.
- Never stop doing what you love.
- Always trust your team, as together you can achieve so much more.

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