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Guest Editorial

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Sharing best practice in health care

At the beginning of each academic year the cry goes up "why do we have to do research? I only want to be a nurse or midwife". As a midwife researcher I used to get quite upset about this and wonder to myself and to my colleagues "how can they not understand the benefits of research?" Being asked to write this editorial has helped me to reflect some more on this question and to reconsider my views.

How did I come to enter the research world?

My first introduction to research was during my Advanced Diploma in Nursing when I was training to become a nurse teacher and I was expected to do a small research project. We learned statistics and I was actually quite good at them so got enthusiastic about the rest of the research process (which nobody ever taught us!). My project compared how much time nurses spent with women being treated with caesium implants for cervical cancer with those who had Wertheim's hysterectomies. My hunch was correct, those having the hysterectomies had more than double the nursing hours. It was not a very well executed research project but it did enable me to go back to the senior nurses on the ward to say that something needed to be done, and, to my surprise, it was. The research had impact on practice.

From that time on, I endeavoured to do research that was relevant to clinical practice as I progressed through Bachelor's, Master's and Doctoral degrees. It was not like that for everyone, however. One of my fellow Master's students wrote a thesis that was hailed by all as being at PhD level. Sadly, few of us could plough our way through the jargon and understand what she was trying to say. Until recent times, this has often been the case with funding bodies requiring publications by means of advertising the research that they have funded. These publications must conform to the journal's format and often carry recommendations for further research, which take precedence over recommendations for practice.

In practice based disciplines such as nursing and midwifery it must surely be wrong to prioritise further research over benefits to practice. Indeed, it often appears as "jobs for the boys" rather than "what does this mean for us". I was delighted to see, after six years away from the UK that research councils are now firmly focused on impact. Who is this study going to benefit and how are they going to benefit are key questions asked. Additionally, researchers bidding for grants are asked to show they pathways they propose to take on the way to creating those impacts. This can only be good news and firmly link good research to professional practice and this to better service for those who need our care.

What does all this have to do with sharing of best practice?

Thinking over the 43 years since I began my nursing education, I shudder as I reflect on our care, which at that time mostly consisted of a series of tasks. Take pressure sores for example. Each ward sister had her own prescription for these, varying from a liberal application of “tinc benz co”, which certainly caused the patients a lot of pain, to rubbing on egg whites, which simply gave us more work to do changing the sheets. There was no best practice. It is through research that we have come to know what the best practice(s) are and we have a NICE guideline on pressure sores. Many of the other tasks we undertook have had similar developments. That is why I advocate research, insist that every nursing and midwifery student must learn to be an active consumer of research and hope that many will come to be researchers in the future.

Using the Chapelhow Framework to deliver patient care

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Abstract
The aim of this article is to discuss two of the Chapelhow enablers: communication and managing risk. These can be the difference between a therapeutic relationship with the patient or an incident due to the patient becoming agitated. The author would suggest that more work needs to be done on the impact gender can have on communication, such as male care providers upon female patients, and the potential associated risk and how this can be reduced with risk management.

Keywords
Chapelhow enablers, Communication, Gender, Risk Management, Positive Risk

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Introduction

This article will reflect on the care given to a patient who has been detained under the Mental Health Act 1983 (amended 2007) using the framework by Chapelhow et al. (2005), who identified several enablers considered to be fundamental in delivering expert care. These include assessment, communication, documentation, managing risk, professional decision making and managing uncertainty. For the purposes of this article the focus will be placed on communication and risk management.

Communication is fundamental to patient care as there can be no caring or therapeutic relationship without it (Morrissey and Callaghan 2011). Indeed, it is only by obtaining a patient's perspective on what they hope to achieve throughout their care as well as engaging with other care-providers and professional bodies within a multi-disciplinary team (MDT) that we can hope to provide person-centred holistic care. Meanwhile risk management proves essential in the provision of care and according to Gilbert, Adams and Buckingham (2011) particularly significant for those within a secure mental health setting as personalised risk management plans are put into place to facilitate recovery as well as ensuring that safety is paramount. Higgins et al. (2016) found that it was only through proper risk management that care can be truly person-centred.

These two enablers will be applied to a reflection on the care given to a patient residing in an adult forensic psychiatric medium secure unit. To ensure the individual's confidentiality is maintained as outlined by the Nursing and Midwifery Council Code of Conduct (NMC 2015), the subject of the case study shall be referred to using the pseudonym Toni. Toni has given verbal consent for her personal case details to be

used as part of a student's coursework.

Toni is a 25-year-old woman who has been detained under the *Mental Health Act* 1983 (amended 2007) and has been residing in a medium secure setting. Previously she has had numerous violent altercations with the public and police force and has been volatile with staff and peers on the ward when experiencing a manic episode, with little regard for the consequences. Subsequently, Toni often suffers from prolonged periods of depression and anxiety due to her psychotic state. According to the International Statistical Classification of Diseases and Related Health Problems, these are all indications of her dual diagnosis of bi polar and borderline personality disorder (World Health Organization 1993). Under details of her section, Toni was required to utilise therapeutic interventions to aid in her recovery of mental health as well as her overall wellbeing. In the situation already discussed the MDT were utilising one to one therapeutic nursing sessions where Toni could openly express her feelings including any negative thoughts she was experiencing.

Communication

Within nursing practice, communication is a broad term and involves utilising an individual's knowledge, information, and ideas to exchange either in the form of speaking, listening, reading, or writing and can also include non – verbal communication (Eadie et al. 2006). Verbal communication was used during one-to-one sessions to help Toni to become more self-aware and improve her insight into her illness. During these therapy sessions, the primary goal was to ensure that Toni felt included in the decisions involving her care and was able to openly discuss her mental wellbeing and overall health because as Marbley et al. (2015) note, this is often key to an individual's

recovery. The trusting therapeutic relationship and effective communication individuals had with Toni during this one-to-one session proved instrumental in ensuring that she felt comfortable enough with care providers to openly disclose the fact she had been experiencing hallucinations. Subsequently, this enabled further effective communication between Toni's care providers and the wider MDT to provide a clearer understanding of where she was in her recovery pathway and the care interventions needed for further progression.

One potential issue that arose during these sessions was the impact that gender differences between Toni and her carers could have on the effectiveness of her one-to-one therapy. This concern was supported by a study by Dysvik and Sommerseth (2010), who found that within the mental health sector, women can come across as more caring and empathetic than men which may enable the patient to talk more openly with female members of staff. Eadie et al. (2006) noted the significance of empathy in the development of the underpinning relationship and feelings of trust a patient has with nursing providers and, as such, it is possible that female patients might experience difficulties in disclosing information to male carers as they may struggle to find an empathetic common ground with them (Dysvik and Sommerseth 2010).

Therefore, as a male university student being present during the therapy sessions of a female patient it was noted that potentially Toni might withhold certain information. It was important to build a therapeutic rapport with Toni prior to the one-to-one session. This was done by engaging Toni in conversation involving common topics of interest

such as music, films and the news which had enabled her to feel comfortable conversing with male care providers. Furthermore, Toni chose to have one-to-one therapy and she indicated that she preferred talking to the male members of staff as she felt the female nurses tended to be too emotionally involved in her care.

The issue of confidentiality regarding the content of Toni's one-to-one therapy was mentioned at the beginning of each session. Toni understood that if she indicated either verbally or physically any serious intention to harm herself or others, staff would be professionally obliged to pass it on to other members of the MDT in accordance with local safeguarding policy (Safeguarding Adults Board 2015). Elger, Handtke and Wangmo (2015) discovered a potential issue in communication here when they recognised that mental health professionals sometimes struggled to determine the circumstances in which they should pass on information as well as what information they could/could not share. Issues such as suicidal plans and abuse being suffered emotionally, physically, and financially need to be reported in accordance with local safeguarding procedures (Safeguarding Adults Board 2015), as these have a major impact upon an individual's holistic health. Toni did not reveal suicidal plans or an abusive history in her discussion about the hallucinations she had recently been experiencing. Toni was involved and communicated with accordingly, particularly when other healthcare professionals needed to be involved so that her care plan could be updated.

Stensrud et al. (2014) found that as well as having the ability to *explore* the emotions of

the individuals under their care, it was equally important that care providers learned to respond empathetically to what the patient was disclosing. Therefore, although it was important to communicate the medical knowledge that Toni was suffering hallucinations to the relevant professionals within the MDT after the one-to-one session ended, it was equally important to consider the present circumstance and continue to listen to Toni as she revealed the personal impacts the hallucinations had on her feelings and reassure her that there was nothing wrong with her somatically (Stensrud et al. 2014). This aspect of communication is proven to be of the upmost importance within the mental health sector especially, given that people with a mental health history have a higher number of somatic complaints than those without mental health issues (Kekkonen et al. 2015).

Furthermore, Stensrud et al (2014) revealed that to listen and reassure patients effectively, staff should have the skills and access to explore other therapeutic resources. For instance, when Toni mentioned she started to feel anxious when other patients on the ward became unsettled resulting in shouting for prolonged periods of time. She was offered the use of an MP3 player to distract her from these noise levels. The use of a low stimulus room gave her some solace and a way to cope with these daily stressors on her mental wellbeing. This approach was based on a study by Brown, Rutherford and Crawford (2015) who found that music could be utilised in this way. By discussing this as an option with Toni without needing to have the decision reviewed by a third party first, we not only succeeded in reassuring Toni but also secured a level of trust and communication that underpinned our therapeutic relationship with her.

Gilbert, Adams and Buckingham (2011) discovered that choice of language was also a significant factor in effective communication within the mental health setting and when conversing with a patient in a one-to-one setting. Staff must respect boundaries and comply with pre-written care plans detailing what topics or specific words to avoid, as they may be classed as a trigger for some individuals. It is a staff member's duty to ensure that they manage the risks of Toni becoming agitated and distressed and are aware of the ways communication can be used when in the one-to-one therapeutic sessions. It was included in Toni's care plan that subjects relating to her biological family and questions that may probe into the psychological abuse that she suffered as an adolescent should be avoided.

Risk Management

A study by Briner and Manser (2013) revealed that the ability to put clinical risk management plans into practice was fundamental in reducing instances of patient self-harm. Although this was a qualitative piece of research, relying on testimonies of nursing professionals over quantitative data, it does seem reasonable to assume that any actions that may reduce risk to the patient would increase their safety. However, there is still a lot of debate concerning what constitutes effective risk management of patient and staff safety and how this may directly impact on the individual's progress towards recovery. Nolan and Quinn (2012) concluded that staff should be in the position, with support of their organisation, to effectively manage risk. They must assess whether constraining a patient's rights and autonomy is the best way for individuals to recover in long term inpatient settings on a case by case basis. They also

suggested that staff should be taking positive action and interpreting risk for the benefit of patients and their recovery.

Indeed, as Reddington (2017) revealed risk management is often a ‘grey area’ especially when the factor of positive risk is considered, as many healthcare professionals find themselves bound by the standards and regulations of the NMC (2015). When undertaking risk assessments consideration needs to be given to the most effective recovery pathway for the individual patient. For example, as Toni has a history of becoming violent when she has misunderstood something or has become agitated due to her confusion leading her to assault a member of staff, it would be reasonable and within NMC guidelines (2015) to have Toni escorted by two members of staff when in a closed space both for her own protection and the safety of her care providers based on the assessment of this risk. On the other hand, the progress Toni had made throughout her one-to-one sessions meant that we took the positive risk to continue using these therapy sessions without noticeable restrictions.

Of course these positive risks are not undertaken lightly and still involve a lot of careful planning and risk management strategies to ensure that this takes place in the safest environment possible (NHS Foundation Trust, 2015). For instance, when in a one-to-one session with Toni, the low stimulus room was used to help maintain a level of calm and reduce anxiety levels. In addition, the seating in the room was laid out so that the staff member was situated closest to the door facing Toni who was strategically sitting with her back towards the wall. This seating arrangement significantly reduced the risk

of Toni causing harm to herself or a staff member as the door was always accessible. Whilst the door remained closed to maintain a level of privacy and confidentiality, both Toni and the staff member could be viewed through a clear window by other professionals which prevented the opportunity for behaviour to become dangerously aggressive in accordance with local guidance and policies (Safeguarding Adult Board 2015).

It was important that assessments were carried out often to highlight any new risks to the patient and her overall wellbeing and subsequently manage them accordingly (NHS Foundation Trust 2015). These routine assessments allow for changes to be made to a patient's care plan which may also have the positive implication of allowing staff members to identify a new positive risk that may aid in the recovery of the individual. Toni's care plan included risk assessments that were reviewed routinely on a four-week basis in accordance with hospital policies which allow the MDT to monitor her recovery progress and adjust her plan where necessary. For example, when Toni was first admitted to the ward she could not participate in one-to-one therapy due to her spontaneous outbursts of violent behaviour, which posed a high risk to her own safety as well as the physical safety of staff. However, as time progressed and more risk assessments were carried out, the MDT decided that Toni had displayed more self-control and was participating enough to be offered the positive risk of one-to-one therapy sessions within her care plan to aid her recovery further.

Conclusion

After reflecting on Toni's care in the context of both communication and risk

management, it has been demonstrated that these two enablers are key to providing a holistic and person-centred approach to care, specifically but not exclusively within a mental health setting (Chapelhow et al. (2005). It has been demonstrated that effective communication is fundamental within the care system between the patient and care provider and also within a MDT. It has also been shown that communication is a very broad term and encompasses the effective use of other enablers such as the founding of relationships, choice of language and listening (Elgar et al. 2015), which have enabled Toni to take an active part in her recovery process and care planning. Furthermore, effective risk management alongside the ability to take positive risks, identified by Nolan and Quinn (2012), is equally important in providing a holistic care approach. This was an integral aspect of Toni's care plan as the strategically planned environment of the one-to-one sessions ensured that her progress was in line with her recovery pathway. These therapy sessions not only proved useful in allowing staff an insight into Toni's mental state but simultaneously allowed her to gain an understanding of her illness. This increased self-awareness could undoubtedly have a positive impact for Toni's long-term care plans and may reduce the risk of violent outbursts that she displayed during her earlier years within a residential care setting.

Equally, it is important to note that research into these enablers is constantly evolving. The potential negative consequences that the issue of gender differences can have on the effectiveness of communication, highlighted by Dysvik and Sommerseth (2010), should be further researched to ensure that the upholding of a professional boundary does not prevent the finding and utilising of an empathetic "middle ground" particularly

between male care providers and female patients. Meanwhile, further research into the 'grey area' of risk management, as highlighted by Reddington (2017), could prove significant in seeking further improvement in patient treatments particularly if built upon research by Nolan and Quinn (2012), which highlights the importance of including the patient and their opinions on what 'positive risks' they feel comfortable with. This highlights the intrinsic interlinking nature of the enablers in delivering patient-centred care, the importance of which, as highlighted in the reflection on Toni's one-to-one sessions, should not be underestimated.

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Why Chapelhow enablers are important when providing patient care

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Abstract
The Chapelhow framework is based on six fundamental concepts often referred to as enablers. These enablers are the building blocks that all healthcare professionals need in order to deliver patient care. They include; assessment, communication, risk management and managing uncertainty, professional judgement and decision-making, documentation and record keeping. This article will consider two enablers assessment and communication, essential skills for delivering patient care. It was apparent that both enablers were linked and used together when caring for a patient.

Keywords
Communication, Assessment, Nursing Care.

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The Chapelhow et al. (2005) framework is based on several different elements which enable nurses to reflect on their practice whilst learning new skills. Chapelhow et al. (2005) suggests that there are six fundamental concepts that are the basis of all skill delivery for all healthcare professionals. They refer to them as 'enabling skills' of nursing practice consisting of; assessment, communication, professional judgement and decision making, documentation and record keeping, risk management and managing uncertainty. This article will consider two 'enablers' assessment and communication (Chapelhow et al. 2005). It will consider why assessment and communication are important skills for nursing practice and the patient journey.

Verbal consent was obtained from the patient to use the experience as part of my learning. Additionally, gaining informed consent ensured that patients are not misled. For confidentiality reasons the name of this patient was changed to Patient X. The Nursing and Midwifery Council (2015) state that we should respect a patients' right to privacy and confidentiality, and information about them should always be shared appropriately.

Patient X was an 82-year-old lady who lived alone in her own home. She was admitted to hospital following a fall and fracture to her left femur. Her previous medical history was that she was partially sighted, with an increased Body Mass Index (BMI) which is a weight-for-height measure (Morrissey 2013). She also took warfarin for her atrial fibrillation (AF) and she had a history of congestive cardiac failure (CCF). She has also had a previous ORIF (open reduction and internal fixation) to her right ankle. According to Fawcett and Rhynas (2012) a patient's history is essential to making an accurate

diagnosis.

The first enabler to be discussed will be assessment. Patient assessment can be defined as a process of evaluating a patients physical, social, mental, cultural and personal needs (Howatson-Jones, Standing and Roberts 2012). Patient assessment was important so that appropriate care can be given and a patients' needs met. If we do not respond to a patients' care needs we could be putting the patient at risk and therefore failing to give effective care (Barret, Wilson and Woodlands 2009).

In this case Patient X was first assessed when admitted to the ward as patients need to be assessed at key points throughout their journey (Howatson-Jones, Standing and Roberts 2012). Patient X came to the ward from theatre following the insertion of an intra-medullary nail to her femur to correct the fracture.

To assess Patient X a variety of assessment tools were used to get an in depth, accurate assessment (Howatson-Jones, Standing and Roberts, 2012). These included: Waterlow pressure sore scoring system, MEWS (Modified Early Warning Score) screening charts, patient rounding tool and pain assessment charts. Firstly, baseline observations such as blood pressure, oxygen saturations, heart rate and temperature were taken on Patient X to enable nurses to monitor her condition. Observations were taken regularly so that any change in condition was identified early (Royal College of Nursing 2015). Following these observations a score was generated and recorded. This score provided a benchmark for her condition and was used to identify any deterioration/improvement. A pain

assessment was also done by asking Patient X if she was experiencing any pain, location of the pain and the type of pain (Turk and Melzack 2011). Nurses can decide following medical advice what pain relief should be given and when to give it dependent on the prescription. Even though these assessment tools can be useful, some professionals may become over reliant on them, ignoring their own clinical judgement to assess a patient. Therefore Barret, Wilson and Woodlands (2009) says that both clinical observation and assessment tools should be used together to holistically assess a patient. The assessment was done using quantitative and qualitative techniques. According to Howatson-Jones, Standing and Roberts (2012) it was important to use both techniques to ensure an effective patient assessment in order to provide safe patient care.

To gather information about the patient, a variety of questions needed to be asked so that healthcare professionals can assess their care needs and build up an initial relationship. Egan (2009) reported that to get this information it was important that communication skills were used and the right questions were asked to ensure that the patient understood what was being said to her. On initial assessment, a variety of open and closed questions were used to obtain the information that was needed. According to Nolan and Ellis (2008) using this variety of questions allowed the nurses to get specific information and identify problems.

In relation to Patients X's care, an assessment was completed to identify any changes since admission to hospital. Nurses assessed mobility, nutritional needs, elimination needs and personal hygiene and dressing. For Patient X, mobility was an issue as she

used to walk with a zimmer frame and following her surgery she had become non-weight-bearing. It was important to find out if she took any regular medications for her health conditions. Fitzgerald (2009) stated that medication history is critical to prevent adverse effects from medications which may have negative consequences to the patient.

When assessing the patient, we identified that Patient X had an increased BMI which was over 30, classifying her as obese and therefore, we needed to order a bariatric bed and chair. This was to ensure that the patient was comfortable during her stay on the ward. Due to her reduced mobility we needed to ensure that her pressure areas were checked regularly and policies followed to reduce her susceptibility to pressure sores. Patients with an increased BMI are at higher risk of pressure sores making it important to check pressure areas regularly (Royal Children's Hospital Melbourne 2012). An example of this was when Patient X required an air mattress used to reduce the risk of pressure sores (Rubayi 2015) and also, the need to change her position regularly to relieve pressure on that may be susceptible to pressure sores.

Patient X explained that she had recently been constipated. From this information, a stool chart was put in her file so that we could monitor her current bowel habits and if the problem persisted, consideration could be given about the most appropriate management (Scully and Wilson 2014).

The second enabler that will be discussed will be communication. Communication enables information to be exchanged between individuals (Berry 2007). The Nursing and

Midwifery Council (NMC 2015, p.7-8) state that nurses must “communicate effectively” in order to practice effectively. According to Bach and Grant (2015) the effectiveness of communication was dependent on the quality of communication. Therefore, if the quality of communication was poor, this may impact on the quality of care provided.

Communication with the patient was important as Patient X was partially blind. This meant that we needed to explain everything clearly. Moonie (2005) reports that if individual differences are not understood, communication can be affected suggesting that information cannot be transmitted as well as it should which may lead to errors when providing care.

One example was when we were dressing her wound. We explained that we were cleaning it first using sterile water and gauze, following this applied the dressing. Doing this involved the patient in her care and reduced potential feelings of vulnerability. Webb (2011) stated that communication in nursing was essential as the skills that nurses developed throughout training were supported by effective communication. Within the healthcare environment communication is a vital part of patient care. This was supported by Bach and Grant (2002 cited in Norcross 2015) suggesting that practice of communication skills made a difference to patients as they felt supported and involved in their own care.

During this placement, there were many communication issues that came to my attention. According to Berry (2007) ineffective communication can lead to a variety of negative

outcomes, including poor patient care. Primarily, Patient X had reduced mobility, consequently was in bed for 14 days following surgery on her femur (EDIO healthcare 2013). The physiotherapists on the ward came to assess Patient X to help her to sit in the bariatric chair provided (Long, Kneafsey and Ryan 2003). On assessment, it was made clear that Patient X would need to be hoisted using the 'Viking' hoist. This specific piece of equipment was used to transfer patients, who had a greater body mass index of 25 from their bed to a chair or commode. As this hoist differed from others regularly used on the ward, it was important that the nurses were shown how to use it.

It was apparent that there were issues with communication between the physiotherapists and nurses because they had not been told which specific straps to use for this hoist. The time taken to resolve this made Patient X feel anxious as she thought the staff did not know how to use the hoist as they needed to seek reassurance from the physiotherapists. O'Daniel and Rostenstein (2008) state that effective teamwork is best when healthcare professionals work collaboratively. Also, they found patients prefered communicating with a cohesive team, rather than talking to individuals who did not fully understand their care.

Additionally, the physiotherapists had communicated with the nurses and decided that a bariatric commode would be useful for Patient X. However, due to how busy the ward was this was only ordered two weeks after the initial assessment. This impacted on nursing care as it meant that the nurses needed to provide a bed pan for Patient X and help her with personal hygiene each time she required the toilet. This impacted on her

care (O'Daniel and Rostenstein 2008) making her feel she was a burden on staff and she had no dignity as she was unable to undertake personal hygiene or use a toilet.

Webb (2011) pointed out that the nature of healthcare had changed focusing on the patient rather than the illness. This meant that when we treat a patient we look at them holistically, assessing all their individual needs. In this case the healthcare professionals that were involved in Patient Xs' care assessed each need separately such as mobility, elimination needs, her sight and how she was most comfortable etc. It was important that communication was effective due to Patient X's partial blindness; so, this meant that she did not always know what was happening and potentially could make her feel isolated (Bramhall 2014).

This article has set out to examine the Chapelhow et al. (2005) framework and in particular the two enablers (assessment and communication) and how they were used in practice to influence patient care. I chose a patient and looked at how her care was influenced and how assessment and communication were used in relation to her care. It has shown that both assessment and communication were both vital parts of nursing and played an important part when providing patient care. It was evident that the care provided to patient X was effective and the assessment tools used were appropriate and using effective communication meant her needs were met.

It was clear that assessment and communication both linked together when caring for a patient. The assessment tools were reliant on effective communication. This was because

many of the assessment tools required the use of verbal communication. There were strengths and weaknesses to using the assessment tools and it was important that as well as this, nurses own clinical judgement was also used to assess the patient. A patient may appear asymptomatic when looking at observations alone, however, when looking at the patient the nurse may identify different issues.

The strengths of healthcare professionals using assessment tools enabled them to identify the patients' individual needs and plan how they were going to manage them. They also gave an indication about what needed to be put in place when she was discharged as her independence level may have changed. A weakness of using assessment tools are that patients need to be reassessed within an agreed timeframe and sometimes this may be difficult to achieve if the ward is busy. Therefore, some re-assessments may be delayed.

Communication was vital when caring for Patient X. It was important that the assessment was done as there was a barrier to communication (partial blindness). Doing this initial assessment allowed us to adapt our communication strategies to meet Patient X's needs. Communication played a huge part in patient care and therefore understanding how to communicate effectively was essential when providing care (Van Servellen 2009). If communication was not effective then errors may occur directly affecting the patient.

During this study, I learnt about the different assessment tools used when assessing patients and how to use these effectively. Additionally, I could see how important

communication was in a healthcare setting and how it is essential to communicate effectively to avoid errors in care and ensure patient needs are met. Overall, communication with patients, parents and other nurses was good and information was passed on appropriately. However, it was recognized that communication between the multi-disciplinary team could be improved.

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20 Minutes of Care – using the Chapelhow Enablers

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Abstract
There are six fundamental skills that enable a health care practitioner to become an expert practitioner. Two of these skills needed will be considered before communication and risk management. These skills will be discussed in relation to an 81-year-old woman who lives in a nursing home, with Alzheimer's disease and diabetes. Good communication skills promote person-centred care and examples of verbal and non-verbal communication will be considered. The management of risk associated with dysphagia, malnutrition, osteoarthritis and diabetes will be described. This article demonstrates the clear links between the two enablers chosen.

Keywords
Chapelhow Enablers, Communication, Alzheimer's, Feeding, Risk.

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Chapelhow et al. (2005) suggest there are six fundamental skills/enablers that are essential for health care professionals, the development of which will enable a nurse to become an expert practitioner. These are communication, documentation, risk management, assessment, managing uncertainty and professional decision making. This article will discuss two of these enablers (communication and risk management) in connection with an element of care (feeding) given to an individual. Due to the individual's condition and understanding, verbal consent was gained from the individual whilst their daughter was present. To maintain confidentiality under section five of the Nursing and Midwifery Council Code of Conduct (NMC, 2015), a pseudonym will be used.

Amy is an 81-year-old woman who was diagnosed with Alzheimer's disease 4 years ago. Alzheimer's is a progressive brain disease where over time more areas of the brain are damaged (Alzheimer's Society 2014). When the brain is damaged by the disease, symptoms such as memory loss, difficulties with problem solving, thinking and language occur. These symptoms are known as dementia. Amy required patience and time from health care professionals and her family in order to be able to communicate her needs.

Amy has lived in a nursing home for 2 years and has required assistance with all activities of daily living from the staff at the home. Amy also has a swallowing problem due to her alzheimer's and requires a pureed diet and custard thick fluids. An increase in the severity of alzheimer's disease causes swallowing function to significantly deteriorate (Sato 2014). Amy is also a type two diabetic and requires assistance at

meals due to her osteoarthritis and Alzheimer's.

During one meal time, I assisted Amy with her meal after asking Amy if she would like to eat. Amy agreed and was in the sitting room with other individuals who were also eating alongside her. I brought the spoon to Amy's mouth whilst explaining that the spoon was at her lips. Amy paused before opening her mouth to take the food and then beginning to chew. Whilst Amy was chewing I spoke to her and encouraged her to eat, giving her time to speak throughout her meal. After she appeared to have finished one mouthful I would bring another spoonful to her lips, letting her know it was there. Amy would then open her mouth again. Before putting another spoon into her mouth, I checked to ensure she had swallowed the previous offering of food. If there was still food present I would remove the spoon and again encourage Amy to chew, demonstrating this action using my own mouth.

An essential part of person-centred care is being able to communicate with individuals in meaningful ways, which is even more crucial in the context of dementia (Royal College of Nursing (RCN 2016a). All aspects of an individual's care require good communication skills by all health care professionals. It is essential that nurses have good communication with patients to provide successful and individualised nursing care (Kourkouta and Papathanasiou 2014). It is not only communication between health care professionals and patients, communication that is important between health care professionals and outside agencies in order to provide high quality individualised care to patients who require it (Chapelhow et al. 2005). If there are issues with communication

between healthcare professionals this can affect the care received, which may have a detrimental effect on the individual as well as family members.

Communication is a complicated process that requires the exchange of information between two individuals (Downs and Collins 2015). For Amy, this became difficult and frustrating. Communication difficulties in dementia are a source of stress for the individual and the caregiver (Aselage and Amella 2010). So, giving Amy time to speak and express her needs can help to reduce stress and frustration that may occur.

However, good communication is about more than just speech. Written communication is vital to record important details about a person's care, for example, recording an individual's food and fluid intake on the correct charts to monitor of their nutritional intake. While providing time for Amy to talk I also interpreted her non-verbal communication throughout the meal such as facial expressions. Both the verbal and non-verbal language of an individual acknowledge that communication involves more speech alone (Martinsen and Norlyk 2011). For example, on one occasion a health care assistant informed me that Amy enjoyed a drink of tea. I then approached Amy with a cup of tea and asked if she would like to taste this, putting the drink to her lips. She took a small mouthful and then turned her head away.

After enquiring with another health care assistant, I found that Amy did not like tea but preferred black coffee instead. This demonstrated that communication between health care professionals can impact on quality of care. The RCN (2016b) found that a

common cause of irritation for healthcare professionals was poor communication.

Throughout Amy's meal I explained everything I was doing and informed her when I was bringing a spoon to her lips. It is essential a carer has good communication skills for individuals living with dementia, which ensure they receive the information and support required (National Institute for Health and Care Excellence (NICE) 2016). Good communication skills are seen as best practice and promote person-centred care. Delivering high quality care for individuals with dementia requires a person-centred and an integrated approach to their care (NICE 2013). Whilst assisting Amy with her meal I was also communicating with her on a one-to-one basis. Martinsen and Norlyk (2011) stated that feeding provided individuals who had a language impairment with an opportunity to be closer to carers, which enabled them to express any concerns they had.

For the duration of the meal Amy was seated in the sitting room where other individuals who lived in the nursing home ate their meals. If individuals are eating a meal together their food intake increases, when individuals are eating alone they eat less (Martinsen and Norlyk 2012). However, Kyle (2011) states that an individual with dementia should be fed in a peaceful calm athmosphere without distractions. Giving plenty of encouragement and praise to Amy ensured she had a sufficient amount of food. Aselage and Amella (2010) found that providing praise during meals demonstrated a noticeable effect on the amount of food consumed by individuals with dementia.

Sufficient nutrients are required by all living organisms in order to survive by providing growth, repair and energy to the body. When certain conditions prevent the intake of these nutrients into the body the individual is at risk and the consequences of this can lead to serious illness or death. A healthcare professional's duty is to protect the individual and reduce risk.

The correlation between deteriorating swallowing function and increasing symptoms of Alzheimer's is well known (Sato et al. 2013). Amy has dysphagia brought on by her Alzheimer's and requires a pureed diet and thickened fluids in order to manage eating and the risk of choking or aspirating. Dysphagia is when an individual has a problem with some or all of the swallowing process (Thompson 2016). One of the main risks with dysphagia is poor nutritional intake. An individual living with dysphagia is at higher risk of malnutrition than other individuals (Willis 2014).

Individuals living in nursing homes can experience mealtime difficulties which lead to weight loss and malnutrition (Aselage, Watson and Amella 2011). Providing plenty of encouragement and making eating a sociable time for an individual living with dementia reduces their risk of malnutrition. However, managing the risk of malnutrition in individuals with dementia can be a challenge due to the condition itself (Jansen et al 2015).

All individuals at risk of malnutrition from a condition such as dementia should have nutritional support in order to maintain or improve their level of nutrition. NICE (2014)

state that healthcare professionals need to consider using nutritional support for individuals who are at risk of malnutrition. In the nursing home Amy has a diet high in fortified foods to ensure her nutrition is adequate and her weight remains at a stable level.

Type 2 diabetes is a condition where not enough insulin is produced for the body to function properly or cells cannot react correctly to insulin (RCN 2016c). Amy's diabetes was mainly controlled through her diet, so it was important that Amy's diet was healthy and well-balanced. Having a healthy well-balanced diet ensures blood glucose is controlled and a healthy weight is maintained (Diabetes UK 2016). To manage Amy's risk of having a high or low blood sugar level it was especially important that Amy's diet was balanced between nutrients that reduce her risk of malnutrition alongside the management of her diabetes. By offering regular snacks to Amy ensured her blood sugar level was kept constant and avoided it dropping too low.

Amy's osteoarthritis presented a risk with Amy unable to give herself sufficient diet and fluids. Osteoarthritis is when the joints are damaged preventing the joint moving smoothly (Arthritis Research 2016). This means that Amy struggles to use a knife, fork and spoon independently. Also, being unable to recognise everyday objects is a risk with individuals who have dementia. In dementia, it is common to lose the ability to recognise common objects such as food, cutlery or tableware (Aselage and Amella 2010). Meaning an individual such as Amy may not recognise or realise to eat food that is placed in front of her. So, in order to maintain her nutritional intake and manage the

risk of weight loss and malnutrition it was important to assist Amy with her nutrition needs.

It was also important to observe Amy closely whilst assisting her with her meal to ensure she was swallowing here food before the next portion of food was given to her. Difficulty in an individual's ability to empty their mouth is a sign of dysphagia and therefore it is essential to monitor for this in individuals living with Alzheimer's (Sato et al 2013). Ensuring that Amy had emptied her mouth of food before the next mouthful reduced her risk of choking or aspirating. It was important to check that Amy was not storing the food in her mouth. Storing food like this is due to problems with mastication where food is sent into the pharynx (Sato 2014). This could mean that Amy could not manage with the pureed diet and be at risk of choking.

Whilst feeding Amy I sat close to her and was careful not to rush her to finish quickly due to her swallowing problems that have been caused by her dementia. Individuals with dementia may take twice as long to finish a meal and require assistance with feeding in an unhurried manner by a caregiver (Kyle 2011). Giving Amy more time enabled her to control each mouthful of food and reduced the risk of choking from being rushed.

Whilst my element of care with Amy lasted no more than 20 minutes, there were several examples of where the communication and risk assessment enablers, as defined by Chapelhow et al (2005), were apparent in relation to the care given to her.

Communication with Amy was important when feeding her to understand her feelings about the food and ensure she received the best possible care. The risks of choking and malnutrition were also addressed. The link between the enablers was also evident. Communication of Amy's conditions ensures that the person feeding her is aware of the potential risks that could arise. An example of poor communication showed that Amy was given a drink that she disliked.

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Obesity and the nurse's role: reducing health inequalities through health promotion

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Abstract
The obesity epidemic currently costs the National Health Service £6.1bn each year. This, combined with the co-morbidities associated with obesity means that the epidemic needs to be addressed. Nurses play a key role in health promotion. However, as health inequalities may relate to obesity nurses must be aware of the wider determinants of health. The present training nurses receive should be reviewed to include this.

Keywords
Obesity, health promotion, determinants of health, socio-economic status, inequalities.

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Introduction

This article will focus on obesity. It will consider the nurse's role as a health promoter and the determinants of health that may contribute to this growing problem. It will aim to explore what barriers exist to promoting health, the ethical principles which need to be considered and what Government policies exist to help reduce obesity. The World Health Organization (2016) classes individuals with a body mass index (BMI) of 30 or more as obese. Currently, 27% of adults are obese in the UK (NHS Digital 2016), an increase of 12% from 1993 (Health and Social Care Information Centre 2016). The World Health Organization (2015 cited in Datta 2016) predict that by 2030, one-third of adults will be obese. The cost of obesity is two-fold; the economic impact and the direct impact on the individual (Lobstein 2015). According to Public Health England (PHE 2015), obesity costs the National Health Service £6.1bn each year.

Interestingly, NHS Digital (2016) reports that Orlistat (a medication used in the treatment of obesity (BNF 2017)) is prescribed more frequently in Merseyside than in any other area in the UK. Orlistat acts by reducing the amount of fat that is reabsorbed in the gastrointestinal system, from food that is consumed (Padwal and Majumdar 2007). This is achieved by the drug inhibiting the hydrolysis of triglycerides, thereby limiting the absorption of fat (Halpern et al. 2010). Hruby et al. (2016) stress that being obese can increase the risk of morbidity (including; cardiovascular disease, cancer, hypertension and diabetes) and mortality.

This health issue is relevant to the role of the nurse. Nault (2015) explains how obese patients can require more nursing care in relation to wound healing and reduced mobility. Finer (2015) highlights that stereotyping often exists towards this patient group. The Nursing and Midwifery Council code of conduct (NMC 2015) reminds nurses they should avoid bias and treat everyone with compassion and respect. Finally, Nguyen et al. (2016) found that obese patients experience longer hospital stays and have greater economic impact associated with their treatment; significant at a time when the National Health Service has a £1.85bn deficit (Dunn, McKenna and Murray 2016).

There are wider determinants of health which could contribute to obesity (Public Health England 2014a). 30.7% of men and 34.2% of women, with no qualifications are classed as obese, compared with 19.9% of men and 18.2% of women educated at degree level. There is a direct link between socio-economic status and obesity. Booth, Charlton and Gulliford (2017) found a link in the UK, between obesity and income.. This differed from the US, where the prevalence of obesity was only lower in those with the highest income, suggesting that other determinants maybe contributing to obesity. Drewnowski (2009) highlighted that food with a high fat and sugar content often cost less than healthier, fresh food. Therefore, those with a lower socio-economic status may opt for the cheaper, more calorific alternatives. Davis and Chapa (2015) discuss how those with a poor education may be unemployed or in a low paid job, which may lead to them living in a deprived area, with limited access to opportunities for physical activity and/or shops to purchase healthy food. Thus, education may be the only escape from the obesity 'trap'.

Environmental factors also contribute. Burgoine et al. (2016) concluded that participants who had higher exposure to fast-food outlets had a higher BMI in contrast to those with lesser exposure. Additionally, Jilcott et al. (2011) found obesity was less prevalent in populations with greater access to fresh fruit and vegetables through green-grocers or supermarkets. Nonetheless, Wang et al. (2007) found that participants who lived closer to a supermarket had a higher BMI than those who did not. They concluded that the results could be due to limited nutritional knowledge which needed broadening to enable them to make healthy choices. In this way both environmental factors and education can be linked.

Finally, ethnicity as a determinant of obesity has been considered. El-Sayed, Scarborough and Galea (2011) conducted a systematic review and found that Black Africans and Black Caribbeans were more likely to be obese, compared to Caucasians, with adults of Chinese ethnicity having the lowest prevalence. This was consistent with Public Health England (PHE 2017) whose recent data found that 67.2% of Black adults, 65.8% of Caucasians and 40.9% of Chinese adults were classed as being overweight. El-Sayed, Scarborough and Galea (2011) add that the main reason for this difference could be due to the fact that ethnic minorities, living in the United Kingdom, generally have a lower socio-economic status than Caucasians. This was consistent with Drewnowski (2009) who suggested that those from a lower socio-economic status would opt for convenient, high calorific food due to it being cheaper.

Trigwell et al. (2014) looked at parental attitudes towards overweight children, in Liverpool. They found that Black Somali parents considered a much larger body size as healthy and that they did not recognise being overweight as a health issue. Watkins and Jones (2015) note that children who are overweight are more likely to become overweight adults. Therefore, ethnic attitudinal differences need to be addressed. Additionally, more black adults are unemployed compared to any other ethnic group (Brown 2016). Therefore, low socio-economic status could be contributing to the high prevalence of obesity.

In England, the effect of the environment on obesity has been recognised by briefings produced by Public Health England (PHE 2013; 2014b) which advise local authorities on how to create environments to reduce obesity. Their focus is on ensuring new housing developments are close to local amenities so that people are encouraged to walk rather than taking a car. Public Health England (PHE 2016) provides advice on the correct portions of the food groups to be consumed through the Eatwell Guide, a revised version of the Eatwell Plate in which pictures and words promote accessibly to all, regardless of education. Locally, Liverpool launched a Living Well programme, which will see £3m being invested to encourage participation in physical activity. The aim is to do this through encouraging active travel, having a GP referral scheme for exercise and rewarding those who do participate (NHS Liverpool Clinical Commissioning Group 2015).

Nurses can play a major role in reducing obesity. This is emphasised in the NMC (2015) Code of Conduct which states that nurses should promote health and prevent illness. Models of health promotion exist to help practitioners develop new ways of thinking, such as Beattie's (1991 cited in Naidoo and Wills 2016) model. It comprises of four components. It can be used top down which is authoritative in nature or bottom up which is negotiated in nature, ranging from being individual to population focused (Naidoo and Wills 2016). A personal counselling approach is also recommended. It enables nurses to empower the individual by working in partnership and considers the wider determinants of health. Lazarou and Kouta (2010) support a tailored, individualised health promotion programme. Kable et al. (2015) points out, that nurses are at the forefront of patient care, have more patient contact than other healthcare professionals and make up more of the healthcare workforce.

The Royal College of Nursing (2012) suggested nurses should take an upstream approach by preventing illness/disease. Nurses see patients throughout their life, so their awareness of current guidance, collaboration with health providers and delivery of health promotion techniques such as motivational interviewing can have a powerful effect. Low et al. (2013) reported some individuals experienced significant weight loss with motivational interviewing when compared to nutrition counselling. This approach empowered the individuals as they determine the costs/benefits for themselves (Naidoo and Wills 2016). Interestingly, Barnes and Ivezaj's (2014) literature review found that motivational interviewing only contributed to weight loss in 50% of cases. They related

this to the intervention alone whereas in some cases this intervention would have been provided alongside an individualised treatment plan.

Reutter and Kushner (2010) stated that nurses can reduce inequalities by acting as advocates for patients. They can also lobby Government to make policy changes and provide input to health strategies. Reutter and Kushner (2010) cited the importance of an increase in the minimum wage, which can also impact positively on equality. However, Cohen and Marshall (2017) argued that barriers such as thinking the problem is individual rather than population focused need to be overcome, and that nurses need education and confidence to act as effective advocates.

Brown et al. (2007) highlighted a lack of health professional training as a further barrier in successful health promotion and the management of obesity. This was supported by the work of Kable et al. (2015) who reported that the majority of nurses they interviewed had not awareness of weight management best practice guidelines. Additionally they found that nurses did not feel confident and experienced significant time restraints. Consistent with these conclusions, Nolan et al. (2012) found that practice nurses were unaware of current guidelines and had poor cultural awareness in the management of obesity with ethnic minority patients. Zhu et al. (2015) agreed that not having enough time and training prevented effective tackling of obesity issues for patients. These barriers were recurrent themes in the literature.

Nevertheless, there are ethical principles which nurses must consider when promoting health, without which Azevedo and Vartanian (2015) warn, health promotion may have negative consequences. They argued that the principle of autonomy was key to promoting health as individuals felt empowered making their own decisions and may feel restricted if told what to do. Beneficence refers to the benefits of a decision and behaviour, to either the individual or society (Naidoo and Wills 2016). However, as Doody and Noonan (2016) highlighted beneficence as subjective as the same beneifts may not be experienced by all. Therefore an ethical dilemma may exist between providing autonomy and ensuring beneficence. As beneficence considers the wider population, Pope, Hough and Chase (2016) argued that this stance may ignore individual autonomy. Dunbar (2003) suggested that in these instances, autonomy is always a priority. This view resonates with the NMC (2015) Code of Conduct which clearly states that nurses should respect an individual's right to either accept or refuse treatment.

In conclusion, the obesity epidemic in England is resulting in costs to the economy, society and the individual. There are many determinants of health which cause health inequalities, particularly with regards to obesity. It would seem that education is essential in escaping the obesity 'trap'. Nurses play a major role in reducing inequalities through health promotion and patient advocacy, although it is clear that barriers exist including nurses not having sufficient time to deliver health education and being unaware of how to act as advocates and/or best practice guidelines.

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Smoking, alcohol and obesity: Health promotion relevant to acutely ill vascular and urology patients

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Abstract
Alcohol, smoking and obesity are considered serious public health issues. This article will examine the role of the nurse in health promotion and consider the legal, ethical and policy context relevant to a group of acutely ill patients on a vascular surgery and urology ward. It will discuss how the majority of these patients suffer primarily from vascular disease caused by modifiable risk factors such as smoking and alcohol. It will explore how such patients can be empowered to improve their own health. Nurses have a duty to help patients to make informed decisions regarding their health. However, patients are entitled to make their own choices and the nurse must be respectful of their autonomy.

Keywords
Alcohol, smoking, obesity, health promotion, vascular, urology

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Introduction

The World Health Organization (WHO 2016a) describes health promotion as the means of empowering individuals to manage and improve their own health. It shifts the emphasis from individual behaviour to include a variety of social and environmental factors. WHO (2016a) state that there are three elements of health promotion: good governance for health, health literacy and healthy cities. These are intended to help safeguard an individual's well-being and quality of life by tackling and inhibiting the original source of their illness, as opposed to concentrating on treatment and cure alone. The Nursing and Midwifery Council (NMC 2015) emphasise the importance of reviewing and reacting to the individual's physical, psychological and social needs by concentrating on promoting welfare, preventing illness and addressing the varying healthcare needs of individuals throughout all stages of life.

This article will address three health promotion issues: smoking, alcohol and obesity. It will consider the legal, ethical and policy context, relevant to a group of acutely ill patients on a vascular surgery and urology ward during a practice placement. Before embarking on this study, consent was obtained from the patients for the use of their clinical information. Any information which may identify the patients has been amended in accordance with the professional guidelines set out by the NMC (2015) to maintain confidentiality.

Background

The placement was six weeks in duration and involved nursing patients with acute vascular and urological problems. It comprises24 beds, 8 of which are dedicated to enhanced recovery. The patients had a range of conditions including: single and multiple limb amputations, complex urological problems, bladder surgery, emergency urological procedures and vascular rehabilitation. Various health promotion issues became apparent whilst in this setting, given that most patients suffered from vascular disease, which is caused primarily by modifiable risk factors such as smoking, hyperlipidaemia, hypertension, high alcohol intake, diabetes, obesity and renal failure (Walsh and Crumbie 2007).

The hospital is monitored by the Care Quality Commission (2016) who are the independent regulators of health and social care in England, ensuring care provided meets fundamental guidelines for quality and safety. The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires the promotion of a comprehensive health service, to secure continuous improvement in the quality of services provided for the prevention, diagnosis and treatment of illness, or the protection or improvement of public health (Department of Health 2012).

Smoking

According to WHO (2016b) the widespread use of tobacco is one of the greatest risks to public health, globally causing approximately six million deaths each year. In

England, smoking is the primary cause of preventable death, with cardiovascular disease recognised as a major non-communicable disease alongside cancer, diabetes and chronic respiratory diseases (Office for National Statistics 2014). Treatment of smoking-related illnesses puts significant pressure on the National Health Service (NHS), with research showing the NHS spends approximately £2 billion a year treating smoking-related diseases (Action on Smoking and Health 2015). The nurses on the ward have a significant role when working with patients who smoke. Techniques to aid smokers to give up are extremely cost-effective (Parrot and Godfrey 2004) decreasing the prevalence of smoking is one of the government's fundamental objectives (Office for National Statistics 2014).

Vascular diseases such as ischaemic heart disease and stroke, are caused by arteriosclerosis, a degenerative arterial disease which causes the arteries to calcify, harden and narrow. Progressive reduction in blood flow to the lower limbs can result in peripheral vascular disease (PVD), potentially causing necrotic tissue to develop in the feet and toes (Walsh and Crumbie 2007). During this placement, it became apparent that the patients requiring nursing care for peripheral vascular disease were typically late middle age to elderly, with a history of smoking and/or diabetes and often presented with chronic complications such as coronary heart disease, stroke and limb ischaemia. This observation was supported by research conducted by Emdin et al. (2015), who found an associated risk between peripheral vascular disease and ischaemic heart disease, heart failure, aortic aneurysm and chronic kidney disease. It is therefore important for the nurse to identify the risk to the patient caused by their smoking to

support individuals to help them manage this. According to WHO (2016b), studies show that many people fail to comprehend the health hazards of tobacco use. For example, Hirsch et al. (2007) found that the public are inadequately educated about PVD, facing considerable disparities in their understanding of the risk factors, with half of the individuals surveyed being naïve to the risks associated with smoking and diabetes, despite the abundance of relevant health advertisements available.

Nursing staff on the ward may offer brief interventions to the patient, including discussion, opportunistic advice, encouragement or negotiation (NICE 2006). This type of health promotion is frequently used in a range of healthcare areas and is provided by a variety of care professionals, both in primary care and in the community, as recommended by the National Institute for Health and Care Excellence (NICE 2006). Any patient who currently smokes and wishes to quit is offered a referral to Smoke Free Liverpool, a local NHS smoking cessation service. Further information is also offered from other sources such as Quitline, GP surgeries or local health education units. The Department of Health (2009) guidance also encourages nursing staff to deliver concise advice to advocate smoking cessation. Therefore, when caring for a patient who smokes, nurses on the ward must ask and record the patient's smoking status, advising the patient of health advantages and acting on the response of the patient. As well as referring patients to smoking cessation services, nurses may offer guidance regarding national campaigns such as No Smoking Day, or offer nicotine replacement therapy. Counselling and medication combined have been shown to significantly increase the likelihood of stopping smoking (WHO 2016b).

Alcohol

NICE (2012) defines low alcohol consumption as regularly drinking less than the recommended daily units, whereas high consumption equates to regularly consuming more than 14 units of alcohol per week. Some of the patients on the ward self-reported having a high alcohol intake. Excessive alcohol intake is a risk factor for vascular disease and one of the top causes of premature mortality (Public Health England 2013). High alcohol consumption has been reported to be associated with an increased risk of PVD (Wakabayashi and Sotoda 2014). The links between alcohol intake and cardiovascular diseases are multifaceted. Moderately low levels of alcohol consumption have a cardio-protective effect, although as alcohol intake increases this protective effect decreases. Additionally, higher alcohol intake also has a damaging impact on hypertension, atrial fibrillation and haemorrhagic stroke (Roerecke and Rehm 2012).

In 2012, alcohol consumption accounted for approximately 3.3 million deaths worldwide, with the greatest number of deaths from cardiovascular diseases (WHO 2014). Throughout the UK, the harmful effects of alcohol misuse are now acknowledged, with alcohol misuse being recognised as a serious health and social issue, leading nurses to incorporate counselling and educating patients about the health hazards related to alcohol abuse within their role (Govier and Rees 2013). During this placement, the nursing staff were ideally positioned to promote safe alcohol consumption using brief interventions centred around motivational interviewing. Patients who were at risk of their condition worsening by their continued alcohol misuse were supported if they wanted to change their behaviour (Miller and Rose 2009). Motivational interviewing is now

commonly accepted as a method of therapy for promoting modifications in behaviour, with interventions often summarised using the FRAMES guidelines, that is: giving the patient information or 'Feedback', 'Responsibility', 'Advice', list of effective 'Menu Options', 'Empathy' and 'Self-Efficacy' (Miller 1996).

If patients are willing to undertake treatment and accept help for their alcohol issues, nursing staff may refer them to the local Community Alcohol Service, an initiative involving alcohol nurses, hospital specialists and experts in addiction. This service offers a variety of advice and support to those affected by alcohol misuse, such as health assessment, ways to safely and sensibly detox, and referral to specialist services. This programme helps service users to control their alcohol intake, or to quit completely (Liverpool Community Alcohol Service 2011). However, nurses should be aware that some of the patients who misuse alcohol may not wish to modify their drinking habits and in these circumstances the nurses must acknowledge the patient's right to justice, autonomy, beneficence and non-maleficence (Gillon 2015).

Obesity

Obesity is a complex chronic disorder which represents a significant public health issue and a global epidemic, with associated risks of developing vascular diseases, diabetes and some cancers (Gómez-Hernández et al. 2016). Research indicates an annual increase in obesity of 2% (Public Health England 2013), with current statistics suggesting that around a quarter of adults in England are obese (Health and Social Care Information Centre 2014).

The opportunity to promote the advantages of maintaining a healthy weight and taking physical exercise should be taken by the nurse, irrespective of the patient's weight status. However, if a patient presents as obese, this should be considered a risk factor and support and advice should be given in accordance with guidelines on assessment and management of obesity, and, if appropriate, referral to the relevant services with the patient's consent (NICE 2016). If the nurse provides guidance on weight management, it is vital that the plan meets the needs of the individual. For example, considerations of the patient's commitment, self-confidence, culture, stage of life and their personal obstacles must all be factored in to their personalised care plan. Additionally, the nurse should be mindful of the patient's alcohol intake and the association between excessive alcohol consumption and obesity discussed (Department of Health 2009).

On admission to the ward, the patient's height and weight were recorded. These measurements were repeated regularly during their stay in hospital to identify any change. The patient had access to healthy, low-calorie options on the menu, so that they could monitor their energy intake. Patients considered obese were sometimes referred to a dietician who can provide information regarding the importance of maintaining a healthy diet. Throughout the planning and delivery of services relevant to obesity, it was essential that any care provided by nursing staff was safe and that the individual was in receipt of a high-quality service. They should be cared for with dignity and be included in the decision-making process, with the support and opportunity to discuss and identify their options, and comprehend their condition and how to prevent

its progression (NICE, 2016).

Health promotion surrounding alcohol, smoking and obesity in relation to vascular disease, requires well-defined, precise information. Many patients are not aware of the facts, which can lead to confusion and impede the health promotion strategies. This presents the opportunity for health care professionals to promote a healthy lifestyle and educate patients (Hirsch et al. 2007).

Legal, Ethical and Policy Context

Health promotion issues have faced scrutiny from the arena of public health and are often modifiable behaviours which can affect people medically, socially and economically. Thus, several policies and practices have been introduced by the government to increase public awareness (Bell, Salmon and McNaughton, 2011). Health Education England (2016) developed 'Making Every Contact Count', which is a framework for changing behaviour and improving health, in addition to educating people about prevention and health inequalities.

The House of Commons (2012) released the Government's *Alcohol Strategy*, defining public health concerns relating to excessive alcohol consumption. The Department of Health's (2015a) *Smoking Policy* includes anti-smoking campaigns such as 'Smokefree', and discusses E-cigarettes and the smoking ban. The Department of Health (2015b) also introduced the *Obesity and Healthy Eating Policy* as well as the *Harmful Drinking Policy* (Department of Health 2015c). National NHS-backed

campaigns, such as Change4Life, aim to improve the health of the nation by encouraging exercise and healthy eating. Other legislation relevant to this patient group includes: the *Human Rights Act* (1998), *National Health Service Act* (2006) (as amended by the *Health and Social Care Act*, 2012), *Equality Act* (2010), *Misuse of Drugs Act* (1971), and *Data Protection Act* (1998).

In conclusion, alcohol, smoking and obesity are considered serious public health issues, involving social and economic implications. Nurses have a duty to help individuals to make informed decisions regarding their health. It is vital that nurses offer support and education to patients in making positive lifestyle changes by providing advice, encouragement and education using a non-judgemental approach. By considering my experiences and learning objectives within this placement using the Gibbs (1988) model of reflection, I have discovered that individuals may choose to ignore the advice of the nurse, potentially jeopardising their health further. These patients are entitled to make their own choices and the nurse must be respectful of their autonomy, whilst empowering them to make informed decisions (NMC 2015).

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A review of teenage pregnancy and related socio-economic factors

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Abstract
This article will review pre-existing socio-economic factors that could potentially influence teenage pregnancy. Research shows that teenage pregnancy within England remains consistently the highest within Europe with no obvious reason. A combination of social and economic factors will be considered that could predispose to teenage pregnancy with particular focus on the involvement of healthcare practitioners in appropriate health promotion strategies.

Keywords
Teenage pregnancy, Health Promotion, Sexual Health, Nursing,

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Introduction

Teenage pregnancy in England consistently remains the highest in Europe, averaging a total of 24.3 conceptions per every thousand females aged 15 to 17 with the rate varying greatly between geographical areas in England. Further research from Public Health England (PHE 2016) concludes that teenage mothers are more likely to suffer from postnatal depression and associated poor mental health. Furthermore, this group are predicted to be less likely to complete their education leaving them vulnerable to a 63% increased chance of experiencing poverty in adulthood (PHE 2016).

The Royal College of Nursing (RCN 2011) in it's Public Health's White Paper "Healthy lives, healthy people: our strategy for public health in England", reiterated the unique role nurses play in both primary and secondary healthcare settings to deliver health promotion. While (2014) provided further support for the role of the nurse confirming how public health nurses were traditionally seen as those in specialist community roles. The article highlighted how in recent years, there was an increasing emphasis for all nurses to act as agents for improving public health and should aim to incorporate health promotion into clinical practice.

To understand the role of the nurse in health promotion this article will aim to provide an insight into the social determinants of health that could lead an individual to becoming pregnant as a teenager. This article will address specific government initiatives related to this issue, whilst giving adequate consideration to the role of the nurse in promoting safe sexual health and reducing health inequalities.

Analyzing the role of the nurse

Frances (2011) highlighted the important role nurses play in society in relation to promoting safe sexual health and suggested how nurses needed to be supportive towards young people and encourage a more 'teenage friendly' environment so that they feel comfortable talking about such a sensitive subject. However, he also acknowledged the need for nurses to be aware of the underlying factors that can contribute towards teenage pregnancy and to continue to promote preventive public health measures, such as contraception.

Considering the social determinants of health

Teenage pregnancy has been identified as a national public health issue due to its association with economic, social and health costs and is a subject on many professional and government agendas (Department of Health 2002, Royal College of Obstetrics and Gynaecology 2007, Department for Children Schools and Families (DCFS) and Department of Health 2010).

The Marmot Review (2010) addressed the collective views of whom as regards the health inequalities experienced by certain groups of people in society. The review concluded that those individuals who were considered to hold a higher socioeconomic position within society had a wider range of lifestyle choices and opportunities to lead a good life. Both social and economic factors were believed to be key to shaping an individual's health and wellbeing, material circumstances, social environment, psychological factors, behaviours and biological factors (Commission on Social Determinants of Health 2008). Teenagers highlighted to be 'at risk' of underage pregnancy included those living in poverty, disengagement in schooling and low

education attainment. Research by PHE (2016) labelled these factors as having the potential to contribute to poor academic progress which can leave young people vulnerable to a range of risky behaviours.

Relation to government/local directives

Public Health England (2016) exists to protect and improve the health of the nation and highlights particular health inequalities experienced by certain groups of people within society, with teenage pregnancy a particular policy focus for the organization.

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In 2016, Public Health England implemented a strategic action plan targeting the health promotion of sexual and reproductive health within England (PHE 2016). A key priority outlined within the plan was to further reduce conception rates in under 16 and 18 year olds. The National Institute For Health and Care Excellence (NICE 2007) confirmed that there were a total of 39,545 under-18 conceptions, with 41% ending in termination, out of that number a total of 7,179 under-16 conceptions with 57.6% ending in termination. The action plan gave suggestions as to how they aimed to establish effective health promotion for this group in both clinical and educational settings, by placing an increased emphasis on accessibility to information regarding safe sexual health for school aged people. It hoped that increased awareness of the issue and long term preventive measures would be discussed with teenagers.

Promoting health and reducing health inequalities

A primary preventative measure suggested to decrease the number of teenage pregnancies was to introduce sex education programmes into the school curriculum (Centre for the Advancement of Health 2008). Leishman (2004) suggested that

childhood experiences and teenage pregnancy were interlinking factors and could be considered a significant cause of health and social issues. An inter-professional approach is considered to be most effective for professionals working with pregnant teenagers. Leishman (2004) suggested that attempts should be made to involve all allied health professionals who had responsibilities in the control and prevention of teenage pregnancy to implement the care for the young person. The Faculty of Public Health (2015) suggested that there was a need for a wider range of services to work inter-professionally by considering the relationship between health, educational and social care systems.

The All-Party Parliamentary Group on Global Health (APPG 2016) identified nurses as the first and sometimes, the only health professionals that young people came into contact with and therefore the quality of their initial assessment, care and treatment was considered crucial. Nurses were viewed as being ‘part of the community’ able to share aspects of culture and strengths, giving particular attention to the vulnerable individuals or groups identified within society. This evidence highlighted the fact that nurses had the ability to both shape and implement effective health interventions, by offering advice on emergency contraception, long term contraception and how to prevent unwanted pregnancies in order to meet the needs of young people (APPG 2016).

Strategies that can be used by the nurse

To aid nurses in using health promotion techniques, Beattie’s (1991) Model of Health Promotion is a widely used tool designed to advise health professionals on the best approach to take when trying to encourage behavioural change. This model incorporates a wide range of guidance and includes information that is evidence based,

ensuring that accurate information is delivered to the patient so they can make informed choices, as the Nursing Midwifery Council (NMC 2015) suggests. The strategy identifies four ways a health professional can try to establish health promotion and with teenage pregnancy, an individual approach would be recommended. An individual approach evokes personal development within the young person whilst trying to establish central focus points within their life to encourage behavioural change. The dialogue between the nurse and the young person is paramount within this approach, as NICE (2007) places great value on the importance of the vulnerable young person being given the opportunity for individual sexual health advice to prevent unwanted pregnancies alongwith knowledge of emergency and reversible contraception.

It is important that the nurse views the young person holistically, taking into account for those factors surrounding the individual by considering personal factors that have the potential to affect the young person both physically and mentally (RCN 2012). Graham (2004) suggested that the social determinants of health surrounding the young person can correlate with health inequalities experienced throughout society and this root cause was what healthcare professionals needed to address. Reutter and Kushner (2010) provided further support by emphasising the need to identify the underlying causes of health inequalities by systematically focusing upon the social conditions surrounding the individual and what is producing them.

Barriers to opportunities

While it is important to discuss the need for more health promotion surrounding the issue of teenage pregnancy, it is also important to acknowledge the barriers that healthcare professionals can be confronted with whilst trying to implement it. A study by

McFarlane et al. (2016) concluded the main barriers to health promotion were: a lack of management and support for the need for change, insufficient numbers of dedicated and qualified staff who were competent in both the skills and training required for health promotion and the lack of time and resources. The conclusions drawn from this research highlighted the need for health professionals to receive adequate training and support and for them to have access to appropriate resources for health promotion to be of effective.

Ethics and Health Promotion

The rights of young people need to be considered when working with teenagers, as Wray (2005) confirmed that this was a crucial factor in gaining the trust of a young person. The NMC (2015) Code of Conduct states that nurses should treat people as individuals and respect their dignity by ensuring their human rights are being upheld and that they are acting in the best interests of the young person by considering an individual's right to accept or refuse treatment. The NMC (2015) also state that a nurse must be aware of their duty of confidentiality towards patients and should respect a young person's right to privacy of their information.

Recommendations for nursing practice

Public health should be viewed as a responsibility of all nurses and should not be considered as a separate area of clinical practice. The RCN (2016) recommend that nurses should be equipped with the relevant skills and knowledge to be able to provide both a meaningful and holistic approach to public health interventions across all health

and social care settings. The NMC (2015) also recommend that when health professionals are engaged in the care of young people, they must keep up-to-date with the relevant laws and policies of how to protect and care for vulnerable people and thus, if concerns become evident, extra support and protection is identified when necessary.

Conclusion

This article has highlighted a number of significant health and social care issues while exploring how specific factors can contribute to a teenage pregnancy. The evidence provided emphasised the need for inter-professional collaboration across health and social care settings in the primary prevention of teenage pregnancy, whilst encouraging the need for wider sexual health advice to be implemented within schools. It has also focused attention on the need for nurses to receive specialist training in health promotion and to view it as a major influence for change. Implemented it within the healthcare setting can reduce the existing inequalities and provide everyone with equal opportunities to health and wellbeing.

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