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Links to Health and Social Care

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Table of Contents

Reflections on Practice

Articles

Guest Editorial

Professor David Gibson
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As Head of Entrepreneurship Education at LJMU I recognise the development and co creation of this journal Links to Health and Social Care by academics and student nurses as an excellent example of an activity that will enhance the development of enterprise skills within the University nursing student community.

It is vital that students enhance their self-efficacy and resilience with creativity, innovation, personal branding, negotiation, teamwork as well as leadership, the core enterprising skills and behaviour needed by the students.

Students involved in the co creation of this e-journal have had the opportunity to create a new innovative product and deal with the associated challenges that this process brings. In producing scholarly work, they are creating a new product and attempt by the quality of their research and their communication skills to get the research published. Those involved in editing are assuming the perceptual position of the academic who is assessing the work of others and learning to provide constructive feedback. The process will enhance not only their own enterprise skills but also their own capabilities in articulating and publishing their own practice based work as a reflective practitioner.

The entire entrepreneurial process consists of creating an innovative solution to an existing problem by implementing the solution in a practical environment. This will include the capacity to negotiate and to sell solutions to others in the work environment. It also includes learning to build your own personal profile through publication and dissemination of your practice. To develop these competencies and mind set requires experience of both creation of an innovative product and service but also getting agreement to the use and implementation of your work. The opportunity to act as both writers and editors allows students to understand this process both from the creator and the assessor of an innovative solution.

The Higher Education Academy have confirmed that student /staff co creation of a journal of this type represents best practice in transformational learning to create practitioners who can not only implement innovative practice solutions but articulate to others the learnings and challenges of implementation. This is of particular relevance to nursing education which must prepare students to deal with delivering healthcare solutions in a challenging environment.

I applaud this journal as an excellent example of brilliant learning student pedagogy for professional development. LJMU have recently won a national award in enterprise education from the UK government and have been shortlisted for the European Enterprise Promotion Award as one of the top three projects within the EU

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and the winner will be announced in November. This journal is an excellent example of the ground breaking nurse education in LJMU. I am convinced it is likely to further develop to meet international demand for transformational nursing projects in healthcare education.

Authors in this Issue

Angela Dempsey: Angela is working as a a practice nurse and now safeguarding lead with a busy inner-city GP practice looking after patients of all ages with a variety of medical conditions, both chronic and acute. She also has had experience working in Accident and Emergency care in a very busy hospital in the North West of England. Angela has a particular interest in safeguarding and her role as a practice nurse gives her a lot of exposure to it. Recently undertaking a module on safeguarding has helped her to identify gaps in her knowledge whilst using the knowledge gained during the module to improve her practice.

Danielle Mather: Danielle is a newly qualified Registered Nurse working on a female surgical ward on the Isle of Man. She studied Adult Nursing at Liverpool John Moores University (LJMU) and gained a first class honours degree. Whilst studying at LJMU, she gained an interest in surgical and emergency nursing whilst participating in placements within a busy city hospital.

Prior to commencing her final year of study, she lost someone very close to her from asthma. This led her to develop a passion for respiratory nursing and she chose to focus on asthma for the summative assignments she completed in her final year. Her article for this journal is dedicated to Stuart Baggs who is missed by many every day.

Hannah Oldfield: Hannah is a student nurse in her second year of training to become an adult nurse. She has experienced numerous clinical placements (renal ward, urology ward and orthopaedic clinic), and found that I enjoy working in an acute setting. Having worked on several hospital wards, she has found long term conditions to be particularly interesting. The article she has written presents a vignette of her experience on a renal ward, which she believes helped her to develop her understanding of both the science underpinning long term conditions alongside the nursing care provided to this group of patients.

Pat Clarke: RGN, RHV, BSc (Hons), M Res, MA (Ed Man). Pat is a Senior Lecturer in the School of Nursing & Allied Health at Liverpool John Moores University. She is also a senior fellow with the higher education academy. Pat was nominated for the ‘Amazing Teacher’ award in 2013 and ‘Amazing Personal Tutor in 2015. She is the representative for LJMU on the ELLAN (European Later Life Active Network) project contributing to the development of a European Core Competency Framework for Health and Social Care Professionals.

She manages a safeguarding module for qualified staff and teaches it alongside a social work colleague. Pat is very interested in safeguarding and has written a discussion about using a whistleblowing policy in practice.

Safeguarding – Reflecting on Practice

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Abstract

The focus of this reflection is around an allegation of neglect. Using Gibbs' model of reflection has enabled the author to systematically explore the issues. It will explore some of the challenges that can be experienced by a practitioner when managing such issues. There is acknowledgement of the need for organisational and individual change if we are to improve practice in the management of safeguarding issues. It is recognised that we need to be able to identify the challenges and opportunities in the first instance if we are to improve practice.

Keywords

Safeguarding~~;~~ Inter-agency working~~;~~ Decision Making~~;~~ Assessment

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This article reflects on an incident which occurred within the community concerning an allegation of neglect and the subsequent concerns raised regarding safeguarding issues. National and local safeguarding policies such as the ‘Safeguarding Children and Young People’ toolkit for general practice (Royal College of General Practitioners and National Society for the Prevention of Cruelty to Children (RCGP and NSPCC) 2014) will be critically analysed and Gibbs’ (1988) model of reflection will help to understand the situation. Individual and organisational changes will be considered and their influence on improving future outcomes along with implications of management decisions relating to this incident. In line with the Nursing and Midwifery Council (NMC) Code of Conduct (2015), confidentiality will be maintained. A pseudonym of ‘Liam’ will be used when referring to the child who was a baby aged thirteen months.

Working as a practice nurse in a busy, inner-city practice can be challenging as the role involves interaction with patients of all ages, ethnicities and cultures. A large part of this role requires collaboration with other agencies to ensure continuity of patient care. In this incident, a letter was received at the surgery from an Accident and Emergency department detailing Liam’s attendance with perianal thrush. There was a statement explaining concerns for Liam’s unkempt appearance, which suggested the presumption of neglect (Hunt 2014) and questioned whether our surgery had any safeguarding concerns. Neglect is the persistent failure to meet basic physical/psychological needs (Department of Education 2015). The family were newly registered with the surgery; however, the child was not known to the clinicians. Therefore, this letter from an Accident and Emergency department formed the basis of this allegation.

A previous consultation was documented for the child’s mother regarding her mental health. Her lack of engagement was noted by the General Practitioner as was the domineering attitude of her partner. Parental mental illness is a common risk factor in child neglect (Webber, McCree and Angeli 2013) as well as domestic violence (Parton, 2011) supporting the need for these heightened concerns. However, these suspicions were raised from professional documentation alone. Relying on documentation alone may lead to difficulties forming balanced views while trying to protect Liam. The investigation was challenging due to the health visitor's limited contact with the family and inability to access previous health-visiting notes as the family had recently moved into the area.

Hunt (2014) states information sharing between professionals is vital for effective safeguarding, yet even at an intra-agency level between two health-visiting teams this was not possible due to incompatible computer systems. IT systems that facilitate safe information sharing could have allowed for more proficient information sharing and earlier intervention. Information sharing between professionals is paramount (Department of Education 2015) and having one accessible multi-agency file would secure this process (Hunt 2014). Laming (2003) supports this, proposing a national database for accessing information regarding all children as this would ensure those moving across localities would remain detectable. However, this would be challenging to create (House of Commons Health Committee 2003). NHS England created the local 'Child Health Information system', a database detailing vaccination history and current safeguarding alerts but it is not widely available. With issues such as confidentiality and access rights affecting its expansion (El-Radhi 2015), it will be some time before it is widely accessible.

An integrated system would allow agencies to interact more successfully, will ultimately improve practice. Dunne and Finalay (2016) support this notion stating information sharing in a timely and effective way between agencies can lead to higher quality safeguarding responses. Through an integrated system, this could be achieved as all appropriate staff would have the ability to promptly view patient case histories and upload essential information. This should not surpass the need for dialogue between multi-agency staff as this is equally important in attaining a fuller picture (Webber, McCree and Angeli 2011). The need for quality inter-agency collaboration and information sharing is clearly evident if effective safeguarding practice is to be achieved.

Our local safeguarding policy incorporates the 'Safeguarding Children and Young People' toolkit for general practice (RCGP and NSPCC 2014) including processes for early intervention, referral and service requirements. It advocates the use of an 'Early Help Assessment Tool' (EHAT) for identifying children's needs, inter-agency collaboration and coordination (RCGP and NSPCC 2014). This can be used by all agencies, allowing for collation of relevant information. In practice, however, this tool is not fully utilised, possibly due to time constraints and competing priorities (Peckover and Golding 2015). The priority for a hospital doctor may vary from that of a practice nurse running a routine vaccination clinic; however, Laming (2003) states that no set of responsibilities is subordinate to another and agencies have equal responsibility (RCGP and NSPCC2014). Utilisation of appropriate guidance to standardise practice, therefore, is essential (Webber, McCree and Angeli 2013).

The toolkit focuses on inter-agency collaboration and documentation, common themes highlighted in the 2003 'Every Child Matters' Green Paper (HM Treasury 2003) and supported by the ‘Working to Safeguard Children’ document (Department of Education 2015). Inter-agency working between services such as practice nurses, health visitors and social workers, is vital for creating a wider picture but unfortunately, despite Government legislation and policy intention, service gaps remain (Maddams 2013), particularly with the sharing of information. Patient records/letter/documentation, once received at the surgery, are processed by administrative staff before reaching the clinician which can cause information to be delayed or omitted. This highlights the importance of ensuring robust systems and processes are in place. Electronic records may help to speed up this, but there are challenges of hacking, viruses along with system failure which leads to no access until repairs completed.

It is well recognised that interdisciplinary working is essential (Day, Bantry-White and Glavin 2010) and this cannot be achieved where agencies work alone (Laming 2003). Although more information creates deeper insight for investigation (Herbert et al. 2014) problems with confidentiality and inter-agency gaps remain a challenge (Darlington, Feeney and Rixon, 2005). Using the previously mentioned EHAT can bridge these gaps, enabling agencies to collate all concerns at a central point, namely Social Services (RCGP and NSPCC 2014).

Attendance at multi-agency child protection case conferences where cases are discussed and management proposals offered between agencies is another area highlighted within the EHAT as essential for effective safeguarding yet this is an area where improvements could be made in general practice. There will often be differing perceptions of how to manage ‘at-risk’ children (Liverpool City Council 2014) and attendance at conferences enables sharing of information between agencies so that decisions can be reached based on all available information from agencies (RCGP and NSPCC 2014). Case discussions with other agencies are also paramount (Laming 2003)

Feelings

A vital component of a practitioner’s role involves reflecting on thoughts and feelings which guide decisions (Jones 2007). As a practitioner reflection is an essential part of practice; however, decisions around safeguarding concerns can be distressing for those working in healthcare (Sturdy 2012). Gibbs’ (1988) model of reflection has, therefore, aided critical analysis and evaluation of this incident. On reflection, the initial feeling was one of frustration at being left to undertake responsibility for managing this safeguarding issue instigated by another professional’s concern. Safeguarding is everyone’s responsibility (Webber, McCree and Angeli 2010) yet actions that could have been taken by the hospital were not. Nurses have a duty to act in the patient’s best interests (NMC 2015); supported by the General Medical Council (GMC 2014) Code of Conduct, the regulator of practising doctors.

This was incorporated with a feeling of the magnitude of the task and associated accountability. Munro (2010) explains the very nature of safeguarding is exacerbated by high levels of scrutiny (from colleagues, social services and health visiting services), and this was evident by my apprehension at having to make those decisions. Referring Liam to Social Services, an agency accountable for managing safeguarding issues on a daily basis, brought an anticipated feeling of incompetence in my own judgement. This prompted the question as to whether the correct course of action was to make this referral, knowing the potential impact this would have on Liam and his family. In light of the concern, however, and with a duty of care owed to the child a referral was deemed unavoidable.

Evaluation and Analysis

On reflection, following local policy clarified the process for me in managing this case. The lack of information sharing, however, particularly with the health visitor, as well as poor documentation from the hospital made gaining an insight into events challenging. This contributed towards feelings of anxiety in making decisions. Ruch (2012) supports this stating anxiety can affect capacity to think clearly. The lack of collaboration acted as a barrier in the process but following the local safeguarding policy provided some clarity. The main concern was for Liam's welfare although feelings of guilt were prominent. In general practice, building relationships with families is paramount (Wainwright and Gallagher 2010) making families more likely to engage (Woodman, Rafi and De-Lusigan 2014). Barriers were made before the family had even engaged with the practice decreasing the likelihood of relationship-building. On analysis, however, if Liam was at risk, engagement with social services may have triggered the family to engage with services facilitating them to receive the help and support needed to ensure Liam's safety.

Conclusion and action plan

In conclusion, a referral to Social Services could have been delayed and a surgery consultation arranged to gain more information. In doing so, a referral may have been avoided until a more detailed picture may have emerged through interaction with the family. Observation of the family during a consultation would have allowed for assessment of the parent/child interaction and potential neglect. Engaging with the family may have also altered judgements, during relationship building with the parents (Wainwright and Gallagher 2010) potentially influencing decisions to refer/not to refer. On balance, however, a combination of family interaction prior to referral to gain more insight along with better inter-agency collaboration would have been the best course of action, but the family's change of address created an interruption to the potential for this.

Both organisational and individual change is required if safeguarding practice is to advance. Individual perceptions and demographic influences in relation to safeguarding play a role in how situations are viewed (Herman-Smith 2013). In the case of Liam, there may have been a variety of views between the hospital and general practice with regard to the level of safeguarding concerns.

There is a media influence which affects our perception of abuse, and physical and sexual abuse tend to be higher on the list. This is supported by Davies, O'Leary and Read (2015) who state neglect and emotional abuse, are relatively invisible in the media but sexual abuse is commonly reported. Neglect may be viewed by some as 'less damaging' and not as harmful (Kendall-Taylor, Lindland and O'Neil 2014) hence more acceptable to some. Definitions of neglect can vary between individuals (Kendal-Taylor, Lindland and O'Neil 2014) and are often influenced by organisations, media and cultural directions. It is a challenge to change individual perceptions but through shared learning (Domac and Haider 2013) and improved training (Day, McCarthy and Leahy-Warren 2009) this could be more achievable. Changing individual perceptions is required if there is any hope of organisational change.

As Government legislation repeatedly advises, inter-agency working is a major factor which needs improvement (Laming 2003). Safeguarding requires a team approach (Maddams 2013) and an appreciation of the different roles required to produce this effective inter-agency working (Peckover and Trotter 2015) but is not always realistic or wholly achievable in practice. Practitioners are generally mindful that inter-agency working can create an enhanced safeguarding service yet it is difficult to achieve. Barriers such as time limitations and work pressures (Woodman, Rafi and De-Lusigan 2014), lack of knowledge and effective training (Hunt 2014), and separate protocols (Webber, McCree and Angeli 2013) are just some of the areas which need addressing to establish effective inter-agency working.

Individual case-loads and other responsibilities can limit opportunities to interact fully with colleagues, especially when this often requires leaving messages and awaiting correspondence from colleagues who are equally stretched to their limits. There are also multiple places patients can access care including hospitals, walk-in centres and general practice to name but a few. This widens the possibility that safeguarding issues can be missed as communication between services can be fragmented. Each service is juggling its own organisational and professional priorities hence there may be differences with the importance given to safeguarding issues (Peckover and Golding 2015). Making a conscious effort to liaise effectively with colleagues, however, will go some way to influencing organisational change.

On evaluation of the management decisions with regards to Liam, the hospital's documentation was fundamental yet inadequate creating challenges in its interpretation. From a nurse perspective, the Code of Conduct (NMC 2015) stipulates the importance of concise documentation, particularly in safeguarding (Mott and Thomas 2014). Poor documentation could potentially have hindered further investigation of this case, potentially delaying any referral/intervention from the statutory services for Liam.

Another barrier was a lack of inter-agency collaboration, mainly associated with difficulties gaining patient notes from across boundaries. Fears over information sharing should not hinder safeguarding investigations (Department of Education 2015) and this is supported through local policy but unfortunately it proved challenging in practice.

Devaney (2008) describes health visitors as feeling GPs act on the periphery of safeguarding, thus creating power imbalances between services with health visitors feeling they have ‘more right’ to the information. This should not be the case as all parties should have equal access to information for safeguarding to be effective (Woodman et al. 2012). Creating better working relationships with health visitors would improve information sharing and Herbert et al. (2014) feel this would be a logical development.

In recent weeks, arrangements have been made within practice to initiate monthly safeguarding meetings with our health visiting team. This will not only improve services in line with local policy through information sharing but also create a safer service for patients. It will also go some way to improving collaboration across boundaries and with services such as walk-in centres and hospitals as inter-agency involvement expands.

Lack of an appointed safeguarding lead was also flagged as an issue which needed addressing in light of the local policy. A safeguarding lead can offer appropriate advice and support (Sturdy 2012) allowing ideas to be shared and support for professionals (Morris-Thompson et al. 2012) but currently this position does not exist in the surgery.

As information is often ambiguous and incomplete with safeguarding (Galpin and Hughes 2011) the need for a lead would enable practitioners to gain direction (El-Radhi 2015). No one can be an 'expert' in safeguarding and it would be wrong to assume this would determine the criteria for the position but having that support when required would assist clinicians, providing a point of support/advice when they encounter such issues in practice. This would subsequently lead to safer practice.

In conclusion, our local policy proved successful in managing these safeguarding issues for Liam. It aided decision-making and displayed both individual and organisational requirements. As a result of the referral to Social Services it was identified that the family required further support and education which was implemented with agreement from the family. Reflecting on this case has allowed for issues such as inter-agency collaboration, information sharing and service gaps to be raised. It has also highlighted how individual perception can influence patient outcomes. There are many changes still to be made to improve safeguarding practice and as Ruch (2012) recognises, these changes require time and work. Recognition of practice weaknesses is the first step to change, however, and only then can we begin to improve patient care.

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Chronic Kidney Disease - A Case Study

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Abstract

An exploration of chronic kidney disease (CKD) focusing on a patient's experience on admission to a nephrology ward. Causes of the disease include hypertension, diabetes and acute kidney injury, and progression could be slowed by medication to reduce blood pressure and glucose levels, along with dietary and lifestyle changes. As the average wait for a kidney transplant is around 3 years, finding a donor match is becoming increasingly difficult. Patients have several different treatment options, the most common being haemodialysis and peritoneal dialysis, both with advantages and issues. Complications of the disease include respiratory problems and fluid overload, with possible interventions being fluid monitoring and restrictions on fluid intake. Effects of the disease on the everyday life of patients include the need for regular invasive dialysis treatment, the necessary behavioural changes surrounding fluid intake and diet, and debilitating symptoms such as nausea and respiratory difficulty.

Keywords

Chronic Kidney Disease; Renal Failure; Dialysis; Nurse.

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This article will focus on a patient who was admitted onto a nephrology ward in a local NHS hospital. Treating patients with a variety of kidney conditions, including acute kidney injury (AKI) and chronic kidney disease (CKD), this ward specialised in peritoneal dialysis. It was adjacent to a haemodialysis unit utilised regularly by the patients. A definition of CKD will be given along with its possible causes, some of the complications associated with the disease, the treatments available to the patient and how these treatments can impact on the patient's life. In accordance with the Nursing and Midwifery Council (NMC) Code of Conduct (2015), no names, places and dates will be disclosed. Therefore, the patient in this study will be called Mrs Smith. Mrs Smith gave verbal consent for her condition and care process to be discussed.

Mrs Smith is a 56-year-old woman who presented to the ward with stage 5 CKD. She had found her current treatment plan challenging due to her experiencing unpleasant side effects including dizziness and nausea. As a result of stopping this treatment plan, her clinical symptoms of CKD progressed and she began to suffer with vomiting and breathlessness. She was fully mobile and self-caring. She suffered with hypertension and had a history of alcohol misuse. She currently lived alone in the local area. She had two sisters who supported her when possible, but no other immediate family to take part in her care. She received no professional care in the community, aside from her regular dialysis treatment.

Mrs Smith's advanced CKD involved a significant decline in her kidney function. The human body has two kidneys, which perform a variety of complex functions

(Aschenbrenner and Venable 2009). They maintain a balance of fluid, pH and electrolytes within the blood, stimulate red blood cell production by the release of erythropoietin, assist in the production of vitamin D and regulate blood pressure via the renin-angiotensin-aldosterone system (Martini, Nath and Bartholomew 2015). CKD has five stages that increase in severity, with stage 1 being the most minimally impaired kidney function, and stage ~~f~~5 being the most severely impaired kidney function (Smeltzer et al. 2010).

The level to which the kidneys perform these complex functions is typically measured by the Glomerular Filtration Rate (GFR), the rate at which blood is filtered by the kidneys and waste products removed. The National Institute for Health and Care Excellence (NICE) (2014) states that a GFR of below 60ml/min/1.73m^2 can indicate kidney damage. CKD is classified as any kidney damage present for more than 3 months (Himmelfarb and Sayegh 2010). The first two stages of CKD require other indicators of kidney damage aside from a low GFR in order to be diagnosed, including pathological abnormalities of the kidney or the presence of common indicators such as high levels of protein in the urine, known as proteinuria (Daugirdas, Blake and Ing 2007).

According to the National Kidney Foundation (2016a), the normal GFR is 90 or above, although this decreases slightly with age. Mrs. Smith had suffered with increasing impaired kidney function for several years, and at the time of admission had a GFR of 6ml/min/1.73m^2, which would indicate that she had stage five CKD, or kidney failure, classified by a GFR or below 15ml/min/1.73m^2 (NICE 2014), and is insufficient to sustain health (Lewis 2012). Consequently, a patient with kidney failure would need to undergo dialysis to compensate for this lost kidney function.

GFR can be determined when a chemical marker, which is known to be filtered exclusively by the glomerulus, is inserted intravenously, and its levels in the blood are measured after a specific time. However, this method is expensive and time consuming and so is not often used for clinical diagnosis (Lewis 2012). Alternatively, the creatinine levels in the urine can be measured over 24 hours. Creatinine is filtered by the glomerulus, and so gives a good estimate of kidney function and GFR (Reilly and Perazella 2014).

NICE (2014) suggest that people at risk of developing CKD, for example those with hypertension, diabetes, AKI or cardiovascular disease, should undergo screening for the disease. Mrs Smith’s hypertension was the reason for her initial screening and subsequent diagnosis of CKD. From tests such as measuring creatinine levels, the GFR can be estimated and consequently, stages of CKD can be further investigated (Daugirdas 2011). Levels of urea and electrolytes can also be measured via a blood test; high amounts would indicate impaired kidney function as the blood is not being filtered efficiently (Davidson 2005). These tests are repeated regularly to monitor the patient’s kidney function, alerting staff of any deterioration and allowing for early intervention, such as hypertension medication or diet changes. (Mahon, Jenkins and Burnapp 2013).

The nurse’s role when performing these tests is of high importance. They should be able to recognise abnormal results, both visually and through the use of testing equipment such as test strips (Brooker and Waugh 2013). The nurse should be appropriately trained as it is essential that any abnormal findings are reported, and that results are recorded and reported accurately in order to reach a correct diagnosis (Altman 2010). Despite her already low level of kidney function, Mrs Smith underwent these tests on admission to the ward to determine her kidney function at that time, so that treatment could begin accordingly.

Kidney disease is often caused by other underlying health issues that put pressure on the kidneys' ability to function (Peate, Wild and Nair 2014). These include diabetes, as excessive glucose levels in the blood can damage the glomerulus, as well as hypertension, acute kidney injury, glomerulonephritis and polycystic kidney disease (Lerma and Nissenson 2012). Mrs. Smith had a long history of hypertension, meaning that blood entered the nephrons at a high pressure, causing damage (Kaplan 2010). Although hypertension plays an important role in causing kidney damage, the exact manner in which it causes damage is debated (Peixoto and Bakris 2015).

In addition, CKD also affects one of the kidneys' main functions, the regulation of blood pressure. In healthy kidneys, a raised blood pressure is needed to push the blood through the nephrons to complete the filtration process (Boore, Cook and Shepherd 2016). To achieve this higher pressure, the kidneys release renin which converts into angiotensin and aldosterone in order to cause vasoconstriction and sodium retention, thus causing pressure to rise to a suitable level for filtration (Martini, Nath and Bartholomew 2015). However, if the blood pressure is already high, as it was in Mrs. Smith's case, this function becomes detrimental to the kidneys as a further increase in pressure would cause the flow of blood through the nephrons to become too forceful and cause irreparable damage (Mancia, Grassi and Kjeldsen 2014).

It is important for the nurse to have good observational skills in order to notice patterns of deterioration or improvement (Bullock, Clark and Rycroft-Malone 2012). Mrs Smith's blood pressure was closely monitored to ensure her prescribed dose of ramipril was effective in reducing it and therefore avoiding further damage to her kidneys due to hypertension.

The progression from hypertension to CKD is known as hypertensive nephrosclerosis and is cited as the second leading cause of CKD after diabetes (Kaplan 2010). Mrs. Smith's history of prolonged alcohol misuse could be a factor that caused her hypertension; although the initial cause of chronic hypertension is often unknown, it can be affected by lifestyle choices including diet, exercise and alcohol consumption (Sherwood 2015).

As kidney function declines, levels of sodium can be affected. This can lead to the kidneys releasing an excessive amount of renin, causing angiotensin and aldosterone to continue to raise blood pressure (Lewis 2012). Mrs Smith presented with hypertension prior to her diagnosis of CKD, so it was assumed by medical staff to be a cause and not a consequence of her decline in kidney function. When looking after patients with CKD and hypertension, the nurse should offer advice on lifestyle changes such as a low sodium diet and regular exercise in order to help improve the condition alongside any medical interventions. This would help the patient manage their condition when discharged from hospital, as increased autonomy is known to improve patient's confidence and independence (Peate, Wild and Nair 2014).

Mrs Smith's CKD had progressed to end stage kidney failure; she did not realise she was suffering from the disease until its later stages. A decline in kidney function is initially asymptomatic, and often clinical manifestations only occur later in the disease (Himmelfarb, and Sayegh 2010). Mrs Smith was experiencing nausea, vomiting, and loss of appetite as a result of her end stage CKD, and this is common among patients with such extreme kidney failure (Cash and Glass 2016). The exact cause of these symptoms remains the subject of debate; however, it is thought to be linked with the kidneys' inability to control the body's acid-base balance (Lew and Radhakrishnan 2015).

Mrs Smith was prescribed cyclizine, an anti-emetic, to reduce her nausea and vomiting. To counter her loss of appetite, Mrs. Smith was also prescribed dietary supplements in the form of a milkshake twice daily, as she rarely ate meals and often vomited after eating. This became problematic, as like many CKD patients, Mrs. Smith was on a fluid restriction due to her reduced kidney function (Ignatavicius and Workman 2016). The liquid diet supplement was detrimental to this as she often requested several additional drinks and therefore struggled to remain within the restriction.

It is important that the nurse explains to the patient the rationale for the fluid restriction, including any complications non-compliance may lead to, including fluid retention and respiratory difficulty. Advice on how to choose low sodium foods, including how to read food labels to find sodium levels, can be very useful to encourage autonomy and compliance after discharge (Peate, Wild and Nair 2014). This explanation helped Mrs Smith to understand her condition and to become more aware of her fluid intake. This was also beneficial to her discharge; she stated she would attempt to continue monitoring her fluid intake and diet content at home, as she was aware of the risks of non-compliance.

Fluid restrictions are common in patients with advanced CKD. Due to reduced kidney function, fluids are not removed as efficiently from the body and can quickly lead to fluid overload if intake is not controlled. Fluid overload causes patients to become oedematous, meaning they appear to have swollen limbs and faces due to the increase in fluid in their bodies, in severe cases making it difficult for them to move. To alleviate some of these symptoms, Mrs Smith was prescribed furosemide, a diuretic, to reduce fluid retention, alongside her fluid restriction.

Lewis (2012) explains that although fluid restrictions are an effective intervention to prevent such overload, they should not be implemented to the extent that the patient's thirst becomes intrusive, and recommends that at least a litre a day should be allowed. Fluid restriction can be beneficial, as fluid overload can cause serious issues such as respiratory problems, causing patients to become breathless (Goldstein and Morrison 2013). Mrs. Smith, like many patients on a restriction, struggled to adhere to it. This was because unexpected items contribute to fluid intake, such as soups, milk used for cereal and liquid diet supplements. It is important for the nurse to keep a fluid balance chart for patients with CKD to ensure they do not exceed their fluid restriction, yet remain hydrated throughout the day.

To assist with Mrs Smith's control of her fluid intake, doctors and pharmacists worked together to prescribe tablets for Mrs. Smith as opposed to liquid or intravenous medications to prevent these from contributing to her fluid intake. Mrs Smith had requested her Cylcizine be given intravenously as she had difficulty swallowing tablets when nauseous. She also preferred her Paracetamol to be in liquid form. After discussion with the doctor, and the nurse having explained the benefits of a reduced fluid intake, she agreed that she would try both medications in tablet form.

Mrs Smith was often breathless performing the smallest physical action, such as transferring from chair to bed. The nurse could refer Mrs Smith to members of the multi-disciplinary team (MDT) in order to relieve some of these symptoms. A physiotherapist could help with her movement issues, alongside an occupational therapist who could suggest home adjustments including bathroom rails and a stair lift to make transferring easier.

The nurse should also make a dietician referral to help Mrs Smith adjust her diet; choosing low sodium foods and advice on ways to reduce fluid intake (Peate, Wild and Nair 2014). Alongside this, the nurse should provide frequent skin oral hygiene care such as mouthwashes and rinses to prevent the patient's mouth and lips becoming dry and uncomfortable (Bullock, Clark and Rycroft-Malone 2012).

Mrs Smith was admitted to the ward due to issues with her CKD treatment. Unfortunately, due to the irreversible damage to the kidneys at stage five CKD, Mrs. Smith had two options for treatment; dialysis or kidney transplant (Smeltzer et al. 2010). The average wait for a deceased donor kidney in the United Kingdom is currently around 3 years (Chandak and Callaghan 2016). As the transplant list is extensive and the chances of finding a matching donor are small, Mrs. Smith commenced dialysis while she waited for a suitable donor.

There are two types of dialysis; haemodialysis (HD) and peritoneal dialysis (PD). HD consists of the blood being removed from the body and filtered across a dialysis membrane in a machine which removes all the excess fluids and solutes, for example urea and creatinine, in the same way a fully functioning kidney would (Levy, Morgan and Brown 2009). The blood is then returned to the body. This has many advantages, including control over blood flow into the machine and low infection rates (Lewis and Noble 2013). Should a fistula not yet have been surgically created, blood can be removed though a femoral or neck line. This is ideal in an emergency situation where a patient needs immediate dialysis without time to have a fistula created or repaired (Danielson, Deutsch and White 2010). Patients normally have HD about three times weekly, but this can vary according to patient needs (Turner, Goldsmith and Lumiere 2016).

A disadvantage of HD is that because a machine is needed to filter the blood, the patient would have to travel to hospital or to another health centre to undergo the session (Levy, Morgan and Brown 2009). On admission to the ward, Mrs Smith refused any sessions of HD, explaining that she found it extremely difficult to tolerate, causing dizziness, anxiety and nausea. This is known as ‘osmotic disequilibrium syndrome’ and has been known to occur in numerous HD patients (Thomas 2004). The nurse emphasised the importance of treatment and the benefits Mrs Smith would experience, such as improved breathing and movement. However, it is not uncommon for patients to consider discontinuing treatment, and patients should be given the opportunity to talk to a specialist nurse and have their ultimate decision respected (Smeltzer et al. 2010).

After finding HD intolerable, Mrs Smith initially wanted to cease dialysis altogether. A decision such as this could have had a major impact on her already diminished kidney function (Patel and Holley 2015). In the absence of a transplant, dialysis was Mrs Smith’s only option to live with such severe loss of kidney function. Without any form of dialysis, she would likely experience an accumulation of uremic toxins, excess fluid and metabolic acidosis, ultimately leading to death (Goldstein and Morrison 2013).

Following several meetings with the multi-disciplinary team, including a specialist renal nurse, during which these concerns were explained to Mrs Smith, she agreed to have PD. PD involves surgically inserting a cannula into the patient's abdominal cavity. Large bags of fluid called dialysate are pushed in and out of this cannula regularly, and serve to filter the blood using the peritoneal lining as a membrane (The National Kidney Foundation 2016b). Fluid and solutes are removed from the blood into the dialysate via osmosis and diffusion across the membrane. There are two types of PD, continuous ambulatory peritoneal dialysis (CAPD), and automated peritoneal dialysis (APD). APD occurs overnight by an automated cycler. CAPD, which Mrs Smith opted to try, typically involves four bags of fluid being inserted and drained through the cannula daily, each lasting approximately four to six hours (Daugirdas, Blake and Ing2007).

An advantage of PD is that the patient does not need to travel to a dialysis unit to undergo treatment. They can begin and end the sessions themselves, even whilst travelling or at work, whereas access to a haemodialysis unit would need to be arranged should a HD patient go on holiday, which usually incurs a cost (Levy, Morgan and Brown 2009). Bags of fluid are delivered to an address of the patient's choice regularly.

A common issue for CKD patients due to their altered diet and fluid intake is constipation. The increased pressure in the bowel can cause the PD cannula to flip into an inappropriate position and be insufficient for dialysis sessions (Lee 2011). This would require a small surgical procedure to correct, and could mean the patient misses one or more vital dialysis sessions whilst this is rectified. As a result, PD patients are prescribed to take regular laxatives, such as lactulose. Another disadvantage of PD is the increased risk of peritonitis, due to a foreign body inserted into the peritoneum; however, this risk can be reduced by effective hygiene techniques and patient education (Levy, Morgan and Brown 2009).

Upon discharge Mrs Smith seemed content with her PD sessions, having been educated by a specialist nurse on how to initiate, maintain and complete sessions independently. She was assessed by an occupational therapist to ensure she was able to complete sessions at home, and her sisters had also been given PD education, so they were aware of how to assist Mrs Smith should she require it. She was given her medication to take home, and instructed how and when to take it. A community nurse referral was made to ensure Mrs Smith was coping well during her first weeks of PD at home. She was also given information on clinic appointments to attend regularly to ensure her PD was working efficiently (Rosner and Ronco 2012). She had not reported any negative side effects of PD, unlike those that she suffered during her initial HD sessions. In 2015, the average wait for an adult kidney transplant in the UK was 2-3 years (NHS Organ Donation 2016). Unless a suitable donor is found, Mrs Smith will require PD for the rest of her life, as a consequence of the irreversible nature of CKD.

Being involved in the care of Mrs Smith and subsequently exploring the disease and its treatment in this article has allowed me to expand my knowledge of CKD, its associated conditions, and the different treatment options available to patients. The need for individual patient care became clear to me when I was looking after Mrs Smith. I have become more familiar with the two main types of dialysis used to treat CKD, and would feel more confident explaining the advantages and disadvantages of each to prospective patients.

This experience also introduced me to the difficulty in obtaining suitable organ donors for those suffering with chronic, life changing conditions, and how a lack of available donors can mean a patient spends the rest of their life undergoing invasive and sometimes uncomfortable treatment. This can have a negative impact on their everyday living including employment, education and even holiday opportunities. Finally, I have come to realise through this experience the importance of the kidneys and the renal system as a whole, and the impact even a minor reduction in function can have on someone's life.

Following this experience, I would consider a career in specialist renal nursing. Renal nurses must have a high level of knowledge surrounding the renal system and dialysis treatments, but also of the psychological effects a chronic renal condition can have (Bonner and Douglas 2014). They must understand the impact waiting for a transplant and undergoing regular invasive treatment can have, and how a patient may be uncomfortable with or not understand treatment options. It is important that they are able to alleviate fears and suggest ways in which patients can minimise the effect of their condition and treatment on their daily life. Renal nurses must provide support for patients whilst also encouraging autonomy and independence.

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Role of the nurse in managing asthma in the community

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Abstract

This article will examine the role of nurses managing asthma patients in the community, investigating factors around the management of asthma, such as education, triggers and local initiatives to prevent future exacerbations of asthma. Further research suggestions include investigating a correlation between asthma deaths and whether the patient received the advised annual review.

Key Words
Asthma; Management; Community Nursing; Respiratory Care

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Introduction

Asthma is a chronic condition affecting the airways, causing them to constrict in response to a range of stimuli. Symptoms include shortness of breath, coughing, wheezing and a sense of tightness in the chest (Department of Health 2013). Within the UK, 5.4 million people are receiving treatment for this incurable condition (Asthma UK 2015a) highlighting the importance of asthma being monitored closely within the community to prevent avoidable hospital admissions (Peterken 2014). Furthermore, Asthma UK (2015b) states that the common triggers of asthma include animals and pets, cold and flu illnesses, emotions and stress, exercise, house dust mites, moulds and fungi, pollen, pollutants, recreational drugs and smoking, and weather.

Highly skilled nurses working within the community team, such as community matrons, aim to prevent hospital admissions by managing long-term conditions (Carter 2009, p.88). Procter et al (2013) supports this, finding high patient satisfaction for the service provided within the community as opposed to a hospital admission.

Education

According to the 2014 National Review of Asthma Deaths, there should be an emphasis around the patient education of ‘how’, ‘why’ and ‘when’ asthma medication should be used for both emergency situations and everyday life. Those who do not use an inhaler effectively increase the risk of poorly controlled asthma and therefore an attack; this can be monitored and corrected by the recommended National Institute for Health and Clinical Excellence (NICE) annual review with an asthma specialist nurse in the community, an example of a local initiative to prevent unnecessary asthma attacks (Mendes 2015). NICE (2013) states that this annual review improves clinical outcomes for patients with asthma, reducing absence from work or school. As patient education plays a key role in managing asthma, community nurses can provide training on how to use peak flow meters effectively as well as identifying strategies to identify triggers as this will improve quality of life (Janssen and Harver 2015). However, despite the previously mentioned community initiatives available for asthma patients, Hoffmann et al. (2008) found patients to be non-compliant with community appointments and medication meaning that they would not be monitored and the nurse would be unable to provide education. In addition, Hoffman et al. (2008) found reasons for non-compliance to include over-reliance on emergency departments for episodic care and poor self-management skills.

Another form of education is assisting patients to identify triggers. Turyk et al. (2013) suggests that a home assessment carried out by the community nurse to identify triggers, alongside providing asthma management education, is effective in reducing asthma morbidity. From visiting a patient’s home, the nurse will be able to assess for any potential triggers, such as moulds or pets, and assist the patient to adjust their activities of daily living in order to reduce the likelihood of an asthma attack.

NICE (2016) also proposes the use of personalised action plans to improve self-efficacy, knowledge and confidence for sufferers; these should be produced by the community nurse. Woods et al. (2012) found this initiative in the community to improve health outcomes and cost-effectiveness, reducing emergency room admissions, showing this to be a successful measure. This is cost-effective because, by effectively managing asthma in the community, less money will be spent on emergency hospital admissions long term. However, care plans are not always effective, as they can be rushed during an emergency admission and lack of practitioner understanding and having a care plan created by a professional who does not know the patient can cause frustration and distrust (Newbould et al. 2012). The European Institute for Women's Health (2014) investigated avoidable hospital admissions due to asthma for patients over the age of 15 within EU countries. The United Kingdom has the highest figure for females and is also shy of the highest figure for males. Braido (2013) found females to be more susceptible as a sociodemographic risk factor when it comes to influencing how well asthma is controlled, as opposed to males, with the main sociodemographic characteristic being smoking. Takeda et al. (2013) supports this, further suggesting that female hormones also have a role in developing allergic airway inflammation therefore explaining the trend found for all EU countries whereby female values are higher than males. The Department of Health (2015, pp.10-13) recorded females to be the gender with more smokers, thus explaining the correlation of results.

Nutrition

The Nursing and Midwifery Council (2015) states that nutrition is a fundamental part of care which nurses must provide for their patients, including promoting wellbeing and education. Therefore, when the community nurse comes into contact with an asthma patient, the nurse should ensure that the asthmatic's diet is healthy and avoids triggering an asthma attack.

Varraso (2012) suggests that modern diets show a decreased intake of fruit and vegetables and an increased intake of processed foods, with lack of vitamin D from food and sunlight contributing towards the rise in asthma prevalence. This is due to antioxidants having a role in protecting lung tissue against damage and therefore, community nurses should be encouraging their patients to have increased levels of vitamins A, C, D and E as well as selenium and zinc, in their diets.

A specific patient group that will require close monitoring within the community in regards to nutrition is pregnant asthmatics. Bunyavanich et al. (2014) suggest asthmatics should have a higher maternal intake of peanut, milk and wheat in early pregnancy to reduce the chances of their offspring suffering from asthma, providing the mother is not put at risk if she has allergies present. Brown et al. (2014) add support to this, adding that there is a positive yet weak correlation between high maternal folate levels and the development of asthma. However, Beckhaus et al. (2015) suggest vitamins D and E as well as zinc show a protective effect against childhood wheeze, but found it inconclusive to say whether there was an effect on asthma directly, showing uncertainty as to whether maternal nutritional support can prevent asthma in offspring.

NICE guidelines for asthma management (2013) specify that pregnant women and those breastfeeding should be encouraged by the community nurse and midwives to breastfeed their newborn, in order to build up natural immunity. Other recommendations include continuing all medications as normal, but not starting leukotriene receptor antagonists, as well as taking oral corticosteroids for an acute asthma attack and encouraging smoking cessation. Further recommendations are input from respiratory physiotherapists, if required, regular patient contact for monitoring and reporting any exacerbations.

Asthma UK (2015c) also advises that certain foods can cause histamine release to trigger asthma attacks; these include milk, eggs, food additives and salicylates. As some asthmatics are sensitive to anti-inflammatory painkillers, such as aspirin, it is highly recommended to avoid salicylates due to this natural chemical being a main ingredient in aspirin. Sommer et al. (2014) suggest that asthmatics should monitor their diet to consume only low levels of salicylates as research showed improved nasal and airway symptoms. In addition, Castro-Rodriguez et al. (2013) found a correlation between nitrates triggering asthma attacks; with nitrates being classed as food additives. This demonstrates the importance of diet modification and monitoring. However, they found a useful monitoring measure consisting of sputum samples to show levels of nitrites; this is a cost effective strategy that can be carried out by a community nurse during routine patient visits. The community nurse would be able to analyse results of the sputum samples once analysed by a laboratory technician, and advise the patient of any dietary intake changes required, which would have an overall improvement on the patient's management of asthma.

Medication Management

Community nurses are involved in the management of chronic health conditions, such as asthma (Lee and Parnell 2011, p.212). They can work alongside other members of the multidisciplinary team to form Asthma Action Plans; this is tailored to each asthmatic individual's needs to enable the patient to recognise symptom worsening with actions to take to avoid symptom deterioration (NICE 2016). Any alterations can be made during the recommended yearly review or more regular appointments with a GP or nurse.

Asthma UK (2014) states that those on an Asthma Action Plan are four times less likely to be admitted to hospital due to asthma. These plans contain:

- Name of patient and date of which the plan is devised
- Date of next asthma review
- GP and nurse contact details (including out-of-hours services)
- How to use the plan; keeping this accessible for the patient and family

An easy-to-use traffic light colour co-ordinated system is used. Green indicates everyday asthma care; the nurse writes in the patient's personal best peak flow value, the name of the preventer and reliever inhalers used including the colours and how many puffs of each to take, as well as any other medication used to control asthma. This section advises the patient to have a GP/nurse review if they have not required their reliever inhaler or had symptoms within 12 weeks.

Amber signifies when the patient feels worse; when symptoms return such as a wheeze or tightness of chest, night time awakening, interference with activities of daily living, using their reliever inhaler more times than an agreed amount within a week with the nurse, or when peak flow value drops to an agreed value. Recommendations are to increase preventer and reliever inhaler dosages to an agreed amount, as well as taking Prednisolone tablets (if already prescribed). If these steps fail, contact GP/nurse and be seen within 24 hours.

Red steps are followed during an asthma attack. This is used if the reliever inhaler is not helping or is required more regularly, difficulty in talking or breathing, significant wheezing or tight chest with excessive coughing or peak flow value falls below an agreed amount. This is a medical emergency; patients should sit up straight, keeping calm, whilst taking reliever inhaler every 30-60 seconds and call an ambulance if no improvement after 10 puffs. Steps are to be repeated whilst waiting for ambulance arrival.

However, Shonna Yin et al. (2015) encourage nurses to use a low-literacy approach to improve Asthma Action Plans' effectiveness, after finding that plans which used complex language cause patients confusion. Self-explanatory plans could still be effective if verbal communication was clear with patients, and colour co-ordination appealed well with paediatric patients.

The *British National Formulary* (BNF 2013, pp.177-178) states that drugs used for management of chronic asthma within the community are in the following chronological steps:

1. Relief bronchodilators; use inhaled short-acting beta2 agonist once daily for mild to moderate symptoms, such as Salbutamol.
2. Regular inhaled preventer therapy; same as step 1, plus standard-dose inhaled corticosteroid.
3. Inhaled corticosteroid and long-acting inhaled beta2 agonist; same as step 2, plus inhaled long-acting beta2 agonist and short term of either leukotriene receptor antagonist/modified-release oral Theophylline/modified-release oral beta2 agonist.
4. High-dose inhaled corticosteroid and regular bronchodilators; same as step 3, but increasing trial to six weeks of either leukotriene receptor antagonist/modified-release oral Theophylline/modified-release oral beta2 agonist.

5. Regular corticosteroid tablets; must be referred to a respiratory specialist, plus inhaled short-acting beta2 agonist, high-dose inhaled corticosteroid, one or more long-acting bronchodilators and regular Prednisolone tablets.

Treatment is recommended to be reviewed every three months in order to achieve control and gradually step down. Inhaler technique is also advised to be reviewed by a nurse at the annual asthma review (NICE 2013).

Carey et al. (2014) found nurse prescribers for respiratory patients in the community to have improved and extended points of access to treatment. Furthermore, specialist nurses being able to prescribe improved job satisfaction and the self-confidence of nurses, whilst reducing unnecessary hospital admissions and improving patient satisfaction. In addition to prescribing, having asthma specialist nurses both in hospitals and the community showed improved adherence to asthma guidelines for asthma reviews and action plans (Ainley et al. 2015). This is supported by Maguire (2015), who found that specialist nurse-led asthma clinics in the community provide positive, effective care which subsequently lead to a decrease in emergency department admissions. Patients found this convenient for receiving reviews and medication management.

However, one problem with nurses prescribing asthma medication to patients is the fact that asthmatics are required to pay for their prescription items until the age of 60, whereas other chronic conditions such as diabetes are exempt (NHS England 2016). By issuing a charge onto essential and potentially lifesaving medication, patients may adopt a behavioural approach of under-using the medication even if it is required, in order to save costs (Schafheutle and Noyce 2008). This is added to the fact that prescription costs are ever-increasing annually and overall, could be fatal, with Makela et al. (2013) stating that medication costs are a factor affecting adherence.

As well as providing effective nursing care outside of hospitals, community nurses can also carry out or refer patients for participation in research, with research and development being one of the competencies for specialist community nurses who choose this field of work (Royal College of Nursing 2013). With the ultimate goal of research to develop, refine, expand knowledge and solve problems (Polit and Beck 2017), this is an important part of nursing practice for asthma as a cure has yet to be found.

Barthlow et al. (2015) found that as well as conducting research, community research nurses possess a range of skills to work with patients and their families by using their knowledge and working autonomously. This shows that research can be conducted on a visit whilst the nurse is enabled to assess the patient therefore improving patient care.

During a review, the community nurse could also suggest smoking cessation for any asthma patients or relatives to reduce triggering asthma attacks. By having community nurses prescribing medications such as Varenicline, as long as monitoring for non-adherence is carried out, then it is an effective way for quitting smoking in the community (Liberman et al. 2013). This supports the use of asthma reviews to monitor triggers and also displays the community nurses competence for specialist prescribing and promoting good public health (Public Health England

2013).

Conclusion

This article has examined the role of the community nurse in managing asthma outside of hospitals. With 5.4 million people suffering from asthma in the UK (Asthma UK 2015), Peterken (2014) raised the importance of monitoring asthma within the community, as this can improve patient satisfaction in a less stressful environment (Procter et al. 2013).

NICE guidelines (2013) have suggested annual asthma reviews in the community, for the nurse to focus on education, monitoring and managing medications. This is used alongside an Asthma Action Plan, which has been found to be effective if completed correctly by the nurse and used with a low-literacy verbal explanation (Shonna Yin et al. 2015). Furthermore, the colour co-ordination appeals to children, assisting them with steps during an emergency.

Annual reviews enable the community nurse to promote education around medications used and their importance (Royal College of Physicians 2014), medication compliance (Hoffmann et al. 2008) and trigger recognition (Janssen and Harver 2015); all factors to improve cost-effectiveness and reduce emergency admissions whilst promoting patient-centred care within the community (Woods et al. 2012). Furthermore, with an increase in community nurse prescribers, point of care has been increased for asthma patients which has improved patient's satisfaction (Carey et al. 2014).

Nutrition has proven to be another factor affecting asthma; nutrition being a fundamental part of care (NMC 2015) showing the importance of health promotion by the community nurse. NICE guidelines (2013) highlight the importance of monitoring the nutrition of pregnant and breastfeeding mothers suffering asthma, whereby the community nurse should encourage breastfeeding to build a newborn's natural immunity. NICE (2013) also promotes medication management for pregnant women as well as highlighting the importance of community nurses offering smoking cessation, with prescriptions of Varenicline and close monitoring proving to be effective within the community (Liberman et al. 2013).

A future recommendation I would support would be to ensure that annual reviews are carried out effectively, and strictly yearly. This would ensure that patients are correctly diagnosed with asthma; monitoring peak flow, testing for allergies and providing education surrounding inhaler technique (NICE 2015).

During the annual review, patients should also participate in the Asthma Control Questionnaire and peak flow checks to measure lung function and, if conducted at every review, the community nurse will be able to monitor for condition deterioration (NICE 2015). By having a range of clinical settings within community nursing, the annual review should be easy to conduct, with places ranging from patients' homes, specialist clinics, GP practices and schools (Clark 2012). In addition, community nurses could also raise awareness that patients can use community pharmacies as a primary care point-of-call to discuss medications or concerns if they are unable to obtain an appointment with GPs and nurses (Avery et al. 2013).

A further recommendation is for community nurses to reduce misdiagnosis of asthma. This can be monitored within initial and yearly reviews, by conducting spirometry and peak flow metering to measure lung capacity as advised by NICE guidelines (Jain et al. 2015). Healthcare professionals within the community can contribute to over-diagnosis due to an increased awareness around asthma, highlighting the importance of testing to reach the correct diagnosis as this will benefit the patient and demonstrates patient-centred care (Heffler et al. 2015). Furthermore, working alongside school nurses for health promotion can raise awareness in school children (Medaglia et al. 2013).

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Whistleblowing as a means to raise concerns, or a means to an end!

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Abstract

This is a discussion about a whistleblowing policy in practice. This will be linked to a specific issue from practice relating to the nursing care of residents in an older person setting. This reflection will consider the impact of culture within the setting and its impact on the ability of me to raise concerns.

While whistleblowing is an option where a staff member has serious concerns about quality of care, it is one that is only taken when all other avenues are exhausted. It will explore some of the challenges that staff and healthcare professionals which can include student nurses or allied health professionals can encounter when making a decision whether or not to whistleblow. It will explain how a whistleblowing policy can support professionals in practice. It argues how those on the receiving end of care may have limited choice on the quality of that care, but as healthcare professionals we do have choices and it is about the choices we make.

Keywords

Safeguarding; Nurse; Documentation; Whistleblowing; Culture

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Introduction

I worked as a staff nurse in an area providing long term care for older people. Most of the residents had lived there for a number of years. Equally many of the staff had been employed in this area for a number of years. This was my first post as a staff nurse and I was the first new member of staff in this area for a number of years. I have chosen to discuss our local policy on whistleblowing relating it to the Winterbourne View Serious Case Review (Flynn 2012). Phrases such as raising concerns or speaking up can also be used in relation to whistleblowing (Francis 2015). He has described whistleblowing as raising concerns where there are issues of safety and this could include issues about bullying or oppressive behaviour.

I have chosen the Whistleblowing policy to enable me to discuss how as a healthcare professional we can raise concerns about practice and care and I will use the Winterbourne Inquiry (Flynn 2012) to consider some of the challenges and opportunities associated with this. Healthcare staff can choose this option when they have exhausted all other avenues to have issues addressed. There was a failure by the organisation Castlebeck Care Limited to act on allegations of abuse which were made (DoH 2012). Some issues such as poor professional practice can give rise to safeguarding concerns, for example what happened in Stafford (Francis 2013b). There were patients whose drinks were out of reach, medication errors and patients treated with cruel indifference (Francis 2013a). Under the Nursing and Midwifery Council (NMC) *Code*, the nurse is required to have a "… 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk" (NMC 2015, p.22), one of the recommendations of Francis (2013b). Moreover, it is included in the NHS

Constitution (DoH 2013, p.12) where staff "…can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest".

Examples of staff such as Margaret Haywood in 2005 who went to *Panorama* (a BBC programme used to expose issues in the public interest through their investigative journalism) to raise concerns about standards of care, having tried a number of other avenues, led to the NMC suspending her registration pending an inquiry, later to reverse this decision following a public outcry (Mandelstam 2013). This case amplified the need for a formal process to raise concerns where other avenues had failed, known as whistleblowing.

The whistleblowing policy supports staff to raise concerns, making the process explicit to the member of staff, where there are issues in the workplace that can or may impact on the quality of care and this supports the requirements of the *Code of Conduct* (NMC 2015), the regulator for nurses midwives and health visitors, when other avenues have been exhausted. However, the decision whether to raise concerns remains the responsibility of the healthcare professional and whether they feel the issue is a concern.

Impact of past experiences on future practice

The issues in Winterbourne View private hospital were first exposed by *Panorama*. Winterbourne View was a private hospital responsible for residents with learning disabilities (Flynn 2012). It took a TV programme to expose the poor standards of practice staff had with the residents in their care. It was not until this programme was in the public domain that actions were taken to safeguard the residents in Winterbourne View. Despite the poor care experienced by the residents on a daily basis it was not a permanent member of staff but an agency nurse who attempted to raise these concerns initially at a local level. However, as the nurse was not listened to, he, like Margaret Haywood in 2005, turned to Panorama to have the concerns heard.

No Secrets (DoH 2000) was introduced to raise the profile of safeguarding and protect vulnerable adults from abuse and neglect, omissions of care and/or institutional abuse. However, it did not stop what happened at Winterbourne View. Publications such as No Secrets (DoH 2000) can raise public awareness of such issues, the document in itself cannot prevent such behaviour towards people occurring.

The question remains whether vulnerability already exists or is created by the actions or omissions of others who are responsible for looking after them such as happened at Winterbourne. It has been suggested that some groups of people are considered vulnerable because they are dependent on other people for essential needs such as food, care, comfort or protection from harm (Baillie and Black 2015). Many of the residents in Winterbourne View and the setting where I worked may be considered more vulnerable due to their lack of capacity under the *Mental Capacity Act* (2005 cited in Baillie and Black 2015) in addition to the illnesses which they lived with. Where there are concerns staff make a decision about the action that should be taken. Some may choose to act on a concern where others would not. As healthcare professionals we make judgements every day and sometimes they can be difficult particularly if we fear what the consequences of raising such concerns may be (Francis 2015). This was one of the issues that concerned me when I was considering whether to raise concerns over the quality of care delivered by some colleagues of mine. I wondered if my views/concerns were an exaggeration of reality or what the consequences of raising such concerns might be.

The Care Quality Commission (CQC) under the *Health and Social Care Act* of 2008 registers, reviews and can investigate health and social care providers (Mandelstam 2013). The CQC were made aware of some of the issues at Winterbourne View but did not act on the concerns at the time (Flynn 2012). Furthermore these concerns were not identified by the CQC through their routine inspections bringing the CQC as the regulator under scrutiny. As a consequence the CQC were given greater powers to make more unannounced inspections, get feedback from service users and families along with putting all reports in the public domain (Francis 2013b).

The *Care Act 2014* (DoH 2015) is the first act to focus on safeguarding specifically, prior to this there was no similar legal framework. It introduced a model which allows lessons to be learnt from safeguarding adult reviews, similar to how lessons can be learnt from serious case reviews such as Winterbourne View (Flynn 2012).

Policy – organisation, service users

While healthcare professionals may observe poor practice, Francis (2015, p.22) suggested there may be a “... disproportionate impact on others who are deterred from speaking up by the fear of adverse consequences or the belief nothing will be done”. Students working in healthcare environments can see practice on a day to day basis and are in a key position to ask challenging questions about practice as part of their learning experience central to the nursing *Code of Conduct* (NMC 2015, p.13) where the nurse is expected to “…take all reasonable step to protect people who are vulnerable or at risk from harm neglect or abuse’. The whistleblowing policy provides the pathway for staff who wish to raise concerns in the workplace, formalising the process.

Some student nurses may feel reluctant to raise concerns as they are reliant on their mentor to complete their documentation for the placement. Students may fear the repercussions of raising concerns about a placement area. Students have failed placements after raising concerns during their experience (Francis 2015). Negative experiences (Milligan et al. 2016) when raising concerns may impact on their decision should they need to raise concerns again. Moreover the student may learn the negative consequences of raising concerns. The staff nurse is also vulnerable by their need for the job to fund their lifestyle in addition to its contribution to their career (Mandelstam 2013). This may affect their perceptions of the seriousness of the issues.

Those who choose to raise concerns have sometimes experienced victimisation because of the actions they have taken (Francis 2015) which can lead to the nurse becoming considered as an ‘outsider’ (Becker 1963) among the team. This can act as a deterrent to raising concerns. Certain groups of staff are thought to be more vulnerable than others should they make the choice to raise concerns. These include agency and bank staff, staff from black and minority ethnic backgrounds, student nurses as well as staff working in primary care organisations (Francis 2015). While organisations encourage whistleblowing, in reality many only pay lip service to it (Mandelstam 2013, Plomin 2013).

At the centre of this are the residents in our care and a decision needs to be made whether to raise a concern or not. While at the extremes it may be easy for the nurse to raise concerns, there may be times when it is challenging to understand whether the threshold has been reached, that the standard of care delivered is having a negative impact on a resident? Considering the case of Phyllis Foster who died following poor care from Whipps Cross Hospital (Mandelstam 2011), helps to highlight the potential outcomes of substandard care. Decisions about threshold are often made on our own experiences both personal and professional, therefore each one of us might have different thresholds (Clarke 2015).

Exploring Challenges

In relation to the healthcare context, culture has been described as how we do what we do (Vincent 2010 cited in Francis 2013b). The culture within the placement constitutes the place of work for the staff nurse and other healthcare professionals as well as the home of the residents who live there. Milligan et al. (2016, p.5) refer to a “…positive safety culture” as one that can encourage healthcare professionals to raise concerns if needed. Many areas have more than one culture within an organisation such as different teams and departments (Francis 2015) often considered subcultures, suggesting there are many ways to do the same thing. There may be some that may not be considered as “positive safety cultures” as described by Milligan et al. (2016). The ability to raise concerns may depend on the culture prevailing within the workplace and whether it is deemed the right thing for staff to speak up. Those who choose to raise concerns may be considered as ‘outsiders’ within some settings such behaviour may be deemed unacceptable by those who work there (Becker 1963).

While training may help staff to understand the process of questioning practice, there must be a culture of openness supported by good management to enable this to happen (Francis 2015). Training can update the staff about the processes and policies within the workplace but in the absence of organisational support for best practice, the impact of the individual can be limited (Pike et al. 2010). Policies alone do not protect/safeguard people, it is the actions taken by people that protect the person or increase their vulnerability.

As Mandelstam (2013) suggested, where staff have mortgages, bills and career hopes, they may choose to keep quiet or fear victimisation or as Francis (2015) suggested, some may regard the act of raising concerns as risky. While policies and procedures can be in place for staff to follow, in the absence of support from the organisation, and a positive safety culture (Milligan et al. 2016) of listening to staff concerns about practice, it can be difficult to challenge poor practice.

Conclusion

Staff who use whistleblowing do so as a last resort, where they feel they have exhausted all other avenues, an example of this was Margaret Haywood who had tried other avenues to get her concerns addressed before whistleblowing. Whistleblowing can create a dilemma for the health professional. Professional regulations require nurses to raise concerns but individual reasons may deter them, such as the consequences of the decision, not being listened to, victimisation in addition to a belief they will be ostracised (Mandelstam 2013).

This article has raised my awareness of some of the challenges of whistleblowing. It is multifactorial, increasing my awareness of the courage of staff such as Margaret Haywood who choose to raise concerns, putting the care of patients beyond themselves and their career. While the healthcare professional has a choice about whistleblowing, the resident has limited choice whether to receive sub-standard care, particularly if they lack mental capacity. While policies provide a pathway to follow should healthcare professionals wish to raise concerns, they do not eliminate the perceived risk that can be associated with raising concerns (Francis 2015, Milligan et al. 2016).

Nurses are expected to have courage as one of the 6 Cs (Star 2012), indeed the 6C's (courage, commitment, communication, courage, care and compassion) are considered desirable for all healthcare professionals (Baillie 2015). Those who choose the whistleblowing route are examples of staff who have courage and put the people in their care at the centre of what they do. Healthcare professionals need to be encouraged to move away from what could be considered "…a cowardly stance, given the vulnerability of some of their patients; that is, passing by in silence the suffering of those they are meant to be caring for” (Mandelstam 2011, p.366).

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