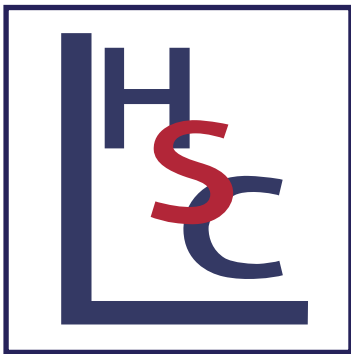


Links to Health and Social Care



Editorial

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Celebrating Student Achievement

We are at a very exciting time in the development of this e journal. This is our sixth issue and more interest is been shown in it from students and academics alike. Research and scholarly activity are higher profile in nursing than ever before. There is no better time to start publishing what we are doing than as a student. In recognition of McGachie and Webster (2009) suggest that skills needed to publish are developed over a long period of time, it seems obvious that we should be encouraging our students to publish, gaining some skills before qualification as a registrant.

This e-journal was developed locally to encourage our students to publish their work providing a realistic pathway for this to happen. It also provided an opportunity to celebrate student achievement. To date many students have engaged in this and found the journey to be positively challenging and rewarding.

Many nurses are anxious about the writing process lacking the confidence in their own abilities as well as anxieties about putting their work in the public arena. Much research is done but never gets into the public arena (Costello 2012). Allaying some of these fears of writing is so important at an early stage and this journal can provide that supportive environment for those starting out on this road to gain confidence and experience the process on the journey to publication.

Indeed Roberts (2018) argue that everyone has a first publication and for that to happen we have to start somewhere. Like our students writing for the e journal is likely to be their first publication. Moreover she argues the importance of mentoring during this critical phase is crucial for the student encouraging them to publish further work.

As healthcare professionals we talk about using the most up to date evidence/knowledge (NMC 2018, HCPC 2016), we explore how we can ensure that our practice is underpinned by evidence, therefore it seems a natural step to want to engage in the creation of that evidence through research and publication. Practice is rich with innovative ideas. The need to share best practice is more important than ever to avoid reinventing the wheel. Such publications can help to raise the profile of nursing among colleagues as well as further afield (McMillan and Raines 2010).

This journal welcomes expressions of interest from students who have achieved high marks for their work. We also welcome expressions of interest from those who would like to become editors for the journal.

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Using the Chapelhow Framework to Deliver Nursing Care

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Abstract

Chapelhow et al. (2005) devised a framework consisting of six enablers which nurses must undertake to provide competent, objective and specialised nursing care. This case study focuses upon two enablers: assessment and communication, with reference to a patient's journey when admitted to a gastroenterology ward. Assessment and communication are important aspects of providing nursing care and this is demonstrated throughout this case study. Furthermore, they interlink to provide efficient nursing care; however, both are not without limitations. This is further explored throughout this case study.

Keywords

Chapelhow, Assessment, Communication, Nursing Care,

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The assumption that nursing care is merely the delivery of clinical skills, such as measuring blood pressure, is challenged by Chapelhow et al. (2005). They suggest six essential skills which enable the nurse to deliver expert, safe and effective healthcare: Page | 5
assessment, communication, professional judgement and decision making, risk management, record keeping and documentation, and managing uncertainty. This case study will discuss the care given to a sixty-eight-year-old male admitted to hospital whilst referring to two of the above enablers. The first enabler to be discussed will be assessment.

Assessment is fundamental to the safety, continuity and quality of care a patient receives (NMC 2018). Assessments allow holistic need-based care to be implemented (Miller and Webb 2011). The second enabler to be discussed will be communication. Chapelhow et al. (2005) propose communication is an essential nursing skill when undertaking assessment. According to O'Hagan et al. (2014) communication between patients and healthcare providers influences patients' outcomes and allows the development of a therapeutic relationship (NMC 2018).

The patient discussed in this case study will be referred to as 'Stephen'; a pseudonym to protect his identity and maintain confidentiality (NMC 2018). Stephen gave verbal consent for relevant information to be used within this case study (NMC 2018). He was informed how his information would be used and what information would be used (NMC 2018). He was admitted to hospital presenting with pallor, tachycardia and melaena; black stool due to digested blood caused by internal bleeding (Zhu et al. 2018). This resulted in a Hb

(Haemoglobin) level of 61 (g/L). Therefore, the oxygen saturation within Stephen's red blood cells was below normal as normal Hb levels for Stephen's demographics range between Hb118 and148 (g/L) (Sormunen 2010). This resulted in hypotension (Atsma et al. 2012). Hypotension is abnormally low blood pressure. Blood pressure is the force of blood pushing against the walls of the arteries as the heart pumps blood. The normal range for blood pressure in an adult is 120 systolic and diastolic of 80 mmHG (120/80mmHG), however hypotension is blood pressure that is lower than 90/60 mmHG (NHLBI 2018). This had reduced Stephen's mobility.

The first enabler to be discussed is assessment. Assessments allow for the evaluation of a patient's physical, mental, social and cultural needs (Howatson-Jones, Standing and Roberts 2015). Assessment is an interactive process during which the patient and nurse collaborate to identify patient need(s) through in-depth information provided (Chapelhow et al. 2005). Engagement with the patient is essential (Barrett, Wilson and Woodlands 2009). Failure to recognise and respond to the needs of patients can result in unmet care needs and is thus detrimental to one's wellbeing (McCormack and McCance 2010).

A comprehensive assessment followed Stephen's admission (Wade and Halligan 2017). Mayo (2017) and Bennett, Penny and Lawrence (2009) reiterate that completing comprehensive assessments allow comorbidities to be identified, deterioration of a patient's condition and provide appropriate care and treatment with the aim of optimising his/her well-being. Therefore, informed decisions were based upon current and best practice (Bennett, Penny and Lawrence 2009). This skill must be acquired during pre-

registration nursing (McCallum et al. 2013). Therefore, it is suggested assessments are an integral and essential skill for nurses, which in turn optimises a patient's well-being.

Stephen was assessed using quantitative and qualitative assessment methods. This enabled nurses to collate information to identify care needs (Taylor 2017). The National Early Warning Score (NEWS), Waterlow Pressure Ulcer Scoring System, Bristol Stool Chart and the Geriatric Depression Scale were used. Within the first six hours following admission, Stephen was assessed using the NEWS (RCP 2017). This provided a baseline for Stephen's respiratory rate, oxygen saturations, heart rate, blood pressure, temperature and level of consciousness (Prytherch et al. 2010). As Stephen had symptoms of internal bleeding, it was vital to repeat the NEWS every four hours to monitor this (RCP 2017). This provided staff with data to compare to baseline observations that were taken on admission (Tollefson, Bishop and Jelly 2011).

Stephen was assessed using the Waterlow Pressure Ulcer Scoring System (Waterlow 2008) within the first six hours following his admission (NICE 2015). This was implemented because upon completing the MUST (Malnutrition Universal Screening Tool), Stephen had a BMI (Body Mass Index) of 16 (kg/m²), considered underweight (Zaidi and Lanigan 2010) and had fragile skin and poor mobility. A BMI less than 18.5 (kg/m²) is considered underweight, a BMI ranging between 18.5 and 24.9 (kg/m²) is considered normal, a BMI ranging between 25 and 29.9 (kg/m²) is considered overweight and a BMI over 30 (kg/m²) is considered obese (Lukaski 2014). In addition, Stephen had both urinary and faecal incontinence. There was a need to ensure the care plan included

measures to reduce risk of pressure ulcers. Stephen was therefore repositioned frequently (Gillespie et al. 2014) and barrier cream applied to pressure areas to protect the skin (NICE 2014a).

When Stephen was admitted initially, his faecal output was not assessed. When this was recognised the Bristol Stool Chart was implemented to monitor melaena as it is considered valid and reliable for assessing an individual's stool (Chumpitazzi et al. 2016). Identifying the stool type, frequency of bowel opening, and the amount of faeces excreted against an objective chart enabled the correct treatment to be prescribed and administered (Bayless and Hanauer 2011).

As Stephen had hypotension, a fluid input/output chart was implemented. Hypotension can result in acute kidney injury whereby the nephrons do not produce urine regularly (Cockwell, Stringer and Marriott 2018) leading to reduction in excretion of waste and ultimately toxicity for the patient (Patton and Thibodeau 2016).

Stephen complained of feeling low in mood, especially since this deterioration of his physical health. The Geriatric Depression Scale (GDS), created by Yesavage et al. (1983) objectively assessed Stephen's depressive symptoms. The GDS is a screening tool used to identify depressive symptoms in adults over 65 years (Esiwe et al. 2016). Shorter versions of the GDS have been developed, albeit they lack the detail of the full version which could impact on the reliability and validity of the tool (Pocklington et al. 2016).

The GDS has 30 closed questions, making it easy to use (Lim 2008). However, due to the quantitative design, limited qualitative information will be present (Langridge and Hagger-Johnson 2009). As the GDS does not provide contextual information it should be used as a scaffold for treatment along with other tools (DiNapoli and Scogin 2017).

Stephen scored 19 on the GDS suggesting he was experiencing symptoms synonymous with mild depression (Li et al. 2015). However, it can be argued, as the cut off for an indicative score of mild depression is 10, environmental factors may lead to an increase in the score to major depression: a score of 20-30 (Li et al. 2015). However, Yesavage et al. (1983) found the three classifications of no depression, mild and major depression were valid, thus the three classifications were distinguishable. As Yesavage et al. (1983) developed the GDS, there could be interpreter bias which would reduce the validity of the above assertion (Langdrige and Hagger-Johnson 2009). Moreover, Xie et al. (2015) further validated these results and found the GDS was applicable to eastern cultures.

Negative attitudes often exist among nurses when caring for people with mental health issues (Lethoba, Netswera and Rankhumise 2006). Ross and Goldner (2009) completed a meta-review and found RGNs held the stereotypical assumption that patients on a general medical ward diagnosed or presenting as mentally ill were dangerous and unpredictable. Furthermore, RGNs often lack the confidence and skills to competently assess and manage a patient's physical and mental illness needs (Schreuders 2007). This empirical research is important because it suggests a dichotomy, stigma and failings of assessing a patient from a holistic viewpoint, thus neglecting patients' well-being.

Comprehensive assessments were implemented throughout Stephen's admission (Clarke 2014). This was integral to his care as it allowed the nurses to collate the necessary information to understand and prioritise his needs and implement treatment (Dougherty, Lister and West-Oram 2015). The patient is required to engage in the assessment process (Chapelhow et al. 2005); however, assessments do not consider if the patient is withdrawn, unable or unwilling to take part. Thus excellent communication skills on the part of the assessor are necessary to encourage the patient to engage (Tobiano et al. 2015).

The second enabler to be discussed is communication. Communication is the reciprocated exchange of information, verbally and non-verbally, between individuals (Dougherty, Lister and West-Oram 2015; NMC 2018). Within nursing, communication is interpersonal (NMC 2018, McCabe and Timmins 2013); the process by which a therapeutic relationship is developed where compassion, support and empathy is demonstrated (Bach and Grant 2015).

The NMC (2018) Code of Conduct posits nurses must communicate effectively with patients. O'Hagan et al. (2014) identify effective communication as dependent upon the nurse's approach, manner, interaction techniques, for example, using layman's terms and communication styles, for example, using the SOLER model.

Egan (1990) developed the SOLER model for listeners to ensure they are actively present when interacting, allowing the development of a therapeutic relationship with a patient.

SOLER is the acronym used where the listener Sits squarely, has an Open posture, Leans towards the patient, has good Eye contact and is Relaxed (Egan 2013). Crouch (2005) found the application of SOLER ensures patients feel uninhibited to express themselves as they have the listener's full attention, thus it is reliable and valid as a tool of effective communication.

As Stephen had depressive symptoms, the nurses used strategies to engage him with assessments (Bryant 2009). In addition, communication between the nurse and patient needs to include active listening. Active listening demonstrates to the patient the nurse is committed, supportive and caring (McCabe and Timmins 2013) which promotes empowerment and person-centred care (Gilmartin and Wright 2008). Active listening encouraged Stephen to give information, express his concerns and needs which allowed the nurse to holistically plan his care (Miller and Webb 2011). The absence of active listening can result in the patient feeling abandoned and disrespected (Barrere 2007; Gilmartin and Wright 2008).

One in four people experience mental illness (World Health Organization 2014) which can result in a communication difficulty. Depression can impair cognition (Wang and Blazer 2015) and reduce the ability to engage (Ayalon, Feliciano and Arean 2010). This could impact on patient care and well-being, so it is essential that nurses adapt to the patient's needs to enhance their well-being through adopting SOLER and active listening (Taylor 2017).

Effective communication is integral to delivering holistic, personalised and need-centred care (O'Hagan et al. 2014). It is a key determinant in patient recovery, satisfaction and perception of care and allows the establishment of interpersonal relationships between the nurse and patients admitted onto physical (McFadden et al. 2017) and mental illness wards (Kameg et al. 2009) and patients with severe communication impairments (Finke, Light and Kitko 2008). Therefore, nurses must be aware how their approach to patients influences the way a patient responds; thus, SOLER is integral to the promotion of patient well-being (Sale and Neale 2014).

During any involvement with the patient, the nurse should communicate to the patient to explain why and what they need to complete (Taylor 2017). This allows the patient to give their consent, essential before completing any care (Department of Health (DH) 2012), and treats the patient with dignity and respect (NMC 2018). Therefore, the patient is supported and involved in their care (Bach and Grant 2015). Rathert, Wyrwich and Boren (2013) found that involving patients in their care increased their satisfaction with the care and their well-being.

To reduce vulnerability to pressure ulcers on the sacrum and heels, Stephen's care plan outlined how he should be re-positioned to help assess and prevent ulcers and barrier cream applied: at least every six hours for those areas at risk and every 4 hours for those at high risk (NICE 2014b). Although Stephen consented to this care plan, before completing any care, Stephen's consent was sought (NMC 2018). Throughout this procedure nurses communicated with Stephen and provided a rationale. This allowed him

to ask any questions or discuss any issues he may have had.

Whilst empirical evidence demonstrates effective communication skills are integral to delivering patient-centred care, poor communication is still commonplace in some nursing environments (Mullan and Kothe 2010). Poor communication is a common complaint within nursing resulting in failure of effective care (DH 2013). The Mid Staffordshire NHS Public Enquiry (Francis 2013) found poor communication between healthcare staff and patients resulted in neglect, delayed treatment and preventable deaths. Cummins et al. (2018) have also reinforced the importance of communication. It can be posited that poor communication can impact upon the quality of care received. It is essential that communication is effective to enhance patients' care and ultimately their well-being.

Furthermore, communication includes how patients express their needs (Chapelhow et al. 2005). For example, a patient may be embarrassed, or scared to disclose information. Stephen was required to use a bed pan so that his faeces could be examined. Stephen initially stated the bleeding had stopped; however, nurses noticed Stephen was apprehensive and embarrassed. Empathy was required, and it was important he understood the reason why it was necessary for his faeces to be examined (Taylor 2017). Therefore, the nurse/patient relationship was essential in this instance and great sensitivity was required (Chapelhow et al. 2005).

The use of jargon is a major issue within healthcare (Silverman, Kurtz and Draper 2013). This can result in the patient feeling confused and frustrated, not comprehending what

nurses are verbalising (Connelly and Gupta 2017). Nurses need to communicate in clear and comprehensible language (Riley 2015).

However, it is essential patients are not patronised (Hanson 2014). However, Williams, Kemper and Hummert (2016) argue some nurses use 'elder-speak' to adults over 65 years old. Elder-speak is based on the stereotype that older adults are less competent, so healthcare professionals simplify their language, patronise and alter their tone of language (Williams 2011). Elder-speak was used towards Stephen. He found this insulting which had a detrimental effect on the therapeutic relationship between him and a nurse (Hanson 2014).

Poor communication occurred during Stephen's admission. Doctors explained to Stephen he had melaena; however, Stephen did not understand. Silverman, Kurtz and Draper (2013) argue patients rarely ask for clarification. This heightened his anxiety as he believed he had another physical illness. Recognising this, the nurses explained what melaena was and this appeared to reduce Stephen's anxiety.

Communication within the multidisciplinary team (MDT) is imperative. The enthusiasm for MDT work within healthcare reflects a profound recognition that working together can deliver improvements for the patient that might not otherwise be achieved (Clarke and Forster 2015). The benefit of the MDT is that each member brings their own skills and knowledge relating to their speciality thereby providing holistic care for the patient (Friedland et al. 2011). This allows for the team to develop mutual goals to enhance

patient well-being (Thomson et al. 2015). Therefore, the MDT provides personalised and holistic care and support (Speck 2006).

Stephen was reviewed by an MDT. He was assessed by the consultant and nurses within gastroenterology. A referral was made to the dietician as he was underweight. He was referred to psychiatric liaison, so they could assess and provide treatment for his depression (Page 2012). However, MDT working can be challenging. Atwal and Caldwell (2006) found different perceptions of teamwork sometimes hindered MDT working.

Stephen was *expressing* symptoms of depression; however, he did not have a formal diagnosis of depression. During handover, nurses stated Stephen had a *diagnosis* of depression, leading to misinterpretation by staff. Referral to Psychiatric Liaison was delayed until confirmation of the diagnosis. It is important to note a symptom is a change from usual state of functioning (Mulley and Albert 2010), whereas a diagnosis is the confirmation of an illness by examining the symptoms (Dougherty, Lister, and West-Oram 2015).

As Stephen was under the MDT framework, it was essential to maintain confidentiality (NMC 2018). Professionals were given relevant information. Whilst communication is essential for MDT working and completing assessments, confidentiality could be easily broken. Therefore, it is everybody's responsibility to ensure confidentiality is maintained (NMC 2018).

This case study has discussed the care given to Stephen, referring to two Chapelhow et al. (2005) enabling skills: assessment and communication. It has identified that effective communication was imperative for comprehensive assessments to be reliable and valid, suggesting these skills are not mutually exclusive. Using the case study of Stephen has demonstrated the importance of effective assessment and communication skills. These must be developed to optimise the care delivered. This case study has demonstrated how using different assessments can help assess a patient and their needs to ensure the most appropriate treatment is employed.

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Page | 23

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The Importance of Assessment and Communication as Fundamental Skills of Nursing Practice

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Abstract

Chapelhow et al. (2005) stated nursing assessments are non-static. One of the aspects of the nursing assessment procedure is that a set of customised results are agreed, which can be achieved through established teamwork and efficient communication. The Chapelhow Framework was established around six enablers: assessment, communication, risk management, managing uncertainty, record keeping and documentation, professional judgement and decision making. These enablers help healthcare professionals including student nurses to develop their skills to the best of their ability to deliver holistic and person-centred care. This article will discuss two of the enablers: assessment and communication, exploring the importance of effective assessment and communication, and the barriers highlighted in delivering and upholding the duty of care in the health sector.

Keywords

Assessment, Chapelhow, Communication, Parkinson's disease

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Introduction

This article will discuss the nursing care provided to a 74 year old male patient throughout a hospital placement of five weeks. I will be using a pseudonym throughout this article to ensure patient anonymity and he will be referred to as Mark (NMC 2018). Mark verbally gave full consent to utilize his personal clinical records for this article. The National Institute for Health and Care Excellence (NICE 2017) advise healthcare professionals to obtain and record informed consent from the patient. It was explained to Mark that confidentiality would be maintained throughout, and there would be nothing mentioned in this article that could identify him (NMC 2018). According to Chapelhow et al. (2005), a student nurse will be required to become proficient with the Chapelhow enablers. These enablers are assessment, communication, risk assessment, managing uncertainty, record keeping and documentation and professional judgement and decision making. This article will provide a brief context of Mark's present and past medical history, and then discuss assessment and communication from the Chapelhow et al. (2005) enablers related to the care Mark received and conclude with a summary of key points discussed in the article.

Mark lived with his 64-year-old wife and together they have one daughter. Mark was referred to the respiratory ward with symptoms of feeling unwell, shortness of breath, chest pain, pyrexia, and oliguria from accident and emergency. He had a body mass index (BMI) 24 kg/m² which is within the normal ideal range (18.5 kg/m² – 24.9 kg/m²) for adults (NICE 2014). Van Der Marck et al. (2012) conducted a study in which it is stated that people with Parkinson's disease have a lower BMI but that does not mean that all

Parkinson's disease patients are underweight. According to his medical history, Mark was diagnosed with Parkinson's disease 10 years ago and has been diagnosed with diverticular disease, osteoporosis, asthma and cerebral ischemia. Mark reported forgetfulness and stated that his Parkinson's disease was progressing; hence, he has been in and out of the hospital since the beginning of the year. Parkinson's disease is a slowly progressive neurological disease that begins insidiously and usually asymmetrically without a known aetiology (Grayson 2016). It is also known as shaking palsy with characteristics of physical traits such as rigidity, tremor and shuffling (Grayson 2016; World Health Organization (WHO) 2006).

Assessment

Nursing assessments are an integral part of patient care. It is the initial stage in the process of person-centred care and providing an individualised patient-centred care in nursing practice (Dougherty and Lister 2015). Carrying out the nursing assessment key information such as family, medication, psychosocial, and past and present medical history were recorded in Mark's care plan (Jensen 2018). The data collected helped in the continuity of Mark's care while he was in hospital. As a result, it ultimately enabled nurses to assist Mark in establishing control over his health (Foulds et al. 2015). The assessment process requires nurses to conduct relevant observations, to collect, confirm and organise data and to make judgements to decide care and treatment needs (NMC 2018).

Vital Signs

Mark was assessed using National Early Warning Scores (NEWS). Smith et al. (2017) suggested that all assessments should be repeated on the ward once the patient has been admitted in case of any deterioration. NEWS was used for Mark's assessment with easy-to-measure parameters. Parameters such as level of consciousness and vital signs facilitate early intervention and predict mortality (Day and Oxtan 2014). The Royal College of Physicians (2012) recommend the use of the NEWS assessment tool in the hospital as it has been estimated to save around 6000 lives each year. Also, evidence shows that NEWS can contribute to early detection of sepsis which was ruled out during Mark's assessment (Jones 2017).

Mark was responding to voice and pain, respiratory rate was 20 breaths per minute, oxygen saturation of 75%, blood pressure (BP) 80/53 mmHg, heartrate 60 bpm, and low urine output of less than 400ml over 24hrs. As a result, his NEWS score was 3 and he was put on oxygen. Scoring 3 on NEWS indicates abnormalities and calls for close observation; in this case it was due to Mark's hypotension and oxygen saturation (Day and Oxtan 2014). He was monitored at least every two hours where all observations were repeated as recommended by NICE (2017).

Both NICE (2007) and National Patient Safety Agency (NPSA 2007) recommended that good observations can detect when Mark's condition required further investigation or needed more intense observation. Early intervention can reduce morbidity and mortality rate (NICE 2007; NPSA 2007). Mark's hypotension was due to Parkinson's disease which can cause blood pressure abnormalities such as orthostatic hypotension (low blood

pressure occurs when a patient stands up from sitting or lying down), or postprandial hypotension (low BP that occurs after a meal) (Ziemssen and Reichmann 2010). Jain (2011) and Chen et al. (2014) state that Parkinson's disease patients often have dysautonomia (conditions that affect the autonomic nervous system), neuropsychiatric and sleep disorders (sleep apnoea, insomnia, etc.) that normally influence blood pressure. However, fluids through intravenous therapy (IV) with the aim of increasing his blood pressure to the normal range (120/80 mmHg -140/90 mmHg) and keep Mark hydrated were given as a first intervention. Additionally, a reassessment and monitoring plan was put in place (NICE 2013).

Activities of Daily Living

Part of a nurse's role is to facilitate people to carry out their activities (Foulds et al. 2015). Roper, Logan and Tierney (2000) Activities of Daily Living's (ADLs) framework were used to assess Mark's physical, psychological, spiritual, social and cultural dimensions as it was vital in his assessment (Dougherty and Lister 2015). ADLs are an efficient structure, which recognised Mark's beliefs and individuality. The ADL framework reflects twelve essential ideas and provides a scale in recognition that dependency can change through time (Roper, Logan and Tierney 2000). Dougherty and Lister (2015) advise the use of a logical approach together with ADLs framework as guidance for making decisions professionally. In Mark's case, the nurse utilised the ADL framework to spot a change in the need of care. Due to his forgetfulness, tremor and unstable gait, Mark required assistance with mobilising, personal care and other necessary care needs as explained

by the Department of Health (DoH) (2018). However, Mark was given informed choices, privacy, and his autonomy was respected (NMC 2018).

Nutrition

Meal times are normally challenging as patients are monitored and staff make sure that everyone is in an upright position to eat their meals to avoid choking (NMC 2018). Further assistance is offered to help patients consume their food (NICE 2017). As a student nurse in charge of Mark, I noticed that Mark was suffering from dysphagia (Akbar, Dham and Okun 2013). An immediate referral was made to speech and language therapy (SLT) (NICE 2017). This was because dysphagia can cause chest infection due to aspiration pneumonia (Akbar, Dham and Okun 2013). NICE (2017) recommend early referrals to the SLT team for early intervention and to avoid the occurrence of aspiration pneumonia.

The speech and language therapy team are responsible for assessing patients with speech and swallowing problems (Royal College of Speech and Language Therapists 2006). Mark was assessed by a speech and language therapist using a simple swallowing test. He was given a piece of soft biscuit, and a drink. Movement of his lips, tongue, and the muscles of his throat and swallowing were observed (NHS 2018). There are other assessment tools such as nasoendoscopy and Fibreoptic Endoscopic Evaluation of Swallowing (FEES) but these were not used in Mark's assessment (NHS 2018; RCSLT 2006). The SLT assessment clearly indicated that Mark appeared acutely unwell and was at very high risk of aspiration. As a result, the speech and language therapist recommended Mark to be nil by mouth, a Nasogastric Tube (NGT) to be inserted and regular mouth care to be given for comfort (Martinez-Ramirez et al. 2015).

It was important that Mark had all the required nutrition to prevent malnutrition (NICE 2017). Mark was referred to a dietician for specialist advice to avoid a reduction in his total daily protein consumption. The dietician recommended a nutritional requirement (Henry BMR (energy) 2030/day, protein 75-110g/day and fluids 2125ml/day). It was important that Mark's weight was kept under close observation as good BMI does not indicate a good nutritional status. Even though his weight is normal, he may still be at risk of malnutrition (Ådén et al. 2011).

However, the results were evaluated continuously to monitor Mark's development and clinical judgement was used to adjust these outcomes where necessary to tally with Mark's needs (Burman 2010). The effectiveness of nursing assessments depends on good communication skills between the multidisciplinary team (NMC 2018).

Communication

Communication is a two-way process which occurs between the sender and the receiver and the message sent (Bach and Grant 2011). Communication was an essential part of Mark's everyday life and a crucial element of the good nursing care that Mark received (Bach and Grant 2011).

This enabled me to establish a therapeutic relationship with Mark which facilitated the gathering and sharing of information and ideas regarding Mark's health (NMC 2018). Due to Parkinson's disease Mark's speech was slurred, hoarse, unsteady and quiet (NICE 2017). He found it difficult to control how quickly he could speak or to start talking and

part of the speech and language therapist assessment report showed that Mark's speech and volume was low.

It was known by staff that communication might be challenging for Mark. During assessment he was allocated a cubicle for privacy and dignity as per NMC (2018) *Code of Conduct* to provide a quieter environment. Additionally, patient dignity can be promoted by allowing him to express his concerns in a safe, quiet and private environment (Dougherty and Lister 2015). Based on the ideas of Arnold and Underman Boggs (2011), active listening, observation skills, verbal and non-verbal exchanges of information are some elements nurses must consider. When communicating with Mark, slow pace was essential. It was important to ensure he could see your face, make eye contact and listen attentively (Baillie and Black 2015). Active listening kept him engaged while communicating, and was essential when conducting observations, paying attention to his tone, rate and depth of speech (Dougherty and Lister 2015). Reflecting on what had been agreed helped Mark to remember, recognising his legitimate contribution to the discussion (McCabe and Timmins 2013). On the other hand, Silverman, Kurtz and Draper (2013) argue that overuse of reflection technique can be inappropriate.

Closed questions were used to make it easy for Mark to respond (Baillie and Black 2015). It is difficult with Parkinson's disease to gather information to answer questions (NICE 2017). Dougherty and Lister (2015) suggested the use of closed questions for people with communication problems, as open questions might be inappropriate for them. Therefore, when communicating with Mark, it was vital to speak slowly, clearly, carefully and most

importantly be patient (NMC 2018; McCabe and Timmins 2013; Dougherty and Lister 2015; NICE 2017).

Non-verbal communication includes sitting or standing up, facial expression, gestures and postures, whether it is a nod or smile can influence the whole communication (Dougherty and Lister 2015). The elements of non-verbal communication can be represented by the acronym SOLER meaning: Squarely face the patients, maintain Open posture, Lean forward slightly to show interest, maintain Eye contact (if it is culturally appropriate), and Relax. Dougherty and Lister (2015) also highlight that non-verbal communication is more important to patients who are verbally impaired. Mark often made gestures like nodding his head, rolling his eyes and occasionally used his finger (Egan 2013). During this time, it was important to acknowledge these gestures by verbally indicating that you were paying attention to him (NMC 2018). Missing the signs could make Mark anxious and stressed (Egan 2013). Berridge and Liddle (2010) emphasise that nurses must be aware of actions which may cause patients to lose interest, become aggressive or stop communicating as it may affect their health.

It was important for Mark and the care team to know the right time to communicate with him. Knowing the right time is a necessity to effective communication in both the sender and the receiver to communicate efficiently (Baillie and Black 2015). During placement, the best time to communicate with Mark was late mornings following his morning medication. This is because some of his medication such as levodopa and dopamine agonists help to improve his speech and reduced his tremor, making him become more relaxed and less anxious (NICE 2017). In contrast, dopamine agonists carry a high risk

of hallucination and delirium and a medication review is recommended if this should become uncontrollable for the patient (NICE 2017). However, it was essential to consider the side effects to be able to interact with Mark and to make sure it was the right time to achieve effective communication (Berridge and Liddle 2010).

Communication is not just limited to the nurse-patient relationship but also includes communication with other team members (NMC 2018). The NMC (2018) stated that effective communication within the multidisciplinary team was vital to health care provision. Berridge and Liddle (2010) advise nurses to communicate with other health care professionals such as doctors, SLT, physiotherapists etc. Thomas, Pollard and Sellman (2014) also state that nursing staff are at the heart of communication in health care. Nurses assessed patients and reported back to other health care professionals (Wheeler 2013). Moreover, they can increase patient compliance, satisfaction, cooperation, and acceptance with the multidisciplinary team (Berridge and Liddle 2010). Thus, it improves the physiological and functional status of the patient and the NMC (2018) state that it is important to share information for the best interest of the patient and to achieve quality of care.

Barriers to Communication

There are so many barriers that can affect communication and assessment in nursing practices (NMC 2018). On the other hand, there are barriers that can hinder the patient care (Ballie and Black 2015). In Mark's case there was a problem with poor documentation on the NGT. As a result the NGT was removed and had to be re- inserted

causing pain and discomfort for Mark in addition to the omission of some of his nutritional requirements which he received via his NGT.

An effective assessment depends on good communication, efficient staff numbers, training and equipment needed, well-known networks and continuing staff training (NICE 2007). Nevertheless, the main component is communication. Lack/ineffective of communication during patient assessment is problematic and causes many problems that can result in patient complication or death (Ballie and Black 2015). The NMC (2018) advise nurses to maintain appropriate documentation and communication to avoid such problems. A good example is the inquiry of the Mid Staffordshire hospital (Francis 2013). Many deaths could have been prevented if there had been active communication between agencies (Francis 2013). The inquiry reported that the responsibilities and roles were not communicated clearly (NMC 2018). The warning signs were not communicated which resulted in the poor assessment of the critically ill and critically injured patients within the trust (Francis 2013).

Barriers such as education level, preconceptions, cultural and religious, environment, listening habits, and language are some of the many restrictions that can hinder effective communication (Bramhall 2014). Lack of privacy and time, background noise and competing demands are all possible obstacles to effective communication between patients and nurses (Arungwa 2014). Much information is picked up from a speaker's facial expression, their body language and posture (Bramhall 2014). Consequently, staff might have misinterpreted Mark's mood and feelings due to his altered hand gestures, reduced facial expression or body posture because of his medical condition (NICE 2017).

To overcome some of these barriers, Coleman and Angosta (2016) and Hemsley, Balandin, and Worrall (2012) suggest that nurses dedicate extra time and determination to communicate efficiently. This was employed for the improvement of Mark's physical and mental health. Coleman and Angosta (2016) identifies that nurses can overcome the barriers of communication with the right experience and education.

Conclusion

In conclusion, effective assessment and communication are very important and unavoidable in delivering and upholding the duty of care in the community healthcare and primary health sector. I can relate to the emphasis made by the NMC (2018) and the importance which Chapelhow et al. (2005) place on assessment and communication in nursing practice. Nurses should be able to develop interpersonal skills and relationships with patients, colleagues and patients' families for there to be competency. Therefore, nursing communication and assessment must be done simultaneously as one cannot be done effectively without the other.

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Using Two Chapelhow Enablers to Deliver Care

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Abstract

This article will demonstrate how two of the six Chapelhow et al. (2005) enablers were utilised throughout the care of one individual. The two enablers that will be considered in this article will be communication and professional decision making. This article will use both experience from placement and current research to inform practice to demonstrate how these enablers were used in practice. Communication and professional decision making enable healthcare professionals to deliver effective and efficient care. This article aims to enable healthcare students to develop their understanding of how these two enablers are used in practice and to raise awareness of their importance.

Keywords

Chapelhow, Assessment, Waterlow, Communication, NEWS, Decision Making, Clinical Judgement,

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Introduction

The enablers proposed by Chapelhow et al. (2005 cited in Lovell 2016) collectively comprised a Meaningful Assimilation of Skills for Care Model (MASC) that aims to identify the central elements for the effective and efficient delivery of skills in nursing. These 'enablers' are simplified and explained in the model and include: assessment, record keeping/documentation, communication, risk management, managing uncertainty and professional decision making (Lovell 2016). Within clinical practice, a nurse's work is shaped by the professional frameworks within which he/she must operate. This case study will explore the processes, issues and outcomes of nursing assessment and professional decision making over a period of 5 weeks as these are paramount to the chosen patient's needs. As recommended by the Nursing and Midwifery Council's (NMC) Code of Professional Conduct (2018), verbal consent was sought from the ward manager who oversaw the care of this patient as the patient was unable to give consent due to being deceased; patient confidentiality is maintained throughout via the use of a pseudonym.

Contextual Information

Mr. Douglas was an 82-year-old man from a working-class background; he fought in the war and was exposed to an extreme amount of stress. Den-Velde et al. (2011) found that the morbidity and mortality rates of war veterans was approximately 35.5% higher than a randomly selected population-based sample of similar aged males, suggesting that Mr. Douglas had a higher risk of developing illness due to his past. The only other significant factor that could have had an impact on Mr. Douglas' health was smoking which he was

addicted to for 30 years before stopping in 1995. Den-Velde et al. (2011) also proposed that smoking was the single, greatest contributor to mortality in people over the age of 60. Cox (2010 cited in Lovell 2016) states that collecting an accurate medical history is a critical diagnostic tool. Although Mr. Douglas had been generally well throughout his life, a fall in December 2017 resulted in a dislocated left hip and a fractured right elbow, which subsequently led to the identification of multiple health-related issues which had not been previously addressed.

Assessment

Nursing assessment is the systematic and continuous compilation and documentation of information (Berman, Kozier and Erb 2010) including a complete set of examinations that provide information about a patient's physiological, psychological, spiritual and sociological health (Weber and Kelley 2010). An assessment is usually carried out by a registered nurse or doctor at the beginning of a patient's care and the results are used to identify issues/treatments that a patient may have or need (Weber and Kelley 2010). Mr. Douglas was admitted to Accident and Emergency (A&E) before being moved to the orthopaedics ward where he waited for his x-ray. It was unclear how long Mr. Douglas would be waiting to get a diagnosis due to an increase in waiting times for x-ray results; a survey conducted by the Royal College of Radiologists found that 330,000 in/outpatients across a range of NHS trusts waited up to a month to receive x-ray results, including computerised tomography (CT), magnetic resonance imaging (MRI) and ultrasound scans (Mayor 2015).

The first assessment Mr. Douglas received on the orthopaedics ward was called the National Early Warning Score (NEWS) (Mitchell, McKay and Van Leuvan 2010). NEWS scores collect quantitative data that indicate any significant concerns regarding a patient's general health. NEWS scores have been refined to enhance early detection of patient deterioration. They are used to categorise the severity of illness and prompt nursing staff to alert medical staff if required (Mitchell, McKay and Van Leuvan 2010). NEWS scores are based on a scoring system which relates to the measurement of physiological factors: respiration rate, oxygen saturation, pulse rate, systolic blood pressure, temperature and level of consciousness or new confusion. A score is assigned to each parameter as it is measured; the higher the score the greater the deviation from the norm (Royal College of Physicians 2017). Mr. Douglas' observations were measured routinely, these measurements included: blood pressure, heart rate, oxygen saturation, respiration rate, temperature and AVPU (alert, voice, pain, unresponsive) (National Clinical Effectiveness Committee 2014).

Most staff within acute hospital trusts carry out NEWS measurements and take appropriate action if necessary; however, there are multiple barriers which may hinder the effectiveness of the NEWS assessment tool. For example, Spiers et al. (2015) conducted a study on 1,000 adults experiencing serious illness across several acute hospitals and estimated that an average of 1 in 20 deaths (5.2%) were preventable if the NEWS tool had been implemented accurately (if the results gained from patients were recorded precisely and responded to immediately). It was important that the roles and responsibilities of healthcare staff were clearly identified and the communication process following the identification of any problems was quick and efficient; any delay of vital

information, such as Mr Douglas' previous NEWS scores, could have had a profound effect on his health (National Clinical Effectiveness Committee 2014). Because NEWS scores don't always give an accurate indication of whether something is right or wrong, it was critical that the healthcare staff were able to identify changes in Mr. Douglas' behaviour and deviations from his normal observations. Buykx et al. (2011) suggests that a nurse can identify the deterioration of a patient using her own qualitative and subjective clinical judgement, for example, by recognising a change in how a patient looks and behaves. NEWS should be used as a tool and supplemented by professional knowledge to gain the most efficient care.

Following the initial assessment of Mr. Douglas, his nurse had to complete his admission paperwork which included a range of assessments, such as a bed rail assessment, a Waterlow chart and a pain chart. Some of the questions asked in this process were of a private/intimate nature, which could have made Mr. Douglas hesitant to answer honestly. As proposed by *The Data Protection Act* (1998), it was important for the nurse to emphasise confidentiality and inform Mr. Douglas that his information would only be shared with the necessary people to guarantee effective care could be maintained. Establishing a therapeutic relationship was essential for the maintenance of trust between the nursing staff and Mr. Douglas (Doherty and Thompson 2014) and this is found to be a key factor when gathering relevant and accurate information (Silverman, Kurtz and Draper 2013).

A Waterlow chart was used to measure Mr. Douglas' risk of developing a pressure ulcer

and this suggested that his risk was increased. Because of this, Mr. Douglas was provided with an air mattress and was repositioned as often as possible (NICE, 2018). As recommended by NICE (2018), Mr. Douglas was encouraged to change his position frequently but due to his lack of mobility, he was offered help to make sure this was done every 4 hours. However, because of the increasing pain he was experiencing, Mr. Douglas often refused to be rolled and therefore, other methods of pressure ulcer prevention, such as barrier creams, were used to prevent moisture lesions and sores due to incontinence and dry skin (Burch 2015).

From day 1 to 6, Mr. Douglas had a maximum NEWS score of 3; Mr. Douglas was scoring 1 for low blood pressure, 1 for low heart rate and 1 for a high respiration rate. Although this score would be concerning for most people, the healthcare staff felt that this wasn't a major cause for concern as Mr. Douglas presented himself as alert and generally well. On day 7, nurses were concerned as Mr. Douglas had a severely low blood pressure (systolic number was below 80, possibly due to an internal bleed or dehydration) and he was vomiting, light-headed, breathless and tired very easily, resulting in a score of 5 on his NEWS chart. It was Trust policy that a score of 5 should be followed up immediately with a call to the Medical Emergency Team (MET). The MET would assess the deteriorating patient closely and take the appropriate medical pathways. In a study of 370 patients, 18.9% of them had an incorrectly calculated NEWS score, which could have been due to inaccurate assessment of patients or no assessment at all; furthermore, an appropriate clinical response was only seen in 74.1% of cases that required medical attention (Kolic et al. 2015). Normal saline (sodium chloride and water) is normally used

intravenously for dehydrated patients who are struggling to consume any food or liquids. It was used to rehydrate Mr. Douglas and stabilise hypotension until the medical staff could determine its cause.

After a series of blood tests and physical examinations, doctors concluded that although they could put Mr. Douglas' arm in a sling, they were unable to put his hip back in place due to his current poor health. After 4 weeks of managing his pain with oral and intravenous (IV) analgesia, Mr. Douglas began to excrete blood from his rectum. Rectal bleeding has a positive correlation with colorectal malignancy and 8% of patients aged 50 years and over who present with rectal bleeding are diagnosed with colorectal cancer (Royal College of Surgeons 2013). Mr. Douglas underwent an examination of his abdomen to exclude abdominal mass and had a colonoscopy. He was then referred to a specialist consultant based on initial presentation and the results of his tests. This was followed by more baseline blood tests, such as a full blood count.

After a few days under investigation, the consultant found that Mr. Douglas had an upper gastro-intestinal (UGI) bleed that had been caused by a malignant stomach tumour, which was also the cause of his hypotension. Because of this, the staff on the orthopaedic ward felt a move to a gastrointestinal ward was appropriate. This caused a barrier to effective treatment as moving Mr. Douglas meant he became uncomfortable and confused. Furthermore, it had taken a week before healthcare professionals recognised that he had multiple underlying health issues that required reviewing; this delay may have influenced the effectiveness of any future treatment. On transfer to another ward it is crucial all the

documentation is present to ensure continuity of care (Kripalani, Yao and Haynes 2007). Failure to communicate effectively at the transfer stage could have adversely affected the treatment that Mr. Douglas received.

Professional Decision Making

Each day we make judgements based on what we observe and what we know; when these perceptions are implemented in practice, they become 'clinical judgements' (Thompson and Dowding 2009). The process of making a judgement includes: observation of a patient's vital signs (such as Mr. Douglas' NEWS score), medical history, test results and behavioural changes (Lovell, 2016). It was only after observing Mr. Douglas and informing him of their findings that the team could validate their perceptions and make appropriate clinical judgements and decisions (Dougherty, Lister and West-Oram 2018). Based on clinical judgement, the medical professionals who were caring for Mr. Douglas decided that his condition was deteriorating quickly. The Royal College of Nursing (2008) propose that the aim of professional decision making is to improve, maintain or recover health and to ensure the affected patient leads the best quality of life until their death, and therefore, it was paramount for the healthcare staff to consider what would benefit Mr. Douglas most.

Within the *Mental Capacity Act*, the Department of Health (DoH) (2005) states that a person must be assumed to have capacity, unless proven otherwise. *The Mental Capacity Act* also suggests that a patient has the right to decide even if the decision is seen to be unwise and these decisions should be respected unless it could cause harm to their health (DoH 2005). Mrs. Douglas stated that she believed her husband lacked capacity due to

recent memory loss and confusion. To overcome this barrier, he completed a 'mini-mental' test, along with several other assessments (Mitchell et al. 2014). His results suggested that he did not have dementia and was able to make his own decisions regarding his health. Mr. Douglas' family were encouraged to aid him when making decisions but advised to refrain from influencing them. It is found that when relatives take part in the decision-making process, it helps the nursing staff individualise, and therefore improve, patient care (Mitchell and Chaboyer 2010).

By week 4, and after numerous episodes of rectal bleeding, the palliative care team were advised to speak to Mr. Douglas and his family about developing an 'Advanced Care Plan'. The concept of palliative care was introduced by Dame Cicely Saunders in 1967 and has now developed to provide high quality care and services for patients who are at the end-of-life (Faull et al. 2012). Mr. Douglas required primary care and the team were advised to follow *The End-of-Life Care Strategy* which is a pathway used in England and Wales to optimise continuous high-quality care during a patient's last days, weeks or months of life (Faull et al. 2012).

Advanced care planning is a process which involves the patient, their relatives and the healthcare team. It is predominantly associated with preparation for future incapacity and supports the holistic practice of multidirectional communication between those involved in the patient's care, to ensure their needs and requests are met (Faull et al. 2012). It was crucial for Mr. Douglas to make his own decisions regarding his care with support from the team. As medical professionals, the staff involved in Mr. Douglas' care evaluated his

condition using questions such as: 'Is the patient dying?', 'Are they comfortable?', 'What do we need to decide?', 'What do we need to anticipate?' and 'Have we spoken to the patient and their relatives?' (Faull et al. 2012). OMEGA (2009) found that only 27% of patients who died had been identified as needing an advanced care plan. Out of these, only 58% were involved in their end-of-life care and only 42% had their preferences recorded.

During the advanced care planning process, the issues surrounding cardiopulmonary resuscitation (CPR) naturally became the focus of many conversations. As advised by the medical staff, a 'Do Not Attempt Resuscitation' (DNAR) order was put in place for Mr. Douglas and a sensitive discussion between him, his family and the consultant in charge of his care took place. After coming to terms with his terminal illness, Mr. Douglas decided that he would like to spend his last days at home. In a retrospective study of two practices in Leicestershire (Exley, Field and McKinley 2003) 95% of patients had requested to die at home and 77% of their carers felt that this was the right decision, suggesting that many patients feel most comfortable in a more familiar environment, but possibly indicating that some carers believe that the patient would benefit more from being in hospital.

After the palliative care team had spoken with Mr. Douglas and his family, Mrs. Douglas followed the nurse out of the room and confided that she felt that Mr. Douglas should stay in hospital, as she would be unable to care for him at home having recently suffered a heart attack herself. McAndrew, Leske and Schroeter (2016) suggested that nursing staff engender a moral obligation to reduce the suffering of patients during end-of-life; conflict

and uncertainty around this professional decision making is the cause of such moral distress. Due to increasing confusion and disorientation of Mr. Douglas over the next few days, the healthcare team felt it would be most appropriate to hold a 'best-interest' meeting regarding his advanced care plan. A best interest meeting is carried out when a person lacks capacity (Griffith 2018). The people involved were his doctor, nurse, family members and other people who cared for and had knowledge about him. The decisions made during this meeting were based on existing knowledge of his wishes and values and allowed all parties involved to voice their opinions and come to the agreement that a hospice would be the most suitable place for him to receive end-of-life care.

Conclusion

In conclusion, all six of the Chapelhow et al. (2005 cited in Lovell 2016) enablers are vital when providing effective nursing care. This case study proposes that without efficient assessment, it is impossible to make beneficial, professional decisions. Furthermore, nursing staff should be educated on how assessment tools work and consult with other medical professionals if they feel that something is wrong; it is made apparent in this case study that not all clinical judgements and assessments should be based on outcomes from tools such as Waterlow; therefore, a nurse's judgement of the patient should be recognised as being equally important. However, nurses should always follow the legal and ethical guidelines when making professional decisions such as data protection and confidentiality, and should not allow their own moral conscience to affect their clinical judgements.

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How Chapelhow Enablers Contribute to High Quality Care

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Abstract

The six Chapelhow enablers were developed to assist student nurses and other healthcare professionals to be able to develop essential skills needed for the successful delivery of care. These six enablers are assessment, communication, risk management, managing uncertainty, record keeping and documentation. This article discusses the preoperative care of a seventy-year-old patient undergoing cataract surgery, in relation to two enablers: assessment and communication. It will then discuss the factors which contribute to raised anxiety levels in the perioperative period, and how assessment and communication are linked. The article concludes with a discussion of the importance of holistic, person-centred care in reducing anxiety.

Keywords

Anxiety, Assessment, Communication, Chapelhow,

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Introduction

This article will discuss the nursing care that was provided to an individual based on two Chapelhow et al. (2005) enablers. These are assessment and communication as these were significant skills involved in the care. Consent was gained from the patient to discuss their care in accordance with the Nursing and Midwifery Council (NMC 2018). The patient will be referred to as Joan. Firstly, there will be a brief introduction to Joan's care, followed by discussion of the issues that arose regarding communication and assessment, and the link between these. The conclusion will summarise the main themes discussed.

Joan was a seventy-year-old lady who lived alone. She was referred to the cataract clinic after a diagnosis of cataracts from her optician, which led to her pre-planned admission to the day surgery ward. She found that her vision was becoming increasingly blurred over time, which was having an impact on her ability to do certain activities she enjoyed such as reading and knitting. Her medical history stated that she had previously suffered with anxiety and had previously had high blood pressure which was now deemed to be within normal parameters. Joan was short-sighted and therefore required glasses for day-to-day use. It was suggested that she could request some sedation on the day as she was becoming quite anxious at the thought of having the operation.

Assessment

A holistic approach to nursing assessment ensures the patient's entire experience is

taken into consideration rather than just their diagnosis, which is vital to improve the patient's journey (Lockey and Hassan 2009). The nursing assessment enables the nurse to monitor a patient's condition. Such assessments can help the nurse identify relevant nursing interventions for the patient such as increased frequency of observations that can lead to early detection of bleeding and infection (Scott, Matthews and Kirwan 2014). It is important patients with eye problems are fully assessed and documented which includes thorough history taking and eye examinations (Watkinson and Seewoodhary 2007).

When Joan arrived on the ward, her observations were assessed and recorded using a National Early Warning Score (NEWS) chart which records respiration rate, oxygen saturations, systolic blood pressure, pulse rate, level of consciousness and temperature (Royal College of Physicians (RCP) 2017a). As stated by the RCP (2017b), NHS England have approved the NEWS to be used as a system to monitor patient observations in order to detect any deterioration. This is assessed by giving a score to each of the patient's observations. The NEWS indicated that Joan's systolic blood pressure was one hundred and seventy-one which scored a zero (RCP 2017a). Although her blood pressure was not giving a warning score, the recording was elevated and the nurse in charge was informed. It was advised that her blood pressure should be taken again once Joan had settled onto the ward. However, it is highlighted by Motiang (2013) that blood pressure should be well controlled before the patient's scheduled admission, rather than taking multiple readings after admission until blood pressure is at a satisfactory level.

A report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) stated that the NEWS system should be used to monitor a patient's condition, but it is vital to be aware of the patient's physical state (NCEPOD 2005 cited in Morris and Davies 2010). In the case of Joan, she was very clearly anxious about her anticipated cataract operation. This could have contributed to her elevated blood pressure reading as stress and anxiety can affect homeostasis (Ko and Lin 2011).

On completion of her baseline observations, biometry was performed to determine what Intra-Ocular Lens (IOL), would be used in theatre. Biometry involves measuring the corneal curvature and the axial length of the eye using specialised machinery (Lockey and Hassan 2009). The patient is required to place their chin onto a rest, and their forehead into a frame which could look quite invasive although, this process was non-contact. The nurse told Joan to take a seat and said we would be taking measurements of her eye. The nurse placed Joan's head into the correct position and did not explain what would be happening during the measurements. At this point, Joan appeared to be distressed, not knowing what was happening. The use of the equipment to assess which IOL implant would be used in theatre was relatively fast and provided immediate and reliable results (Lee et al. 2008 cited in Millbank 2011). However, as highlighted by Millbank (2011), explaining what the procedure was during the measurement and why it was done before performing the biometry, may have helped to reduce Joan's anxiety. If the nurse had recognised Joan's anxieties, she could have taken the time to explain the measurement to Joan, which may have reduced preoperative stress (Oakley and Pudner 2010). Preoperative anxiety experienced by Joan could have affected her

recovery as preoperative stress is associated with increased postoperative pain which consequently, requires postoperative analgesia (Kil et al. 2012 cited in Alanazi, 2014).

Although patient assessment is an important skill which all nurses must have, it can be time consuming for nurses who are working under increased workloads with several complex patients to care for (Ansell, Meyer and Thompson 2015). As there is only a short amount of time for nurses to assess and plan the care that is required for the patient on the day surgery unit, feelings of anxiety and fear may be missed due to physical aspects of their care becoming the priority (Oakley 2010). As a result, patients may experience more anxiety as they only have a short time in which to prepare for their surgery (Foss and Bernard 2012).

There were two lists happening on the ward on the day that Joan was attending, meaning there were around twelve patients in total. Therefore, her assessments were rushed as they had to be fitted into a short time frame and her psychological feelings were missed (Mottram 2009). Effective assessment on the ward would involve the nursing staff, doctors and anaesthetists working together as a team to ensure continuity on the patient journey (Edwards et al. 2008 cited in Woods 2018). Even under increased pressure, the NMC (2018) emphasises the importance for nurses of collaborating with other healthcare professionals so that they can support patients. This ensures that both their physical and emotional needs are assessed and met (Lockey and Hassan 2009).

Communication

Successful and effective communication in nursing ensures that good quality care is given, and that a patient's anxieties and concerns can be expressed and understood (Jones 2012). The Department of Health describes communication as the process where two people discuss thoughts, feelings, opinions and other information both verbally and non-verbally, including written communication (Department of Health, 2010 cited in Jones 2012). In the day surgery setting, it is important for nurses to assess the patient's needs for information so that these can be addressed appropriately (Martin 2007). This may include, for example, empowering the patient to ask questions throughout, or assessing their ability to communicate, with the aim of patient understanding (Martin 2007). Patients find that good communication happens when they feel the nurse is listening and understanding, allowing them enough time to understand and explain, not when they feel rushed and that they do not have the full attention of their nurse due to other factors (Moulton 2008).

The nurse taking Joan's observations approached her and stated that she needed to take her blood pressure, then proceeded to place the blood pressure cuff onto her arm. The NMC (2018) states the importance of gaining consent before commencing any physical interventions. Whilst the nurse was carrying out her observations, Joan appeared very quiet and visibly anxious about the whole situation. Martin (2007) highlights that a patient's non-verbal communication cues such as Joan's facial expressions and posture could convey her worries or fears.

A significant element in preparation for surgery is to ensure that the patient is

psychologically prepared for theatre in addition to being fit for surgery (Pritchard 2009). It is vital for nurses to have excellent communication skills which enable them to recognise when a patient is feeling vulnerable and be able to respond with compassion and empathy (Pavord and Donnelly 2015).

The National Institute for Health and Care Excellence (NICE 2017) guidelines on cataract surgery state that patients should be given both oral and written information on what cataracts are, how long the procedure will take, potential risks and benefits, potential post-operative support, the recovery time and the intended outcome prior to their cataract surgery. Joan had received this information but was overwhelmed with how much she was given and therefore had not really understood much, hence her anxious feelings (Sudore and Schillinger 2009). According to Ozlu, Tug and Yayla (2016), one of the major contributing factors to pre-operative anxiety in cataract surgery is fear of not knowing what to expect from the surgery. Emotional distress before surgery can arise from patients not being provided with enough information both verbally and written (Ozlu, Tug and Yayla 2016). As Joan was very anxious about what to expect from her surgery, explanations about the surgery were given to her and this helped to reassure her (Pritchard 2009 cited in Renouf, Leary and Wiseman 2014). It was explained to her that consent would be needed and if she needed further explanations she would be given them as they can help people to remember what has been said to them (Martin 2007).

Once Joan had been admitted to the ward, she was taken to a bay so that we could go

through her consent form and take her medical history. The curtain was pulled around her bed space which had seats and a small table. The environment had lots of background noise from other patients and members of the multi-professional team therefore, we attempted to respect Joan's privacy as much as physically possible to maintain her confidentiality (NMC 2018). As the nurse was trying to talk above the noise, she was speaking rather loud to Joan about her personal information.

Poor consultations that arise from environmental factors could give the patient the impression that the nurse was not really listening to her leading to poor communication (Moulton 2008). Patients may be discouraged from disclosing personal information, if they feel they may be overheard; therefore, it is vital for their privacy and dignity to be respected (Edwards 2011). It is important for barriers like noise to be acknowledged and approached sensitively; although, it may have been more beneficial to take Joan into a quieter space which would have respected her confidentiality more (Pavord and Donnelly 2015).

The cataract procedure was explained to Joan along with the risks and benefits of the operation, so that she could make a decision respecting her autonomy (Cole 2012). Although all the information was given, it was delivered hurriedly due to the noisy environment, and medical terms and words were used which Joan may not have understood. Therefore, Joan may have misinterpreted some information that was given in regards to the surgery (Moulton 2008). Because of this, it is important for nurses to tailor communication for each patient based on their ability to understand and use language to avoid any misunderstandings (Sudore and Schillinger 2009).

Consent was required from Joan which was signed and dated by the consultant requesting the procedure as well as Joan (Smith and Parkhouse 2018). Consent demonstrates that the patient is aware of what the procedure entails, risks associated with the surgery and that they agree that the procedure can be carried out (Anderson 2010). With the background noise acting as an interference whilst obtaining the consent, it was unclear whether Joan had fully understood all the information that was delivered. It would have been beneficial to prompt Joan to ask questions if anything was unclear to clarify her understanding (Martin 2007). This would have ensured that Joan had felt involved in the decision-making process after she had been provided with all the information (Joolae, Faghanipour and Hajibabae 2015).

The Chapelhow enablers that I have discussed, assessment and communication, link together in many ways. To effectively assess a patient's condition, Stevenson et al. (2016) state that it is important to document vital signs including respiratory rate, heart rate, systolic blood pressure, temperature and altered mental state. This is significant in recognising any patient deterioration (Stevenson et al. 2016). The NEWS chart generates a National Early Warning score, which triggers a clinical response (RCP 2017b). Nurses can then escalate this to the Medical Emergency Team based on the score if necessary. Joan's observational readings scored a one which triggered a response of informing the nurse and a requirement to repeat these observations (RCP 2017b).

For nurses to communicate effectively, they need to assess an individual's ability to

communicate, which may be affected by barriers such as understanding or physical factors like hearing and sight (Martin 2007). Nurses not only have to verbally communicate, it is important to assess the patient's understanding of what has been said which can be by: tone of voice, facial expressions and body language (Jirwe, Gerrish and Emani 2010). Joan's eyesight could have been affecting her ability to communicate as her vision was poor due to her cataracts. Therefore, she might not have fully understood the importance of certain information due to not being able to read non-verbal communication such as body language and eye contact. Assessing a patient's ability to communicate when attending for ophthalmic surgery allows the emphasis on certain factors of non-verbal communication, such as tone of voice, to reinforce important information and to establish an effective understanding (Knight and Hart 2010).

Sometimes information that needs to be discussed can be sensitive or complex; therefore, it is vital that nurses assess an individual's physical and emotional state, to establish the most appropriate way to deliver this information (Weaver 2010). Different individuals have different ways of coping with anxiety so when nurses assess and establish an individual's coping technique, they can decide how to appropriately give the information to the patient (Oakley and Pudner 2010). As previously discussed, Joan was feeling extremely anxious about her cataract surgery and wanted to gather as much information as possible which according to Oakley and Pudner (2010) may have helped her to feel more in control of the situation. As anxiety can impact on communication, it is vital that nurses carry out an assessment whilst communicating and

attempt to form a therapeutic and trusting relationship with their patient to encourage a discussion about their anxiety issues (Weaver 2010).

The importance of considering the patient holistically for eye surgery and not just by their presenting condition is essential in improving the patient's quality of care and their overall journey (Lockey and Hassan 2009). Anxiety, a main focal point throughout this article, is common in cataract surgery as the risk of vision loss is feared by patients (Ozlu, Tug and Yayla 2016). Using empathy and compassion can reduce a person's anxiety (NMC 2018). The care that Joan experienced has allowed me to reflect that patients are individuals and not everyone has the same coping technique (Oakley and Pudner 2010). These skills discussed when practised effectively, will help to better prepare the patient for surgery.

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Proposing a change to oral care for patients undergoing chemotherapy

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Abstract

Oral mucositis is a common side effect for patients living with blood cancers receiving high dose chemotherapy. However, studies have shown that maintaining good oral care during chemotherapy can help reduce the likelihood of this painful condition developing. This article will explore the importance of effective leadership to successfully implement a change in practice. Its aim is to improve the oral care of patients undergoing chemotherapy and reduce the risk of oral mucositis. By implementing this change in practice, health care professionals can have a positive influence on patient care, incorporating the evidence-base of good oral care management.

Keywords

Mucositis, Oral Care, Chemotherapy, Change Management, Leadership,

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Introduction

Oral care in patients with blood cancers undergoing chemotherapy is an area of particular interest to me. I have witnessed the poor management of oral care in patients receiving chemotherapy and the negative impact it can have on their experience in hospital. During treatment, patients are prescribed various mouthwashes, gels and sprays with limited guidance on how and when they should be used. As a result, I found many patients and health care assistants neglected mouth care or did not use the mouthwashes as prescribed as they were unsure how to use the various treatments.

Care plans should include mouth care for those receiving high dose chemotherapy (Health Education England 2016). Despite this, there are no national clinical guidelines or protocols published by the National Institute for Health and Care Excellence (NICE) to support the delivery of high standards of oral care for patients receiving high dose chemotherapy. This is an important issue in nursing due to the risk of patients in this group developing oral mucositis. Riley et al. (2015) found that over 75% of patients receiving treatment are affected by oral mucositis, causing inflammation and ulceration of the mouth, leading to severe pain and difficulty eating and drinking. Due to this condition patients often need artificial hydration and nutrition. Additionally, these patients have a weaker immune system, so there is a high risk of them developing life-threatening infections through these ulcers. These complications can lead to a prolonged stay in hospital and disruption to patients' cancer treatment, meaning they are not receiving the best possible treatment. However, studies have shown that maintaining good oral care during chemotherapy treatment can help reduce the likelihood of oral mucositis (McGuire

et al. 2013; Lalla et al. 2010).

This change aims to implement a system in clinical practice which will improve oral care thus reducing the risk of oral mucositis in this group of patients.

The Change Management Process

Effective management is essential during periods of change. Change management is described by Stanley (2016) as the way we deal with or direct change. The change management process involves using tools and models, which entails recognising the need for change, analysis of the available options, preparation and planning for the change, identifying strategies for implementing the change, evaluating and monitoring its impact and sustaining the change (Gopee and Galloway 2017). It is important to plan the process of change in detail as this can impact on the success rate, as well as helping to avoid unexpected issues/challenges. Having a plan that details every step of a proposed change, and timescales, enables you to check whether you have thought of everything including resources and support needed and whether milestones are reached (Hewitt-Taylor 2013). This is supported by Persily (2014) who claims that changes often fail due to lack of planning and change agents taking an unstructured approach to implementation.

Leadership

In addition to good change management, effective leadership is also needed for change to be successfully implemented and sustained. Gopee and Galloway (2017) define leadership as individuals who can influence and motivate so that goals can be achieved

in the workplace. Conversely Barr and Dowding (2016) believe that leadership can be viewed from various perspectives such as a characteristic trait, the qualities a person may have or the effect someone has on group behaviour.

When analysing the literature on both leadership and management, it is evident that both concepts are beneficial when used together to implement change. Daly, Speedy and Jackson (2015) state that the two concepts must be integrated for managers and leaders to function and implement change effectively. This is underpinned by the Nursing and Midwifery Council (NMC) Code of Conduct (2018) which states that nurses must provide leadership to ensure people's wellbeing is protected and to improve their experiences of the healthcare system.

Leadership and management can be interchangeable in the workplace. Kelly and Tazbir (2014) state that positive and effective leadership is often apparent through the leader's characteristics or personal traits, their leadership styles or leadership behaviours. There are two main leadership styles: transactional leadership and transformational leadership (Gopee and Galloway 2017). These leadership styles refer to the particular ways in which individual leaders conduct themselves in leadership positions.

Transactional Leadership

Transactional leadership is described by Gopee and Galloway (2017) as a style of leadership in which leaders aim to achieve organisational goals, following policies and

procedures by setting clear objectives and expectations for followers. Rewards and incentives are used to enhance employee performance and influence staff motivation. In that respect, Barr and Dowding (2016) describe transactional leadership as more of a 'give and take' working relationship between leader and follower, dealing with the basic needs of the organisation rather than the needs of the followers.

A limitation of this leadership style is that higher demotivation and attrition arise when individuals don't feel empowered. There are limited opportunities to make suggestions, which can lead to resentment, increased resistance to change and high staff turnover (Tirado 2013). However, Hartley and Benington (2010) argue that transactional leaders are underestimated and possess important leadership skills and traits such as being authoritarian, directive and focussed as well as clarifying what is expected, focusing on expectations and giving feedback on whether followers are meeting objectives. These skills are particularly useful in organisations where the followers are focussed on achieving clear task objectives or in emergency situations.

Findings from a meta-analytic review conducted by Clarke (2012) suggest that transactional leadership is positively related to improved patient safety, linking it to compliance with rules and regulations, monitoring while taking proactive steps to implement corrective actions.

Transformational Leadership

A transformational leader can inspire and influence followers to work towards common

goals. Curtis, de Vries and Sheerin (2013) claim that the power of transformational leaders comes from their ability to empower, stimulate and motivate others to achieve exceptional work without giving orders. Holly and Igwee (2011) identify transformational leadership as comprising intellectual stimulation by encouraging new ideas, individual consideration of followers, stimulating creativity, leading by example and instilling pride and motivation in followers. In addition, Jasper and Jumaa (2016) suggest that transformational leaders are visionary, self-aware, balanced and confident in breaking professional boundaries to develop a multi-disciplinary team approach to patient care.

Transformational leadership contributes to nursing practice and is associated with improved patient care and high-performing teams. A concept analysis of transformational leadership in nursing conducted by Fischer (2016) revealed that transformational leadership creates a supportive environment, improves job satisfaction and morale resulting in significant reductions in staff turnover and greater job performance. All of which was found to be linked to improved team performance and patient care. Transformational leaders motivate staff to see the good in proposed changes, so this style of leadership can help to reduce resistance to change. There is limited research identifying the potential issues of transformational leadership style. However, Hutchinson and Jackson (2013) suggest that depending on their motivation and vision, transformational leaders can influence changes to poor practice.

Transformational leadership is viewed as the most effective leadership style when implementing change because, while it recognises the importance of rewards, it also

engages followers emotionally and intellectually. However, many believe that effective leaders have both transformational and transactional characteristics, using a combination of the two styles enhancing and complementing each other (West et al. 2015; Hartley and Benington 2010). Applying the right leadership style throughout the various steps of change will influence the implementation and sustainability of the change.

Effective leadership is important when planning change to ensure high-quality care. There must be direction, and effective leadership ensures everyone is clear about what they are required to do. Effective leadership has been linked with good service delivery and patient care as the primary outcome (Armit et al. 2015). Alternatively, poor leadership has been associated with suboptimal clinical outcomes for patients. Francis (2013) raised concerns about the leadership and organisational culture that allowed a large number of patients to be harmed unnecessarily. He also highlighted the lessons that can be learnt to succeed in developing effective leadership and a culture that puts patients' needs first. A key message from this report was that clinical teams perform best when their leaders value and support staff, enable them to work as a team and ensure that the primary focus is on patient care (Francis 2013).

The results of an online leadership self-assessment which I completed suggested that my preferred leadership style was transformational; however, my score for transactional leadership style was only slightly lower. Leadership styles will be discussed at each stage of the change management process to ensure the most effective leadership style at each stage.

Model of Change

I have decided to use Kurt Lewin's (1951) model of change management to implement my proposed change in service delivery. I have chosen this model because it is simplistic and easy to follow and although this model was developed many years ago, it remains relevant today. This model has been criticised for being overly simplistic (Brisson-Banks 2010), but as a novice to change management, I feel this would best suit my change of service delivery. I considered using other models of change management such as the Plan-Do-Study-Act (PDSA) cycle; however, research has criticised the complexity of its use in practice (Reed and Card 2015). Lewin's model involves a three-stage process entailing unfreezing, change/movement and refreezing.

Unfreezing

The first stage of this model involves a lot of preparation and planning to create an ideal environment for the change to take place. Cummings, Bridgman and Brown (2015) state that it involves preparing the team to accept that change is necessary and altering the present stable equilibrium which supports existing behaviours and attitudes. Resistance to change is more likely to arise during the unfreezing stage. Some members of the team may try to resist the change even if the change will improve patient care, due to potential disruption and discomfort. Therefore, the central theme of this stage is to shift people from this 'frozen' state to an 'unfrozen' state (Daly, Speedy and Jackson 2015).

The transformational leadership style will be used for this stage as research suggests this

style is most suited to dealing with conflict and resistance (Doody and Doody 2012). Moreover Bach and Ellis (2015) suggest that this style is ideal when preparing people for change as it enables leaders to inspire people through motivation to share the same vision.

The first step I will take is to arrange a meeting to get management approval for my proposed change. Full backing is required from the management team as change will be difficult without their approval. Gopee and Galloway (2017) emphasise the importance of obtaining full management support as this will have a significant influence on the successful implementation and sustaining of the change.

During this stage, I will also arrange a meeting with the haematology-oncology team to explain the need for change and what I am proposing to change and implement in practice. Stanley (2016) suggests that all staff who will be affected by my change should be consulted and respected or resistance will be inevitable. This consultation is crucial to the success of my proposed change. I must get the team on board and motivate them to accept that my change is necessary. Any change in practice may increase stress, fear and uncertainty within the team, so understanding the purpose of my change is critical in its success. The British Medical Association (2017) suggests using evidence to demonstrate my reasoning for change. Therefore, I will present research to the team which links good oral care management with a reduced likelihood of oral mucositis developing. In addition this change aligns with the need to practice effectively on the basis of best evidence available and best practice (NMC 2018). I will ensure that the team is fully involved and has the opportunity to give feedback and raise any concerns. Stanley

(2016) supports this, stating that not allowing people to have significant participation in the change process will leave them feeling undervalued and result in resistance to the change.

Lewin (1951) suggests using tools in the change management process such as a SWOT analysis and a force field analysis. A SWOT analysis was undertaken. This tool was used to highlight the strengths, weaknesses, opportunities and threats that my change will have on the haematology-oncology unit, which allowed any potential obstacles to be highlighted and dealt with. Barr and Dowding (2016) claim that a SWOT analysis needs to be performed with team involvement whenever possible as together they can be more objective.

Change Management

The second stage involves the development of new attitudes and behaviours, and the implementation of the change (Gopee and Galloway 2017). Bach and Ellis (2015) believe that effective communication and support is critical at this step as this is the time when most people struggle with the new reality. Barr and Dowding (2016) also highlight that effective communication is needed at this stage to help overcome resistance and add that the team should be reminded throughout implementation, of the reasons for the change and how it will benefit them once fully implemented. I will use a transformational leadership style at this stage as this approach is believed to be especially effective during times of change (Fischer 2016). During this time the team will require a lot of motivation and support to help alleviate stress and fears.

During this stage, information booklets will be available to educate patients, alongside mouth care daily record sheets. The team will be expected to adopt the new documentation and use it as instructed. Audits will be used to monitor the change. Hewitt-Taylor (2013) supports the use of audits to monitor any change, stating that they will establish whether agreed best practice is being followed. Barr and Dowding (2016) add that audits will determine the effectiveness of the documentation while enabling amendments to be made as needed.

Refreezing

The final stage is about reinforcing and stabilising the change after it has been implemented in practice. Efforts must be made to sustain the change. The change needs to be cemented into the organisation's culture and maintained as the acceptable way of managing oral care (Hewitt-Taylor, 2013). The role of a link nurse is recommended by the Royal Collage of Nursing (2012) to act as an acknowledged contact person, a role model and visible advocate for a change. Link nurses can be very effective in sustaining a change such as this.

Cummings and Worley (2014) recommend using rewards and acknowledgment of individualised efforts to reinforce the change. Taking this into account a transactional leadership style will be beneficial during this stage as the use of rewards and incentives may encourage staff to use the new documentation and challenge those who do not. Cummings, Bridgman and Brown (2015) argue that this refreezing step can be too rigid

and inappropriate due to the continuous need for change. However, without the refreezing stage, there is a high chance that people will revert to the old way of doing things.

Conclusion

Effective leadership is crucial as it helps maximise efficiency and is needed for change to be successfully implemented and sustained. The success of this change relies on commitment from everyone involved. Additionally, those implementing the change must be prepared to overcome any obstacles that may arise. Effective leaders exhibit specific skills and attributes to implement change such as excellent communication skills, empathy, confidence, flexibility and the ability to motivate.

There is clear evidence of the link between effective leadership and a range of important outcomes within health services. These include improved patient satisfaction, reduced patient mortality, improved staff well-being and improved overall quality of care. By implementing this change in practice, health care professionals can positively influence patient care by incorporating evidence-based practice of good oral care management. This improves consistency of care while promoting an intervention of proven benefit against oral mucositis. Additionally, if these changes prove successful, they could be proposed to other haematology-oncology units, improving patient care in other areas by sharing knowledge.

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Population Health Needs Analysis – UK Asylum Seekers and Refugees

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Abstract

This article will explore the healthcare needs of UK asylum seekers and refugees, seeking to identify not only the size and location of these populations, but the range of their healthcare needs alongside the barriers to healthcare experienced by them. Significant focus will be on the mental and physical health needs of these populations, as well as the future for these populations within the UK, relating to their access to healthcare.

Keywords

Refugee, Asylum Seeker, Healthcare, UK,

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Introduction

Recent migration into the UK has meant that healthcare professionals such as paramedics are dealing with an diverse mix of patients, from a variety of different backgrounds and cultures, with ever-changing healthcare needs (Robertshaw, Dhesi and Jones 2017). This article will explore the population health needs of the growing asylum seeker and refugee communities in the UK; a population worthy of an in-depth analysis due to its significant coverage in national and international news and of growing prevalence within our communities. From a moral perspective alone, society's valueless attitude towards these populations as demonstrated in the media (Banks 2011) justify this report. According to Roberts, Murphy and McKee (2016) asylum seekers face humiliation at European borders and even upon reaching comparative safety they still lack access to basic primary healthcare.

Furthermore, from a political standpoint, Kirkwood (2017) highlights the narrative of UK politicians, who can often portray host nations as having limited means and space and therefore a place unable to provide refuge. Kirkwood (2017, p.116) also argues that politicians construct their arguments about these populations in a way that "avoids labelling the speaker as racist, and instead functions to portray speakers as being moral... while arguing against their (the asylum seekers' and refugees') presence."

This article sets out to understand precisely how these populations are defined, as each case is different. Amongst varying definitions of "refugee," the 1951 United Nations Convention Relating to the Status of Refugees defines a refugee as; "Someone who has

been forced to flee his or her country because of persecution, war, or violence, and have a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group” (UNHCR 1951).

It is also important to note that “Refugee Status” according to the Refugee Council (2017a) is only awarded to an asylum seeker that the Home Office recognizes as a refugee after his or her successful application. It is only then that these individuals are permitted to remain in the UK for up to 5 years, with the choice to apply to remain indefinitely. According to Migration Watch UK (2017, p.1) an individual “will remain an asylum seeker for so long as his application or appeal against refusal of his application is pending... while the position of unsuccessful asylum seekers is similar to that of those who enter on short-term visas and overstay.”

Since we often see coverage in the news and media regarding these populations, one can quickly become overwhelmed by the terminology used regarding asylum seekers, refugees and immigrants in general, making it essential to understand what these terms mean. According to Donkoh (2007) in a memorandum by the UNHCR regarding the treatment of asylum seekers and refugees in the UK media, confusion remains between the various terms such as “asylum seekers” and “economic migrant,” thus making it also important to differentiate between them.

Asylum seekers and refugees are by no means a new population within the UK. According to Refugee Week (2015), refugees and those who seek asylum have made a “massive

cultural social and economic contribution to life in the UK in the past 450 years,” (Refugee Week, n.d. p.3) ranging from the first Dutch protestants who fled religious persecution in 1665, to those that reside within the UK today. It is important to note that asylum seekers and refugees have a positive influence on the countries they inhabit, however refugees are more likely to be unemployed than the indigenous populations of those countries in which they reside (Fasani, Frattini and Minale, 2018). However, in a study of Australian refugees the Economist (2016a) suggests refugees pay less in tax than in benefits during the first 20-25 years of residency in a host country. This does not only raise questions about their economic benefit across other nations but negates the added value asylum seekers and refugees may bring such as culture and diversity, as well as the length of time it takes these populations to become settled. It is important to highlight that not only are the aforementioned issues limited only to the economic factors of asylum seekers and refugees but they do not take any account of the moral and ethical responsibilities of “First World” nations and their healthcare systems.

UK Asylum Seeker and Refugee Population Size and Location

This population is relevant due to its prominence in today's society, news and media, with crises such as the Syrian Civil War and the war in Yemen increasing the number of asylum seekers and refugees across the EU and more widely (Kingsley 2015). According to UNHCR (2015a) there are around 1.5 million refugees in Europe and 149,765 refugees known to be living in the UK. According to Blinder (2016), the majority of the UK's asylum applicants come from Eritrea, Iran, Pakistan, Sudan and Syria. However, it is important to note that these countries are not reflective of the nationalities of the world's largest

refugee populations which consist of applicants from countries such as Syria, Afghanistan, Somalia, Sudan and South Sudan (British Red Cross 2017). When we compare the nationalities of UK asylum seekers to those of the world's largest refugee populations it appears that asylum seekers coming to the UK predominantly arrive from relatively politically stable countries such as Eritrea or Iran (Blinder 2016) rather than politically unstable countries such as Syria (British Red Cross 2017), suggesting that many of the UK's asylum seekers and refugees could be economic migrants.

With regard to the management of UK asylum seeker and refugee populations, Liebling et al. (2014) highlight a “culture of disbelief” that exists amongst UK politicians regarding the movement of asylum seekers and refugees into the UK. Liebling et al (2014) found that UK politicians often focus on returning as many asylum seekers and refugees to their home countries as possible, rather than returning them based upon their individual needs. Within this hostile environment it would not be surprising if many asylum seekers and refugees do not wish to present themselves to the Home Office, not only leading to inaccurate government asylum seeker and refugee population statistics, but also causing decreases in the number of applications for asylum within the UK, such as that which occurred from 2015 to 2016 (Refugee Council 2017b).

According to Aiyar et al. (2016) figures suggest that the number of UK refugees is significantly lower than it was thirty years ago. This decrease could be related to the rise of the UK Independence Party in the 2015 election, who according to Ibrahim (2017) encouraged significant negative media coverage towards asylum seekers and refugees

during their election campaigns.

Blinder (2016) finds that asylum seeker applications in the UK have increased since the 1980's and highlighted that there are significant evidence gaps and limitations in information about asylum seekers and refugees in general, going on to state that estimates of asylum seekers' role in net migration are uncertain, reinforcing the notion that asylum seeker and refugee statistics are highly inaccurate.

Nevertheless, whilst reports by Blinder, Ruhs and Vargas-Silva (2011) highlight how public attitudes towards asylum seekers and refugees hope to see numbers of these populations reduced, media reports such as that of Cockburn (2015) highlight the ethically justifiable cause for their entry; linking it to violence in the Middle East and North Africa - including nine civil wars now going on in Islamic countries between Pakistan and Nigeria. The validity of this claim is reinforced by the UNHCR (2015b) who emphasize how war in Syria has caused severe displacement of people and that conflict in Africa, the Middle East, and Asia (in order of significance) has lead to increased asylum seeker and refugee numbers in recent times.

According to the National Audit Office (NAO) (2017) 10% of asylum seekers make their asylum claim at the UK port where they arrive, while the remaining seekers make their application for asylum in Croydon. Following this, they are dispersed across areas outside of London unless they have "exceptional" medical circumstances. Home Office (2017a) figures found that by the end of 2016, 92% of asylum seekers in the UK were placed

outside of London. Furthermore, reports from the Economist (2016b) found that asylum seekers were often sent to the most impoverished communities of the UK.

Healthcare Needs and Barriers to Healthcare

Public Health England (PHE) (2017) highlights that the majority of asylum seekers and refugees in the UK are healthy; however, broader reading suggests otherwise. Health problems can develop for many reasons including: difficulty in accessing healthcare services, lack of awareness of entitlement, problems in registering with primary and community healthcare services and language barriers (Robertshaw, Dhesi and Jones 2017). PHE (2017) suggests health needs for this group range from mental health and physical consequences of torture and imprisonment to loss of family and friends, hostility and housing difficulties upon arrival in the UK.

Unfortunately, there appear to be no uniform benchmarks to identify successful resettlement for asylum seekers and refugees in the UK, and in fact studies by Morris et al. (2009) found that the health status of refugees in the USA declined upon migration. Yako and Biswas (2014) found that language barriers and social isolation were inevitably stressful, contributing to declines in the general health of these populations on arrival in a new country.

UK support for newly resettled asylum seekers and refugees comes from charities such as United Nations International Children's Emergency Fund (UNICEF), Amnesty International, Refugee Action, The Refugee Council, Oxfam and British Red Cross. While

government based campaigns such as The Syrian Resettlement Programme (which focuses specifically on the UK government allocation of 20,000 Syrian Refugees) offer support arrangements for “high cost” cases such as families, offers general support for unaccompanied children and also support with housing costs, thus aiding initial resettlement issues (Home Office, 2017b).

According to the Refugee Council (2017b), in an attempt to support these populations’ health there are other programmes such as the UK government’s Gateway Resettlement Programme which offers resettlement support to asylum seekers during their first 12 months in the UK by a team of project workers, community development workers, and volunteer coordinators, with services including orientation on arrival, housing and tenancy support employment support and access to health services amongst many others.

Another factor affecting the health of asylum seekers and refugees is the quality of healthcare services available in their home country, which is often poor and predominantly outside of the top 100 healthcare systems in the world (WHO 2000). Of the top 10 asylum applicant countries in the UK, the highest ranked healthcare system was Albania (ranked 55th) while the lowest was Nigeria (ranked 187th) (WHO 2000).

Cheng, Drillich and Schattner, (2015) find that asylum seekers’ and refugees’ cultural understanding of healthcare can be a barrier to their health. Cheng, Drillich and Schattner (2015) found that utilization of healthcare is thwarted by asylum seeker and refugee experiences of healthcare services within their country of origin, their unrealistic

expectations of western healthcare systems such as expectations to be healed straightaway, and a failure to understand why they were physically examined in particular ways.

According to Whyte, Whyte and Hires (2015), asylum seekers are often perceived to have lower socioeconomic status than the UK indigenous populations, and ultimately receive a lower level of treatment from UK healthcare institutions, largely due to complex factors such as prejudice, language barriers, lack of understanding and cultural issues. Furthermore they also found that failed asylum applications render individuals destitute and whilst they may receive necessary initial healthcare provision due to ethical responsibilities of healthcare providers, they are often subsequently deported. Religious beliefs can also act as a barrier to refugee and asylum seeker healthcare needs - particularly sexual health, obstetrics, gynaecology, and midwifery. According to Wilson, Sanders and Dumper (2007) religion can also play a significant role in sexual health disparities, while Kolak, Jensen, and Johansson, (2017) reinforce this within asylum seeker and refugee populations, stating that immigrants' religious beliefs affect the efficacy of any antenatal education they might receive.

Mental Health Needs

Mental health issues amongst asylum seekers and refugees are also a significant healthcare need. Steel et al. (2009) found in a study of over 80,000 refugees that there was a 30% prevalence of post-traumatic stress disorder (PTSD) and major depression, often linked to torture experiences and exposure to trauma as a result of conflict in their

home countries. These mental health issues are often exacerbated by resettlement stressors such as unemployment, poor housing and social isolation due to language and cultural barriers and discrimination as seen in the press. Turrini et al. (2017) found that some people within asylum seeker and refugee populations may struggle with high rates of psychiatric illness. The UK government currently fails to screen asylum seekers and refugees for mental health issues, and such screening may help to reduce them, since studies by Polcher and Calloway (2016) found that early recognition of mental health issues can lead to early intervention and therefore reduce their impacts.

Nevertheless, it is evident that asylum seekers and refugees face many health challenges ranging from language barriers to mental health problems. Alongside the complex needs associated with being an asylum seeker or refugee, they also appear to have an increased risk of morbidity compared to indigenous populations (Mangrio and Sjögren Forss 2017). According to Taylor (2009) the health of asylum seekers is significantly worse than that of the indigenous UK population on almost all measures of health and wellbeing. Furthermore, Haroon et al. (2008) believe achieving refugee status can lead to loss of home and financial support which can cause exacerbation of pre-existing mental and physical health and wellbeing issues.

Mental health needs also impact children. The UN Convention on the Rights of the Child (United Nations 1990) recognizes that children often suffer disproportionately as a result of government policy, suggesting there is less support and recognition of mental health issues among child asylum seekers and refugees than adults within these populations.

Nevertheless, there are charity based initiatives such as Mind's Refugee and Asylum Seeker Mental Health Advocacy Project, which are backed by the NHS, open to all ages and seek to ascertain the mental health concerns of refugee organisations. Furthermore, they also deliver training courses for "advocates" within refugee community organisations to cascade what they have learned about mental health information.

Asylum seekers and refugees suffer significant cultural barriers to health; and according to Loewenthal et al. (2012) there is a general lack of understanding about the cultural diversity of Black, Asian and Minority Ethnic (BAME) communities within the UK, leading to poor uptake of psychological/talking therapies by these populations. Loewenthal et al. (2012) also found that asylum seekers and refugees from BAME communities are frequently accessing services at a more critical later stage than Caucasian service users. Studies reviewed by Bellamy et al. (2015) found that cultural differences can affect attitudes toward medical care as well as the ability to understand, manage and deal with the course of an illness.

A further cause of population healthcare needs are the refugee camps from which they originate in their home country. Of the 51 million people currently living as refugees 12 million of these reside in refugee camps (Byler, Gelaw and Koshnood 2017). They also suggest that these camps are overcrowded, and their rudimentary design has a negative impact on delivery of aid, disease levels and safety. Habib, Basma and Yeretzian (2006) found that 69.5% of refugee camp households reported a presence of illness amongst household members and of those that were ill, more than half reported at least two

conditions at the same time. Interestingly, Habib, Basma and Yeretian (2006) also found that over 50% of these illnesses were circulatory, musculoskeletal or respiratory.

Allsopp, Sigona and Phillimore (2014, p.29) found that upon arrival in the UK, asylum seekers and refugees were often placed in poor housing conditions. These include damp, lack of locks on bedroom doors, pest infestation, delays in repairs and lack of heating or hot water, leading to a rise in mental health problems and an increase in suicide risk (Cowburn 2017).

Travel

For many of those seeking asylum the journey to the UK can be treacherous (Squire et al. 2017). Although information specifically related to travel methods is limited, Turner (2015) finds that many asylum seekers and refugees arriving in Europe are often transported across the Mediterranean by people smugglers, in boats that are not fit for the journey, overcrowded and dangerous.

Physical Health

Although there appears to be limited research on the physical health of asylum seekers and refugees specific to the UK, there is evidence to provide an overall perspective of these populations' physical health needs. According to Webb, Ryan and O'Hare (2005) children may arrive without complete immunization schedules, unknown immunization history or with no prior immunizations or screening, while Levi et al. (2014) find that there is widespread uncertainty surrounding which vaccinations asylum seekers have received in their home countries.

According to the World Health Organization (WHO 2000), asylum seekers and refugees have a variety of non-specific health problems. Common health problems include; accidental injuries, hypothermia, burns, gastrointestinal illness, cardiovascular events, pregnancy and delivery-related complications, diabetes, and hypertension. The WHO (2000) also states that risks associated with population movements such as psychosocial disorders and reproductive health issues can increase the risk of non-communicable diseases. Furthermore, it states that these non-communicable diseases such as diabetes and hypertension have a prevalence as high as 25-35% in low or middle-income countries, those from which asylum seekers and refugees predominantly originate.

According to Olsen, Stauffeur, and Barnett (2017), asylum seekers and refugees may also suffer from nutritional deficiencies. Olsen, Stauffeur, and Barnett (2017) explain that nutritional deficiencies are particularly common in refugee populations, stating that 27-32% of Bhutanese and Nepali refugees arriving in the USA suffered from vitamin b12 deficiency due to malnutrition in their home countries.

Abidi et al. (2012) also find that refugee populations from war-afflicted countries are exposed to specific risk factors such as unprotected sex and intravenous drug use that predispose them to communicable diseases such as sexually transmitted diseases, blood-borne diseases and other infections. They also highlight how Afghan asylum seeker and refugee populations suffer from multiple disadvantages such as illiteracy, low socioeconomic conditions, high unemployment and limited life-sustaining resources such as running water and waste management systems, leading to exponential proliferation of

infectious disease.

According to Asif, Baugh and Jones (2015) pregnancy can cause additional healthcare complications for asylum seekers, and they state that it is difficult to ascertain the actual population of pregnant refugee and asylum seekers that reside within the UK. Interestingly, Feldman (2014) found that in 2011 there were 500 pregnant women seeking asylum and receiving support in the UK, in addition to 125 who were refused asylum. Both Asif, Baugh and Jones (2015) and Feldman (2014) agree that pregnant asylum seekers and refugees suffer a complexity of physical and mental health problems, as well as issues surrounding being dispersed to a different area later on in pregnancy causing interruptions and lack of continuity in maternity care. According to Bowyer (2008) the CEMACH (Confidential Enquiry into Maternal and Child Health) report found that black African women, including asylum seekers and refugees, have a mortality rate nearly six times higher than white women which may be linked to interruptions in maternity care.

Lewis (2007) also highlights other issues such as a reluctance to seek maternity care among these populations due to fears about immigration status or shame within their community, in addition to high levels of physical and sexual violence suffered by women asylum seekers and refugees. Additionally the WHO (2006) highlights how the health of asylum seekers and refugees who have undergone FGM (female genital mutilation) may also be at risk of difficulties during labour, including the need to have a caesarean section, dangerously heavy bleeding, and prolonged hospitalisation after birth.

Feldman (2014) finds that the majority of non-English speaking pregnant asylum seekers and refugees did not have access to translation services; a significant factor that may have affected communication of their healthcare needs. Nabb (2008) also finds that provision of maternity care to pregnant asylum seekers is inadequate and must be addressed so that appropriate services that overcome complex barriers to healthcare can be developed and delivered. Nabb (2008) states that these might range from specific midwifery support for women in emergency accommodation, to streamlining of interpreter services so that women can discuss their care in a known language. Nabb (2008) goes on to highlight how interpreter services are integral to providing effective healthcare, since, if this is not available, information can become lost and the standard of treatment ultimately suffers.

The physical and psychological healthcare needs of female asylum seekers may be worse than that of their male counterparts due to war. Canning (2011) states that rape has only recently been recognized as a weapon of war, and considers being female to be more dangerous than being a soldier. War is usually the primary reason behind asylum applications and it could be argued that the psychological and physical healthcare needs of female asylum seekers and refugees arriving from such countries will have greater demand for specialist services in contrast to their male counterparts. Canning (2011) also identifies that there is a lack of suitable support for female asylum seekers who are victims of sexual violence and FGM. Canning (2011) states that not only are a large number of talking therapists male and as a consequence highly unapproachable, but also from a cultural perspective, the notion of speaking to a stranger about such personal

issues may be a bizarre notion for many asylum seekers and refugees.

Diseases related specifically to asylum seekers and refugees can be challenging to identify, as according to Kärki et al. (2014) only just over half of countries where asylum seekers and refugees originate from had screening programmes in place for infectious diseases such as hepatitis B and tuberculosis. Moreover, Rechel et al. (2013) find that it is particularly challenging to ascertain information about specific infectious disease rates amongst asylum seekers and refugees, and that movement into the EU may be a contributing factor to increased rates of tuberculosis and hepatitis B .

Future of healthcare amongst asylum seekers and refugees within the UK

There appears to be a significant lack of research and information surrounding what the future holds for the healthcare provision of asylum seekers and refugees. There does, however, appear to be a series of recommendations for provision improved healthcare amongst them. Taylor (2009) recommends practical solutions, such as mandatory health screening and dedicated healthcare advocates, as well as social solutions such as improved social integration, which Taylor (2009) believes can improve health outcomes for asylum seekers and refugees.

Charities like Mind (2017) suggest that healthcare providers need to build stronger relationships with asylum seeker and refugee communities to improve their mental health, as well as suggesting many strategies to benefit the mental health of these populations such as the development of accredited mental health advocacy qualifications specializing in refugee communities. Mind (2017) also recommends support for mental health

advocates from refugee communities to develop the skills to become Independent Mental Health Advocates and also highlights that there is a need for cultural competence training for NHS staff at all levels.

On a more pragmatic level, Arnold et al. (2015) outline work being undertaken by Public Health England (PHE), who are exploring ways to address the health needs of all UK asylum seekers, refugees and migrants. PHE (cited in Arnold et al. 2015) suggest a revision of guidance on pre-entry health assessments, as well as improved support for health professionals who deal with these groups. The paper identifies the importance of these initiatives to prepare healthcare services for asylum seeker and refugee populations in the future.

Conclusion

Historically, asylum seeker and refugee populations have been overlooked by both politicians and the communities around them for many years. Whilst economic perceptions of asylum seekers and refugees are quick to highlight the financial burden these populations appear to place upon the UK; there is limited research to suggest how we deal with their healthcare issues to reduce this.

The information within this article suggests that not only are the healthcare services which serve these populations severely under-resourced, but also there are significant barriers to effective healthcare for asylum seekers and refugees as a result of cultural disparities between these service users and UK healthcare providers, which can only be resolved through substantial educational interventions amongst asylum seekers, refugees and

healthcare services. Without this education-focused approach, combatting the growing cultural, economic and health disparities between the indigenous population and the population of asylum seekers and refugees within the UK may be impossible.

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Page | 103

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