

Recognising compassion fatigue and protecting wellbeing

Making stuff better to provide the best care possible

Outstanding people and outstanding partnerships

Keeping the nation's nursing profession moving

Eating with your eyes: fighting malnutrition

International recruitment in community nursing

Reflections on life as an international nurse

Pandemic prompts ERIC to diversify services and go digital

Managing cow's milk allergy with hypoallergenic infant formulas

Are pressure injuries unavoidable at the end of life?

Pressure ulcer prevention and use of patient information leaflets

Evaluation of a skin protectant ointment and an incontinence cleanser

Catheter valves: appropriate use and reduction of risk to bladder

Dementia and continence issues

Inaccuracies in dispensing compression garments: survey results

SKIN CARE

PRESCRIBING

WOUND CARE

CONTINENCE

NUTRITION

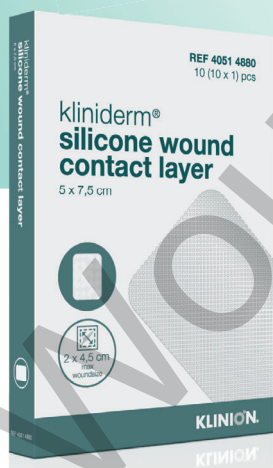
MENTAL HEALTH

LEARNING ZONE



kliniderm[®] silicone wound contact layer

Gentle, transparent
and flexible



- Exceptional clinical results¹
- Easy handling*
- Up to 14 days wear time
- Save up to 29%²

 **h&r healthcare**
A MEDIQ COMPANY

T: +44 (0)1482 631606 E: marketing@hrhealthcare.co.uk

www.kliniderm.co.uk

*One sided adhesive. 1. Barrett, S., King, B and Welch, D (2021) A clinical evaluation of 21 patients using Kliniderm silicone wound contact layer. Wounds UK 17(1): 78-83.
2. Drug Tariff prices correct from September 2021, based on closest comparable size.

Contents

Taking time for yourself Annette Bades	4
Community matters — Recognising compassion fatigue and protecting wellbeing	10
Making stuff better to provide the best care possible Gemma Hawtin	18
Outstanding people and outstanding partnerships Mary Speirs	20
Keeping the nation's nursing profession moving Roger Black	24
Eating with your eyes: fighting malnutrition Emily Stuart	26
International recruitment in community nursing Matthew Bradby	28
Reflections on life as an international nurse: what I wish I'd known Fabio Trovato Monastra	29
Pandemic prompts ERIC to diversify services and go digital Alina Lynden	30
Product snapshot — Managing cow's milk allergy with hypoallergenic infant formulas	32
Are pressure injuries unavoidable at the end of life? Annemarie Brown	36
Pressure ulcer prevention and use of patient information leaflets Lisa Ledger, Louise Morris	42
Evaluation of a skin protectant ointment and an incontinence cleanser Alexandra Freitas	46
Catheter valves: appropriate use and reduction of risk to bladder Sharon Holroyd	52
Dementia and continence issues Zena Aldridge, Karen Harrison Dening	58
Inaccuracies in dispensing compression garments: survey results	64



Journal of Community Nursing
incorporating *Journal of*
District Nursing
October/November 2021

Managing director

Alec O'Dare
alec@woundcarepeople.com

Editor-in-chief

Annette Bades
In-patient clinical lead,
Bury Hospice

Publisher/editor

Binkie Mais
binkie@jcn.co.uk

Sales manager

Sam Ciotkowski
sam@jcn.co.uk
01789 332162

© Wound Care People Limited 2021

Unit G, Wixford Park, George's Elm Lane,
Bidford on Avon, Alcester B50 4JS

ISSN 0263 4465

t: +44(0) 1789 582000

e: mail@jcn.co.uk

http://www.jcn.co.uk

Journal of Community Nursing is indexed with
CINAHL and British Nursing Index (BNI)

Published bi-monthly and available
free online for community and district
practitioners based at primary and secondary
care locations throughout the United
Kingdom. Also distributed with subscription.

Institutional and overseas subscription rates:

United Kingdom: £155.00

Overseas: £285.00

All rights reserved. No part of this *Journal*
of Community Nursing may be reproduced,
stored in a retrieval system or transmitted
by any means electronic or mechanical,
photocopied or otherwise without the
prior written permission of Wound Care
People Limited.

Opinions expressed in the articles are those
of the authors and do not necessarily reflect
those of the *Journal of Community Nursing*.

Any products referred to by the authors
should only be used as recommended by
manufacturers' data sheets.

If you would like to comment on any of the
articles in JCN, or indeed have ideas of your
own for an article, please contact:
binkie@jcn.co.uk

Taking time for yourself



As we take time to reflect over the past eighteen months, I am sure that many of us find it difficult to process everything that has happened and all the changes that we have been forced to make. Throughout, we have worked to maintain the safety of our patients and teams and have barely had time to consider our own wellbeing. As we now try to return to some kind of normality, remember to take time for yourself — to renew and refresh. Consider a team night out to socialise and support each other and

have some fun in a different environment. Make plans, share thoughts and look after yourselves and each other. Read our community matters feature (pp. 10–17) — you are not alone.

It is always great to hear about inspiring initiatives in the community which are making a real difference to people lives, such as Gemma Hawtin's wheelchair skills programme for children, 'Making Stuff Better', to help them develop independence and participation (pp. 18–19). This piece shows how by working as a team and being open to new ideas, creativity and service improvement can flourish. The work of ERIC, the Children's Bladder and Bowel Service, also demonstrates this, as despite the challenges of the pandemic, it has diversified to enable the charity not only to survive, but also thrive (pp. 30–31).

The journal again has a variety of clinical articles which cover conditions you face during your day-to-day caseloads. Annemarie Brown takes a thoughtful look at skin damage at the end of life and why some injury is perhaps unavoidable (pp. 36–41). There is also a useful article on catheter valves and how they can help to improve the chances of normal bladder function after removing a catheter (pp. 52–56), while the fourth part in our dementia series explores issues relating to dementia and continence and their impact on patients and families (pp. 58–62).

As always, I hope you enjoy reading this issue. If you have any ideas for articles, please get in touch, as it is always great to hear from our readers. And finally, here at JCN, we are delighted to say that our exhibition and study days are now back on the road. So, why not take a look to see when we are next in your area — www.jcn.co.uk/events/series/roadshow-study-day.

Annette Bades, editor-in-chief, JCN

Pictures on front cover courtesy of:
Savannah1969; Alexander Rath; Dml5050;
Dvkorn; John Keith; Elena Elisseeva; all at
Dreamstime.com

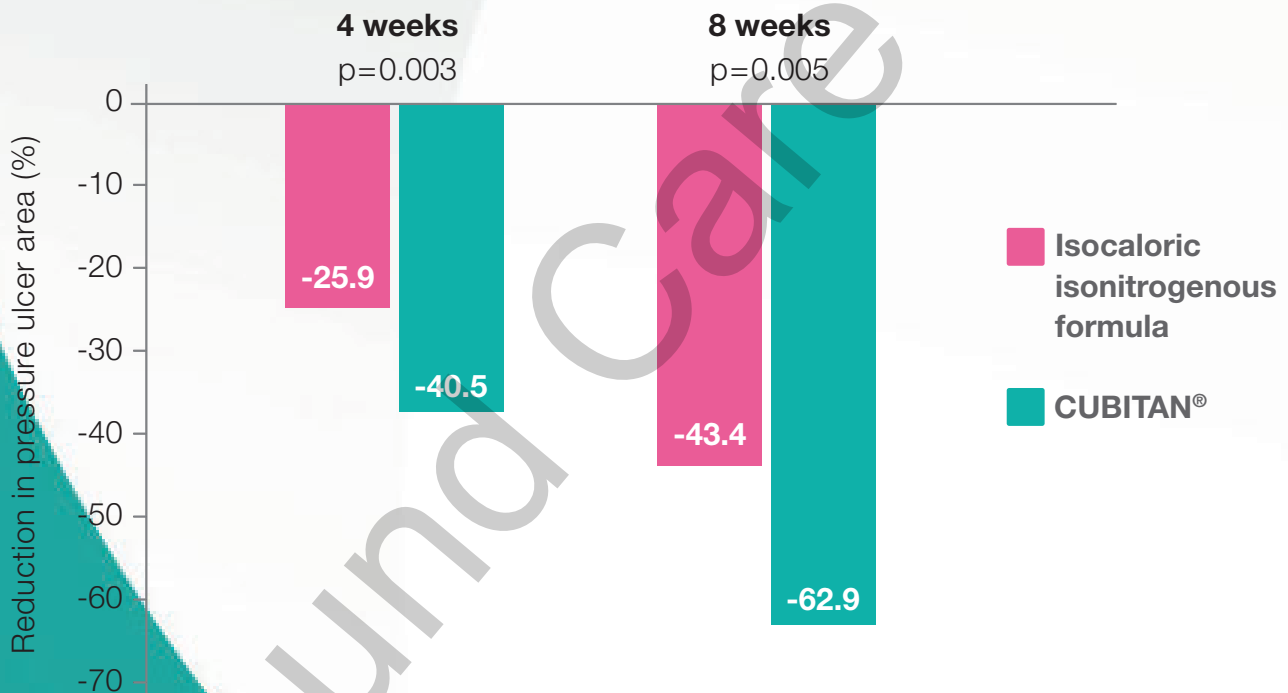


**NEW
PRODUCT**

CUBITAN – THE ORAL NUTRITIONAL SUPPLEMENT FOR CHRONIC WOUND MANAGEMENT

Cubitan demonstrates a **significant reduction in pressure ulcer (PU) area – at 4 and 8 weeks¹**

A randomised, controlled study conducted on 157 malnourished elderly patients, average age of 81, with PU grades II, III and IV; institutionalised or home care based



For more information and to order free samples* direct to your patient, please go to <https://www.nutricia.co.uk/hcp/products>

Reference: 1. Cereda E, et al. Disease-specific nutritional support in malnourished pressure ulcer patients: a randomised, controlled trial. *Ann Intern Med*, 2015; 162: 167-174.

*Product can be provided to patients upon the request of a healthcare professional. They are intended for the purpose of professional evaluation only.

This information is intended for healthcare professionals only.

Cubitan is a Food for Special Medical Purposes for the dietary management of malnourished patients with chronic wounds and must be used under medical supervision.

Accurate at time of publication: August 2021.



**NUTRICIA
Cubitan**

Annette Bades, *in-patient clinical lead, Bury Hospice*

Sue Boran, *director of nursing programmes, Queen's Nursing Institute*

Beverley Brathwaite, *senior lecturer adult nursing, University of Hertfordshire*

Helen Brewah, *community matron, Hampshire*

Sara Burr, *community dermatology nurse specialist, Norfolk Community Health and Care NHS Trust*

Rosie Callaghan, *tissue viability nurse, Stourport Health Centre*

Rachel Drago, *advanced nurse practitioner, The Mount Surgery, Pontypool; Queen's Nurse*

Sharon Eustice, *consultant nurse, Cornwall Foundation Trust*

Stefan Franks, *school nurse, West Sussex*

Sharon Holroyd, *retired lead continence nurse*

Sally Lee, *post-doctoral research fellow at Bournemouth University*

Melanie Lumbers, *freelance tissue viability nurse*

Shirley Pickstock, *advanced clinical practitioner, Shrewsbury and Telford NHS Trust*

Georgina Ritchie, *deputy director of education, Accelerate*

Jane Todhunter, *vascular nurse practitioner, North Cumbria University Hospitals*

Anne Williams, *Lecturer, University of the West of Scotland; lymphoedema nurse consultant, Esklymphology*

Janelle Yorke, *senior lecturer, School of Nursing, Midwifery and Social Work, University of Manchester*



I am a consultant nurse, championing bladder and bowel health across Cornwall and the Isles of Scilly for children, young people and adults. Being in a position to help people with these problems is a privilege. We strive to provide a service embedded with quality and evidence-based treatment opportunities. Building and leading a countywide service can be challenging, yet inspiring and motivating when managing the demands across the health and social care systems. It is an honour to be invited and contribute to the JCN editorial board.
Sharon Eustice

I am a district nurse, nurse teacher and Queen's Nurse with a passion for excellent community nursing education and practice. I am also an advocate for care being close to people's homes and for supporting people to self-care and regain independence where possible. I also have an interest in nurse prescribing, dementia, frailty, loneliness and social isolation. I am delighted to be a part of the JCN Editorial Board, a journal for all community nurses to access for the very latest and best evidence to inform their practice.
Sue Boran



I am a freelance tissue viability nurse (TVN) and health visitor. My true passions are in pressure area care and moisture-associated skin damage. I sit as a registrant panel member on the NMC Fitness to Practice Hearings, and work with the Institute of Health Visiting (IHV), where I have recently supported the development of a training package on domestic violence and abuse (DVA). I am delighted to be part of the JCN editorial board, where current best practice can be discussed.
Melanie Lumbers

From my experience as a specialist nurse for an adult/child bladder and bowel service, I have seen the impact that issues with continence can have on an individual's ability to function. It crosses all ages, gender and boundaries, and can result in devastating physical, psychological and social effects. I am delighted to be on the editorial board of the JCN, and to be given the opportunity to share ideas and experience and highlight the essentials of continence care.
Sharon Holroyd

medi's Leg Ulcer Therapy Chain of products supports the National Wound Care Strategy Programme. Find out how we can help you and your patients at www.medi.co.uk or call 01432 373 500

NEW:
also available
as a glove

UCS[®] Debridement

Unique mix of ingredients to remove biofilms¹ (Poloxamer), moisten (Allantoin) and soothe (Aloe barbadensis leaf extract):

- Pre-moistened and ready to use, can use both sides
- Sterile and individually wrapped
- Easy to open and use, supporting patient self-care

¹ Percival SL et al. Surfactants and their role in wound cleansing and biofilm management. *J Wound Care* 2017;26(11):680-690.

Intended Purpose: Sterile system for initial and maintenance wound debridement, cleansing and hydration of the peri-lesional area as well as the whole limb.

WELCOME TO MICROWORLD[®]



INDEPENDENT WOUND CARE EDUCATION
THAT INSPIRES HEALING[™]

**HEALING WOUNDS CAN BE COMPLEX,
LEARNING HOW TO DOESN'T NEED TO BE**



FOR HEALTHCARE PROFESSIONALS.
FOR PATIENTS. FOR CARERS. FOR STUDENTS.

REGISTER TODAY FOR FREE

www.mymicroworld.online

Microworld is a free, subscription-based educational platform that provides patients, students and healthcare professionals access to engaging, interactive, CPD validated, animated medical content that helps further the understanding of advanced wound care.


Mölnlycke®

GET ANIMATED⁺
MEDICAL


WOUND CARE TODAY

■ ■ ■ In each issue of the *Journal of Community Nursing*, we investigate a topic currently affecting our readers. Here, Kate Upton, representative for Nursing Professions on the Crisis, Disaster and Trauma Psychology Section of the British Psychological Society, looks at...



Recognising compassion fatigue and protecting wellbeing

Since the first patient in the UK was diagnosed with Covid-19 on the 31st January 2020, the last 18 months have been unlike any we have experienced in our lifetime. The impact of the pandemic has been dramatic, turning our lives upside down and changing them beyond recognition — and not least for community nurses, like yourselves.

With the presence of Covid-19, community nurses not only had to deal with pre-existing concerns (many of which have been exasperated by the virus), but also with new challenges and pressures. Having to battle a shared enemy that appears to thrive on hiding in plain sight, many of you will have been thrust into having to operate outside of your comfort zone and in environments where you may have felt a loss of control. You will have experienced a huge shift in the way you carry out your work, having been pushed into being more open-minded and creative in managing workloads, as well as having to rapidly adapt to ever evolving new ways of providing patient care. For some, you may also have been redeployed to roles where you have needed to make use of new or rarely used skills. And, of course, underlying all of this, there is the understandable additional concern of contracting the virus and passing it on to others.

It should therefore not come as any surprise that, for some, this may be a period of increased anxiety and a time when you may feel overwhelmed and overstretched by the situation you now find yourselves working in. It is only



Well, this is one that has hit home for me! I departed the familiarity of primary care to head back to critical care at the height of the first wave of the pandemic, to the job I left 18 years ago. I was not alone, nurses from a variety of backgrounds came together to help in the fight against Covid-19. I was one of the lucky ones who was at least familiar with caring for ventilated patients, although a slightly distant memory. Caring for dying patients who could not have their family at their side and breaking bad news via video call were new ones on me, as was the horror of some of these patients being our colleagues. I absolutely recognise the signs and symptoms described in the context of compassion fatigue, in myself and many colleagues. Am I practising any of the positive coping strategies I would advise my colleagues to do? Of course I'm not, I'm far too busy! Outside of work, I'm caring for elderly parents, shopping, collecting prescriptions, participating in childcare bubbles... all of those things that we all do. I juggle and make it all work somehow — we all do, we are nurses and this is what we do. Why can't we be kind to ourselves, as we are to others... maybe we're just not used to it? Maybe this is like all the other unhealthy behaviours we talk to our patients about — we know it's bad for us, but we still do it. We know behaviour change is a lot more complex than just knowing something is bad for us, perhaps that's one to think about.

Joanne Loades

Independent nurse consultant and specialist in cardiovascular disease, Norwich; clinical director, Learn with Nurses CIC

natural and inevitable that the challenges and pressures you are experiencing could take their toll. Even in 'normal' times, many of us faced challenges when it came to prioritising our own emotional, psychological and physical wellbeing, a situation that I observed when studying the prevalence of compassion fatigue (CF) in acute

medical care hospital nurses (Upton, 2018).

Often referred to as the 'cost of caring' (Showalter, 2010), CF is a type of stress and fatigue. It develops when prolonged, continuous and intense contact with suffering patients overwhelms a caregiver's psychological resilience

to a point where the compassionate energy used by the carer exceeds their restorative processes. As a consequence, recovery power is lost and CF develops (Gilbert, 2009). The process of CF is progressive and cumulative in nature, moving from discomfort to stress and, finally, to fatigue (Coetzee and Klopper, 2009).

CF is often associated with the concepts of secondary (vicarious) traumatic stress (STS) (Beck, 2011) and burnout (Thieleman and Cacciatore, 2014). Burnout arises from conflict within the work setting (Kash et al, 2000; Alkema et al, 2008; Aycocock and Boyle, 2009; Bush, 2009; Potter et al, 2010). The conflicts can include dissatisfaction with salary, inadequate working conditions and disagreements with managers or co-workers. Secondary traumatic stress (STS) is often used interchangeably with the term compassion fatigue (Sabin, 2013). The symptoms of it can take the form of those found in post-traumatic stress disorder (PTSD) diagnosis and include 'intrusion', 'avoidance' and 'hyperarousal' (Bride, et al, 2007), but the symptoms develop through exposure to a person suffering the effects of trauma (Figley, 1995; Baird and Kracen, 2006; Dominguez-Gomez and Rutledge, 2009), rather than to the traumatic event itself (Sabo, 2006).

The effect of CF is multifaceted, including physical, emotional, social, spiritual and intellectual effects. Symptoms of CF include; boredom, cynicism, anxiety, discouragement, intrusive thoughts, irritability, persistent arousal, sleep disturbances, depression, intolerance, detachment, apathy and not least, a loss of compassion (Joinson, 1992; Figley, 1995; Dominguez-Gomez and Rutledge, 2009; Quinal et al, 2009; Hooper et al, 2010; Boyle, 2011). Those experiencing CF can also develop physical symptoms, including; increased blood pressure, weight gain, fatigue, stiff neck, immune dysfunction and, an increase in gastrointestinal problems, cardiovascular disease and diabetes (Aycocock and Boyle, 2009).

The stress and emotional exhaustion caused by caring not only



If you want to read an important article that has been published over the last three years, please read this feature by Kate Upton very carefully. If you read what Kate says and ignore my comments I am happy, but it can change you and make you ready for the future.

As a general practitioner with a background in trying to cope with the many psychological, physical and social conditions our patients present with, along with their spiritual problems, this makes me warm to the holistic themes and recognise that at a national level we have not managed to cope with the psychological consequences of the pandemic well.

More than ever, I think it is important to recognise that people have not only their physical problems, but virtually all have co-existing psychological and social problems that are expressed when we see them. As well as the problems of shielding, management through Covid-19 and coping with co-existing problems, we are faced with a tsunami of need that will become evident over the next few years.

The concept of compassion fatigue is lovely and something that we will all recognise in colleagues who forget to care for people who have problems.

It fits with ethical and social theories of care and recognises that we can lose that care for our patients. I have been providing care since a student in 1979 and wonder how often I lose my care for people... how about you?

I was sad to see that compassion fatigue was linked to salary, work conditions, and problems with managers. As a GP partner, I would be really keen to chat to those who are affected in the practice and try to resolve and improve the conditions my colleagues work in. It is important to talk to the people who have a lead role in your organisation, as I am sure they want to make sure that you feel able to care still.

We certainly need to look after each other — and we need to look to all our colleagues for help and support. When you next go into your clinical workplace, let those around you know how much they are appreciated, especially during such a long period of increased work and pressure.

I hope you will all stay safe, look after yourself and your colleagues — after all, we are so much stronger together.

Steve Holmes

GP, The Park Medical Practice, Shepton Mallet, Somerset; associate postgraduate dean (Somerset), Health Education South West

takes its toll on a nurse on a personal level, but also on their place of work. Worryingly, in order to cope with the emotional and physical symptoms of CF, unproductive, self-protective coping strategies, such as 'avoidance',

'withdrawal' and 'emotional numbing', may be adopted (Upton, 2018). Studies have also shown that CF can cause more sick days, decreased productivity (Pffiferling and Gilley, 2000), changes in job

performance, patient dissatisfaction, poor professional judgment and an increase in mistakes (Schwam, 1998; Bride et al, 2007; Burtson and Stichler, 2010; Potter et al, 2010). Unfortunately, the consequence of these factors is that the quality of compassionate care a patient receives can be negatively impacted upon (Dominguez-Gomez and Rutledge, 2009).

In addition, poor staff retention and falling recruitment have been cited as an effect of CF (Maslach et al, 2001; Gemlik et al, 2010; Parry, 2008; Bartram et al, 2012; King's Fund, 2018). Repeatedly working understaffed, while suffering from stress and ignored mental health needs, only worsens the retention and recruitment crisis we find ourselves in. Indeed, a recent survey conducted by the Royal College of Nursing (RCN, 2020) showed that although nearly 90% of nurses still remain passionate about their profession, the last 12 months has seen an increase in the number of nurses wanting to leave the profession, with over a third considering to do this by the end of 2020 (RCN, 2020). Similarly, in April of this year, a YouGov poll (<https://yougov.co.uk/topics/health/articles-reports/2020/04/15/covid-19-most-nhs-staff-worry-theyll-infect-those->) reported that when asked if Covid-19 had made them more likely to want to leave the sector, 29% of registered nurses and midwives replied 'yes'. What is particularly alarming is that the report also showed that when asked the same question, 22% of all NHS staff replied 'yes', which equates to 300,000 leaving the service. Disturbingly, with this study having taken place back in April of this year, it does not take into account how people are feeling right now. Six months down the line, faced with lower levels of morale and higher levels of burnout, it has been suggested that the impending turnover rate of 300,000 healthcare workers, is actually underestimated.

So, as individual nurses and as healthcare managers and leaders, what can we do to help mitigate the prevalence and levels of stressors that are impacting the mental

health and wellbeing of community nurses, and ultimately, the care our patients receive?

To begin with, we need to accept that phenomenon like CF and burnout do exist. We need to recognise that they are not diseases, but a set of warning signs, and the unfortunate trade-off of providing competent, compassionate patient care. We also need to acknowledge that denial can be one of the most damaging symptoms (Compassion Fatigue Awareness Project), as it hampers those of us whose wellbeing is suffering from accurately judging how stressed, anxious and fatigued we really are, which in turn prevents us from seeking help and support. We therefore need to arm ourselves as nurses with an awareness of what CF and burnout are, and the sorts of symptoms one may experience. In doing so, we will be better equipped at identifying it in ourselves and others, and subsequently, be in a better position to minimise and prevent it. The Professional Quality of Life (PROQOL) questionnaire is a measure that can give you quick feedback about CF, burnout and life stress (Stamm, 2005).

Coupled with an increase in awareness, healthy self-care is extremely important if we are to start to understand and alleviate the emotional, cognitive, behavioural and physical effect of our work. Both at and outside of work, community nurses need to prioritise their own wellbeing as much as possible. You can help to begin to achieve this by evaluating your own coping skills and thinking about your habits by asking the question, 'when I am feeling overstretched and overwhelmed, do I adopt positive or

negative coping strategies?'. *Table 1* shows some examples.

Then, think about what you value and need on a daily basis during these difficult times. These needs could be physical, emotional, spiritual, financial, professional, psychological and/or social. Next, reflect on what existing coping strategies are/or not working and start working towards reducing and then eliminating any negative coping strategies you may have adopted. Also, ask yourself whether there are any barriers to maintaining your self-care and, if so, do you need help to overcome these barriers? Once you have determined your personal needs and strategies, write them down and create a self-care plan, just as you would for a patient in your care.

To support wellbeing, it is also helpful to appreciate that our own feelings of anxiety and distress (and of other's) is a normal response to the exceptional nature of the present crisis, remembering that 'it is okay to not be okay'. We need to foster a sense of self-acceptance and strengthen our self-compassion by being gentle, kind and understanding with ourselves, accepting that we are not perfect and that we are not alone in the way we are feeling (Neff, 2003).

Although improving our individual coping strategies and skills on a personal level has an important role in improving our health and wellbeing (Cooper et al, 2001; Ruotsalainen et al, 2008), evidence suggests that a systems-level approach (including organisational, cultural, social and physical aspects) is needed if effective and sustainable health and wellbeing interventions

Table 1: Coping strategies

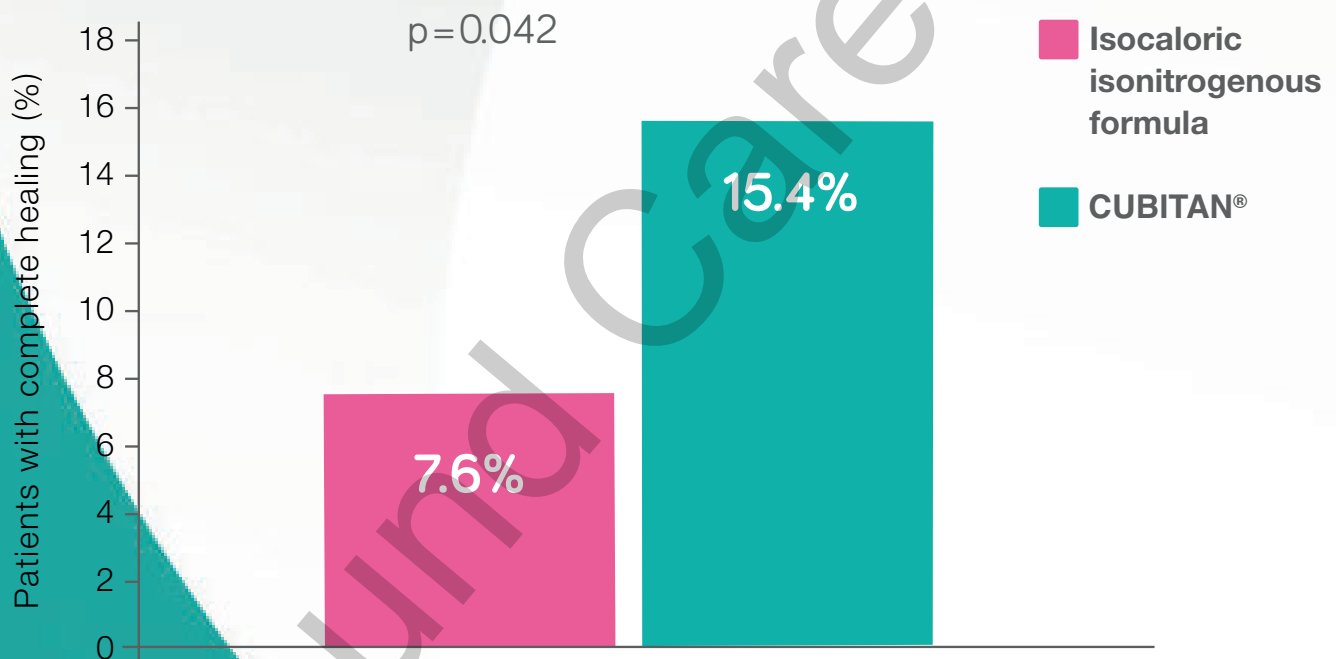
Positive	Negative
Exercise	Skipping meals
Engaging in a hobby	Working through breaks
Yoga and meditation	Smoking
Connecting with others	Excessive drinking of alcohol
Listening to music	Withdrawing from family and friends
Watching a film	Being snappy and irritable towards others

NEW
PRODUCT

CUBITAN – THE ORAL NUTRITIONAL SUPPLEMENT FOR CHRONIC WOUND MANAGEMENT

Cubitan: twice as many patients with pressure ulcers (PU) have complete healing by 8 weeks¹

A randomised, controlled study conducted on 157 malnourished elderly patients, average age of 81, with PU grades II, III and IV; institutionalised or home care based



For more information and to order free samples* direct to your patient, please go to <https://www.nutricia.co.uk/hcp/products>

Reference: 1. Cereda E, et al. Disease-specific nutritional support in malnourished pressure ulcer patients: a randomised, controlled trial. *Ann Intern Med*, 2015; 162: 167-174.

*Product can be provided to patients upon the request of a healthcare professional. They are intended for the purpose of professional evaluation only.

This information is intended for healthcare professionals only.

Cubitan is a Food for Special Medical Purposes for the dietary management of malnourished patients with chronic wounds and must be used under medical supervision.

Accurate at time of publication: August 2021.



NUTRICIA
Cubitan

are to be created (Boorman, 2009; Poland et al, 2009; Brand et al, 2017; Health Education England [HEE], 2019). Indeed, a recent report published by The King's Fund (West et al, 2020) calls on healthcare leaders and organisations to commit to prioritising the health and wellbeing of nursing and midwifery staff, and highlighted the need to concentrate efforts on changing factors that 'cause' stress in order for nurses and midwives to flourish and thrive at work.

Recently, the International Council of Nurses (ICN, 2020) has echoed these views, having stressed that, in order to prevent and alleviate the mental health and wellbeing consequences of this pandemic in nursing staff, there is a need to actively support and build resilience across teams and the healthcare system as a whole. The new report published by the King's Fund (West et al, 2020) argues that the health and wellbeing of nurses and midwives is critical to the quality of the compassionate care they provide for patients and communities. The report sets out eight key recommendations aimed at supporting nurses and midwives to flourish in their work and to provide sustainable, compassionate and high-quality care. One of these recommendations is to ensure that health and care environments have compassionate leadership and nurturing cultures.

For healthcare organisations to nurture a culture of compassion, they need their leaders — as the carriers of culture — to embody compassion in their leadership. Compassionate leadership is about treating people well, as well as understanding yourself and those around you. As a compassionate leader, you will need to encourage staff to share their thoughts and ideas so that they feel that their voices are listened to and valued. Rather than telling staff what to do, you will also need to work collaboratively to find resources and strategies to improve ways of working that are intelligent and thoughtful (Atkins and Parker, 2012).

For more strategies and resources



The advice to stay home, save the NHS and save lives is a powerful message and yet has it missed an opportunity to embrace the notion of self-care for us; as individuals, those we care for and our communities? Never has it been clearer that by following simple self-care advice, i.e. effective handwashing, staying at home, and socially distancing wherever possible, will and has benefited individuals, families, friends, work colleagues and the wider community — in many instances, with acts of kindness and community engagement,

At the same time, individuals have been reminded of the importance of achieving good basic physical and mental health. There are significant concerns however, that for many this means they haven't sought help and advice early enough. It is essential that people seek the help that they need for issues other than Covid-19.

Vaccines make people understandably see the potential light at the 'end of the tunnel' and the road 'back to normal'. The need for basic hygiene to help prevent transmission of numerous infections; the SARs-CoV2, influenza and noroviruses to name just a few, should always be paramount and is a fundamental principle of self-care.

Self-care doesn't mean just being on your own, it is about acting quickly and seeking advice from the most appropriate people as quickly as possible.

There are many aspects of people's self-care behaviours however, which should be encouraged in the long term. Not just the principles of effective self-care, but also some of the initiatives to eat healthier and partake in regular exercise not only to maintain health and wellbeing, but also to greatly improve it.

Helen Donovan
Chair, Self Care Forum; professional lead for public health, Royal College of Nursing (RCN)

that can facilitate supporting the physical and emotional wellbeing of nurses during these unprecedented times, the British Psychological Society's Crisis, Disaster and Trauma Psychology (CDT) Section (of which I am the external representative for the nursing profession), has drawn together a collection of resources that healthcare organisations, managers and team leaders may find helpful in supporting their staff to navigate through the 'active' phase of these uncertain times

(www.bpscrisistrauma.net/staff-support). The website also contains information on how individuals can protect their own health and wellbeing at work, including self-care strategies, how to be compassionate towards oneself (self-compassion), and how to recognise CF.

What we also need to be mindful of is that for some nurses, the mental health consequences of the pandemic may currently not be clear, but could surface in the weeks, months and

years to come. The ICN and the British Psychological Society (BPS) recognise not only the importance of considering the immediate health and wellbeing issues that healthcare staff may be experiencing caring for patients during these new and demanding times, but also of preventing the long-term emotional, psychological and physical impact. To reflect these concerns, BPS guidance and the CDT website offer resources to support restoring and maintaining staff wellbeing in the 'recovery' phase.

As nurses, we are often better at taking care of others than we are at taking care of ourselves. While it is anticipated that at some point in your nursing careers your wellbeing may be affected by the care you give, you need to remember that if you don't look after yourself you will find it harder to look after others. It is therefore important to develop an awareness of your own limitations and needs, and then address them to support your wellbeing. It is also crucial, as healthcare leaders, that you actively prioritise the value and appreciation placed on nursing staff and encourage them to access and adopt strategies and resources that improve and support their wellbeing. By doing these things, community nurses (as well as nurses in other healthcare settings), will hopefully have a better chance of managing the stresses of work, both today and in the future.

So, to end, I would like to leave you with two things to ponder. First, that we all need to start showing ourselves some kindness and taking comfort in the thought that we are not alone in the way we are feeling... remember, others are having a tough time too. And finally, a few words that express succinctly the impact caring has on those, like you, who care. Taken from the book 'Kitchen Table Wisdom', the words are particularly pertinent for the times we currently find ourselves in:

The expectation that we can be immersed in suffering and loss daily and not be touched by it, is as unrealistic as expecting to be able to walk through water without getting wet.

Dr Rachel Remen, 1996: 2



Working closely alongside nurses in primary care, I can appreciate how challenging a time this has been for you all in practice and would like to take this opportunity to express my heartfelt thanks and appreciation for the compassion and dedication you have all shown to your patients and colleagues during this difficult time. The Covid-19 pandemic has arguably proven to be one of the most difficult challenges faced by modern medicine. It has resulted in increased pressure and demand on our health service, forcing us to practice in an environment of rapid and significant change. This changing environment has meant that many of us are adjusting to new and innovative ways of working, making greater use of digital and remote consultations, as well as managing patients with increasingly complex mental health needs — all of which can understandably result in feeling overwhelmed and experiencing compassion fatigue, as Kate's article has importantly highlighted. It has never been of greater importance for us all to work across interprofessional boundaries and check-in with/support our colleagues' wellbeing, as we navigate through this challenging time together. That said, I would like to echo the importance of recognising compassion fatigue within ourselves and of avoiding those negative maladaptive coping strategies listed within the article, and instead looking to adopt positive and healthier strategies to improve our mental health and wellbeing again, seeking support from colleagues, management or our own healthcare professionals. Taking time for self-care and relaxation after a stressful day is as equally important as the care we provide to our patients, as we need to be well to continue to provide high quality care. The notion that Kate quoted of the expectation to be unaffected by suffering as comparable and as 'unrealistic as expecting to walk through water without getting wet' really resonated with me, and I shall endeavour to be more mindful of this in my own future practice.

Caroline McIntyre
Primary care pharmacist, Falkirk

REFERENCES

- Alkema K, Linton JM, Davies R (2008) A study of the relationship between self-care, compassion satisfaction, and burnout among hospice professionals. *J Soc Work End Life Palliat Care* 4(2): 101–19
- Atkins PWB, Parker SK (2012) Understanding individual compassion in organisations: the role of appraisals and psychological flexibility. *Acad Management Rev* 37(4): 524–46
- Aycock N, Boyle D (2009) Interventions to manage compassion fatigue in oncology nursing. *Clin J Oncol Nurs* 13(2): 183–91
- Baird K, Kracen AC (2006) Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychol Q* 19(2): 181–88
- Bartram T, Casimir G, Djurkovic N, Leggat SG, Stanton P (2012) Do perceived high performance work systems influence the relationship between emotional labour, burnout and intention to leave? A study of Australian nurses. *J Adv Nurs* 68(7): 1567–78
- Beck C (2011) Secondary traumatic stress in nurses: a systematic review. *Arch Psychiatr Nurs* 25(1): 1–10



Nurses in primary care have faced a year of unprecedented challenges in 2020. While this has been acknowledged, including at the highest level by our chief nursing officers, we are concerned that some nurses — and perhaps some employers — are still underestimating the impact of the pandemic on individual health and wellbeing.

As well as challenges in the workplace, people have also faced disruption to their home lives and many have felt unable to relax or to have a real holiday. Many of us have also been separated from family members and other loved ones.

Earlier this year, the Queen's Nursing Institute (QNI) created a telephone listening service, TalkToUs, specifically for nurses working in community settings and in social care. We have trained listeners, all of whom are Queen's Nurses, who are available to speak with any nurse who needs a listening ear, whether it is about work or any other aspects of their life. All calls are dealt with in complete confidence.

To arrange a call, please send an email to talktous@qni.org.uk and we will arrange a time to speak. We offer emotional support — we do not offer counselling, but we can signpost you to other sources of help and advice. Nurses have told us this has been a real boost during these difficult times, so please don't hesitate, talk to us.

Matthew Bradby
Head of Communications, Queen's Nursing Institute (QNI)



I think everyone reading this will have had a challenging year, not only professionally but also personally. Covid-19 has changed the world as we know it, causing high levels of stress and anxiety while considerably adding to our already high workload levels. Looking after your own mental health and wellbeing is more important now than ever. Burnout seems to be a common factor with all members of healthcare teams across secondary and primary care settings at this point. Everyone seems exhausted and exacerbated with ongoing personal life restrictions, and the pressure of providing high quality care with what feels like one hand tied behind our back. GPNs across the country have had to adapt care delivery and increase digital reviews by means of phone calls and video assessments with no time to prepare for

this. Personally, I have tried to embrace the changes positively as a way to improve how I deliver my clinics in order to reach as many patients as possible, and to ensure that they aren't missing their annual reviews and regular health checks, although this has been a challenging task!

I have often felt overwhelmed and worried for patient's health and wellbeing and the impact that the Covid-19 pandemic will have on chronic disease management in the longer term. With the added anxiety of potentially catching coronavirus and passing it on to patients, co-workers or family, I would be lying if I said this year hasn't had an effect on me on a very personal level, and I am certain others feel the same.

It is vital to be able to make time for self-care — something I often struggle with, as having two children under five at home does not allow much time for self-care. I often feel like I go from nurse to mum and vice versa with not so much as a cup of coffee in between. I wish I could say I had great tips for self-management for anxiety/stress, but I am my own worst enemy for giving all of myself to others without leaving much energy or time for myself.

I actively try and maintain a healthy work life balance (not easy), ensure I take even a 10-minute shower at the end of the day just to take a step back, breathe and reflect on the day. One thing that has been helpful during this stressful year is having good working team relationships; we ensure a weekly meeting (via MS teams) to discuss practice matters. However, this is also a safe space to raise any concerns or worries. I feel that this really helps, as not only does it improve team communication, but it also allows us to support each other during these uncertain times. Communication is absolutely vital, not just from nurse to patient, but also to your team. If you are struggling, speak to someone, reach out for support, you never know, others may be feeling exactly the same.

Cheryl Crawford
Practice sister, Braehead Medical Practice, Renfrew

- Boorman S (2009) NHS Health and Well-being: Final Report. Available online: www.healthyregions.eu/uk/Boorman%20NHS%20HWB%20Final%20Report%20Nov%202009.pdf
- Boyle DA (2011) Countering compassion fatigue: a requisite nursing agenda. *OJIN* 16(1): Manuscript 2
- Brand S, Thompson J, Fleming L, Carroll L, Bethel A, Wyatt K (2017) Whole-system approaches to improving the health and wellbeing of healthcare workers: A systematic review. *PLoS ONE* 12(12): e0188418
- Bride BE, Radey M, Figley CR (2007) Measuring compassion fatigue. *Clin Social Work J* 35(3): 155–63
- Burtson PL, Stichler JF (2010) Nursing work environment and nurse caring: relationship among motivational factors. *J Adv Nurs* 66(8): 1819–31
- Bush NJ (2009) Compassion fatigue: Are you at risk? *Oncol Nurs Forum* 36(1): 24–8
- Coetzee SK, Klopper HC (2009) Compassion fatigue within nursing practice: A concept analysis. *Nurs Health Sci* 12: 235–43
- Cooper CL, Dewe PJ, O'Driscoll MP (2001) *Foundations for organisational science. Organisational stress: A review and critique of theory, research, and applications*. Sage Publications, Inc
- Dominquez-Gomez E, Rutledge DN (2009) Prevalence of secondary traumatic stress among emergency nurses. *J Emerg Nurs* 35: 199–204
- Figley C (1995) *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised*. Brunner-Routledge, New York
- Gemlik N, Sisman FA, Sigrı U (2010) The relationship between burnout and organizational commitment among health sector staff in Turkey. *J Global Strategic Management* 8: 137–49
- Gilbert P (2009) *The compassionate mind*. Constable, London
- Health Education England (2019) *NHS staff and learners' mental wellbeing commission*. Available online: www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf
- Hooper C, Craig J, Janvin, DR, Wetzel MA, Reimels E (2010) Compassion satisfaction, burnout and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *J Emerg Nurs* 36(5): 420–7
- International Council of Nurses (2020) *ICN calls for government action to stop attacks on nurses at a time when their mental health and wellbeing are already under threat because of COVID-19 pandemic*. Press release. Available online: www.icn.ch/sites/default/files/inline-files/PR_19_COVID-19%20Violence%20and%20Mental%20Health.pdf
- Joinson C (1992) Coping with compassion fatigue. *Nursing* 22: 116–120
- Kash KM, Holland JC, Breitbart W, Berenson S, Dougherty J, Ouellette-Kobasa S, Lesko L (2000) Stress and burnout in oncology. *Oncology* 14(11): 1621–29, 1633
- King's Fund (2018) *The health care workforce in England: Make or break?* Available online: www.kingsfund.org.uk/publications/health-care-workforce-england
- King's Fund (2020) *The courage of compassion: Supporting nurses and midwives to deliver high-quality care*. Available online: www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives
- Maslach C, Schaufeli W, Leiter M (2001) Job burnout. *Annual Rev Psychol* 52: 397–422
- Neff KD (2003) Self-compassion: An alternative conceptualisation of a healthy attitude toward oneself. *Self and Identity* 2: 85–102
- Parry J (2008) Intention to leave the profession: Antecedents and role in nurse turnover. *J Adv Nurs* 64(2): 157–67
- Pfifferling J-H, Gilley K (2000) Overcoming compassion fatigue. *Fam Pract Management* 7: 39–44
- Poland B, Krupa G, McCall D (2009). Settings for health promotion: an analytic framework to guide intervention design and implementation. *Health Promot Pract* 10(4): 505–1
- Potter P, Deshields T, Divanbeigi J, Berger J, Cipriano D, Norris L, Olsen S (2010) Compassion fatigue and burnout: Prevalence among oncology nurses. *Clin J Oncol Nurs* 14(5): 56–62
- Quinal L, Harford S, Rutledge DN (2009) Secondary traumatic stress in oncology staff. *Cancer Nurs* 32(4): E1–E7
- Remen NR (1996) *Kitchen Table Wisdom: Stories That Heal*. Riverhead Books, New York
- Royal College of Nursing (2020) *Building a Better Future for Nursing: RCN members have their say*. Available: www.rcn.org.uk/professional-development/publications/rcn-building-a-better-future-covid-pub-009366
- Ruotsalainen J, Serra C, Marine A, Verbeek J (2008) Systematic review of interventions for reducing occupational stress in health care workers. *Scand J Work Environ Health* 34(3): 169–78
- Sabin K (2013) Compassion fatigue in liver and kidney transplant nurse coordinators: A descriptive research study. *Prog Transplant* 23(4): 329–35
- Sabo BM (2006) Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *Int J Nurs Pract* 12(3): 136–42
- Schwam K (1998) The phenomenon of compassion fatigue in perioperative nursing. *AORN J* 68(4): 642–5, 647–8
- Showalter SE (2010) Compassion fatigue: What is it? Why does it matter? Recognising the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue and strengthen the professional already suffering from the effects. *Am J Hosp Palliat Med* 27(4): 239–42
- Stamm BH (2005) *The ProQOL manual. The professional quality of life scale: Compassion satisfaction, burnout and compassion fatigue/secondary trauma scales*. Idaho, USA: Idaho State University.
- Thielemann K, Cacciatore J (2014) Witness to suffering: Mindfulness and compassion fatigue among traumatic bereavement volunteers and professionals. *Social Work* 59(1): 34–41
- Upton KV (2018) An investigation into compassion fatigue and self-compassion in acute medical care hospital nurses: a mixed methods study. *J Compassionate Health Care* 5(7). Available online: <https://jcompassionatehc.biomedcentral.com/articles/10.1186/s40639-018-0050-x>
- West M, Bailey S, Williams E (2020) *The courage of compassion: supporting nurses and midwives to deliver high-quality care*. King's Fund, London. Available online: www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives



Gemma Hawtin, physiotherapy assistant, Leeds Community Healthcare NHS Trust

Making stuff better to provide the best care possible

'Innovation is a word we hear a lot. But what is innovation and quality improvement? How do we do it and what sort of process enables its success?'



The author's trust, Leeds Community Healthcare NHS Trust, has a dynamic methodology around quality and service improvement called 'Making Stuff Better'. It is a simple phrase, but holds some meaningful principles which the staff aim to follow.

The first is that everyone can make stuff better at work — we can all have ideas that can result in a positive difference. The second is promoting a culture of service improvement, where this approach can just happen and flourish.

My work around improvement and innovation was a wheelchair skills programme for children to help them develop independence and participation. This was started after I noticed that children in the specialist learning centres in schools were struggling to use their wheelchairs due to lack of independence. Staff were pushing children around, so the child was unable to make the choice of where to move.

Thus, after discussion with colleagues and managers, a new wheelchair skills training programme with a flexible child-centred approach was developed. This programme included, outcome measures at start and finish, 4–6-week sessions up to an hour with the physiotherapy assistant working on skills, games, confidence, independence and making their own choice to move.

After searching the internet, it became apparent that there were only charity run sessions locally, which occurred on an annual basis. I thus spoke to management about evaluating our wheelchair skills intervention at 4–6 sessions every other week with children at the specialist learning centre. The children responded well to the intervention and the parents thought it was a good idea. I used



this to create an intervention that could be used alongside our current interventions, i.e. hydrotherapy, rebound, constraint induced movement therapy (CIMT) and land-based sessions. This would also mean that, unlike previously, a child was not waiting a long period for a course with a charity who used to come in (funding for these sessions had also dropped).

The project gained momentum with these evaluations, with the PDSA (plan, do, study, act) cycle being used on a regular basis to help with development of the programme. Parents, and children using the wheelchair training, have

reported an increase in confidence and participation, as well as gaining increased independence and mobility with their newly learnt wheelchair skills.

The training package is now used by physiotherapy assistants across Leeds as part of the service offered. The fact that children can be seen by the physiotherapy assistant has also resulted in a 90% reduction in waiting times. Before the intervention was created, children had been waiting up to a year for a course.

The patient-centred nature of the programme is ongoing because, as said, it is constantly being re-evaluated to ensure it is relevant to the current situation for each individual child.

Seeing children's faces when they achieve their goals and are able to move the wheelchair with help and guidance makes it all worthwhile.

In October 2020, the project won the NHS Employer's Award for outstanding achievement by an allied healthcare professional (AHP), or healthcare science apprentice, support worker or technician in the Advancing Healthcare Awards (AHA).

The AHA judges said, 'The team showed a huge commitment to the



children they work with — their passion shone through... They did what they knew was the right thing and showed real leadership in action, taking more senior colleagues with them.'

The skills and knowledge, I've gained through creating this intervention has also enabled me to assist physiotherapists with other projects and areas of development, creating a better service for families. Indeed, families who have used the programme have told us that they think it works well for the children as it gives them independence and choice. The waiting times have made a huge difference. When the child revisited the wheelchair centre, most improved skills, kept their wheelchairs, and progressed rather than regressed due to being able to take part in the programme.

Trust manager, Sarah Cantwell, commented, 'It's been great to see the project grow from an initial idea to meet a gap in service into a training/ intervention package and outcome measure that has gone on to win an award. Gemma was full of enthusiasm and ideas which helped drive the project forward; all she needed from us was some guidance and encouragement along the way.

It's wonderful to see assistant staff lead on a project and develop their skills and confidence. It has certainly inspired the rest of the team too.'

A work colleague, Michelle Reynolds, shared that: 'Gemma's success with her project work has been inspiring. She has removed the barriers (perceived and actual) that had prevented me from engaging with project work. Knowing that she

is willing to share the knowledge she has gained makes me feel more confident to push myself further in my own project work.'

Three aspects became apparent from this service development, without which it would have floundered rather than flourished, namely:

- ▶ Culture
- ▶ Leadership
- ▶ Process.

The first is creating a culture where those who do the work name and create change. Myron Rogers, one of the world's leading system experts, in his famous 'Myron's Maxims' named three essential principles of work as:

- ▶ People own what they help create
- ▶ Real change happens in real work
- ▶ Those who do the work, do the change.

The second is open leadership. My manager was open, interested and supportive and trusted and let me explore and test ideas. This approach enabled innovation to happen. Leaders and managers should be enablers of creative innovation and service improvement.

The third is a process to allow ideas to become actions — where what we see becomes living improvement. This meant a clear plan of action and measures to gauge success. This was underpinned by reflection and feedback.

Part of the process was celebrating the work as it developed and unfolded. This involved listening to and acting on service user thoughts and reflections.

Sam Prince, director of operations at Leeds Community Healthcare NHS Trust said: 'Gemma is an inspiration and demonstrates our values and behaviours within Leeds Community Healthcare Trust. We actively encourage everyone to look at how they can continuously improve their work/role and "Make Stuff Better" ...'.

In the author's experience, the 'Making Stuff Better' approach helps release creativity, offer quality services and enhance the health experience of services users. **JCN**



Mary Speirs, director of nursing,
Coloplast

Outstanding people and outstanding partnerships

The day we got the announcement from the Care Quality Commission (CQC) confirming our nursing and telehealth service had been awarded 'outstanding', I felt so proud. I also thought about all the NHS nurses who are so incredibly tired and hardworking, and I wished they could all be told they too are outstanding. For after the 18 months they have had, they completely deserve it.

Of course, I already knew that the staff we have and the service we provide is truly outstanding, but having the CQC confirm this, is such a fantastic recognition of the hard work the team at Coloplast put in every single day to make life easier for people living with intimate healthcare needs. Receiving this rating means that Coloplast is the only one in its field to have received an 'outstanding' rating for a service like this in England.

Our extensive experience in developing products and services for people with deeply personal medical conditions, which are often associated with trauma and taboo, means that we know it makes sense to be able to deliver care based around a person, removing some of the administrative burden, plus treating them, where possible, in a place of their choice. This administrative burden includes finding information about lifestyle, returning to work, going on holidays, diet and nutrition. We can also arrange for the collection of the GP prescription when

needed and signpost to other sources or support services.

Our CQC accredited service can be trusted to deliver for patients, their families and the NHS.

For many years now, Coloplast UK has invested in clinical and nursing teams to support customers, patients, and their loved ones, with their ostomy, continence, wound care and interventional urology product needs. We do this by providing a range of services to the NHS, including community nurse partnerships and telehealth services. This not only helps those living with intimate healthcare needs to live their lives to the full, but also significantly reduces pressure on the NHS. This is something that has become of even greater importance over the last eighteen months, when our health service has been tested like never before.

We work by helping the NHS to respond to patients' needs by establishing joint pathways of care. Our team undertake clinical and lifestyle reviews with individuals, their families and carers, during which the specialist advice we give can prevent complications occurring and ensure that they are getting the best out of their products. In addition, our staff are trained and able to detect any problems an individual might be currently experiencing during these reviews, ensuring that there is efficient and timely referral to the appropriate clinical team where required. We always escalate when clinical or medical issues are identified; our staff are trained in safeguarding, consent and data protection. As a result of our nursing and telehealth teams, there are:

- ▶ Fewer emergency admissions to hospital
- ▶ A reduction in the need for

potentially avoidable GP appointments

- ▶ The prevention of social and economic difficulties for individuals often associated with the poor management of such conditions. For example, this might mean fewer emergency admissions to hospital or a reduction in the need for potentially avoidable GP appointments. This can be quantified by data from Coloplast Charter Telehealth Service Data in 2018: 31% of patients who benefited from Charter would have accessed NHS services if they had not received this support, amounting to £100,000 per year equivalent NHS appointment costs, thus reducing demand in the system from this group of patients.

Indeed, the CQC inspection found our staff go 'the extra mile'.

We like 'a first' at Coloplast. Ours was the first commercial nursing team in our field to obtain CQC registration in 2011 and has achieved consistently successful inspections for the safety and quality of care delivered. As part of our commitment to provide appropriate and continuity of care, we were successful in extending our nursing service CQC registration to include telehealth services in 2018. As a result, we are currently the only private provider in our field to offer a CQC registered joint nursing and telehealth service.

Our latest CQC inspection took place in June. As you would expect, it was a rigorous process. The CQC spent time in clinics with nurses, met the teams and leaders involved, including myself, and most importantly, asked patients, carers and customers themselves for their views on our service. (Patients can



*Before use, always consult the 'Instructions For Use' document provided with the products.

Wound management can be complicated, choosing the right solution doesn't have to be.

When you want to create optimal healing conditions for your patients' wounds, you need an optimised solution. After assessing your patient, prepare the wound with the Alprep Pad and then choose a wound bed conforming dressing, such as Biatain Silicone, based on your treatment objectives.

Visit www.coloplast.to/wound-care to request your free samples.



Alprep® Pad
Biatain® Silicone

access our clinics via GP or healthcare professional referral, or through self-referral via Coloplast Charter.) The inspection reviewed the service's performance against a wide range of criteria, including staffing levels, infection control measures and staff training and competencies.

Following the feedback they received and their own assessments, the CQC report described us as having staff who are 'committed and prepared to go the extra mile to provide care for their patients'. The report goes on to say that staff in the nursing and telehealth service 'treated patients with compassion and kindness and respected their privacy and dignity. Staff took account of their individual needs and helped them understand their conditions'. In addition, the CQC 'found highly dedicated and passionate staff who were committed to providing a good service for patients and partner organisations. All staff we spoke with were positive, knowledgeable and passionate about their work.'

To say that I am proud of our team, the culture we have fostered of utmost commitment to high quality care, and all of what we have achieved is an understatement.

Here is just one example of where our team has gone the extra mile to

ensure patient safety, helping avoid additional complications and accessing NHS services.

As part of a community review partnership, one of our stoma care nurses contacted an established stoma patient who also suffers with chronic obstructive pulmonary disease (COPD) to offer a home visit. During the call, the patient became very breathless, distressed and wanted to call 999. Our nurse visited the patient within the hour, carried out a full assessment, concluded a chest infection and put the patient on a nebuliser. Following the visit, the nurse informed the patient's GP of the situation, referred the patient to the community catheter support team and reinforced his stoma care routine.

WHERE DO WE GO NEXT?

So, what's next for the team? Few can deny that the current Covid-19 pandemic has been one of, if not the greatest challenge the NHS will have faced over its years. We have strived to support the NHS in any way that we can during this time, and we will continue to display the drive and determination to deliver trusted advice and care to support people with intimate healthcare needs.

Where the public has looked after

vulnerable neighbours or people have made homemade scrubs, facemasks and laundry bags for NHS staff, has shown how kindness has been king over recent months. I, along with the other senior staff at Coloplast, will also be making sure we look after our nurses too and thank them for all of their hard work at such a difficult time.

This outstanding CQC rating means that patients and healthcare professionals can continue to have the utmost confidence that Coloplast's nursing and telehealth services are nationally recognised for providing high quality care. We are constantly striving to evolve and improve the service we deliver, and this rating will spur us on even further. We will use this recognition as a testament to our work, but also an opportunity to reflect and consider what we can do even better in the future.

We are proud of all that we do and the dedication shown by our members of staff, particularly through the difficult last eighteen months when our patients and consumers have needed us most. However, we are only one part of the system that makes the life of a person with intimate care needs that bit easier. So, to all my nurse colleagues out there in the NHS, I want to say that we think you are all outstanding. **JCN**

Members of the Coloplast nursing and telehealth team.

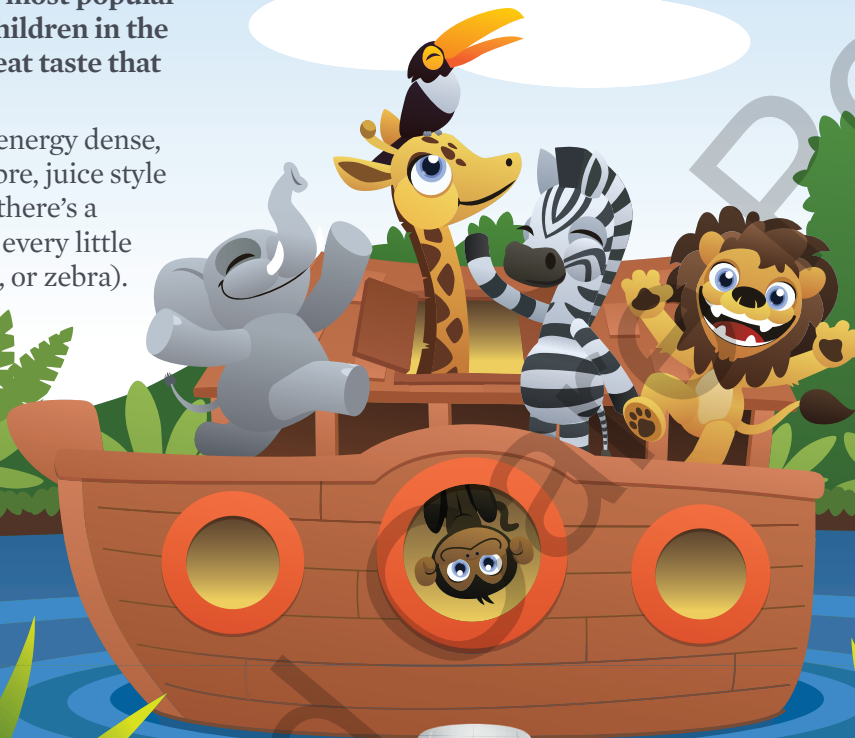


PaediaSure®

THERE'S A PAEDIASURE TO SUIT EVERYONE ON BOARD

PaediaSure is the most popular ONS* brand for children in the UK,¹ and has a great taste that kids love.²⁻⁵

From standard to energy dense, with or without fibre, juice style or peptide-based, there's a PaediaSure to suit every little monkey (elephant, or zebra).



*Oral Nutritional Supplement

REGISTER FOR A FREE DIRECT-TO-PATIENT SAMPLE AT samples.nutrition.abbott

HELPING KIDS BE KIDS AGAIN



life. to the fullest.

References: 1. Data on file. Abbott Laboratories Ltd., 2019 (IMS data, May 2020 - April 2021). 2. Data on File. Abbott Laboratories Ltd., 2007 (PaediaSure Plus & PaediaSure Plus Fibre taste testing). 3. Data on File. Abbott Laboratories Ltd., 2013 (PaediaSure Fibre taste testing). 4. Data on File. Abbott Laboratories Ltd., 2013 (PaediaSure & PaediaSure Peptide vs. Peptamen Junior Powder). 5. Data on file. Abbott Laboratories Ltd., 2017 (Sensory research and evaluation: PaediaSure Plus vs. PaediaSure Compact).

Date of preparation: May 2021 UK-PDS-210007

Abbott



Roger Black MBE, founder of www.rogerblackfitness.com

Keeping the nation's nursing profession moving...

'It may be easy to push health and fitness down a list of priorities when working crazy shifts, but consider the wise words of Aristotle: 'We are what we repeatedly do.'

lifestyle that I now lead. Many of you may work long shifts within stressful environments and struggle to eat regular meals and practice self-care. Then you might log on to social media and feel overwhelmed with health and fitness advice. You may even feel you are under-achieving or inadequate in relation to your health and wellness when you see the fitness regimes of others. We all need to find a routine that fits into our working and personal life, that is both achievable and realistic and becomes our normality — a daily habit.

The Roger Black Fitness strapline is 'fitness for every body'. Health and wellbeing is for all and is prescriptive to you and you only. It may be easy to push health and fitness down a list of priorities when working crazy shifts, but consider the wise words of Aristotle: 'We are what we repeatedly do'.

Fitness needs to become a habit and slot into your day, without associating guilt or fear of 'not having enough time' for you and your physical and mental wellbeing. If you can't exercise outside, you can work out at home or do some stretching during a work break. We need to keep surprising our bodies and to keep them active and mobile. But exercise doesn't have to be for long periods of time. It just needs to be frequent.

So, how much exercise should we be doing? While numbers vary, according to a 2021 CNN report, the Norwegian School of Sports Medicine conducted research into time spent exercising per day as a precursor to life longevity. They found that just 11 minutes of moderate exercise, equivalent to a brisk walk, had a noticeable effect on

In the late '80s, Soul II Soul released the song 'Keep on Movin'. At the time, I thought I was invincible. I was European and Commonwealth 400m champion and it became the anthem for my trackside warm-ups. Back then, I didn't think about my fragility or the fact that I had a congenital heart condition to consider every time I stepped onto the track. I kept on moving. And fast. It all changed when I broke my foot and was on crutches for several months. I would have given anything to get moving again; to compete for Great Britain and challenge for medals on the track against the world's best athletes. I slowly recovered, began moving again, and after nearly two years, was once again back on the warm-up track listening to Soul II Soul and dreaming of Olympic success.

Roll forward to today; I'm a 55-year-old with two dogs, three children, a busy family life, juggling a portfolio of businesses and living with a far greater respect for my heart condition. I'm still able to relive the glory days of winning World and Olympic medals by speaking at conferences and dinners, which often reminds me that time stands still for nobody. I am now in my sixth decade and managing my health and fitness in the best way I can, with very different goals.

Since retiring from athletics in 1998, the question I am most frequently asked is: 'What exercise do you do now?'. I find this fascinating. Of all my life experiences, from winning Olympic medals, to Strictly Come Dancing (fifth place, series 2!), it is my fitness regime that people are most interested in. As a nation exposed to so much social media, health and fitness has never been more visible. Back in my athlete days, in the '80s and early '90s, we were limited to video sets and breakfast TV with Mr Motivator or The Green Goddess. We can now access the world of fitness at the click of a finger, whenever we like and wherever we are.

My answer to the question is this: I go for a 30-minute jog most mornings with my wife, Jules, and the dogs and then enjoy a variety of activities throughout the week, including swimming, tennis, outdoor games with my children or inside on my home fitness equipment — I've had to give up football as my ageing knees made it hard for me to move the next day! I try to eat well, enjoy a drink, a Netflix binge and the occasional takeaway. But everything within reason. The important thing for me is to include fitness as a daily 'habit'.

My routine certainly isn't groundbreaking. It just fits in with the

your life expectancy, with optimum results derived from those who exercised 35 minutes a day (www.cnn.com/2021/01/06/health/daily-exercise-increase-life-span-study-wellness/index.html).

Covid not only put health centre stage around the world, but also showed us the value of managing ourselves better mentally, physically and emotionally, particularly if we are clinically vulnerable in terms of age or condition. During lockdown, it was also reported that we should move our bodies for five minutes every hour to counteract inactivity (www.sciencedaily.com/releases/2021/03/210322112904.htm).

While we were inside, with gyms and sporting facilities closed, many people took great joy in their one hour of outdoor exercise a day. We valued it and prioritised it. Finding joy in exercise doesn't have to be high-brow or complicated. If you are limited on time and funds, there are always solutions to improve your overall health without spending over the odds.

If you don't have weights or fitness equipment at home, you can be creative by using cans or bags of rice as weights; use a chair or wall to stretch against, or a belt as a yoga strap. Walk up the stairs or brave two at a time; there are sustainable fitness choices to be made throughout the day.

When my mother-in-law was recovering from heart surgery some



Right to left: Roger Black, John Regis, Kriss Akabusi and Derek Redmond winning gold for the relay at the World Championships in 1991. Photograph reproduced courtesy of Mark Shearman.

'Covid not only put health centre stage around the world, but also showed us the value of managing ourselves better mentally, physically and emotionally, particularly if we are clinically vulnerable in terms of age or condition.'

years ago, her nurses encouraged her to take short walks or at least to try and get out of bed (as soon as she was able) as part of her rehabilitation process. There is also the mindset of getting a patient ready for surgery, as suggested by some GP friends of mine. Increased fitness levels, statistically, may lead to quicker recovery times.

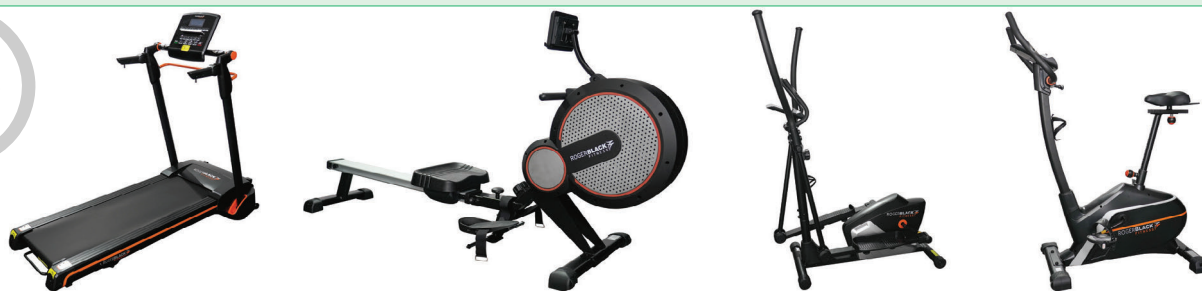
We are more grateful than ever for the dedicated work of the nursing profession and can only imagine how challenging the pandemic must be for you all. Investing in yourself is a commitment for life. A car won't run on empty and neither will you. You owe it to yourself, your family and your patients to be the best version of yourself possible, whatever that means to you.

At Roger Black Fitness, we have customers who decide to get fit in their 70s and 80s and we love hearing their stories. It is never too late to change your fitness routine, except when you can no longer keep moving. In the words of 'Soul II Soul' '...Keep on moving, Don't stop, like the hands of time...'. **JCN**

Special offer for JCN readers...

Roger Black is offering every reader of the *Journal of Community Nursing* a 10% discount on any purchase from the Roger Black Fitness range of folding and static home fitness equipment. Use code 'JCN10' when checking out at: www.rogerblackfitness.com. Offer is available until 31 December, 2021.

Got a question about the range? Email #TeamRBF at hello@rogerblackfitness.com





Emily Stuart, dietitian,
Wiltshire Farm Foods

Eating with your eyes: fighting malnutrition

'Exploring the reasons behind weight loss is a viable route to go down, as malnutrition is not always an inevitable consequence of infections, illness or ageing — nutrition plays a crucial role in health and recovery.'

For those living with swallowing difficulties — otherwise known as dysphagia — it is not just the physical side-effects of the condition that can be debilitating. Eating home-blended texture-modified food that one is not accustomed to can, despite best efforts, often be unappealing and have a negative impact on a person's quality of life.

Josephine Bailey has dysphagia as a result of oesophageal cancer and did not enjoy the experience of home-blending once discharged from hospital three years ago:

I'd lost a massive amount of weight and didn't want to be tube fed anymore. Mealtimes were becoming really stressful. I didn't know what to eat, I was pureeing everything with my hand-held blender, which wasn't working very well, and everything resembled mush.

There are a number of things that nurses can do to support malnutrition management. Exploring the reasons behind weight loss is a viable route to go down, as malnutrition is not always an inevitable consequence of infections, illness or ageing — nutrition plays a crucial role in health and recovery. Sufficient protein is important to regain muscle mass and strength (as well as repairing damaged tissues), so promoting rich foods such as meat, fish, eggs, cheese, beans and pulses is recommended.

Those living with dysphagia are frequently at risk of malnutrition,

with studies showing that some 51% are malnourished (Rofes et al, 2011). Any healthcare professional will know that when a patient is unwell or apprehensive about eating food, encouraging them to eat a full meal can be a challenge due to reduced appetite. This can be made worse when food is unappetising, something again which is often a challenge for those on texture modified diets.

Being presented with a pureed meal that does not resemble food that a patient is used to can make the eating process even harder. People with dysphagia still eat with their eyes and if a meal is not visually appealing this can fail to trigger salivation, which can further negatively impact the already weakened swallowing process.

Josephine adds:

My healthcare professional recommended Wiltshire Farm Foods as they have meals with different levels to suit various swallowing needs. So, it means I'm able to switch from level 4 to level 5 depending on how my dilatations go. The meals look and taste great and were a welcome relief from my home-blended food.

At the time I started ordering them, I was having radiotherapy and wasn't feeling well, so also appreciated the convenience of having them delivered. This meant I could just pop a meal in the microwave straight from the freezer, which really did take the stress out of mealtimes.

The latest innovation from Wiltshire Farm Foods involves the 'browning' effect of its duchess potatoes across the company's award-winning level 4 Purée Petite range, to enhance the visual appeal of its meals even further and bring the dignity back to dining.

Favourites such as Puréed Steak Casserole, Puréed Cheese & Onion Bake and Puréed Lamb & Gravy are now accompanied by delicious looking browned potatoes; an innovation which Josephine — who enjoys the pureed meals — is delighted:

For me, having a meal which resembles regularly textured food is an all-important part of the inclusivity factor of mealtimes, especially when we have friends or family round. These new 'browned' potatoes don't just look and taste fantastic, they're also the right texture for my swallowing needs, so they really do tick all the boxes.

REFERENCE

Rofes L, Arreola V, Almirall J, et al (2011) Diagnosis and management of oropharyngeal dysphagia and its nutritional and respiratory complications in the elderly. *Gastroenterol Res Pract* 818979



GPN Academy

FREE online platform for all your CPD needs

Struggling to keep up to date with your clinical and personal development?

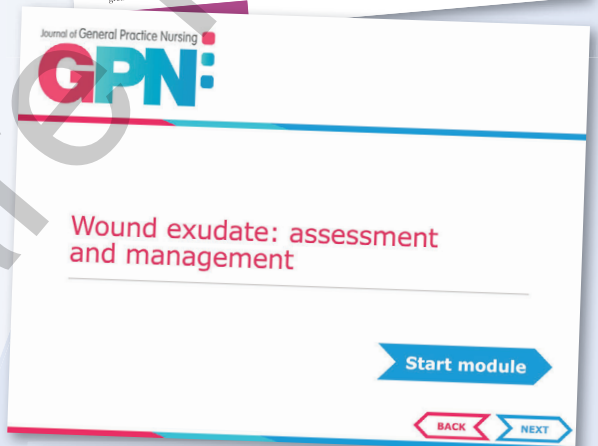
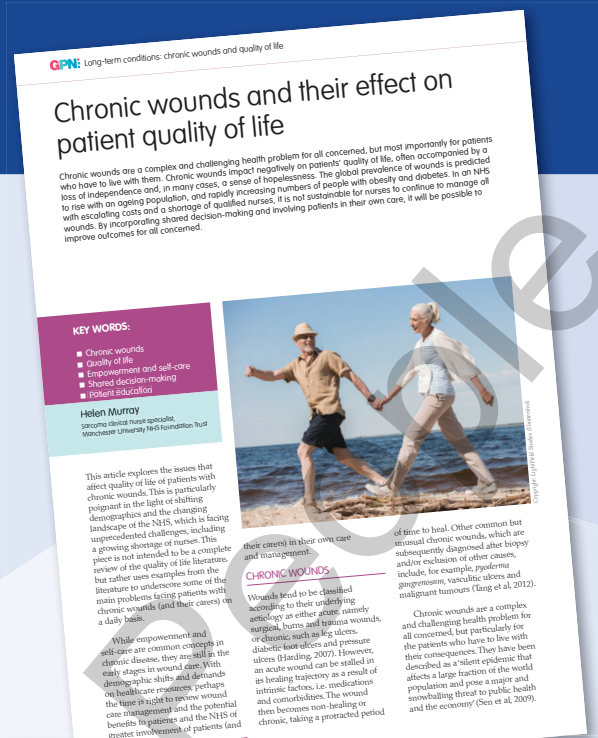
The new GPN Academy, brought to you in partnership with HARTMANN, might just be the answer. Not only can you improve clinical skills through the academy's e-learning modules, articles and videos, but also create your personal development plan through a range of units on key areas such as leadership, business planning, project management etc... and all while building evidence of your CPD.

So, log on today and get involved in this accessible and engaging FREE e-learning platform:

www.gpnursing.com/hartmann-academy



Going further for health





Matthew Bradby, head of communications, QNI

International recruitment in community nursing

'... new project to support the recruitment of internationally trained registered nurses to community service providers in England.'

The Queen's Nursing Institute (QNI) has recently launched a new project to support recruitment of internationally trained registered nurses to community service providers in England, in line with the overall national strategy to fill nursing vacancies and secure a sustainable workforce (www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf).

This work is supported by NHS England and Improvement and dovetails with the work they are undertaking to support six pilot sites around the country with their international recruitment to the community efforts (www.england.nhs.uk/nursingmidwifery/international-recruitment/). The QNI project is not limited to the pilot sites and may be of relevance to any organisation that employs registered nurses in the community.

While the QNI does not employ nurses in a clinical capacity and is not in a position to support individual nurses who are applying from overseas, we hope that the information and learning from this project will make the process of coming to work in England smoother for employers, managers and overseas applicants alike.

Coming to a new country to work is never going to be a straightforward process, even when

the host country is urgently seeking workers from overseas. The QNI is working to respond to the new requirement to bring more nurses in to support community services, and to develop new knowledge and best practice in this field. We have created a new area on the QNI website where we are bringing together resources and we are very keen to hear from anyone who has a story to tell, or a case study to contribute (*read Fabio Trovato Monastra's story opposite*).

Historically, international recruitment has mainly focused on hospitals, and hospital trusts have been the major recruiters of overseas nurses. Many of these nurses will transition to community roles in time. However, there is no reason in principle why a nurse coming to work in England (or any other part of the UK) cannot start in the community straight away.

The QNI has a long track record of working in international recruitment and sharing of knowledge internationally. The QNI's original model of district nursing was used by many other countries when they developed their own home nursing services, such as Singapore, Malta, Canada, Australia and Kenya, and in turn many nurses from overseas have come to the UK to help staff community services for as long as the NHS has existed.

In this new project, the QNI will act as an independent 'hub' for information about international recruitment, and, as such, we would like to be able to assist healthcare managers and nurses who are seeking to find out more about recruiting from overseas to the community, and also from overseas nurses who are either recently arrived, or who are thinking about coming to England and are trying to find out more about what to expect, how to prepare, and how to navigate the practicalities and legalities.

A series of events are being held over the coming months about international recruitment, to share knowledge and learning, and information about these will be shared on our website and social media.

The QNI is also developing a new private Facebook group for those interested in international recruitment, and this will be linked to the QNI's main Facebook page, which you can follow at: www.facebook.com/TheQNI **JCN**

FIND OUT MORE...

To find out more about the QNI's international recruitment work, please visit our website at: www.qni.org.uk/nursing-in-the-community/international-recruitment-to-the-community/

If you would like to contact us, to ask about writing a blog or contributing any other resource that might be useful to others, please email us at: mail@qni.org.uk

Reflections on life as an international nurse: what I wish I'd known...

Here, Fabio Trovato Monastra, who after graduating with distinction from University La Sapienza, Rome, initially began his nursing career in Italy and now has five years' experience as deputy theatre manager and nurse at Highgate Private Hospital and for the NHS, talks about the ups and downs of being an international nurse in the UK.

Being an international nurse was one of the best choices I ever made. If you are considering an experience abroad, I would strongly recommend it. However, you may want to consider a few points before embarking on this undertaking to ensure it is the right choice for you.

When you work in a different country, you will learn new and different systems which you will automatically compare with the ones you came from. This learning opens up your mind, and you are able to pick the best from both systems and improve your skills as well.

Although full of personal development and growth, life as an international nurse is not an easy journey; it takes a great deal of courage and mental preparedness. When you move to another country, one of the first hurdles you may encounter is the language barrier, compounded by local accents, slang and dialects.

Due to the challenges of being an international nurse, many do not stay for the long haul. In no way do I aim to discourage people; I simply wish I had been warned of the pitfalls and hardships before I moved to the UK, so that I would have had more realistic expectations and would have been better prepared.

As should be apparent, nursing is not a regular job, and our textbook education is just

'Working with colleagues from all over the world makes your experience abroad richer, but you will be confronted with different opinions, perspectives and working styles. Flexibility is key and being able to communicate despite the differences is important.'

half of what we are expected to perform. Nursing involves a lot of interpersonal skills that you learn along the way. I have worked with diverse cultures and personalities, and each of them has taught me how to accept diversity — a soft skill that I am proud to have developed.

Working with colleagues from all over the world makes your experience abroad richer, but you will be confronted with different opinions, perspectives and working styles. Flexibility is key and being able to communicate despite the differences is important. Acceptance and understanding flourishes with time and effort.

As nurses, we put the needs of our patients above anything else. Sometimes you can encounter patients who display prejudices and preconceptions. You may feel discouraged, but in nursing it is imperative to maintain a high level of professionalism. You must try and deliver the best care possible, regardless of their attitude.



Fabio Trovato Monastra, CEO, Rohme (www.rohme.uk)

Thankfully, this is rare. Most of the time you will find lovely people, full of gratitude for your hard work, who will share with you their amazing life stories (I have heard so many over the years).

There are many support networks and programmes available to help international nurses acclimatise to their new environment. Many nurse entrepreneurs, including myself, aim to facilitate healthcare professionals' international experience. With Rohme, I offer as much knowledge and information as possible. You can contact me at: fabio@rohme.uk or LinkedIn (www.linkedin.com/in/fabio-trovato-monastra-78922b171/).

If you are considering becoming an international nurse, you will most certainly learn new skills and improve existing ones. Overcoming the challenges will be the biggest reward and achievement. **JCN**

Pandemic prompts ERIC to diversify services and go digital

Like many organisations and charities, the Covid-19 pandemic hastened a rapid period of adaptation and diversification at ERIC, The Children's Bowel and Bladder Charity. Here, Alina Lynden, ERIC's communications manager explains how the charity has risen to the challenge.

2020 — SURVIVING THEN THRIVING

The beginning of lockdown back in March 2020 meant we experienced a drastic drop in income from our shop and training programme. Most of the ERIC team were furloughed. But, with the help of generous donations from our service users, supporters and emergency funding from the Charities Aid Fund, we managed to keep our helpline open so that families could continue to access one-to-one support.

With NHS services reduced as resources were reallocated to deal with the pandemic, our helpline was a lifeline for parents.

During lockdown when all our support networks were taken away, you were the only ones that treated us like a normal family and were able to offer support. To be honest, it saved us.

Faith, ERIC helpline user

An emergency appeal during this difficult period was hugely successful and exceeded the £7,500 target. We are so grateful for the incredible outpouring of support and generosity we received, allowing us not just to continue, but also develop our service.

RESTARTING SERVICES AND GOING DIGITAL

While nobody could have been prepared for events over the last 18 months, our team had fortunately already been preparing for a digital world — becoming more flexible and adaptable. This undoubtedly made it easier to operate remotely as more staff returned to work.

As lockdown restrictions eased, our services were able to hit the ground running — with our online shop providing products to help families cope and generating income to fund vital services (www.eric.org.uk/shop). An expanded range of products includes a variety of reminder watches, which are a great way to prompt children to take medication, drink and use the toilet.

We are also delighted to have cuddly toy versions of our popular wee and poo characters for sale. Designed exclusively for ERIC, these adorable toys are perfect for cuddles when potty training and helping to raise awareness of bladder or bowel conditions within the home, nursery, school, clinic or workplace. The profits from each set purchased supports our charitable services.

EXPANDING OUR FAMILY SERVICES AND RESOURCES

There have also been some exciting developments for our family services offering with a podcast series launched in 2020 (www.eric.org.uk/podcast). Each episode covers a topic or question that is commonly raised by callers to our helpline, such as toilet training children with a disability and following National Institute for Health and Care Excellence (NICE) guidelines on treating childhood constipation with a disimpaction regime. If there is a topic you'd like us to cover in future episodes, or maybe you'd like to take part in a podcast as the expert, please send an email to: alina@eric.org.uk

We've also started broadcasting live on Facebook and Instagram answering questions about



bedwetting and potty training (www.eric.org.uk/potty-training). All the recordings of these Q&As and a Potty Training webinar series are available to watch again via our YouTube channel. Click the YouTube icon on ERIC's homepage to watch this and other videos.

The bowel area of our website has been updated with a new 'Advice sheet for children with constipation' (www.eric.org.uk/advice-for-children-with-constipation), which can be translated into other languages using google translate. Keep an eye on our website for lots more resources like this coming soon.

AWARD WINNING GUIDANCE RECOGNISED

Back in November 2020, we were thrilled to win a *Nursing Times* Award for our best practice guidance document 'Managing Continence Issues at Nursery, School and College'. The award recognised a partnership approach with co-authors Bladder and Bowel UK (BBUK) to providing guidance and practical support for children at school in the category 'Continence Promotion and Care'.

ONLINE TRAINING OPPORTUNITIES

Another outcome of the pandemic has meant that our training programme for health and education professionals transferred online. This proved to be hugely successful reaching many more people than we previously have via face-to-face training — over 900 professionals since January 2021! Attendees have joined from across the globe, including from as far afield as Iceland and Australia, Brazil, New Zealand!

BOOK YOUR PLACE AT OUR VIRTUAL ROADSHOW

ERIC's first ever virtual roadshow will be taking place throughout the week starting 15th November 2021. The format will be a series of short workshops ranging from one to two hours long. The aim is to try and cover new topics, or look at certain aspects in more detail, to offer professionals further opportunities for learning in addition to our standard training programmes. Explore the programme and book your ticket now (www.eric.org.uk/roadshow21).

This event is supported by an unrestricted educational grant from Ferring Pharmaceuticals Ltd

NEW PATHWAY FOR CHILDREN'S CONSTIPATION SERVICES NEEDS YOU

Juliette Rayner, ERIC's CEO, explains what this exciting new project involves and how you can be a part of it:

The Paediatric and Transition Workstream of the NHS England-led National Bladder

KEEPING IN TOUCH...

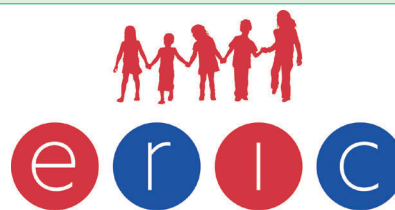
Get all ERIC's latest news, up-to-date resources and training dates at: www.eric.org.uk

Follow us on:

Facebook: ERIC.UK1/

Twitter: ERIC_UK

Instagram:eric_charity and lets.go.potty



The Children's Bowel & Bladder Charity

About ERIC

ERIC is dedicated to helping all children and teenagers manage and overcome distressing continence conditions. Whether it is a toilet-training issue, bedwetting, constipation or soiling problem, ERIC provides expert support, information and understanding to children and young people and enables parents, carers and professionals to help them establish good bowel and bladder health. ERIC's family support includes a free helpline, parent and family workshops, online resources and information. Support for professionals includes training targeted at the needs of the health, education, early years and social care sectors, and working with children and families. Professionals can also access ERIC's free helpline, online tools, resources and information.

Helpline: 0808 169 9949
Email: web@eric.org.uk
Website: www.eric.org.uk

and Bowel Health Project is now well underway.

We are very excited to be working in collaboration with the NHS Children & Young People Transformation Board for the South West and the NHS LeDeR Morbidity Review Team.

Who do we need to join this project?

We are now recruiting to the sub-groups and are particularly keen to hear from community midwives, nursery nurses, health visitors and school nurses. Or, indeed, anyone with an interest and knowledge of providing services, support and education. Our vision is for:

- ▶ Healthcare professionals to have a better understanding of constipation in children and young people and know how to manage it better
- ▶ Parents and carers to have a better understanding of constipation in their children
- ▶ Adolescents to have a way of discussing their bowel issues in a safe, confidential and sensitive environment.

Together, we can make a real

difference to the lives of children and young people with constipation, including those with learning disabilities and autism.

The paediatric and transition workstream has set up three task/finish sub-groups, each with a specific remit to work towards and agree a consistent approach to developing a pathway for constipation from pre-birth to adult services:

1. Birth to four years
2. GP engagement
3. Unplanned hospital admissions.

If you'd like to be involved and get more information, please contact: juliette@eric.org.uk

LOOKING AHEAD

We continue to develop our virtual information and learning offering for parents, carers, healthcare, school and early years sectors. We are working on several exciting new projects focused on raising awareness of healthy toilet habits in primary schools, potty training, and working directly with teenagers to create new, age-relevant resources. **JCN**

Cow's milk allergy (CMA) symptoms present in 2–3% of all infants versus 0.5% of breastfed infants in the first year of life and can impact on growth and quality of life of the child (Venter et al, 2017; National Institute for Health and Care Excellence [NICE], 2021). Once CMA is diagnosed, hypoallergenic formulas are recommended if exclusive breastfeeding is not possible or the mother chooses a mixed feeding approach (Venter et al, 2017; Fox et al, 2019; NICE, 2021). This product snapshot reviews the diagnosis and management of CMA and focuses on Alimentum® and EleCare®, hypoallergenic infant formulas that are clinically effective at the best value price (price per 100ml) (Sicherer et al, 2001; Data on File, 2020; MIMS, 2021).

DIAGNOSING COW'S MILK ALLERGY

Many standard infant formulas are based on cow's milk and so babies have exposure to these proteins from an early age, when breastfeeding is not possible or parents opt for mixed feeding.

Cow's milk allergy (CMA) is an immune-mediated response to one or more of the proteins in cow's milk and is one of the more common food allergies seen in early childhood (NICE, 2020). CMA may be immunoglobulin E (IgE)-mediated or non-IgE-mediated (or a combination of both), which can be distinguished by the presenting signs and symptoms and speed of signs and symptoms onset following ingestion of cow's milk (NICE, 2020):

- ▶ IgE-mediated: signs and symptoms such as urticaria, angio-oedema, itching, wheeze or breathlessness usually occur within minutes or up to two hours after ingestion
- ▶ Non-IgE-mediated: signs and symptoms such as gastro-oesophageal reflux disease, abdominal pain, constipation, diarrhoea, and atopic eczema usually occur 2–72 hours after ingestion.

The signs and symptoms of both IgE- and non-IgE-mediated CMA can range from mild-to-moderate to severe. Some of the signs and symptoms are common in otherwise well infants, particularly in those with mild-to-moderate CMA symptoms, making diagnosis difficult (Venter et al, 2017). Physical examination and an allergy-focused clinical history are important diagnostic tools to differentiate CMA from other conditions (Venter et al, 2017).

The International Milk Allergy in Primary Care (iMAP) guideline encourages early recognition of CMA and emphasises the need to confirm or exclude the diagnosis, either by allergy testing (if IgE-mediated) or exclusion and reintroduction of cow's milk (if non-IgE-mediated). Infants presenting with mild-to-moderate symptoms can be diagnosed and managed in primary care, but those with more severe symptoms should be referred to the local paediatric allergy service (Fox et al, 2019).



MANAGING COW'S MILK ALLERGY — IMAP GUIDELINE

CMA may occur in infants who are exclusively breastfed as well as those who are formula fed or on a 'mixed feeding' regimen of breast and formula. Exclusive breastfeeding is the first-choice recommendation for infants until six months of age, and this should be actively encouraged and supported where possible (Fox et al, 2019):

- ▶ If an exclusively breastfed infant is symptomatic, a strict elimination of cow's milk containing foods from the maternal diet is recommended. Daily supplements of calcium and vitamin D are also recommended (early support from a dietitian is

Practice point

eHF contains small peptide chains which have been hydrolysed or broken down and are less likely to cause an allergic response. AAF, or elemental formulas, contain proteins that have been broken down to their constituent amino acids. These are suitable for infants with more severe or multiple food allergies.



Alimentum (Alimentum Datasheet, 2020)

- ▶ Nutritionally complete hypoallergenic formula
- ▶ Contains extensively hydrolysed casein to manage the symptoms of CMA
- ▶ Contains 2'-FL[†] to help support an infant's developing immune system
- ▶ 33% of fat blend is medium-chain triglycerides (MCT)
- ▶ Osmolality 290 mOsm/kg H₂O (low osmolality is important as infant formulas with higher osmolality may lead to diarrhoea and feed intolerance)
- ▶ Best value eHF in the UK (price per 100 ml) (MIMS online, 2021)

EleCare (EleCare Datasheet, 2020)

- ▶ Nutritionally complete hypoallergenic formula
- ▶ 100% amino acid based for severe CMA and/or multiple food allergies
- ▶ Contains 2'-FL[†] to help support an infant's developing immune system
- ▶ 33% of fat blend is medium-chain triglycerides (MCT)
- ▶ Osmolality 300 mOsm/kg H₂O (AAF with lowest osmolality in the UK)
- ▶ Best value AAF in the UK (price per 100 ml) (MIMS online, September 2021)

advised to facilitate this) (Venter et al, 2017; Fox et al, 2019; NICE, 2021)

- ▶ If exclusive breastfeeding is not possible or the mother chooses a mixed feeding approach, a trial of hypoallergenic formula should be initiated:
 - The iMAP guideline suggests that in most cases an extensively hydrolysed formula (eHF) should be initiated for infants with CMA, with amino acid-based formulas (AAF) recommended if an eHF is not well tolerated or if no clear improvement is seen (Venter et al, 2017; Fox et al, 2019; NICE, 2021).

ALIMENTUM AND ELECARE — FOR INFANTS WITH CMA

Alimentum (eHF) and EleCare (AAF) are hypoallergenic formulas, designed to support infants with CMA. They are the first and only infant

formulas to contain 2'-fucosyllactose (2'-FL)[†], the most abundant of the human milk oligosaccharides (HMOs) found in most mothers' breast milk. HMOs are unique prebiotics and 2'-FL has been shown to help support an infant's developing immune system, aiding development of the gut microbiome, helping gut barrier maturation, providing anti-pathogenic effects and modulating the immune response (Marriage et al, 2015; Goehring et al, 2016; Reverri et al, 2018). Abbott has been researching HMOs for more than 20 years and has a long heritage in this area (Erney et al, 2000).

Remember...

Alimentum and EleCare are hypoallergenic infant formulas for rapid symptom resolution and healthy growth in infants with cow's milk allergy.



Formula fed babies are more vulnerable to immune challenges than breastfed babies and face higher risks of infection, inflammation, eczema and allergies (Gdalevich et al, 2001; Bachrach et al, 2003; Kainonen et al, 2013). Studies have shown that babies fed standard formula with 2'-FL[†] have fewer reports of respiratory infections, significantly lower levels of multiple inflammatory cytokines (comparable to levels seen in breastfed babies), and significantly fewer parent reports of eczema (Marriage et al, 2015; Goehring et al, 2016; Reverri et al, 2018).

CONCLUSION

CMA is one of the most common infant food allergies and hypoallergenic formulas are recommended as a management option (NICE, 2021). Alimentum and EleCare are the first and only infant formulas to contain 2'-FL[†], the most abundant HMO found in most mothers' breastmilk that helps to support an infant's developing immune system (Marriage et al, 2015; Goehring et al, 2016; Reverri et al, 2018). They have been shown to quickly resolve the symptoms of CMA, support healthy growth in infants with CMA and are the best value hypoallergenic formulas of their kind (Data on File, 2020; Sicherer et al, 2001; MIMs online, 2021).

[†] 2'-FL: 2'-fucosyllactose used in this formula is biosynthesised and structurally identical to the human milk oligosaccharide (HMO) found in most mothers' breast milk.

IMPORTANT NOTICE: Breastfeeding is best for infants and is recommended for as long as possible during infancy. Alimentum & EleCare are food for special medical purposes and should only be used under the recommendation or guidance of a healthcare professional.

For further information, please visit:
www.similac.abbott/uk/hcp/cma-management/
 Or call our Freephone Nutrition Helpline on:
 0800 252 882

This article is supported by Abbott.



REFERENCES

- Alimentum datasheet (2020) Alimentum with 2'-FL product composition. Version 2. June 2020
- Bachrach VR, Schwarz E, Bachrach LR (2003) Breastfeeding and the risk of hospitalization for respiratory disease in infancy: a meta-analysis. *Arch Pediatr Adolesc Med* 157(3): 237-43
- Data on File (AL32). April 2020
- EleCare datasheet. EleCare with 2'-FL product composition. Version 5. July 2020
- Erney RM, Malone WT, Skelding MB, et al (2000) Variability of human milk neutral oligosaccharides in a diverse population. *J Pediatr Gastroenterol Nutr* 30(2): 181-92
- Fox A, Brown T, Walsh J, et al (2019) An update to the Milk Allergy in Primary Care guideline. *Clin Transl Allergy* 9: 40
- Gdalevich M, Mimouni D, David M, Mimouni M, et al (2001) Breast-feeding and the onset of atopic dermatitis in childhood: a systematic review and meta-analysis of prospective studies. *J Am Acad Dermatol* 45(4): 520-27
- Goehring KC, Marriage BJ, Oliver JS, Wilder JA, Barrett EG, Buck RH (2016) Similar to those who are breastfed, infants fed a formula containing 2'-fucosyllactose have lower inflammatory cytokines in a randomized controlled trial. *J Nutr* 146(12): 2559-66
- Kainonen E, Rautava S, Isolauri E (2013) Immunological programming by breast milk creates an anti-inflammatory cytokine milieu in breast-fed infants compared to formula-fed infants. *Br J Nutr* 109(11): 1962-70
- Marriage B, Buck RH, Goehring KC, Oliver JS, Williams JA (2015) Infants fed a lower calorie formula with 2'fl show growth and 2'fl uptake like breast-fed infants. *J Pediatr Gastroenterol Nutr* 61(6): 649-58
- MIMs online. www.mims.co.uk (last accessed September 2021)
- National Institute for Health and Care Excellence (2021) Cows' milk allergy in children. NICE, London. Available online: <https://cks.nice.org.uk/cows-milk-allergy-in-children#!backgroundSub:2> (last accessed September 2021)
- Reverri EJ, Devitt AA, Kajzer JA, Baggs GE, Borschel MW (2018) Review of the clinical experiences of feeding infants formula containing the human milk oligosaccharide 2'-fucosyllactose. *Nutrients* 10(10): 1346
- Sicherer SH, Noone SA, Koerner CB, Christie L, Burks AW, Sampson HA (2001) Hypoallergenicity and efficacy of an amino acid-based formula in children with cow's milk and multiple food hypersensitivities. *J Paediatr* 138: 688-93
- Venter C, Brown T, Meyer R, et al (2017) Better recognition, diagnosis and management of non-IgE-mediated cow's milk allergy in infancy: iMAP- an international interpretation of the MAP (Milk Allergy in Primary Care) guideline. *Clin Transl Allergy* 7: 26

UK—2100043. Date of preparation: September 2021.

For healthcare professionals only

Alimentum® EleCare®

THE FIRST AND ONLY HYPOALLERGENIC FORMULAS TO CONTAIN 2'-FL,*† A MAJOR COMPONENT OF HUMAN MILK¹

A biodiverse gut is essential for the development of infants' immune responses and preventing infections.²⁻⁴ Allergic infants often have a lower diversity of gut and skin microbiomes compared to non-allergic infants.⁵

Alimentum and EleCare contain 2'-FL (2'-fucosyllactose),* which is proven to support the development of a healthy microbiome.²

REVOLUTIONISE YOUR MANAGEMENT OF COW'S MILK ALLERGY TODAY:



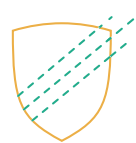
Support **healthy growth and symptom resolution**^{#6-12}



Trusted by **parents and healthcare professionals**^{10,13-15}



Lowest cost hypoallergenic formulas of their kind^{#16}



Contains 2'-FL* which has proven benefits on the gut and systemic immune responses^{#1,17,18}
In addition, supports a more comparable cytokine response to that of breastfed infants^{#18}

**ORDER FREE SAMPLES DIRECT TO YOUR PATIENT: WWW.SAMPLES.NUTRITION.ABBOTT
TO LEARN MORE, VISIT: WWW.SIMILAC.ABBOTT/UK/HCP**

IMPORTANT NOTICE: Breastfeeding is best for infants and is recommended for as long as possible during infancy. Alimentum and EleCare are infant formulas for special medical purposes and should only be used under the recommendation or guidance of a healthcare professional.

*The 2'-FL (2'-fucosyllactose) used in this formula is biosynthesised and structurally identical to the human milk oligosaccharide (HMO) 2'-FL, found in most mothers' breast milk.¹

†MIMS, August 2021.

²Studies conducted in infants fed standard EleCare formula without 2'-FL.

³Parent reports from a single-arm study, where all infants were consuming an extensively hydrolysed formula before being switched to Alimentum with 2'-FL for 60 days. After 7 days of switching to Alimentum with 2'-FL, the majority of parents reported that the following symptoms had improved or resolved: 84% of infants with constipation, 71% of infants with eczema, 100% of infants with vomiting.¹⁰

⁴Based on individual manufacturer scoop sizes, assuming 3 scoops mixed with 90 ml makes up 100 ml.

⁵Studies conducted in healthy-term infants consuming standard Similac formula with 2'-FL (not Alimentum or EleCare), compared to control formula without 2'-FL.

REFERENCES. 1. Reverri EJ, et al. *Nutrients*. 2018;10(10):1346. 2. Van den Abbeele P, et al. *J Funct Foods*. 2019;61:103484. 3. Walter J, Mahony L. *Allergy*. 2019;74(11):2248-2251. 4. Brito IL, et al. *Nat Microbiol*. 2019;4(6):964-971. 5. Lawler M, et al. *Authorea*. 2021;10.22541/au.161891465.51669024/v1. 6. Borschel MW, et al. *Clin Pediatr (Phila)*. 2013;52(10):910-917. 7. Borschel MW, et al. *BMC Pediatr*. 2014;14:136. 8. Sicherer SH, et al. *J Pediatr*. 2001;138:688-693. 9. Borschel MW, et al. *SAGE Open Med*. 2014;2:2050312114551857. 10. Ramirez-Farias et al. *Nutrients*. 2021;13:186. 1-7. 11. Borschel M W. *Allergy*. 2014;69(Suppl.99):454-572. 12. Sampson HA, et al. *J Pediatr*. 1991;118(4 Pt 1):520-525. 13. Abbott. EleCare Promotional Claims Parent Survey. 2019. 14. Abbott. UK Alimentum Market Research. 2018. 15. RTI research. Abbott EleCare No.1 Dr Recommended. Final Results. 2019. 16. MIMS. August 2021. 17. Marriage BJ, et al. *J Pediatr Gastroenterol Nutr*. 2015;61(6):649-658. 18. Goehring KC, et al. *J Nutr*. 2016;146(12):2559-2566.

Are pressure injuries unavoidable at the end of life?

Annemarie Brown

Pressure injuries are sometimes considered to be due to a lack of good nursing care. However, it has been debated as to whether the development of some pressure injuries at the end of life is inevitable. More recently, the term 'skin failure', which occurs in dying patients, has been introduced in the wound care literature, and it is proposed that the presence of skin failure may make pressure injury inevitable. This article defines the theories around skin failure and presents the different terminologies used to describe skin damage typically found in the dying patient, such as the Kennedy ulcer and Trombley-Brennan terminal tissue injury (TB-TTI). It also discusses the importance of healthcare professionals being able to recognise that skin changes, which appear to be pressure injuries, are due to skin failure at the end of life and be able to differentiate between these and usual pressure injuries when planning and delivering care for these patients.

KEYWORDS:

- Pressure injuries ■ End of life ■ Skin changes at end of life
- Kennedy ulcer ■ Focus of care

Pressure injuries are sometimes considered to result from poor nursing care. However, it has been debated as to whether the development of some pressure injuries is unavoidable (Black et al, 2011). Furthermore, the National Pressure Ulcer Advisory Panel (NPUAP) hosted an international multidisciplinary conference in 2010 to develop a consensus on whether pressure injuries may be unavoidable in some patients and whether there is a difference between the skin changes at end of life and pressure injuries (Black et al, 2011). The

delegates attending the conference were asked to reach a consensus on the following points:

- ▶ What is an avoidable or unavoidable pressure ulcer?
- ▶ What is skin failure?
- ▶ What documentation would be adequate evidence that the pressure ulcer was unavoidable?

This article will discuss some of the literature around these topics, specifically focusing on pressure injury at the end of life.

WHAT IS AN AVOIDABLE OR UNAVOIDABLE PRESSURE ULCER?

The consensus on the definition of an avoidable pressure injury is 'a pressure ulcer that develops because the health professional did not do one of the following: evaluate the patient's clinical condition and pressure ulcer risk factors; define and implement interventions consistent with

individual needs, individual goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate' (Black et al, 2011; Sibbald and Ayello, 2020).

A pressure injury, therefore, is considered to be unavoidable if it develops despite the healthcare professional implementing all of the above interventions (Black et al, 2011; Sibbald and Ayello, 2020). However, the delegates attending the NPUAP consensus meeting also acknowledged that there are circumstances (such as haemodynamic instability, which is exacerbated by movement or a very low blood pressure resulting in impaired local tissue perfusion, leading to a pressure injury) where pressure cannot be relieved, and tissue perfusion cannot be improved despite the implementation of all interventions. In addition, the ability to mediate the risk of pressure injury is often limited, such as in the case of dying patients or patients' right to refuse care or non-adherence with the plan of care (Black et al, 2011). Black et al (2011) acknowledged that in order to determine whether a pressure injury was avoidable or unavoidable, the processes of care would have to be evaluated retrospectively, and therefore the unavoidable development of some pressure injuries should not be assumed.

PRESSURE DAMAGE IN DYING PATIENTS

Hotaling and Black (2018: 20) asserted that 'just because pressure injuries can develop in end-of-life, it does not mean that they should' in response to the increasing number of pressure injuries reported at end of life. For example, Carlsson

and Gunningberg (2017) reported that long-term care had the lowest pressure injury rate of 16.8% for hospice patients, whereas inpatient palliative care units had the highest at 29.7%.

Hotaling and Black (2018) also caution that healthcare professionals need to establish that the patient is actually actively dying before assuming that pressure injuries are unavoidable in this patient group. Clinical signs and symptoms of active dying are:

- ▶ Change in level of consciousness or delirium
- ▶ Change in breathing pattern, such as Cheyne-Stokes or agonal breathing
- ▶ Evidence of fluid build-up in the lungs and airway
- ▶ New episodes of incontinence
- ▶ Drop in blood pressure
- ▶ Mottling of the skin
- ▶ Cold extremities
- ▶ An inability to swallow (Hospice Patients Alliance, 2018).

Patients at end of life are at significant risk of severe pressure injury due to a combination of some of the factors listed above in addition to those outlined in *Table 1* (Hench and Gustafsson, 2003; Naylor, 2005; Langemo et al, 2009; Langemo and Black, 2010). Hanson et al (1991) found that the majority of pressure injuries occurred in the two weeks prior to death; however, they asserted that this would not be unexpected as body systems start to shut down approximately 10–14 days before death. Many healthcare professionals agree that it is often not possible to prevent pressure injuries at end of life due to multiple risk factors and comorbidities, and as a result, the pressure damage in



Figure 1.
Kennedy Terminal Ulcer (KTU).

Table 1: Risk factors in patients at terminal stage end of life (adapted from Hotaling and Black, 2018)

Risk factor	Effect
Advanced age	Skin of older patients is drier, fragile and easily injured, and injured skin is more vulnerable to ulceration
Protein-calorie malnutrition	Catabolism is also common in this patient group, due to a combination of cachexia, weakness, debilitation, weight loss, and muscle atrophy. Loss of body fat reserves reduces the natural padding over bones, increasing the vulnerability to pressure and soft tissue breakdown. Unintentional weight loss at any body mass index (BMI) increases the chance of developing a pressure ulcer by 147% (Horn et al, 2004)
Immobility	As patients enter the terminal phase of their life, their mobility will reduce significantly. This may be due to pain or breathlessness
Friction and shearing forces	Friction injuries may develop in patients who are in pain but are not able to process the sensation due to confusion, pain or unconsciousness. Shearing forces may be present when the patient needs to sit up in one position due to breathlessness. Hypoxia may also increase the risk of pressure damage
Exposure to moisture	Diarrhoea strips the outer layer of skin, and the exposed dermis cannot tolerate pressure. Faecal fluid is caustic and can damage the skin quickly. When urine is present in combination with faeces, which contain bacteria and harsh gastrointestinal tract enzymes, the damage can be even quicker and more severe

this patient group can reach category 3 or 4 quite rapidly (Baharestani, 1994; Bale et al, 1995; Chaplin, 2000; Naylor, 2005; Langemo and Brown, 2006; Langemo et al, 2009).

SKIN CHANGES AT LIFE'S END (SCALE)

It is now recognised that the skin can fail within the last few days of life (Black et al, 2011). Skin failure was observed initially by La Puma (1991) and later discussed by Langemo and Brown (2006). It is considered to be part of multi-organ system failure which occurs at the very end of life. The skin is thought to fail due to hypoperfusion and its inability to resist pressure and trauma. In addition, it is unable to repair itself due to its inability to absorb the nutrients necessary for wound repair (Langemo and Brown, 2006). Langemo and Brown (2006) proposed that when there is weak arterial blood flow, the resultant low perfusion of the tissues in a dying patient would result in pressure injury in the stressed skin. However, others suggest that skin damage, which results from severe hypoperfusion, would not just be limited to areas of tissue subject to loading, for example the sacrum, and cite necrotic fingers and toes as an example of this (Worley, 2007; Olshansky, 2010; Sibbald et al, 2010).

To clarify whether skin damage which develops in end-of-life patients is caused by skin failure and whether these should be classified as pressure injuries at all, an international expert panel was established to formulate a consensus on Skin Changes At Life's End (SCALE) in 2019 (Sibbald et al, 2020).

KENNEDY TERMINAL ULCER (KTU)

The type of pressure injury typically seen in end-of-life patients was first described by Kennedy in 1989 and became known as the Kennedy Terminal Ulcer (KTU) (Kennedy, 1989). KTUs occur most commonly over the sacrum or coccyx, develop rapidly, and are described as pear-shaped lesions which can be red, yellow, or black in colour (*Figure 1*). They may present as intact skin or as an ulcer and are thought to be due to local ischaemia rather than unrelieved pressure (Kennedy 1989). This view was supported by 84.29% of the respondents in a survey conducted by Sibbald et al in 2019 (Sibbald and Ayello, 2020). The rationale for this was that the sacral area does not have good collateral circulation, making it prone to injury (Bonanno, 2011). When major organs such as the heart or brain start to fail, the circulation to the skin, kidneys, liver,

lungs and gastrointestinal tract is reduced to preserve vital functions. Vasoconstriction occurs and blood is diverted from the skin and soft tissues towards the brain and the heart to protect these key organs (Bonanno, 2011).

93.82% of the survey respondents agreed that KTUs are indicative of impending death and Sibbald and Ayello (2020) explain that the red/black appearance of a KTU is due to leakage of the capillaries, resulting in a red colour on the surface of the skin. As this bruised effect resolves, the area becomes yellow-brown and, in the absence of a good blood supply, can turn black. Therefore, the colour of the KTU is determined by the level of ischaemia in the area (Sibbald and Ayello, 2020).

'3:30 SYNDROME'

Although the majority of respondents (93.82%) supported the view that presence of KTUs signalled the end of life (Sibbald and Ayello, 2020), it was noted that in Kennedy's data, 44.3% of patients did not die in the six-week period (Sibbald and Ayello, 2020). Indeed, Kennedy introduced the concept of '3:30 syndrome' in 2014, which was a variant of the KTU which presents more quickly. Typically, small black spots are noted on the skin in the morning, similar to felt tip marks or dried faeces and, by the afternoon, the area can be seen to have increased considerably in size (www.kennedyterminalulcer.com). Kennedy (2014) noted that this can evolve in just six to eight hours of sitting in a chair and concluded that the life expectancy of patients with '3:30 syndrome' was approximately 8–24 hours.

TROMBLEY-BRENNAN TERMINAL TISSUE INJURY (TB-TTI)

In a retrospective chart review in 2010, Brennan and Trombley noted skin changes which appeared spontaneously on patients in their inpatient palliative care unit (Brennan and Trombley, 2010). These lesions appeared as pink, purple, or maroon bruise-like butterfly-shaped skin lesions which did not progress

to pressure injury. These skin changes were located both on bony prominences and other locations, for example, thighs. A further study by Trombley et al (2012) confirmed the view that they did not develop due to lack of preventative strategies and the authors cautioned that these terminal tissue injuries could be mistaken for deep tissue injuries, but were actually due to internal organ and skin failure. They also noted that the absence of colour in the centre of the lesion seemed to indicate that death would occur within two hours (Trombley et al, 2012). These changes were consequently named Trombley-Brennan Terminal Tissue Injuries (TB-TTI).

CLARIFICATION ON THE CAUSE OF SKIN CHANGES AND FOCUS OF CARE

Levine (2016) suggests that the differing definitions for terminal ulcerations and disagreement over their aetiology has resulted in confusion for healthcare professionals, and called for a unified classification system. This resulted in the NPUAP developing 10 consensus statements outlining the probable causes of skin changes seen at end of life, with suggestions on the focus of care in this patient group (Table 2). As a result of the paucity of research available on these skin changes at end of life, Sibbald and Ayello (2020) proposed that these lesions are most likely unavoidable and should therefore not be included in pressure injury incidence and prevalence reporting.

IMPLICATIONS FOR CLINICAL PRACTICE

It is widely acknowledged that pressure injuries are extremely painful (Gorecki et al, 2009; Pieper et al, 2009; Kwong et al, 2011; Ahn et al, 2013; Woo et al, 2017), and healthcare professionals have a duty of care to prevent them by implementing prevention strategies, such as:

- ▶ Undertaking risk assessment
- ▶ Providing appropriate pressure-relieving equipment
- ▶ Repositioning appropriately (Black et al, 2011; Sibbald and Ayello, 2020).

Practice point

Focus of nursing care should be on keeping the patient comfortable and pain-free, rather than causing unnecessary distress by frequent repositioning. If a pressure injury does develop, a clear care plan, outlining the wound management in terms of frequency of dressing changes and type of dressing used should be documented.

Nevertheless, it has been established in the literature that despite these interventions, skin changes may be unavoidable in patients at the end of their life (Trombley et al, 2012).

However, Hotaling and Black (2018) suggested that before classifying a pressure injury in a dying patient as inevitable, healthcare professionals need to ascertain if the patient's clinical condition indicates that they are in the dying phase of their life.

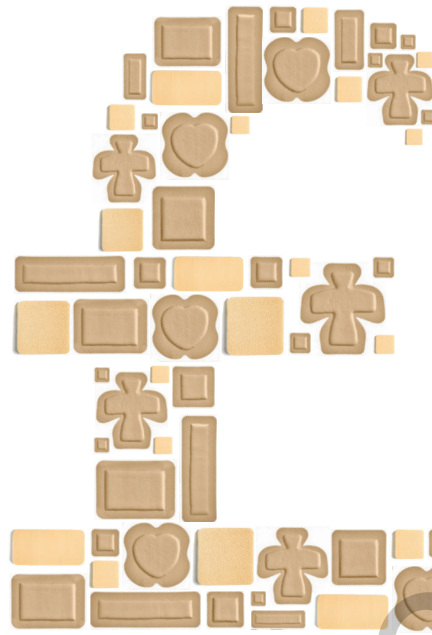
They also suggest that healthcare professionals plan the goals of care in consultation with both the patient and their family and manage their expectations with honesty and compassion (Hotaling and Black, 2018). Healthcare professionals need to explain that if the patient already has pressure injuries, the likelihood of healing is remote and that they are likely to deteriorate further as the patient nears death, or sometimes even hasten death as deep pressure injuries can cause sepsis and death (Khor et al, 2014).

In terms of frequent repositioning, if this causes pain and distress to the patient, the decision may be taken not to do so. However, the consequences of not repositioning and the potential for pressure damage to occur should be discussed with the family and the discussion clearly documented in the nursing and medical records. This may be a distressing situation for both family and healthcare professionals.

Interestingly, Sharp et al (2019) found that the prevalence of pressure

kliniderm®
foam silicone

NEW SACRAL
SIZES NOW
ON DRUG
TARIFF



Significant price reductions¹

Did you know the NHS community spend for foam silicone dressings is over **£38m²** and the Kliniderm foam silicone dressing range can save over **£11m³**?

Kliniderm is a trusted leading brand with proven quality and clinical effectiveness: over **22.5m** dressings sold – **99.999%** satisfaction³. Switching brands has never been easier.

For more information on how you can save money on the Kliniderm range contact marketing@hrhealthcare.co.uk



h&r healthcare
A MEDIQ COMPANY

1. Drug Tariff prices correct from September 2021. 2. IQVIA MAT foam silicone analysis 03-21. 3. Data on file - UK only. KLIN10. Products include Kliniderm foam silicone, Kliniderm superabsorbent and Kliniderm silicone wound contact layer.

injuries in this patient group remained high despite implementing a two-hourly repositioning schedule. As a result of these findings, they question whether it is an effective strategy in these patients, a view shared by others (Clark, 1998; Defloor et al, 2005; Hagsiwa and Ferguson Pell, 2008; Krapfl and Gray, 2008; Rich et al, 2011; Gillespie et al, 2014). Sharp et al (2019) went further to propose that repositioning could be classed as elderly abuse if it results in pain and suffering. If it is not a priority or possible, the patient should, as a minimum, be placed on an alternating pressure mattress with a low air loss feature (Hotaling and Black, 2018).

CONCLUSION

Severe pressure injuries can occur at the end of life and may not be due to factors normally associated with the development of pressure damage. As a result, it has been suggested that these lesions are unavoidable and should not be included in pressure injury incidence and prevalence reporting (Sibbald and Ayello, 2020).

However, it is important that healthcare professionals are able to recognise that skin changes, which appear to be pressure injuries, are due to skin failure at the end of life and be able to differentiate between these and usual pressure injuries when planning and delivering care for these patients.

This article has discussed the literature around and the potential theories on how and why skin changes develop. When prevention is no longer the focus of interventions, healthcare professionals need to target their nursing care on keeping the patient comfortable and pain-free. **JCN**

REFERENCES

Ahn H, Stechmiller J, Horgas A (2013) Pressure ulcer-related pain in nursing home residents with cognitive impairment. *Adv Skin Wound Care* 26(8): 375–80

Table 2: Consensus statements when caring for patients with skin changes at end of life (adapted from Ayello et al, 2019)

1.	The physiological changes that occur in a dying patient may affect the skin and soft tissues and result in observable changes in skin colour, turgor or integrity. These changes may produce localised pain, are unavoidable, and may develop despite appropriate interventions and a high standard of nursing care
2.	The proposed plan of care and patient response should always be clearly documented in the nursing and medical records
3.	Patient-centred concerns should be addressed, including pain and activities of daily living
4.	Skin changes at end of life are a result of compromised skin, reduced perfusion, reduced tolerance to pressure and impaired removal of metabolic waste (skin failure)
5.	The expectations of care at the patient's end of life should be clearly discussed and communicated to all members of the multidisciplinary team and the patient's family. The potential for skin failure, skin changes and breakdown should be explained and the rationale for nursing interventions, such as not repositioning as frequently due to pain etc, discussed with family members
6.	The risk factors and signs that skin failure is occurring are believed to be: <ul style="list-style-type: none"> ▶ Weakness and progressive limitation of mobility ▶ Suboptimal nutrition, including loss of appetite, weight loss, cachexia and wasting, low serum albumin/prealbumin level, and low haemoglobin ▶ Dehydration and diminished tissue perfusion, impaired skin oxygenation, decreased local skin temperature, mottled discoloration, and skin necrosis ▶ Loss of skin integrity from any of a number of factors, including equipment or devices, incontinence, chemical irritants, chronic exposure to body fluids, skin tears, pressure, shear, friction, and infections, and impaired immune function
7.	Regular skin assessment should be performed, and all areas of concern documented and communicated to patient and family, while taking their wishes into account. Assessment should focus on bony prominences and skin areas with underlying cartilage, the sacrum, coccyx, ischial tuberosities, trochanters, scapulae, occiput, heels, digits, nose, and ears. The condition of the skin and any abnormal changes should be documented accurately
8.	Refer to a tissue viability nurse if the skin changes cause increased pain, show signs of infection, or whenever the patient or family member requests this
9.	Consider the five Ps when planning interventions, namely: <ul style="list-style-type: none"> ▶ Prevention ▶ Prescription (if healing is possible) ▶ Preservation (maintain skin condition without deterioration) ▶ Palliation (provide comfort and care) ▶ Preference (patient desires)
10.	Ensure patients and concerned individuals are fully aware of SCALE and the proposed plan of care

Ayello EA, Levine JM, Diane Langemo D, Kennedy-Evans KL, Brennan MR, Sibbald RG (2019) Re-examining the literature on terminal ulcers, SCALE, skin failure, and unavoidable pressure injuries. *Adv Skin Wound Care* 32(3): 109–21

Baharestani MM (1994) The lived experience of wives caring for their frail, home-bound, elderly husbands with pressure ulcers. *Adv Wound Care* 7: 40–52

Bale S, Finlay I, Harding KG (1995) Pressure sore prevention in a hospice. *J Wound Care* 4: 465–8

Black J, Edsberg LE, Baharestani MM, Langemo D, Goldberg M, et al (2011) Pressure ulcers: avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference. *Ostomy Wound Management* 57(2): 24–37

Bonanno FG (2011) Physiopathology of shock. *J Emerg Trauma Shock* 4(2): 222–32

Brennan MB, Trombley K (2010) Kennedy terminal ulcers — a palliative care units experience over a 12-month period of time. *WCET J* 30(3): 20–2

Carlsson ME, Gunningberg L (2017) Predictors for development of pressure ulcer in end-of-life care: a national quality register study. *J Palliat Med* 20(1): 53–8

Chaplin J (2000) Pressure sore risk assessment in palliative care. *J Tissue Viability* 10: 27–31

Clark M (1998) Repositioning to prevent pressure sores — what is the evidence? *Nurs Standard* 13(3): 58–60, 62, 64

Defloor TD, De Bacquer, Grypdonck MH (2005) The effect of various combinations of turning and pressure reducing devices on the incidence of pressure ulcers. *Int J Nurs Stud* 42(1): 37–46

Gillespie BM, Chaboyer WP, McInnes

KEY POINTS

- It has been debated as to whether the development of some pressure injuries is unavoidable (Black et al, 2011).
- Many healthcare professionals agree that it is often not possible to prevent pressure injuries at end of life due to multiple risk factors and comorbidities.
- Hotaling and Black (2018) suggested that before classifying a pressure injury in a dying patient as inevitable, healthcare professionals need to ascertain if the patient's clinical condition indicates that they are in the dying phase of their life.
- When prevention is no longer the focus of interventions, healthcare professionals need to target their nursing care on keeping the patient comfortable and pain-free.

- E, Kent B, Whitty JA, Thalib L (2014) Repositioning for pressure ulcer prevention in adults. *Cochrane Database of Systematic Reviews* (4): CD009958
- Gorecki C, Brown JM, Nelson EA, et al (2009) Impact of pressure ulcers on quality of life in older patients: A systematic review. *J Am Geriatr Soc* 5(7): 1175–83
- Hagisawa S, Ferguson-Pell M (2008) Evidence supporting the use of two-hourly turning for pressure ulcer prevention. *J Tissue Viability* 17(3): 76–81
- Hanson D, Langemo DK, Olson B, et al (1991) The prevalence and incidence of pressure ulcers in the hospice setting: analysis of two methodologies. *Am J Hosp Palliat Care* 8: 18–22
- Henoch I, Gustafsson M (2003) Pressure ulcers in palliative care: development of a hospice pressure ulcer risk assessment scale. *Int J Palliat Nurs* 9: 474–84
- Horn SD, Bender SA, Ferguson ML, et al (2004) The National Pressure Ulcer Long-term Care Study: pressure ulcer development in long-term care residents. *J Am Geriatr Soc* 52: 359–67
- Hospice Patients Alliance (2018) *Signs and Symptoms of Approaching Death*. Available online: www.hospicepatients.org/hospic60.html
- Hotaling P, Black J (2018) Ten top tips: end of life pressure injuries. *Wounds Int* 9(1): 18–21

Revalidation Alert

Having read this article, reflect on:

- Your knowledge of active signs and symptoms of dying
- Skin changes that occur at the end of life
- Nursing care when prevention of pressure ulceration is no longer the main focus.

Then, upload the article to the free JCN revalidation e-portfolio as evidence of your continued learning: www.jcn.co.uk/revalidation

- Kennedy KL (1989) The prevalence of pressure ulcers in an intermediate care facility. *Decubitus* 2(2): 44–5
- Kennedy KL (2014) *What do you mean by the 3:30 syndrome? Kennedy Terminal Ulcer Information and Warning Signs*. Available online: www.kennedyterminalulcer.com/ (accessed 29 March, 2021)
- Khor HM, Tan J, Saedon NI (2014) Determinants of mortality among older adults with pressure ulcers. *Arch Gerontol Geriatr* 59(3): 536–41
- Krapfl LA, Gray M (2008) Does regular repositioning prevent pressure ulcers? *J Wound, Ostomy Continence Nurs* 35(6): 571–7
- Kwong EW, Lau AT, Lee RL, Kwan RY (2011) A pressure ulcer prevention programme specially designed for nursing homes: Does it work? *J Clin Nurs* 20(19–20): 2777–86
- La Puma L (1991) The ethics of pressure ulcers. *Decubitus* 4(2): 43–4
- Langemo DK, Brown G (2006) Skin fails too: acute, chronic, and end-stage skin failure. *Adv Skin Wound Care* 19: 206–11
- Langemo D, Anderson J, Hanson D, et al (2009) Understanding palliative wound care. *Nursing* 37: 65–6
- Langemo D, Black J (2010) Pressure Ulcers in Individuals Receiving Palliative Care: A National Pressure Ulcer Advisory Panel White Paper. *Adv Skin Wound Care* 23(2): 52–72
- Levine J (2016) Unavoidable pressure injuries, terminal ulceration, and skin failure: in search of a unifying classification system. *Adv Skin Wound Care* 30(5): 200–2
- Naylor WA (2005) A guide to wound management in palliative care. *Int J Palliat Nurs* 11: 572–9
- Olshansky K (2010) 'Kennedy terminal ulcer' and 'skin failure', where are the data? *J Wound Ostomy Continence Nurs* 37(5): 466–7
- Pieper B, Langemo D, Cuddigan J (2009) Pressure ulcer pain: A systematic literature review and national pressure ulcer advisory panel white paper. *Ostomy Wound Management* 55(2): 16–31
- Rich SE, Margolis D, Shardell M (2011) Frequent manual repositioning and incidence of pressure ulcers among bedbound elderly hip fracture patients. *Wound Rep Regen* 19(1): 10–18

- Sharp CA, Schulz Moore JS, Mary-Louise McLaws ML (2019) Two-hourly repositioning for prevention of pressure ulcers in the elderly: patient safety or elder abuse? *Bioethical Inquiry* 16: 17–34
- Sibbald RG, Ayello EA (2020) Terminal ulcers, SCALE, skin failure, and unavoidable pressure injuries: results of the 2019 Terminology Survey. *Adv Skin Wound Care* 33: 137–45
- Sibbald RG, Krasner DL, Lutz J (2010) SCALE: Skin changes at life's end: final consensus statement. *Adv Skin Wound Care* 23(5): 225–36
- Trombley K, Brennan MR, Thomas L, Kline M (2012) Prelude to death or practice failure? Trombley Brennan terminal tissue injuries. *Am J Hosp Palliat Care* 29(7): 541–5.
- Woo KY, Sears K, Almost J, Wilson R, Whitehead M, Van Den Kerkhof EG (2017) Exploration of pressure ulcer and related skin problems across the spectrum of health care settings in Ontario using administrative data. *Int Wound J* 14(1): 24–30
- Worley CA (2007) Skin failure: the permissible pressure ulcer? *Dermatol Nurs* 19(4): 384–5

Pressure ulcer prevention and use of patient information leaflets

Lisa Ledger, Louise Morris

There has recently been an increased focus on the use of patient information leaflets as a means of communicating key information and engaging patients in preventative measures. The prevention and management of pressure ulcers depends on proactive and effective communication between nurses and other healthcare professionals and the patients themselves. This is particularly important in community settings, with the increasing responsibility placed on patients to self-manage their conditions. However, despite the use of patient information leaflets as part of the nursing process, there is little research evidence to support their use with regards to pressure ulcer prevention and, in particular, whether patients themselves engage with and understand the information. This article discusses the existing literature and knowledge around patient information leaflets, looking at it in light of a recent study around pressure ulcer prevention in Birmingham Community Healthcare NHS Trust.

KEYWORDS:

- Pressure ulcer prevention
- Patient information leaflet(s)
- Community
- Adherence
- Communication

The National Stop the Pressure Programme describes a pressure ulcer as 'localized damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful' (NHS Improvement, 2018).

A systematic review on the cost of prevention and treatment of pressure ulcers was undertaken by Demarre et al (2015). The review examined 17 studies published between 2001 and 2013, of which three focused on the cost of prevention, five examined both costs of prevention and treatment, and nine looked at costs

of treatment alone. While cost varied significantly between the studies, the overarching conclusion was that the cost of treatment was much higher than prevention. Litigation linked to pressure ulcers was reported to have increased by 43% in the NHS in the three years up to 2017–2018, with the cost of claims alone identified as over £20.8m (Stephenson, 2019).

Guest et al (2018) published a retrospective cohort study examining the costs and outcomes of patients with pressure ulcers at 2015/2016 prices. The patients were selected from The Health Improvement Network (THIN) database, which is a computerised national database of anonymised electronic medical records collected by GP practices. 209 patients with pressure ulcers were monitored over 12 months. The mean NHS cost of wound care for the 12-month period was £8720 per pressure ulcer and only 50% of the pressure ulcers healed within the 12 months (of which 11% were category 1 pressure ulcers).

The cost of an unhealed pressure ulcer was found to be 2.4 times more than managing a healed pressure ulcer. Community nurse visits accounted for around 80% of the management costs.

Guest et al (2020) have recently published an update to their study evaluating the burden of wounds in the UK and estimated there were around 202,000 patients with a pressure ulcer during the study year (2017–2018), which equates to 0.4% of the total adult population. Community nurse visits accounted for around 80% of the management costs, with up to 53% of the pressure ulcers having a wound infection. Therefore, the costs in relation to pressure ulcers and wound management are significant and while these studies do not investigate the impact of non-adherence in relation to the healing and costs of wounds, the implications of this are far-reaching. The studies acknowledge that a better care delivery process is needed to improve patient experience and outcomes (Guest et al, 2018; 2020).

RISK ASSESSMENT AND PATIENT INVOLVEMENT

It is clear that the cost of managing pressure ulcers is high. However, for the patient there are also intangible costs associated with both adhering to advice for prevention and the impact of the condition itself (e.g. the associated discomfort that could arise from frequent repositioning for some individuals, or use of pressure redistributing support surfaces that could make the patient feel uncomfortable). There is currently a paucity of studies that report on the patient experience of having a pressure ulcer and, in particular, patient understanding of risk and factors that may affect adherence to prevention strategies (Ledger et

Lisa Ledger, head of occupational therapy, University of Derby; Louise Morris, prevention of harms nurse practitioner, Birmingham Community Healthcare NHS Foundation Trust

al, 2020). In a survey exploring the role of patients in pressure ulcer prevention in an acute care setting, McInnes et al (2014) identified understanding pressure ulcer risk and patient engagement in prevention strategies was influenced by a number of factors, including:

- ▶ The complexity of tasks that patients were asked to undertake
- ▶ If the patient had any previous experience of pressure ulceration
- ▶ The quality of healthcare personnel interactions.

The study advocated patient-centred educational models to enhance adherence with healthcare strategies for minimising risks and achieving better outcomes. However, the study was undertaken in an acute hospital setting, which may reduce how transferrable the findings are to other settings, such as the community. Nevertheless, there would appear to be some implications for practice, including the importance of holistic assessment to understand if the patient has understood advice and is able to participate in prevention measures. The need to ensure that the patient has fully understood the risk of pressure ulcers and feels empowered within decision-making has also been identified as important in a number of studies (Latimer et al, 2014; McInnes et al, 2018; Rutherford et al, 2018).

Therefore, it is vital in the context of health education and encouraging patients to participate in prevention measures, to consider how educational resources are provided, i.e. language, level of perceived literacy of user, information leaflet, the nature of nurse-patient interactions and whether these are effective in encouraging adherence.

PATIENT INFORMATION: REVIEW OF EXISTING RESEARCH

Communicating pressure ulcer prevention information to patients is under researched, despite communication issues featuring as one of the main areas in root cause analysis (RCA) and patient complaints (Fletcher, 2020). There are a variety of ways of giving information, such as leaflets, booklets, videos, health apps, but in all cases the information

should be clear and focus on key messages, while acknowledging the varied recipient audience. Information should also be reinforced and repeated at different points to check understanding (Fletcher, 2020). There is government guidance when developing written tools, such as language used and layout.

The importance of good communication has also been recognised in the pressure ulcer core curriculum, developed by the National Stop the Pressure Programme (NHS Improvement, 2018). This document provides a guide as to which factors need to be included in training for healthcare staff in a range of different settings. The section on 'giving information' supports the delivery of theory and acquisition of skills related to effective patient communication. Enabling patient engagement and supporting patient concordance is included and a range of communication strategies, such as leaflets, demonstration and instruction, are recommended to equip healthcare workers with a range of approaches to draw upon and support practice.

More recently, the National Wound Care Core Capabilities Framework for England (National Wound Care Strategy Programme [NWCSP], June 2021) has been launched. This document, containing core capabilities, intends to identify the skills, knowledge and behaviours required to deliver high quality personalised wound care. The framework includes five domains and provides clear standards for assuring safe, effective practice. Domain 'D' on personalised care and health promotion includes capability 7 on communication. While concordance is not specified, the detail on adapting communication styles and using communication strategies to promote patient empowerment within decision-making links to the previous studies discussed here that outlined measures to facilitate adherence.

In terms of the existing evidence base, a recent Cochrane systematic review focusing on 'patient and lay carer education for preventing pressure ulceration in at risk populations' reviewed 10 studies as

suitable for inclusion, with two main types of education interventions (O'Connor et al, 2021):

- ▶ The provision of information on prevention of pressure ulcers
- ▶ The use of different types of education programmes.

This review concluded that it is uncertain whether educational interventions make any difference to the number of new pressure ulcers or to patient knowledge, based on evidence from the 10 included studies. However, there is low certainty of evidence, meaning that additional research is required to confirm these results.

Durrant et al (2018) in a mixed methods study considered whether patient information resources routinely provided as leaflets informed patient understanding of pressure injury. Three patient leaflets were included:

- ▶ A patient leaflet provided upon discharge from hospital
- ▶ A patient leaflet provided to community patients identified as being at pressure ulcer risk by the district nursing service
- ▶ The International European Pressure Ulcer Advisory Panel (EPUAP) patient information leaflet — available free online.

Readability of each leaflet was analysed by calculating their SMOG score (Simplified Measure of Gobbledygook) (McLaughlin, 1969). To assess compliance with

Practice points

Consider how information is provided on patient information leaflets — layout, typeface, visuals, language, use of pictures. Also, what about:

- ▶ Availability in different languages
- ▶ Availability of video recorded message with subtitles for those with hearing and sight loss and for those with illiteracy
- ▶ Appropriate styles suitable for paediatrics and those with learning disabilities
- ▶ Equity with accessibility, as not everyone has access to the internet.

national guidance, leaflets were also appraised against the NHS tool for patient literature including the use of headings and shorter sentences (Department of Health [DH], 2003). The results of this study showed that participants had low levels of insight in the causes and understanding of pressure ulcer risk. With regard to information, even when good quality information was provided, participants were passive in relation to engaging with it. Some participants expressed difficulty in using information that was too medically focused and, as they struggled with terminology, did not use it. Key insights from the study revealed that despite having access to patient information leaflets, participants had limited understanding of pressure ulcer causation and risk. Health literacy was also a factor with engagement of the leaflets, potentially hindered by poor readability scores. All leaflets failed to include information relevant to different skin colour with assumptions of a white audience, which may also have increased disengagement from use of the information (Durrant et al, 2018).

The findings of Durrant et al's (2018) study suggest that leaflets alone only play a minor role in improving patient health literacy, as reflected in their knowledge and engagement with prevention measures. Previous studies have revealed similar findings, in that providing patient materials in clinical environments was not an effective method of pressure ulcer education or improving adherence to prevention measures (Latimer et al, 2014; Schoeps et al, 2017). Instead, in the authors' clinical experience, focus should be

Practice points

Consider the nursing approach and 'wrap-around' conversations within patient education and advice:

- ▶ Importance of seeing from the patient perspective — put yourself in the patient's shoes to understand the implications and impact of the advice on their routine, responsibilities and lifestyle and adapting to meet individual needs.

on the quality of interactions and improving nurse-patient relationships and greater verbal dialogue and discussion with patients around pressure ulcer prevention. With regards to leaflet information and retention of knowledge, longitudinal studies that focused on patient retention of information have not extended beyond one week (Hartigan et al, 2012; Vowden et al, 2015). This raises important questions around the frequency and duration of patient retention of information.

A recent qualitative study was conducted in Birmingham Community Healthcare NHS Trust to consider, from the patient perspective, understanding of pressure ulcer risk and potential factors affecting adherence to prevention strategies. The rationale for the research was that patients themselves are increasingly being required to be aware of pressure ulcer risk and to employ preventative measures. However to date, as said above, there is limited research regarding patient understanding of risk and potential factors affecting adherence to prevention measures (Ledger et al, 2020).

The study used a pragmatic research approach and a range of data collection methods, including:

- ▶ Observations of nurse-patient interactions
- ▶ Follow-up interviews with patients
- ▶ Document analysis of the patient information leaflet, provided at the point of care (POC).

A total of 15 participants with capacity and identified as 'at pressure ulcer risk', who were known to the district nursing team, were recruited to the study.

The observational element of the study involved observing nurse-patient interactions, during the routine district nursing visit. During the visit, in addition to the nursing pressure ulcer discussion and risk assessment, a patient information leaflet was provided. This leaflet covered aspects such as how to complete a skin check, incontinence, and the importance of healthy nutrition, repositioning and equipment checks.

Practice points

- ▶ If the patient is not engaging with advice, find out why and try to formulate a mutually agreed solution to strengthen patient participation with this care
- ▶ Consider memory aids, such as post-it notes, for patients with impaired memory/issues with cognition.

One of the key overarching themes to emerge from the study was 'pressure ulcer awareness and prevention knowledge'. Within this theme, the majority of patients in the study reported that they predominantly gained knowledge of pressure ulcers from the nursing visit — through verbal instruction and demonstration by the nurse, such as skin checks and equipment usage. However, in terms of pressure ulcer aetiology and causality, knowledge was quite basic, i.e. patients were able to understand the importance of checking their skin, moving position and eating well, but there was less awareness of aspects such as incontinence in relation to pressure ulcer risk and the importance of pressure-relieving equipment. Furthermore, over half of the sample struggled with terminology such as 'pressure ulcer', better understanding the term 'bed sore' and seeing this as something harmful and to be avoided.

Importantly, only two patients had read the patient information leaflet — of these, one had found it useful. When asked about not using the leaflet, eight out of the 15 patients reported difficulties such as visual problems, fatigue, lack of ability to concentrate meaning that they did not engage with the material. Significantly, these patients had not disclosed to the district nurse their difficulties in using the leaflet, and so this non-use had gone unnoticed.

When asked what type of information was most useful, patients in the study placed value on 'meaningful conversations' with nurses about their care and the day-to-day challenges they faced in carrying out advice.

In this extract, one patient shares what information is of value:

It's like when they (nurse) do take the time to talk to you and go through what they need you to do and we really have a good discussion, I do tend to take that in, so for me the talking instruction is really important.

The importance of nurses' taking the time to care' featured as a theme from the findings of the study in terms of patients feeling they could open up about potential barriers to following advice. The patients in the study were less likely to ask questions or disclose difficulties if they felt the nurses were busy. Here is an extract from another patient:

When it's all rushed and you can see they (nurse) are so busy, well I don't feel they have got the time so I just nod and agree, I don't want to bother them with my woes so I just don't say anything.

CONCLUSION

The clinical significance of these findings support previous studies around the potential for poor uptake of information leaflets by patients (O'Connor et al, 2021). There is a need for further evaluation of educational interventions and approaches to improving patient education and understanding of risk, and facilitating their proactive role in pressure ulcer prevention. In the authors' clinical opinion, patient leaflets should remain subsidiary rather than a substitute for conversations regarding these topics, and these should be tailored to the individual. Also, community nurses should assess patient knowledge and their ability to implement pressure ulcer prevention measures to ensure successful outcomes.

The World Health Organization (WHO, 2012) recommends that health education is not limited to the dissemination of health-related information, but also self-efficacy and fostering motivation and confidence to improve health. This emphasis on patient involvement in health care and their rights to have a central role in decision-making is an important cornerstone of current healthcare policy and practice. The benefits of

patient involvement are thought to include increased motivation, adherence to advice, and ultimately better health outcomes (European Commission, 2012).

However, how to ensure true patient engagement and involvement is often vague as a concept and more research is needed to determine what is needed. What is evident is that there should be more than the education 'leaflet' alone to motivate patient engagement and ensure translation of knowledge acquisition to behavioural change and adherence to advice. **JCN**

REFERENCES

- Department of Health (2003) *Toolkit for Producing Patient Information*. DH, London
- Demarre L, Van Lancker A, Van Hecke A; Verhaeghe S, Gryponck M, Lemey J, Annemans L, Beeckman D (2015) The cost of prevention and treatment of pressure ulcers: A systematic review. *Int J Nurs Stud* 52(11): 1754–74
- Durrant LA, Taylor J, Thompson H, Usher K, Jackson D (2018) Health literacy in pressure injury: Findings from a mixed-methods study of community-based patients and carers. *Nurs Health Sci* 21(1): 37–43
- European Commission (2012) *Eurobarometer qualitative study. Patient involvement: aggregate report*. Available online: https://ec.europa.eu/eip/ageing/library/eurobarometer-qualitative-study-patient-involvement-healthcare_en.html
- Fletcher J (2020) Pressure ulcer education 8: giving information to patients. *Nurs Times* (online) 116(5)
- Guest JF, Fuller GW, Vowden P, Vowden KR (2018) Cohort study evaluating pressure ulcer management in clinical practice in the UK following initial presentation in the community: costs and outcomes. *BMJ Open* 8: e021769
- Guest JF, Fuller GW, Vowden P (2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. *BMJ Open* 10: e045253
- Hartigan I, Murphy S, Hickey M (2012) Older adults' knowledge of pressure ulcer prevention: A prospective quasi-experimental study. *Int J Older People Nurs* 7(3): 208–18
- Latimer S, Chaboyer W, Gillespie B (2014) Patient participation in pressure injury prevention: giving patients a voice. *Scand J Caring Sci* 28(4): 648–56
- Ledger L, Worsley P, Hope J, Schoonhoven L (2020) Patient involvement in pressure ulcer prevention and adherence to prevention strategies: An integrative review. *Int J Nurs Stud* 101: 103449
- McLaughlin GH (1969) SMOG grading a new readability formula. *J Reading* 12(8): 639–46
- McInnes E, Chaboyer W, Murray E, Allen T, Jones P (2014) The role of patients in pressure injury prevention: a survey of acute care patients. *BioMed Central Nurs* 13: 41
- National Wound Care Strategy Programme (2021) *National Wound Care Core Capabilities Framework for England*. Skills for Health
- NHS Improvement (2018) *Pressure ulcers: revised definition and measurement. Summary and recommendations*. June 2018
- O'Connor T, Moore ZEH, Patton D (2021) *Patient and lay carer education for preventing pressure ulceration in at-risk populations*. Cochrane Database of Systematic Reviews. John Wiley & Sons. Available online: www.cochrane.org/CD012006/WOUNDS_patient-and-lay-carer-education-preventing-pressure-ulceration-risk-populations
- Rutherford C, Brown JM, Smith I, McGinnis E, Wilson L, Gilberts R, et al (2018) A patient-reported pressure ulcer health related quality of life instrument for use in prevention trials (PU-QOL-P): psychometric evaluation. *Health Qual Life Outcomes* 16(1): 227
- Schoeps LN, Tallberg AB and Gunningberg L (2017) Patient's knowledge of and participation in preventing pressure ulcers — an intervention study. *Int Wound J* 14(2): 344–8
- Stephenson J (2019) NHS litigation bill for pressure ulcers soars 53% in three years. Available online: <http://www.nursingtimes.net/news/technology/nhs-litigation-bill-for-pressure-ulcers-soars-53-in-three-years-08-05-2019/>
- Vowden K, Warner V, Collins J (2015) Pressure ulcer incidence: Do patients retain information? *EWMA* 16(1): 35–6
- World Health Organization (2012) *Health education: theoretical concepts, effective strategies and core competencies: a foundation document to guide capacity development of health educators*. Available online: <https://apps.who.int/iris/handle/10665/119953>

Evaluation of a skin protectant ointment and an incontinence cleanser

Alexandra Freitas

Incontinence-associated dermatitis (IAD) relates to skin breakdown from exposure to urine or faeces, and its management involves implementation of structured skin care regimens incorporating appropriate use of skin barrier products to protect the skin from exposure to moisture and irritants. Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser are part of the Total Barrier Protection™ (Medicareplus International) range indicated for management of moderate-to-severe IAD and other moisture-associated skin damage (MASD). This article summarises the findings of multi-centred patient evaluations of Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser, and aims to demonstrate the clinical and cost benefits of using these products for the prevention and management of MASD.

KEYWORDS:

- Incontinence-associated dermatitis
- Skin barrier products
- Patient's quality of life
- Cost effectiveness

of pressure ulcer development, as overhydrated skin is much more susceptible to damage from extrinsic factors such as pressure, friction and shear (Clark et al, 2010).

Another important consideration with IAD is the effect on the patient — IAD can be painful and debilitating and has been associated with a reduced quality of life, and therefore appropriate management is key to maintaining high standards of care and promoting good patient outcomes (Doughty et al, 2012). It can also be time-consuming and expensive to treat, which has an impact on clinical resources and financial implications (Doughty et al, 2012).

SKIN CARE REGIMENS

Medicareplus International devised a moisture damage treatment strategy to aid care providers of all levels to manage patients using the most appropriate product at a given time. Total Barrier Protection™ (TBP) provides a unique range of products with clear guidance and rationale for use based on the type and severity of moisture exposure and degree of skin damage, enabling the skin care strategy to be tailored to individual patient needs. In the author's clinical opinion, by introducing a simple and consistent approach to skin protection, implementation of TBP™ should prevent product misuse and drive efficiency savings.

Medi Derma-PRO Skin Protectant Ointment contains dimethicone and bioadhesives, providing the tacky consistency suitable for use on severe skin damage. While similar products available advocate usage across the complete scale of skin damage from

Over the last decade, modern skin barrier products have steadily replaced the use of traditional barrier products to maintain skin integrity of vulnerable patients. These cream, film and ointment formulations are designed to protect skin from the effects of mechanical or chemical injury. They are predominantly used in the prevention and management of moisture-associated skin damage (MASD), an umbrella term used to define the various causes of damage associated with prolonged, or continuous exposure of the skin to moisture (Young, 2017).

'... IAD can be painful and debilitating and has been associated with a reduced quality of life, and therefore appropriate management is key to maintaining high standards of care and promoting good patient outcomes.'

Moisture-associated skin damage (MASD) occurs when there is prolonged exposure of the skin to excessive amounts of moisture from incontinence, wound exudate or perspiration. Incontinence-associated dermatitis (IAD) relates specifically to skin breakdown from faecal and/or urinary incontinence (Beeckman et al, 2009), and has been defined as erythema and oedema of the skin surface (Gray et al, 2012). It has become well-recognised that the presence of IAD greatly increases the likelihood

Alexandra Freitas, Clinical Nurse Advisor,
Medicareplus International, London



CLEANSE AND DEFEND DUO AGAINST MOISTURE-ASSOCIATED SKIN DAMAGE



To find out more or to request
a product demo, please visit:

medicareplus.co.uk/jcn

TOTAL
BARRIER
PROTECTION™

Medicareplus
INTERNATIONAL



intact to severe, the TBP™ strategy guides users to be more selective, using the right product for the right level of MASD. In view of this, Medi Derma-PRO is indicated for skin damage at the more moderate-to-severe end of the spectrum, where maximum barrier protection is required and its properties will provide most benefit. In this manner, use of more expensive products when they are not clinically indicated can be reduced.

The Medi Derma-PRO Foam & Spray Incontinence Cleanser meets the requirements for an appropriate and effective incontinence cleanser — a pH-balanced, non-sting, non-rinse formulation to easily and effectively cleanse skin and remove adherent bodily fluids while minimising the need for unnecessary rubbing (Bradbury et al, 2017). The cleanser contains ingredients such as glycerine that helps protect the skin and promote a soft non-sticky skin feel for patient comfort; the cleanser also contains a surfactant that cleans the skin without drying it out like soap and water.

A series of clinical evaluations were conducted across the UK to gain clinical evidence on the efficacy and efficiency of Medi Derma-PRO Skin Protectant Ointment and Foam & Spray Incontinence Cleanser for management of IAD, and to garner clinical opinion with regards to outcomes, ease of use and cost effectiveness compared to previously used barrier products.

METHOD

A retrospective review of clinical evaluation data of 110 patients from 47 UK acute and community sites was performed. All of the patients were treated with Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser.

PATIENT POPULATION

The evaluation inclusion criteria were:

- ▶ Patients 'at-risk' of, or already being treated for MASD, with an indication suitable for treatment

Medi Derma-PRO Total Barrier Protection™ range



Medi Derma-PRO Total Barrier Protection™ product range.

Medi Derma-PRO Skin Protectant Ointment is available in a 115g tube. A thin, uniform coating should be gently spread over the whole affected area, with reapplication after every episode of cleansing. It should be used in conjunction with Medi Derma-PRO Incontinence Cleanser. Medi Derma-PRO Foam & Spray Incontinence Cleanser is a moisturising cleansing solution indicated for use on moderate to severely damaged skin. Severely damaged skin can be defined as large areas of erythema, with more than 50% of the affected area disrupted (Jones and Winterbottom, 2019). The Cleanser is available in a 250ml bottle and has a foam and spray mode (the foam mode enables the solution to stick better in hard-to-reach areas). It can be applied directly to the skin or onto a clean washcloth; the skin should be gently wiped clean and patted or air dried (there is no need to rinse it off).

- ▶ Participants had to agree to treatment, have capacity to consent, and be reviewed regularly by the clinical evaluator.

This review is a subset of a larger retrospective review of clinical evaluations that included other brands like Medi Derma-S Barrier Cream and Medi Derma-S Barrier Film. Therefore, once the participants were identified by a registered clinician, the most suitable Medi Derma formulation was chosen depending on the assessment of their skin damage (i.e. mild, moderate or severe).

Before starting the evaluations, a Medicareplus International clinical nurse advisor visited each site and provided an overview of the evaluation process and product training to all relevant staff. This included:

- ▶ Clinical indications for use
- ▶ Correct application/removal techniques
- ▶ Frequency of re-application
- ▶ How to complete the documentation.

DATA COLLECTION

The data collected from a standardised product evaluation form was summarised in terms of:

- ▶ Product selection and number of patients who used it
- ▶ Demographics (male/female ratio and age range)
- ▶ Rationale for using the specific barrier product
- ▶ Previous or usual skin barrier products used
- ▶ Level of skin damage before starting the evaluation
- ▶ Average duration of treatment
- ▶ Observations of the skin condition at the end of the evaluation
- ▶ Overall product performance compared to previous or usual barrier products used
- ▶ Clinician and patient additional feedback/comments.

RESULTS

Data from a total of 47 UK acute and community sites showed 110 patients used Medi Derma-PRO Skin Protectant Ointment in combination with Medi Derma-PRO Foam & Spray Incontinence Cleanser.

The age ranges disclosed for these patients varied from 21 to 98 years, although the majority of the cohort (77%) was over 70 years of age.

The main rationale for using Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser was recorded for 100 of the total 110 patients. 77% (n=77) stated that it was used to treat patients with IAD, 19% (n=19) used it for the prevention of IAD, and the remaining 4% (n=4) used it because the patient's skin was dry.

Medi Derma-PRO Skin Protectant Ointment replaced a comparable product on the market as the skin barrier product in 50 (46%) cases. Previous skin cleansing regimens before the evaluation were documented for 79/110 patients: 49% (n=39) were cleansed with a skin barrier ointment and 32% (n=25) with soap and water. The remaining 15 patients had either cleansing foams (n=6), emollient soap substitutes (n=4), wipes (n=3) or water (n=2).

Following their cleansing regimen, these patients had a variety of topical barrier products applied. A total of 86 responses were documented for this element of the evaluation: 46% (n=50) had a barrier product applied following skin cleansing, 20% (n=17) had a barrier film, 6% (n=5) were treated with a modern barrier cream, and 12% (n=10) had no barrier product applied. The remaining four patients had a traditional barrier cream, or antifungal cream.

Before starting the evaluations, the clinicians visually assessed their patients' skin condition and recorded the extent of any MASD. Of the 110 Medi Derma-PRO evaluations, 87 responses were documented:

- ▶ 33% (n=29) suffered with severe skin damage
- ▶ 44% (n=38) with moderate skin damage
- ▶ 21% (n=18) with mild skin damage
- ▶ 2% (n=2) had no skin damage.

The average duration of use for the Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser cohort was 10 days (based on 59/110 responses).

'Findings from these clinical evaluations reinforce that IAD is by far the most common cause of MASD, due to prolonged or chronic exposure of urine and/or stool, particularly liquid stool on the skin.'

On completion of each evaluation, a visual assessment of the patient's skin condition was undertaken by the clinician. Observations were then recorded in terms of whether the skin had deteriorated, remained the same, or improved.

Where applicable, in association with anti-fungal treatments, Medi Derma-PRO Skin Protectant Ointment provided a clinically supportive treatment for the management of skin infections.

A total of 85 clinicians responded from the 110 Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser evaluations:

- ▶ 71% (n=60) noted an improvement
- ▶ 28% (n=24) reported that it remained the same
- ▶ 1% (n=1) stated that the skin had deteriorated.

Following each evaluation, the clinicians were asked to rate the overall performance of Medi Derma-PRO against products used prior to the evaluations, or usual product if no skin barrier had been previously used.

A total of 103 responses from the 110 Medi Derma-PRO Skin Protectant Ointment and Medi

Derma-PRO Foam & Spray Incontinence Cleanser evaluations were returned:

- ▶ 78% of clinicians (n=80) rated it as much better or better
- ▶ 20% (n=21) rated it the same
- ▶ 2% (n=2) rated it as worse than products previously or usually used.

The final element of the evaluations asked the clinician and/or patient to provide any additional feedback regarding the treatment provided or received.

Feedback relating to Medi Derma-PRO ointment and cleanser included:

Much better than soap and water. [patient]

The staff really liked the cleanser, very effective at cleaning; the patient was very happy. [nurse]

Patient reported ointment gave her instant relief, very easy to apply. [nurse and patient]

This treatment does everything the old products did but costs less... will use this again! [nurse]

DISCUSSION

Findings from these clinical evaluations reinforce that IAD is by far the most common cause of MASD, due to prolonged or chronic exposure of urine and/or stool, particularly liquid stool on the skin (Ousey and O'Connor, 2017). This type of damage is also more prevalent in the elderly population, where continence problems are more common and skin integrity is susceptible to damage (Bradbury et al, 2017).

In relation to skin cleansing, it appears that soap and water still remain a common cleansing method. However, this is generally believed to be sub-optimal practice (Beekman et al, 2011). Traditional soaps are alkaline, can alter the protective acidic mantle of skin and remove the natural

sebum, resulting in drier skin and reduced protection from skin commensals (Beeckman et al, 2009). This can further compromise the skin and increase the risk of MASD, especially in patients with vulnerable or fragile skin (Beldon, 2008; Beeckman et al, 2015).

The fundamental aspects of MASD prevention and management should be based on skin cleansing with a mild, pH-balanced soap substitute, or leave-on/no-rinse cleansers, to remove contaminants and microorganisms, followed by the application of a skin moisturiser and an impermeable barrier that provides total skin protection (Beldon, 2012; Beeckman et al, 2015; Lichterfeld-Kottner et al, 2020).

The successful use of Medi Derma-PRO Skin Protectant Ointment in association with fungal treatments also provided useful and clinically relevant information during certain evaluations to support use of the products in this way. While many skin barrier creams are not appropriate for such use due to their moisturisation properties, these evaluation results suggest that Medi Derma-PRO Skin Protectant Ointment will provide a suitable barrier protection required to prevent further exposure to moisture and irritants exacerbating any secondary infection, while not donating excessive moisture to the skin from the product itself.

In the author's clinical opinion, the overall performance ratings and additional feedback received, in comparison to equivalent products previously or usually used, is testimony to the products' efficacy. The majority of clinicians in the evaluations found them to be better than, or at least the same as, similar products currently available at the time, further supporting the effectiveness of these products in clinical practice.

An important consideration is the need for further education and training regarding appropriate use of skin barrier products, an outcome which supports the clinical need

for an easy-to-implement, moisture damage treatment strategy like TBP™. Within this strategy, Medi Derma-PRO is indicated for use on moderate-to-severe moisture-related skin damage — the product is designed to address the problems with managing this degree of damage specifically and not with the aim of replacing simpler and more cost-effective barrier products, such as creams and films.

'Adopting an integrated and holistic approach and focusing on the importance of skin integrity, and effective prevention and management strategies, may serve as a great benefit to improving practice.'

The positive clinician feedback received for Medi Derma-PRO ointment and cleanser provides further support for the efficacy of the products in clinical practice, and is especially encouraging when they were found to be better than or at least the same as the most comparable products available on the market at the time. This provides clinicians with a degree of choice when choosing this type of cleansing and barrier product, and allows for consideration of other important factors, such as unit cost, while still maintaining confidence in achieving good patient outcomes with high quality products.

CONCLUSION

Giving clinicians product choice for managing varying levels of skin damage is important to ensure that IAD and other MASD are managed appropriately and prevented where possible. This, in turn, not only promotes improved quality of life for patients and reduces the prevalence and incidence of such problems, but also offers financial savings. This could also impact on prevalence, incidence and consequences of development

of pressure injuries, due to the accepted association. When used as part of the TBP strategy, the Medi Derma-PRO Skin Protection System can be effective for preventing further deterioration of IAD, while reducing overuse of expensive products when not clinically necessary, as well as enabling all levels of care providers to consistently implement a standardised regimen.

While the use of skin barrier products contributes to the successful maintenance of skin integrity, it is essential that healthcare practitioners have a better understanding of the strategies and evidence to support clinical practice, and effectively manage healthcare resources. Additionally, it is of equal importance to continue to raise awareness that all forms of MASD can have a significant effect on patient wellbeing and quality of life (Fletcher et al, 2020). This can only be achieved through the provision of basic skin care education and training for all registered and non-registered healthcare practitioners, along with guidance for best practice, to reduce the incidence of these and related skin conditions, such as cutaneous infection and pressure ulcers (Stephen-Haynes and Stephens, 2012; Beeckman et al, 2014; Fletcher et al, 2020). Adopting an integrated and holistic approach and focusing on the importance of skin integrity, and effective prevention and management strategies, may serve as a great benefit to improving practice (Beeckman et al, 2020).

The reality for healthcare is that choices have to be made about how money and resources are allocated for maximum overall benefit (International Consensus, 2013), and decisions are often based on the unit cost of a product. In the author's clinical opinion, implementing a prevention or management strategy, such as TBP™, simplifies decision-making, prevents inappropriate product use and reduces costs, while still ensuring confidence in achieving good patient outcomes. **JCN**

REFERENCES

- Beeckman D, Schoonhoven L, Verhaeghe S, et al (2009) Prevention and treatment of incontinence-associated dermatitis: literature review. *J Adv Nurs* 65(6): 1141–54
- Beeckman D, Verhaeghe S, Defloor T, et al (2011) A 3-in-1 perineal care washcloth impregnated with dimethicone 3% versus water and pH neutral soap to prevent and treat incontinence-associated dermatitis. *J WOCN* 38(6): 627–34
- Beeckman D, Woodward S, Gray M (2011) Incontinence-associated dermatitis: step-by-step prevention and treatment. *Br J Community Nurs* 16(8): 382–89
- Beeckman D, Van Lancker A, Van Hecke A, Verhaeghe S (2014) A systematic review and meta-analysis of incontinence-associated dermatitis, incontinence, and moisture as risk factors for pressure ulcer development. *Res Nurs Health* 37(3): 204–18
- Beeckman D, et al (2015) *Proceedings of the Global IAD Expert Panel. Incontinence Associated Dermatitis: Moving Prevention Forward*. Wounds International. Available to download from www.woundsinternational.com
- Beeckman D, Campbell K, Le Blanc K, et al (2020) *Best practice recommendations for holistic strategies to promote and maintain skin integrity*. Available online at: <https://bit.ly/3rxo8v1> (accessed 26 July, 2021)
- Beldon P (2008) Moisture lesions: the

effect of urine and faeces on the skin. *Wound Essentials* 3: 82–7

Beldon P (2012) The latest advances in skin protection. *Wounds UK* (8)2: S17–19

Bradbury S, Price J, Gaffing J, Yoro E (2017) Evaluating an incontinence cleanser and skin protectant ointment for managing incontinence-associated dermatitis. *Wounds UK* 13(1): 79–85

Clark M, Romanelli M, Reger SI, et al (2010) Microclimate in context (19–24). In: *International Review. Pressure Ulcer Prevention: Pressure, Shear, Friction and Microclimate in Context. A Consensus Document*. Available online: www.woundsinternational.com/media/issues/300/files/content_8925.pdf

Doughty D, Junkin J, Kurz P, et al (2012) Incontinence-associated dermatitis. consensus statements, evidence-based guidelines for prevention and treatment, current challenges. *J WOCN* 39(3): 303–15

Fletcher J, Beeckman D, Boyles A, et al (2020) *International Best Practice Recommendations: Prevention and management of moisture-associated skin damage (MASD)*. Available online: <https://bit.ly/3cSAAS3> (accessed 17 June, 2021)

Gray M, Beeckman D, Bliss DZ, et al (2012) Incontinence-associated dermatitis: a comprehensive review and update. *J WOCN* 39(1): 61–74

International Consensus (2013) *Making the case for cost-effective wound management*. Available online: <https://bit.ly/3p113iT> (accessed 20 January, 2021)

Jones S, Winterbottom C (2019) *Skin Moisture Alert Reporting Tool (S.M.A.R.T.)*. Available online: <https://bit.ly/3cMv43o> (accessed 14 June, 2021). The S.M.A.R.T. Resource is the property of Medicareplus International, adapted by S. Jones & C. Winterbottom for Medicareplus International Limited with kind permission from the National Association of Tissue Viability Nurses Scotland (NATVNS) 2014 — Scottish Excoriation & Moisture Related

Skin Damage Tool. <https://medicareplus.co.uk/medicareplus-international-s-m-a-r-t-resource/> OR <https://bit.ly/3uY5fEJ>

Lichterfeld-Kottner A, El Genedy M, Lahmann N, et al (2020) Maintaining skin integrity in the aged: A systematic review. *Int J Nurs Stud* 103: 103509

KEY POINTS

- Incontinence-associated dermatitis (IAD) relates to skin breakdown from exposure to urine or faeces, and its management involves implementation of structured skin care regimens incorporating appropriate use of skin barrier products to protect the skin from exposure to moisture and irritants.
- The fundamental aspects of MASD prevention and management should be based on skin cleansing with a mild, pH-balanced soap substitute, or leave-on/no-rinse cleansers, to remove contaminants and microorganisms, followed by the application of a skin moisturiser and an impermeable barrier that provides total skin protection.
- Total Barrier Protection™ (TBP) provides a unique range of products with clear guidance and rationale for use, based on the type and severity of moisture exposure and degree of skin damage, enabling the skin care strategy to be tailored to individual patient needs.
- Adopting an integrated and holistic approach and focusing on the importance of skin integrity, and effective prevention and management strategies, may serve as a great benefit to improving practice.

Ousey K, O' Connor L (2017) Incontinence Associated Dermatitis Made Easy. *Wounds UK* 13(1)

Stephen-Haynes J, Stephens C (2012) Evaluation of clinical and financial outcomes of a new no-sting barrier film and barrier cream in a large UK primary care organisation. *Int Wound J* 10(6): 689–96

Young T (2017) Back to basics: understanding moisture associated skin damage. *Wounds UK* 13(4): 56–65

Revalidation Alert

Having read this article, reflect on:

- Your knowledge of MASD
- Skin care regimens you introduce to prevent and manage IAD
- How you select which skin barrier product to use.

Then, upload the article to the free JCN revalidation e-portfolio as evidence of your continued learning: www.jcn.co.uk/revalidation

Catheter valves: appropriate use and reduction of risk to bladder

Sharon Holroyd

Indwelling urinary catheters remain one of the most used clinically invasive devices in the UK, with approximately 90,000 people living in community settings in England currently using long-term urinary catheters. There has been a plethora of clinical evidence published demonstrating the risks of prolonged use of indwelling urinary catheters and the increased risk of significant infection, sepsis, and, in some cases, fatality. While the use of an indwelling urinary catheter is in some cases wholly justified and unavoidable, it is the responsibility of healthcare professionals to ensure that risks are mitigated/reduced wherever possible. Use of a catheter valve system may improve the chance of normal bladder function resuming following the removal of the catheter. It is a relatively simple intervention that can be managed by many patients and offers more discretion and dignity. Use of catheter valves should always reflect latest national guidance on best practice and be incorporated into local policy. This article explores some of the clinical evidence supporting the use of catheter valves and advice on best practice.

KEYWORDS:

■ Catheter valves ■ Indwelling urinary catheters ■ Bladder function

Indwelling urinary catheters remain one of the most used clinically invasive devices in the UK (Loveday et al, 2014; Feneley et al, 2015). It is estimated that there are at least 90,000 people living in community settings in England currently using long-term urinary catheters (Gage et al, 2016).

Clinical evidence demonstrates the length of time a catheter is in place can increase the risk of developing an infection and a significant number of patients with long-term catheters develop sepsis, which can lead to death (Chenoweth and Saint, 2013; Loveday et al, 2014). Furthermore, it has been estimated that around 2,100 deaths a year are

'Clinical evidence demonstrates the length of time a catheter is in place can increase the risk of developing an infection and a significant number of patients with long-term catheters develop sepsis, which can lead to death.'

directly caused by using indwelling catheters (Feneley et al, 2015). The cost of treating catheter-related urinary tract infections (CAUTIs) is estimated to be about £2,000 an episode, while the total annual cost of using indwelling catheters in the NHS is estimated to be between £1–2.5 billion (Yates, 2016).

The impact of catheter complications is felt most by the patient who experiences significant issues relating to infection and the need for antibiotics (Chapple et al, 2016). Nursing and social care

services across community and acute care departments report an increased demand on their services with catheter-related issues, leading to a reduction in capacity and ability to respond to the holistic needs of patients with indwelling catheters. This can impact on an already pressured healthcare economy across the NHS and social care sector (Tay et al, 2016; Ansell and Harari, 2017).

There are recognised situations where the use of an indwelling urinary catheter is an acceptable option for managing bladder drainage. However, considering the evidence and risks of urinary catheters, their use must only be considered when all other options have been discounted. Appropriate management and early removal of these devices should also be a priority (National Institute for Health and Care Excellence [NICE], 2014; Davey, 2015; Yates, 2016; Simpson, 2017; Royal College of Nursing [RCN], 2019).

WHEN SHOULD A CATHETER BE USED?

Clinical indications for the use of indwelling urinary catheters have been identified by the Royal College of Nursing (RCN, 2019) and the European Association of Urology Nurses (EAUN) (Geng et al, 2012) (Table 1). There are significant risks associated with the introduction of a foreign body into the bladder (Table 2), not least infection, with statistics demonstrating that the longer a urinary catheter is in place, the more likely an infection is to develop (Loveday et al, 2014). Therefore, it is widely acknowledged that indwelling urinary catheters should only be used as a last resort and when all other options have been considered, tried and failed (RCN, 2019).

Sharon Holroyd, retired lead continence nurse

Table 1: Indications for use of an indwelling urinary catheter (Geng et al, 2012; RCN, 2019)

▶ Acute or chronic retention of urine
▶ Accurate measurement of urine output in critically ill patients
▶ Neurological conditions affecting sensation or control of micturition
▶ Perioperative use for selected surgical procedures
▶ Urology/genito-urinary tract surgery
▶ Prolonged duration of surgery, intraoperative monitoring
▶ Wound healing of open sacral or perineal wounds in incontinent patients
▶ Patients requiring prolonged immobilisation, e.g. unstable thoracic or lumbar spine injuries, multiple trauma injuries
▶ Bladder irrigation/lavage
▶ To maintain skin integrity in intractable incontinence

BLADDER FUNCTION

It is important to understand the normal bladder physiology and the impact of a urinary catheter on normal bladder function to enable practitioners to promote effective and safe use of these devices.

Normal bladder

Urine can only be effectively stored in the bladder if the urethral pressure remains higher than the internal bladder pressure. A sustained substantive contraction of the pelvic floor, urethral wall and external sphincter increases and maintains a higher urethral pressure in comparison with the intravesical pressure to maintain continence (Feneley et al, 2015).

A compliant bladder is achieved when the detrusor muscle actively relaxes during the filling stage of the micturition cycle, allowing the bladder to stretch without allowing the internal pressure to increase. The parasympathetic nervous system inhibits detrusor contraction until the individual is ready to pass urine.

Increased abdominal pressure during coughing, laughing or sneezing is equally distributed to the urethra and bladder in a healthy person to ensure that pressures

are maintained and the pelvic floor supports the bladder effectively preventing leakage.

During the filling stage of the micturition cycle, receptors within the detrusor are stimulated to send messages to the sacral cord via afferent nerve pathways. Motor efferent nerves then transmit signals back to the detrusor muscle, initiating relaxation while maintaining a contracted external sphincter. This mechanism allows stretching and filling of the bladder.

This process is controlled from the pontine micturition centre (PMC) located in the frontal lobe of the brain. The first sensation of needing to pass urine usually occurs in adults at approximately 200–300ml, but the desire to urinate can be deactivated by the PMC until a socially acceptable time and place. The sensation intensifies as the bladder fills, until the voiding phase (usually recognised at approximately 500mls in adults, although this varies individually), where the receptors at the S2–S4 level are activated, initiating sphincter relaxation and bladder contraction in synergy to expel urine. This mechanism is susceptible to muscle fatigue and cannot be sustained indefinitely. Any urine remaining when the mechanism reverses is retained in the bladder until the next time urination is initiated (Feneley et al, 2015).

Aside from normal physiology, bladder function is also affected by social and psychological factors. Learned behaviour obtained through formal toilet training popular in westernised society can adversely affect the function of a normal bladder, as it encourages a belief that toileting is a totally private function

behind a closed, locked door (Holroyd, 2015; Bladder & Bowel UK [BBUK] and ERIC, 2019). Any issue affecting continence, including the need to wear an indwelling catheter, can leave a patient feeling vulnerable and dependent on another person to manage the basic function of bladder emptying, resulting in a feeling of a lack of control (Booth, 2013; Holroyd, 2018).

EFFECT OF INDWELLING CATHETERS ON BLADDER FUNCTION

In some cases, a patient's bladder function will slow down over a period of weeks or months when a catheter is *in situ*, especially if the urine is on continuous drainage into a bag (Addison, 2001; Robinson, 2005). There is an increase in negative pressure within the bladder and catheter drainage system (when on free drainage), which can lead to the mucosal walls of the bladder being 'sucked' into the catheter eyelet holes, causing a disruption to the drainage of urine and resulting in blockage (Geng et al, 2012; Feneley et al, 2015). Choice of the urine drainage bag attached to the catheter, and the distance the bag is placed from the bladder, can also have a negative impact on bladder drainage resulting in pain, urine bypassing, frequent catheter blockage or slower urine drainage (Feneley et al, 2015).

Some common issues reported by patients following removal of an indwelling catheter include incontinence, incomplete bladder emptying, lack of bladder sensation, frequency and urgency of micturition, detrusor over/underactivity, reduced bladder capacity, and urinary tract infection (UTI) (Gilbert, 2006; Colley, 2015; Feneley, 2015, Holroyd, 2018).

Table 2: Complications associated with the use of indwelling urinary catheters (Geng et al, 2012; RCN, 2019)

▶ Catheter-associated urinary tract infection	▶ Haematuria
▶ Catheter blockage	▶ Granulation formation
▶ Catheter bypassing	▶ Urinary extravasation
▶ Iatrogenic trauma	▶ Inability to remove catheter
▶ Bladder spasm	▶ Squamous cell carcinoma (SCC)
▶ Bladder pain	▶ Epididymitis

Table 3: Advantages and disadvantages of using catheter valves (Simpson, 2017)

Advantages	Disadvantages
<ul style="list-style-type: none"> ▶ Discretion ▶ Comfort ▶ Potential for maintenance bladder function, capacity and tone ▶ Mimics normal bladder ▶ Reduces risk of trauma by lifting bladder wall tissue away from catheter tip ▶ Reduces risk of bladder neck trauma caused by drainage bag ▶ The four hourly release schedule may reduce catheter blockage ▶ Possible reduction in risk of infection 	<ul style="list-style-type: none"> ▶ Limited bladder capacity ▶ Potential for detrusor overactivity ▶ Ureteric reflex — when urine is forced back up the ureter towards the kidneys leading to swelling and potential damage of both ureter and kidney ▶ Reflux/anal impairment ▶ Poor dexterity ▶ Impaired bladder sensation ▶ Immobility

CATHETER VALVES

As previously discussed, the bladder protects itself by regularly filling and emptying. Catheter valve devices are attached to the indwelling catheter, negating the continuous use of a free drainage system and allowing controlled filling and emptying of the bladder. This mimics normal bladder function to some extent and reduces the risk of tissue trauma on the bladder neck, mucosal lining and urethra (Woodward, 2013). Additionally, the use of a catheter valve can preserve some bladder sensation and function in some patients (Yates, 2016).

A catheter valve is usually attached direct to the urinary catheter and can remain *in situ* for up to seven days before requiring a complete valve change. Any valve changes should be treated as an aseptic procedure to reduce the risk of infection. Patients or carers who are responsible for changing the valve should be taught by a healthcare professional the appropriate procedure for safe and effective changes. Opening and closing of the valve by a simple lever tap allows the bladder to fill and empty at designated times. This should be managed using appropriate infection control measures, including hand hygiene, and in situations where someone other than the patient is handling the valve, an aseptic technique is advised (RCN, 2019).

To manage the daily care of a valve, current advice is to wash the entry and exit points of the valve thoroughly at least once every 24 hours (RCN, 2019). This should be a clean or aseptic

technique and can be managed in the same way as the standard protocol for catheter care (refer to local policies for exact procedure relevant in your area). It is also advised that before and after each use, the valve is wiped clean using an appropriate alcohol/antiseptic wipe (refer to local policies for relevant procedures). Patients are also advised to wash their hands before and after handling the valve. It is not necessary for the patient to wear protective gloves, although gloves would be advised if a third person was handling the valve (RCN, 2019).

There are some clinical situations that do not support or benefit from the use of a catheter valve. The following factors should be considered before engaging in the use of a catheter valve, and careful individual assessment is key (Yates, 2016):

- ▶ Capacity — the capacity of an individual bladder may affect the ability to store volume of urine, leading to the risk of an overdistended bladder or pain if the valve is not drained appropriately. Bladder capacity may also be dictated by recent surgery that requires avoidance of filling the bladder to protect anastomoses (common in urogynaee, pelvic or abdominal procedures)
- ▶ The risk of renal damage caused by a full bladder should always negate the use of a catheter valve system
- ▶ Sensation — most patients will rely on a feeling of bladder fullness to alert them to open the catheter valve at an appropriate time to empty the bladder. Patients with a lack of bladder

sensation may be taught to use a valve system safely and effectively if bladder capacity and frequency of need to empty can be established. This can be achieved through assessment of fluid intake and urine output over a period of at least 24 hours to establish kidney function and normal urine production, and will include specialised input from appropriately trained staff, preferably supported with the use of bladder scans

- ▶ Cognitive ability — a patient with impaired cognitive function may not be able to safely and effectively manage a catheter valve, even with support of another person.

Table 3 details the potential advantages and disadvantages of using a catheter valve.

The ultimate aim of any catheter should be early and timely removal to reduce the risks previously discussed. There has been some suggestion that using a catheter valve before trial without catheter (TWOC) may improve the success and outcome of the procedure (Woodward, 2013; Yates, 2016). The author has not been able to find any clinical evidence suggesting a minimum amount of time to wear a valve before a TWOC to ensure its success. In practice, the recommended timescale to wear a valve system appears to range from 48 hours to two weeks before removing the catheter. Clinicians should follow local policy and guidelines for use of catheter valves. It should be noted that a successful TWOC is not wholly dependent on the use of catheter valves — other considerations include fluid intake and bowel activity, which are essential to achieving a successful TWOC.

Practice point

It is important to ascertain a patient's dexterity before using a catheter valve, as they vary in how they work — some need to be pushed laterally while others require twisting of a tap-like device (Woodward, 2013).

INTRODUCING OUR **NEW**
CliniSure[®] URINARY SHEATH
with **plastic-free packaging**

Helping you to care
for your patients

Kind to the environment

Easy on your budget



Call for more information on **0800 036 0100**
or email **info@clinimed.co.uk**

CONCLUSION

It is clear that the clinical risks associated with urinary indwelling catheters cause concern, while use of catheters remains a viable and effective treatment option for many patients. However, establishing the cost to a patient's quality of life is difficult to determine, with the risk of serious infection increasing the longer the catheter is in place (Chang et al, 2011; Loveday et al, 2014). Some 45% of all bacteraemia cases caused by *Escherichia coli* are attributed to the urinary tract and the use of catheters (Abernathy, 2017).

It is a Public Health England (PHE) focus to reduce all healthcare-associated Gram-negative bloodstream infections (GNBSI) by 50% by 2021, and all trusts have been challenged with ensuring that a robust action plan is in place to achieve this by closer monitoring, early detection and appropriate treatment of CAUTIs (NHS Improvement, 2017). However, it should be noted that this target was unlikely to have been fully achieved given the focus on the global pandemic over the past 18 months. As health care settles into some kind of post pandemic normality, the reduction of healthcare-associated GNBSI will again become a higher priority. The guidance has been updated to reflect the global challenges with a new target date of 2024/25 for achieving the 50% reduction.

Appropriate use of a catheter valve can be achieved after careful individual assessment and may improve the chance of normal bladder function resuming following removal of the catheter. A valve system offers more discretion to the patient, as it can be hidden in clothing and managed easily by many patients. Use of catheter valves should always reflect latest best practice guidance and local policy. **JCN**

REFERENCES

Abernathy J, Guy R, Sheridan EA, et al (2017) Epidemiology of *Escherichia*

coli bacteraemia in England, Results of an enhanced sentinel surveillance programme. *J Hosp Infect* 95(4): 365–75

Addison R (2001) Trial removal of a catheter. *Nurs Times* 97(4): 45–6

Ansell T, Harari D (2017) Urinary catheter-related visits to the emergency department and implications for community services. *Br J Nurs* 26(9)Suppl: S4–11

Bladder and Bowel UK and ERIC (2019) *Managing bladder and bowel issues in nurseries, schools and colleges*. Available online: www.bbuk.org.uk/schools-resources/

Booth J (2013) Continence care is every nurses' business. *Urol News* 18(1): 17–19

Chang R, Todd GM, Chenoweth CE (2011) Epidemiology of hospital acquired urinary tract related bloodstream infection at a university hospital. *Infect Contr Hosp Epidemiol* 32(11): 1127–9

Chapple A, Prinjha S, Feneley R, et al (2016) Drawing on accounts of long-term urinary catheter use: design for the 'seemingly mundane'. *Qual Health Res* 26(2): 154–63

Chenoweth C, Saint S (2013) Preventing catheter-associated urinary tract infections in the intensive care unit. *Crit Care Clin* 29(1): 19–32

Colley W (2015) Use of frequency volume charts and voiding diaries. *Nurs Times* 111(5): 12–15

Davey G (2015) Troubleshooting indwelling catheter problems in the community. *J Community Nurs* 29(4): 67–74

Feneley R, Hopley I, Wells P (2015) Urinary catheters history: current status, adverse events and research agenda. *J Med Eng Technol* 39(8): 459–70

Gage H, Avery M, Flannery C, Williams P, Fader M (2016) Community prevalence of long-term urinary catheter use in England. *Neurourol Urodyn* 36(2): 293–6

Geng V, Cobussen-Boekhorst H, Farrell J (2012) *Catheterisation: Indwelling in Adults*. European Association of Urology Nurses (EAUN), Holland

Gilbert R (2006) Procedure to undertake a trial without catheter. *Nurs Times* 102(42): 48–50

Holroyd S (2015) What can we do to improve the patient experience of continence care? *J Community Nurs* 29(2): 66–73

Practice point

Avoidance of the use of, or early removal of indwelling catheters, can help reduce the incidence of CAUTIs.

Holroyd S (2018) Best practice for trial without catheter. *Urology and Continence Care Today* 1(1): 35–9

Holroyd S (2018) Best practice in the use of indwelling catheterisation. *Urology and Continence Care Today* 1(1): 28–34

Loveday HP, Wilson JA, Pratt RJ, et al (2014) epic3: national evidence-based guidelines for preventing healthcare associated infections in NHS hospitals in England. *J Hosp Infect* 86(Suppl 1): S1–70

NHS England (2017) Preventing healthcare associated Gram-negative bloodstream infections (GNBSI). Updated 2019. Available online: <https://improvement.nhs.uk/resources/gnbsi-evidence-and-further-resources/>

National Institute for Health and Care Excellence (2014) *Long Term Urinary Catheters: Prevention and Control of Healthcare-associated Infections in Primary and Community Care*. NICE, London

Robinson J (2005) Removing indwelling catheters: trial without catheter in the community. *Br J Community Nurs* 10(12): 553–7

Royal College of Nursing (2019) *Catheter care: RCN guidance for healthcare professionals*. Last updated 2021. Available online: www.rcn.org.uk/professional-development/publications/catheter-care-guidance-for-health-care-professionals-uk-pub-009-915

Simpson P (2017) Long-term urethral catheterisation: guidelines for community nurses. *Br J Nurs* 26(9): S22–S26

Tay LJ, Lyons H, Karrouze I, et al (2016) Impact of the lack of community catheter care services on the emergency department. *BJU Int* 118(2): 327–34

Woodward S (2013) Catheter valves: a welcome alternative to leg bags. *Br J Nurs* 22(11): 650–4

Yates A (2016) Indwelling urinary catheterisation: what is best practice? *Br J Nurs* 25(9 Suppl): S4–12

VISCOPASTE[◇] PB7

An effective treatment for people with skin conditions and chronic wounds using the healing benefits of Zinc Oxide

Viscopaste PB7 bandages may be used to treat inflamed, itchy and lichenified dermatological conditions such as eczema and dermatitis². They are also useful in the management of venous leg ulcerations⁵ and their associated skin conditions which can cause discomfort i.e. varicose eczema, hyperkeratosis, cellulitis².

Trusted for decades to provide effective treatment, use Zinc Oxide paste bandages to help your patient to heal.

- Soothes and reduces inflammation¹³⁴
- Cool to wear, providing relief for itch¹³⁴
- Helps to break the itch-scratch cycle by forming a protective barrier¹³⁴
- Softens lichenified skin¹
- Helps to avoid secondary skin damage and infection caused by scratching
- Cost effective and easy to apply²



Viscopaste
10% Zinc Oxide

NHS Catalogue
Viscopaste 7.5cm x 6m

FP10 Drug Tarrif
Viscopaste 7.5cm x 6m

Order Code
EFA 011

PIP Code
033-2734

Evolan Pharma AB
www.pastebandagesevolan.com
e-mail. pastebandages@evolan.se tel.+44 (0)7554133321

EVOLAN.

References

1. Agren M (1990). Studies on Zinc in Wound Healing. Linköping University Medical Dissertations No. 320. Department of Pathology II, Faculty of Health Science. Linköping, Sweden. 2. Evolan Pharma AB (2021). Data on file. Danderyd, Sweden. 3. Kogan S, Sood A, Granick MS (2017). Zinc and wound healing: A review of zinc physiology and clinical applications. Wounds 29(4): 102-6 4. Lansdown ABG, Mirastschijski U, Stubbs N et al (2007). Zinc in wound healing: Theoretical, experimental, and clinical aspects. Wound Repair Regen 15: 2-16 5. Stacey MC, Jopp-McKay AG, Rashid P, Hoskin SE, Thompson PJ (1997). The Influence of Dressings on Venous Ulcer Healing - A Randomised Trial. Eur J Vasc Endovasc Surg 13, 174-179

Dementia and continence issues

Zena Aldridge, Karen Harrison Dening

Urinary and faecal incontinence are common in the older population, yet incontinence is not a normal part of ageing. Dementia can impact upon a person's ability to remain continent, yet incontinence is unlikely to be a symptom of dementia until the latter stages of disease progression. There is a misconception that nothing can be done if a person with dementia experiences episodes of incontinence. However, many people with dementia often experience functional incontinence caused by immobility, communication difficulties, disorientation, or the inability to find the toilet, which can all be alleviated if the right support and advice is available. Improving the identification, assessment and management of continence issues can not only enable people with dementia to maintain their dignity and improve their health, but also their sense of wellbeing and quality of life. There is also the possibility to improve relationships, reduce carer burden, and reduce the risk of a premature transition into a residential care setting. This fourth paper in the series explores some of the issues relating to dementia and continence and the impact as experienced by our two case studies, Dhriti Singh and Gregory Brewin.

KEYWORDS:

■ Continence ■ Incontinence ■ Dementia ■ Person-centred care

It is estimated that there are more than 14 million people in the UK experiencing issues with their bladder and around 6.5 million people who have bowel problems leading to incontinence, the effects of which can be debilitating (NHS England, 2018). However, it is suggested that figures may be an underestimation due to people failing to report symptoms as a consequence of stigma and feelings of humiliation (Hagglund and Wadensten, 2007). Urinary and faecal incontinence are common in the older population, although incontinence is not a normal part of ageing (Spencer et al, 2017). Despite this, older people, their families and carers often consider

it inevitable, irremediable, and ultimately a sign of incompetence (Gove et al, 2016). People with dementia may already feel stigmatised by their dementia diagnosis, and it is likely that there is an underreporting of continence issues in people living with dementia due to fears of further stigmatisation (Drennan et al, 2013; Gove et al, 2016).

Urinary incontinence can have a significant detrimental impact on a person's quality of life and social functioning and is associated with adverse health outcomes such as falls, depression, and urinary tract infection (UTI) (Wagg et al, 2019). Moreover, incontinence can play a significant factor in decisions to move a person with dementia into residential care (Hope et al, 1998; Luppá et al, 2008; Alzheimer Europe, 2014). This is often a result of the distress and sense of burden that can be caused by

incontinence to both the person with dementia, their families and carers, but equally as a result of the extra support that is needed to manage the symptoms (Alzheimer Europe, 2014).

There is a misconception that urinary incontinence is a symptom of dementia. Urinary incontinence may be concurrent with dementia, although cognitive impairment alone may not be the cause of urinary incontinence particularly in the earlier stages of dementia. However, there is increased prevalence of incontinence as dementia progresses into the advanced stages (Harwood and Cowan, 2021). Dementia rarely travels alone due to high levels of multimorbidity, so incontinence may be as a result of another comorbid condition, such as diabetes, cardiac failure, degenerative joint diseases and arthritis, chronic lung disease, Parkinson's disease, depression, stroke and normal pressure hydrocephalus (Alzheimer Europe, 2014).

URINARY INCONTINENCE

There are four types:

- ▶ Stress incontinence
- ▶ Overflow incontinence
- ▶ Overactive bladder
- ▶ Functional incontinence (Wheatley 1982) (Table 1).

Functional incontinence is considered to be associated with impaired cognition and is caused by immobility, communication difficulties, disorientation, or an inability to find the toilet, rather than abnormalities of the bladder (Harwood and Cowan, 2021). Consequently, given people with dementia experience many of these causative factors, they may be affected disproportionately by functional incontinence to those without dementia (Byles et al, 2009; Gove et al, 2016).

Zena Aldridge, Admiral Nurse research fellow, Dementia UK, PhD student, De Montfort University, Leicester; Karen Harrison Dening, head of research & publications, Dementia UK and professor of dementia nursing, De Montfort University, Leicester

Although it is important to recognise that older people with dementia can experience other issues with continence, it must not be assumed that they are experiencing functional incontinence and any other causal factors of their incontinence should be assessed appropriately (Harwood and Cowan, 2021). Medications may also be a contributory factor. Cholinesterase inhibitor drugs prescribed for Alzheimer’s disease, such as donepezil and rivastigmine, can cause or negatively impact on existing continence issues (Garg et al, 2015). Similarly, medications such as oxybutynin prescribed for an overactive bladder, can also cause cognitive impairment, particularly when a person is subject to polypharmacy and anticholinergic burden (Reppas-Rindlisbacher et al, 2016). Alzheimer Europe (2014: 16) state that:

Neither dementia nor incontinence is a purely physical/ biomedical phenomenon. Consequently, it should not be assumed that urinary incontinence is linked solely to the bladder or that continence problems in the case of a person with dementia are solely due to brain damage.

Therefore, it is important to consider the biopsychosocial causes and impact as part of holistic assessment rather than seeing dementia and continence in isolation of each other.

FAECAL INCONTINENCE

Faecal incontinence can have many underlying causes. The National Institute for Health and Care Excellence guidance (NICE, 2014) acknowledges that healthcare professionals may make assumptions that faecal incontinence is related to a pre-existing condition or disability, such as cognitive impairment, without carrying out a full assessment. People with dementia are four times more likely to be diagnosed with faecal incontinence compared to those without dementia, with care home residents being disproportionately affected with prevalence rates of between 30–50% (Goodman et al, 2015).

Table 1: Four types of urinary incontinence

Stress incontinence	▶ More common in women. The loss of bladder control during physical activity such as laughing, sneezing, coughing, jumping, exercising, lifting or during sexual intercourse. Usually the result of the weakening of, or damage to the muscles used to prevent urination, such as the pelvic floor muscles and the urethral sphincter
Overflow incontinence	▶ More common in men. An inability to completely empty the bladder which leads to overflow. The most common cause in men is an enlarged prostate, but can be caused by blockages of the urethra, weak bladder muscles, nerve damage and medication
Overactive bladder	▶ A combination of symptoms that can cause urinary urgency, increased frequency, urge incontinence and nocturia. Can be caused by weak pelvic muscles, nerve damage, medications, alcohol, caffeine, infection, excess weight, and oestrogen deficiency post menopause
Functional incontinence	▶ Occurs when an individual with normal bladder and urethral function has difficulty getting to the toilet before urination occurs. Functional incontinence is often related to impaired cognitive functioning and mobility

Table 2: Signs of continence problems in people with dementia (Alzheimer Europe, 2014)

<p>The person with dementia may:</p> <ul style="list-style-type: none"> ▶ Spend a long time in the toilet ▶ Have urinary tract symptoms (e.g. frequent urination, rushing to the toilet to urinate, hesitancy, itching ‘after dribble’ and pain) ▶ Be getting up to pass urine more frequently at night (nocturia), perhaps accompanied by daytime sleeping ▶ Change their clothes at unusual times ▶ Use sanitary towels in the absence of menstruation ▶ Not want to go out for fear of needing the toilet, particularly to unfamiliar places ▶ Be reluctant to eat or drink ▶ Sometimes vomit or have pain (this can happen with severe constipation) ▶ Use natural remedies (e.g. against diarrhoea and constipation) ▶ Be restless, agitated, or anxious ▶ Have poor hygiene routines 	<p>You may notice:</p> <ul style="list-style-type: none"> ▶ Wet patches or stains on the furniture ▶ Soiled laundry and toilet paper in strange places (perhaps hidden or forgotten) ▶ Unpleasant smells ▶ A mess in the bathroom/toilet ▶ A change in frequency of elimination (a person should normally pass faeces between three times per day and three times per week, and urinate about six to seven times per day, but there are considerable differences in how people go to the toilet)
---	---

As with urinary incontinence, the cause may be functional. However, there remains the need to consider whether there are any treatable causes or factors that might be impacting on a person’s altered bowel movements.

Loose stools could be caused by overflow due to constipation, or the side-effects of medication, laxative use, antibiotic therapy, or dietary intolerances, all of which can be improved with changes to diet and prescribed medication (Goodman et al, 2015). Importantly, an altered bowel movement should be assessed and investigated, as the person may have other undiagnosed conditions affecting their bowel.

IDENTIFYING AND ACKNOWLEDGING THE SIGNS

Given the detrimental effects that both urinary and faecal incontinence can have on the person with dementia, their families and carers, there is a need to ensure that incontinence is identified swiftly so that a timely and effective assessment can be undertaken. Incontinence can have negative physical health consequences, but can also compromise a person’s dignity and their emotional and psychological wellbeing, affecting their mood, quality of life and relationships (Cole and Drennan 2019). As there may be reluctance or stigma associated with the person with dementia

Dhriti is a 53-year-old woman who has a diagnosis of young onset vascular dementia, heart failure and hypertension. Since her husband Arjun returned from India 18 months ago, he has been providing increasing levels of personal care to Dhriti.

Patient story one

Six months ago, he decided to employ a carer to take Dhriti out a couple of afternoons a week to give him some rest, as Dhriti had become very anxious and would be calling out for him and following him around the house constantly. However, Arjun has continued to prompt and support Dhriti with her personal care, but has noticed at times her underwear appears to have urine stains on them. Dhriti has asked her daughter to buy her some sanitary towels but no longer menstruates. While out with the carer a few weeks ago, Dhriti had an episode of urinary incontinence which upset her and as a result she has become increasingly reluctant to go out with the carer. Dhriti has made lots of excuses saying it was just a one-off incident but now does not want to leave the house. She has also taken to sleeping in a spare bedroom saying it is because Arjun disturbs her at night. Arjun knows this is a sensitive issue, as she asked their daughter, not him, to buy the sanitary towels. He does not know how to support his wife or raise the issue with her, as they have never talked about such things throughout their marriage, but he feels it is having a significant impact on her wellbeing and their relationship. Over a period of a few weeks, Arjun became more concerned as Dhriti was becoming more withdrawn and so he called the GP who advised that Dhriti was due an annual review and for Arjun to make an appointment.

appropriately trained in discussing and assessing issues with continence, and a consultation with a doctor for an examination and possible onward referral to gynaecology or urology, for example, if considered appropriate (Alzheimer Europe, 2014).

This paper will now explore how issues with incontinence may manifest themselves through the lenses of the two case studies.

PATIENT STORY ONE: DHRITI SINGH

Previous articles in this series also follow Dhriti's story (Harrison Denning and Aldridge, 2020; Aldridge and Harrison Denning, 2021; Harrison Denning and Aldridge, 2021).

Family carers

Gender can be an issue in the provision of personal care, with male family carers feeling uncomfortable or unsuitable to provide care in some circumstances, such as for their mother or female partner (Drennan et al, 2011; Gove et al, 2017). Family-caregiving is predominantly an activity undertaken by females, although, as a consequence of changing demographics, family structures and roles, an increasing number of men are taking on the role of primary caregivers (Baker and Robertson 2008; Sharma et al, 2016), as is the case with Arjun and Dhriti.

Although it is inferred that men approach caring roles differently, there has been less attention paid to examining their experiences, especially in providing intimate care (Sharma et al, 2016). However, no matter what the gender of the person

reporting episodes of incontinence, it is important that families and healthcare professionals are aware of the possible cues and clues that may indicate a person with dementia is experiencing difficulties in managing continence. *Table 2* identifies some of the signs to look out for.

It has been highlighted that there is a lack of knowledge and training in relation to incontinence in dementia (Alzheimer Europe, 2014), with Wagg et al (2008) suggesting a propensity for healthcare professionals to provide continence pads to older people as a first action, rather than assessing and treating any underlying causes. Family carers have suggested that when they seek support from GPs and other healthcare professionals, advice is not always helpful or effective, with inconsistent access to continence products and a lack of understanding of the needs and impact on carers when considering which continence products might be appropriate (Drennan et al, 2011).

However, there are opportunities

to improve outcomes for people with dementia, their families and carers by undertaking thorough assessment and considering strategies and investigations to reduce the negative impact that episodes of incontinence may have. There is a need to consider continence within a wider holistic assessment of needs, as the person may be reluctant to disclose their concerns. Asking if they have any issues and creating an environment where they feel safe and reassured is the first important step.

Table 3 suggests some points to think about when assessing the needs for people with dementia in relation to any issues with continence. If the incontinence is a new phenomenon, it is important to consider whether there is an underlying acute and treatable illness that is causing it, such as a UTI which should be investigated and confirmed by dipstick and cultures (Harwood and Cowan, 2021). However, to determine other potential causes of incontinence a person with dementia should be offered an assessment with someone

Reflective points

You have been asked to conduct a review of Dhriti's needs and you are aware that her husband is concerned she might be experiencing symptoms of urinary incontinence. How would you raise this in the review?

What support do you think Dhriti and Arjun each might need? Do you know where to access the correct support locally?

Patient story two

Gregory has a diagnosis of Alzheimer’s disease and vascular dementia and lives at home with a package of formal care, which was put in place by his social worker following recent concerns about his behaviour and safety. He had been seen wandering the streets at night and when neighbours tried to encourage him to go home, at times he had been aggressive. Gregory has been experiencing intermittent urinary incontinence over the past few weeks, which he has not disclosed to anyone, but his carers have found damp pants, trousers and pyjama bottoms secreted around his house. As they have only been providing care to Gregory for a few weeks, they are unclear whether this is a recent or longstanding issue. The carers have also noticed that Gregory’s bedroom smells of urine, although his bed and sheets show no evidence of incontinence and the wooden floors do not appear wet. The carers try and raise the issue with Gregory, who embarrassedly apologised for the wet clothing and says it is just his age and denies that he has a problem. Concerned about the situation, the carers raise the issue with the social worker as they feel Gregory may need more support and might not be able to remain at home.

with dementia or the family carer is, incontinence can have a detrimental effect on relationships, with couples reporting that it can impact negatively on their physical attraction, affection, and intimacy (Gove et al, 2016). This might be due to the person with dementia needing support with intimate personal care, which may lead to changes in the roles within the relationship (Drennan and Cole, 2009; Gove et al, 2016), as well as practical barriers, for example, the need to sleep in separate beds.

Furthermore, there may be increasing demands on carer’s time because of needing to deliver personal care, an increase in household chores, such as laundry and cleaning, and sleep disturbances caused by nocturia (Gove et al, 2016). Therefore, delivering continence care can have a detrimental emotional, physical, and psychological impact on carers, with many reporting that they feel ill-equipped to do so. This demonstrates not only a clear need for support in managing continence issues, but also greater sensitivity and understanding from health and social care practitioners (Alzheimer Europe, 2014). Yet, family carers consider that continence assessments are too brief, and fail to take into account the impact on them both in terms of meeting the practical demands as well as the emotional effect of managing incontinence (Upton and Reed 2005; Drennan et al, 2011; Kyle 2012; Gove et al, 2016).

**PATIENT STORY TWO:
GREGORY BREWIN**

Previous articles in this series also follow Gregory’s story (Harrison Dening and Aldridge, 2020; Aldridge and Harrison Dening, 2021; Harrison Dening and Aldridge, 2021).

A person with dementia may wake up during the night and be disorientated and in searching for the toilet for so long, end up wetting their clothes. This, coupled with nocturia, could lead to a person urinating in inappropriate places, such as in a wardrobe or plant pot, which might be the case with Gregory. People with dementia can have difficulties in recognising when their bladder is full, which impacts on their ability to

gauge or anticipate when they need to void their bladder. This may also lead to them voiding their bladder inappropriately as they are unable to exert a delay in voiding (Si Ching, 2017). This can be misinterpreted as a wilful or resistive act — a ‘behaviour that challenges’, perhaps leading to an increased risk of transfer into a residential setting (Alzheimer Europe, 2014). However, the impact of functional incontinence is remedial if the correct steps are taken to address some of the barriers that affect a person with dementia’s ability to get to the toilet.

In Gregory’s case, it might be advisable to place a nightlight between his bedroom and the bathroom so that he can get his bearings when he wakes up in the night, or if the toilet is too far away consider placing a urine bottle or commode near to his bed. It appears that Gregory does wake before he passes urine as his bed is not wet or soiled, indicating that his environmental factors should be considered in the first instance, before a need for any specific continence aids.

CONCLUSION

Incontinence can be debilitating, stigmatising, and is often considered to be humiliating by those who experience it. People with dementia

do not feel the negative effects of incontinence any less than people without dementia do.

There is a need to dispel the myths associated with dementia and continence to ensure that people with dementia, their families and carers, access the right support and guidance to minimise any negative impact incontinence may have on their lives. This means recognising that incontinence is not a symptom of dementia until the latter, more advanced stages of the disease progression, acknowledging there are things that you can do if a person with dementia experiences episodes of incontinence, and that family carers do not always know what to do, so need support and advice. While continence aids, such as pads, might be part of the solution for some, they should not be considered the only option — maintaining a person’s dignity should always be the priority. **JCN**

Reflective points

Have you come across a scenario like this before? If so, how was it managed?

Having read this article, would you now think about things differently?

Table 3: Some things to think about when considering continence and dementia

▶ Finding out about the person's usual bowel and bladder routines — is this a new problem? Are there any known medical or physical conditions? What medication are they taking?
▶ Finding out if they have communication difficulties. How do they usually communicate their need to use the toilet? Would prompting help?
▶ Are there any medications that might be impacting on the situation? Do medications need reviewing?
▶ Are they having issues with skin integrity and maintaining personal hygiene?
▶ What is their diet like? Are they getting adequate nutrition and hydration? Do they need support with shopping, meal preparation, etc? Would the person benefit from a community care assessment?
▶ Do they have mobility issues? Can the environment be changed in any way to support continence? Do they have the correct mobility aids? Are they in pain on movement? Would pain relief help? Do they have a downstairs/accessible toilet? Would any equipment, such as toilet raisers, commodes etc, help? Would an occupational therapy or physiotherapy assessment help?
▶ Is the person's coordination and dexterity affected by their dementia? For example, would they benefit from clothing that does not have belts and buttons?
▶ Does the person get disorientated? Would a sign on the toilet door help? Is there appropriate lighting at night to enable them to find the bathroom/toilet?
▶ Do they have any visuo spatial difficulties or visual impairment? Would a coloured toilet seat help? Can some of the furniture be removed so it is less cluttered? Would a change in flooring help (busy carpets can appear to move, rugs can look like holes)?
▶ Are they anxious? Is this causing them to visit the toilet more frequently?
▶ How is their carer/spouse coping? Have they had a carer's assessment? Do they need information and advice on how to support the person they care for? Do they need practical support?
▶ For spousal carers/partners, what impact is incontinence having on their relationship and ability to be intimate?
▶ Are they using the best continence products to meet their needs and those of their carer?

REFERENCES

Aldridge Z, Harrison Dening K (2021) Managing comorbid conditions and dementia. *J Community Nurs* 35(2): 54–9

Alzheimer Europe (2014) *Improving continence care for people with dementia living at home*. Available online: www.alzheimer-europe.org/Publications/Alzheimer-Europe-Reports 9

Baker KL, Robertson N (2008) Coping with caring for someone with dementia: reviewing the literature about men. *Aging Ment Health* 12: 413–22

Byles J, Millar CJ, Sibbritt DW, Chiarelli P (2009) Living with urinary incontinence: a longitudinal study of older women. *Age Ageing* 38(3): 333–8

Cole L, Drennan VM (2019) Living with incontinence: The experience of people with dementia. *Dementia* 18(5): 1826–39

Drennan V, Cole L (2009) Promoting continence and managing incontinence with people with dementia living at home: one more challenge for integration. *J Integrated Care* 17(1): 15–25

Drennan VM, Cole L, Iliffe S (2011) A taboo within a stigma? a qualitative study of managing incontinence with people with dementia living at home. *BMC Geriatr* 11: 75

Drennan VM, Rait G, Cole L, et al (2013) The prevalence of incontinence in people with cognitive impairment or dementia living at home: a systematic review. *NeuroUrol Urodyn* 32: 314–24

Garg K, Kishor K, Kar SK (2015) Cholinesterase inhibitor induced urinary incontinence in dementia: a management dilemma. *Toxicol Int* 22(2): 123

Goodman C, Rycroft Malone J, Norton C, et al (2015) Reducing and managing faecal incontinence in people with advanced dementia who are resident in care homes: protocol for a realist synthesis. *BMJ Open* 5: e007728

Gove D, Scerri A, Georges J, van Houten P, Huige N, et al (2016) Continence care for people with dementia living at home in Europe: a review of literature with a focus on problems and challenges. *J Clin Nurs* 26: 356–65

Häggglund D, Wadensten B (2007) Fear of humiliation inhibits women's care-seeking behaviour for long-term urinary incontinence. *Scand J Caring Sci* 21(3): 305–12

Harwood RH, Cowan R (2021) Physical assessment. In: Dening T, Thomas A, Stewart R, Taylor JP, eds. *Oxford Textbook of Old Age Psychiatry*. Oxford University Press: chap 11

Harrison Dening K, Aldridge Z (2021) Dementia: recognition and cognitive testing in primary care settings. *J Community Nurs* 35(1): 43–9

Harrison Dening K, Aldridge Z (2021) Understanding behaviours in dementia. *J Community Nurs* 35(3): 50–5

Hope T, Keene J, Gedling K, Fairburn CG, Jacoby R (1998) predictors of institutionalization for people with dementia living at home with a carer. *Int J Geriatr Psychiatry* 13(10): 682–90

Kyle G (2012) An insight into continence management in patients with dementia. *Br J Community Nurs* 17(3): 125–31

Luppa M, Luck T, Brähler E, König HH, Riedel-Heller SG (2008) Prediction of institutionalisation in dementia. A systematic review. *Dement Geriatr Cogn Disord* 26(1): 65–78

NHS England (2018) *Excellence in continence care practical guidance for commissioners, and leaders in health and social care*. Available online: <https://bit.ly/3oYgPOU>

National Institute for Health and Care Excellence (2014) *Faecal incontinence in adults* (qs54). NICE, London. Available online: <https://bit.ly/3DCxuf3>

Reppas-Rindlisbacher CE, Fischer HD, Fung K, Gill SS, et al (2016) Anticholinergic drug burden in persons with dementia taking a cholinesterase inhibitor: the effect of multiple physicians. *J Am Geriatr Soc* 64(3): 492–500

Sharma N, Chakrabarti S, Grover S (2016) Gender differences in caregiving among family — caregivers of people with mental illnesses. *World J Psychiatry* 6(1): 7–17

Si Ching L (2017) Managing the elderly with urinary incontinence and dementia. *Int Arch Urol Complic* 3: 027

Spencer M, McManus K, Sabourin J (2017) Incontinence in older adults: the role of the geriatric multidisciplinary team. *Br Columbia Med J* 59(2): 99–105

Upton N, Reed V (2005) The meaning of incontinence in dementia care. *Int J Psychiatr Nurs Res* 11(1): 1200–10

Wagg A, Potter J, Peel P, et al (2008) National audit of continence care for older people: management of urinary incontinence. *Age Ageing* 37(1): 39–44

Wagg A, Gove D, Leichsenring K, Ostaszkiwicz J (2019) Development of quality outcome indicators to improve the quality of urinary and faecal continence care. *Int Urogynecol J* 30(1): 23–32

Wheatley JK (1982) Bladder incontinence. *Postgrad Med* 71(1): 75–8

STAND UP FOR LEGS



It's time to stand up and make sure that lower legs and feet aren't the last thing we think about.

**LEGS
MATTER!**

Get the lowdown at legsmatter.org

RESHAPING CARE
TOGETHER...



BLS BRITISH
LYMPHOLOGY
SOCIETY

The COLLEGE
of PODIATRY



LEG CLUB
www.legclub.org



Society of Vascular Nurses
SVN

Tissue
Viability
Society

IN RECOGNITION OF OUR
PLATINUM PARTNERS

3M + KCI
United by purpose.



essity



Medtronic
Further. Together



URGO
MEDICAL
Healing people™

Inaccuracies in dispensing compression garments: survey results

Anecdotally, clinicians have reported difficulties with obtaining the correct compression garments for patients, with dispensing inaccuracies and delays raising concerns of patient safety, clinical inefficiency, unwarranted variation in care and wasted resources. However, limited published evidence exists to support this. JCN therefore carried out two surveys in 2018/19 and 2021 to determine if these issues are experienced widely. Results confirmed these problems were encountered at both points in time and that improvements in dispensing could be made to benefit both health services and patients. The ongoing Coronavirus pandemic has led to a change in preference for product dispensing and delivery, with an emphasis placed on home and self care.

The number of people with venous and/or lymphatic disease that require long-term treatment with compression therapy is growing, as longevity and polymorbidity put more people at risk of developing wounds (Guest et al, 2020).

Unfortunately, these patients are largely managed in the community setting, where the workforce is in decline and under unprecedented pressure (Royal College of Nursing [RCN], 2013). In recognition of the need for change and to alleviate some of the burden placed on community staff, NHS England (2017) recommended improved efficiency, and the elimination of unwarranted variation in care and waste.

The recent Covid pandemic has placed further unprecedented pressure on community workforces, necessitating the need to take a different approach to usual practice, for example by promoting patient self care (Schofield, 2021).

As clinicians, it is reasonable to expect that prescribed compression garments will be dispensed correctly (Stephen-Haynes, 2018). However, with over 10,000 compression garments available via prescription, there is room for error (O'Neill, 2017). Anecdotally, clinicians have reported difficulties with obtaining the correct compression garments for their patients, or dispensing taking a long time, with both problems delaying the start of therapy, and raising concerns over patient safety, and generation of waste (Stephen-Haynes, 2018). However, limited published evidence exists to support these experiences (Stephen-Haynes, 2018).

The Lymphoedema Network Wales identified dispensing problems and carried out an evaluation among people with lymphoedema to determine the extent of difficulties in obtaining the correct compression garment in a timely manner. The results found that 50% of compression prescriptions were dispensed inaccurately, while the average wait time to obtain the garment was 42 days (O'Neill, 2017).

JCN therefore carried out two surveys to determine if these reported problems with inaccurate dispensing are experienced widely in the UK. The surveys were available for completion by registered users of the JCN and GPN websites in November to January 2018/19 (survey one) and JCN website in April 2021 (survey two). The surveys used the majority of the same questions with an additional question added to survey two (Table 1).

RESULTS

Prescribers

Survey one had 376 respondents while survey two had 165. In survey one, 70% (n=263/376) of respondents were prescribers of compression

hosiery, whereas in survey two, 31% (n=51/165) of respondents had prescribing power.

Main supply route

In both surveys, the most common route to obtaining compression garments was via pharmacy (survey one, 82% [n=307/376]; 67% [n=111/165]). In survey one, 'other route', mainly prescription via GP or specialist nurse, was the second most common route. In survey two, non-prescription ordering was the preferred second route (17.58%; n=29/165), while Dispensing Appliance Contract (DAC) was used in third place in both surveys (survey one, 10.6% [n=40/376]; survey two, 10.30% [n=17/165]).

Problems with inaccurate dispensing

In both surveys, respondents reported problems arising as a result of inaccurate dispensing of compression garments. In survey one, 70% (n=261/376) of respondents anticipated issues, while in survey two this was 61% of respondents (n=100/165 (Figure 1).

In survey one, 73% of respondents (n=91/262) stated that up to a quarter of all prescriptions were

Table 1: Survey questions

- ▶ Are you a prescriber of compression garments?
- ▶ Which is the main supply route for compression garments in your trust?
- ▶ Do you and/or your patient experience problems caused by incorrect dispensing of compression garments?
- ▶ If yes, what percentage of prescriptions would you estimate are dispensed inaccurately?
- ▶ Which inaccuracies do you experience the most?
- ▶ Do you and/or your patients anticipate delays in compression garment dispensing?
- ▶ If yes, how many working days on average does it take to get the prescribed compression garment?
- ▶ In the future, where would you prefer your patients' garments to be delivered?*

*Question asked in survey two only

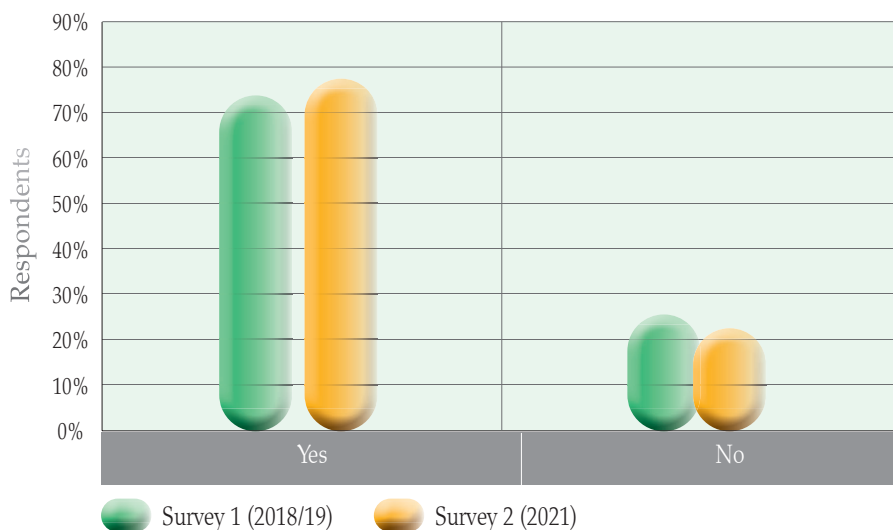


Figure 1.
Percentage of respondents anticipating delays in compression garment dispensing.

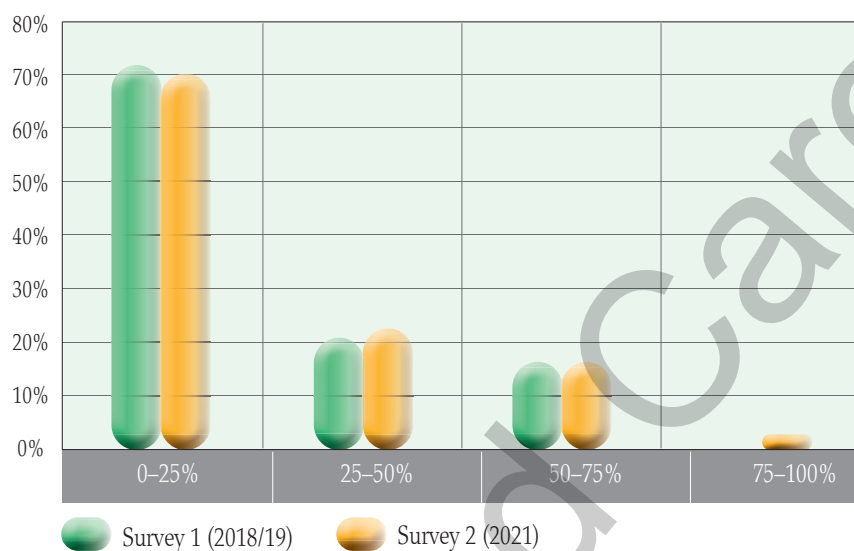


Figure 2.
Percentage of compression garments dispensed inaccurately.

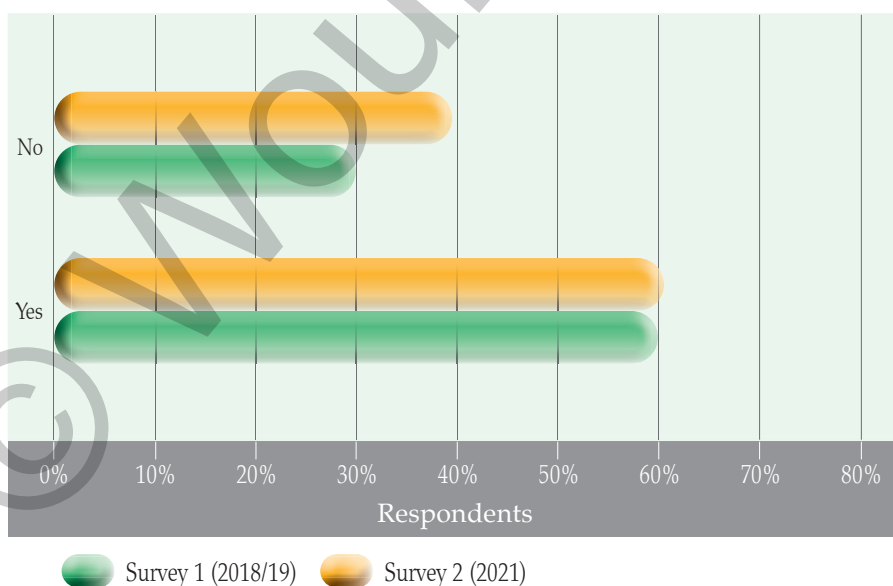


Figure 3.
Percentage of respondents who experience problems caused by incorrect dispensing.

inaccurately dispensed, with 22% (n=56/262) stating a quarter to half of all prescriptions were incorrect versus 69% (n= 86/124) and 24% (n=29/124) of respondents respectively in survey two (Figure 2).

Both surveys also revealed that respondents encountered the same inaccuracies. Survey one listed the wrong size as the most common problem (37%, n=140/376), followed by the wrong garment class (14%, n=53/376), the wrong type of garment (14%, n=53/376), followed by the wrong colour (9.3%, n=35/376). The remaining 26% of problems were classified as 'other'.

In survey two, the wrong size was also the most common issue (42%, n=69/165), followed by the wrong type (18%, n=29/165), change in brand (12%, n= 20/165), then wrong class and colour (7%, n=12/165). Other was also stated for 25% of answers in survey two (n=23/165).

Delays in dispensing

In terms of time delays experienced in dispensing of compression garments, 75% (n=279/376) of respondents in survey one stated they experienced delays (Figure 3). A third of respondents (34%, n=106/376) reported a wait of 5–10 days to receive the garment, while 31% (n=98/376) waited 10–14 days, and 20% (n=64/376) for more than 14 days. Of the respondents, 15% (n=47/376) reported receiving the product within 1–4 days (Figure 4).

In survey two, 77% (n=127) of clinicians also reported expected delays (Figure 3). Again, approximately one-third of respondents (34%; n=50) expected the garment to be dispensed within 10–14 days, 27% (n=40) within 5–10 days, and 24% (n=35) in 14 days or more. As in survey one, 14% reported receiving the product within 1–4 days (n=21) (Figure 4).

In the final question of survey two, 61% of clinicians (n=101/376) stated a preference for compression garments to be delivered direct to the patient's home or residence (e.g. hospice/ nursing home), while 38% (n=62/376) stated a preference for delivery to the care setting, e.g. surgery or hospital.

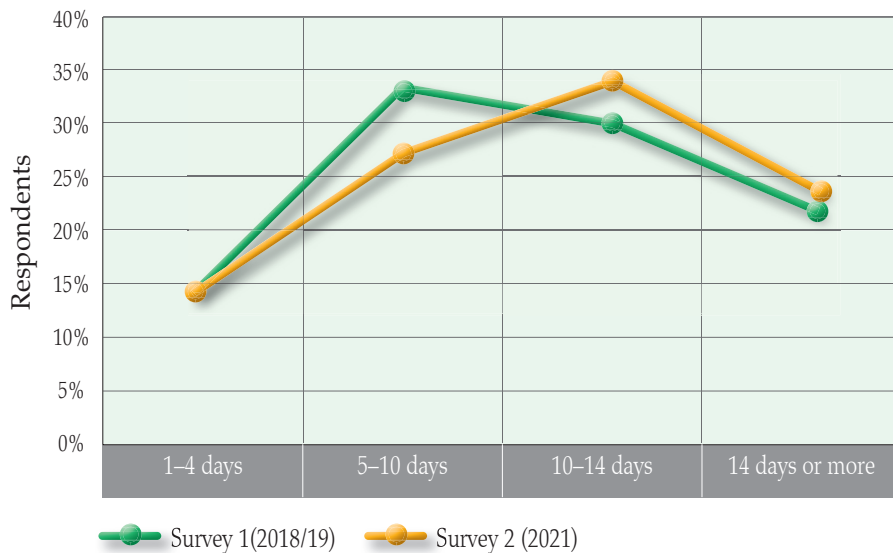


Figure 4.
Number of working days taken to obtain prescribed compression garment.

DISCUSSION

It is recognised that the surveys reported here are not robust studies and provide only topline information relating to dispensing of compression garments in the community. The results do, however, highlight the issues experienced by practitioners, with the themes of inaccuracy and delays in dispensing being common to both sets of respondents over time.

In survey 2, the number of respondents with prescribing power had decreased when compared with survey 1, perhaps reflecting the ongoing decline in the highly skilled community workforce.

In both surveys, approximately three-quarters of respondents stated that up to a quarter of all prescriptions were incorrectly dispensed, with a quarter of clinicians stating that between a quarter to half of all prescriptions were incorrect. This is in line with the findings of Thomas (2017) who reported a 50% inaccuracy in dispensing of compression garments for patients with lymphoedema.

In both surveys, the majority of clinicians expected a delay in dispensing, with the majority of respondents waiting between five to 14 days or more to receive the dispensed prescription. In 2021, more respondents reported a wait of 14 days or longer than in 2018/19. While this

is less than the 42 days reported by Thomas (2017), it is still a significant delay, and may be a consequence of the impact of the pandemic and/or Brexit on the NHS.

These problems with inaccuracies and delays in dispensing could obviously negatively impact upon the patient, with therapy beginning later than planned, unnecessarily wasting clinician time, and could result in both waste and expense for the health service (Stephen-Haynes, 2018).

Overcoming these problems is paramount so that patients can access the correct garments in a timely manner, without experiencing errors and delays (O'Neill, 2017).

DACs provide an alternative route to obtaining compression garments. The surveys revealed that while a minority of settings use DACs, the most common route to obtaining compression is via pharmacy.

However, the use of a DAC with expertise in compression dispensing can help to alleviate some of the issues experienced. For example, Daylong, a specialist compression garment dispenser has a 99.36% accuracy rate (ISO 9001 Audit, 2020) and dispenses in a maximum of five working days for most off-the-shelf and made-to-measure garments (dependent on product supply). Additionally, patients can have their prescription delivered for free to their

nominated address at no extra cost to the NHS. Survey two reported that the ability to have delivery direct to the patient's home or clinical setting was indeed preferred, and is perhaps reflective of the need for a new way of working, with the emphasis placed on self-care for patients due to the Covid-19 pandemic.

CONCLUSION

Community practitioners need to work efficiently to reduce the demands placed upon them. These surveys highlighted the issues that arise from inaccurate compression dispensing and that there is room for improvement that could benefit the patient, clinician and health service alike. The use of DAC with compression dispensing expertise and the added convenience of direct delivery could help to overcome these commonly experienced problems. **JCN**

REFERENCES

- Guest JE, Fuller GW, Vowden P (2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. *BMJ Open* 10: e045253
- NHS England (2017) *Next Steps on The NHS Five Year Forward view*. Available online: www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPSON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
- O'Neill C (2017) Difficulties with getting the right compression garment quickly? *In this Together Magazine* 1. Credenhill Ltd, Derbyshire: 22–4. Available online: www.daylong.co.uk/.../daylong-in-this-together-issue-1.pdf
- Royal College of Nursing (2013) *Frontline First: Nursing on Red Alert*. April 2013. RCN, London
- Schofield A (2021) What have tissue viability services learnt from the coronavirus pandemic? *Nurs Times* 117(3): 23–5
- Stephen-Haynes J (2018) Do you experience problems with the dispensing of compression garments? *J Community Nur* 32(2): 62–4
- Thomas M (2017) Difficulties with getting the right compression garment quickly? *In this Together Magazine* 1. Credenhill Ltd, Derbyshire: 22–4. Available online: www.daylong.co.uk/.../daylong-in-this-together-issue-1.pdf



WHAT IF

you could rely on your dressing choice even if the exudate level increases?

Zetuvit® Plus Silicone Border



Effective:

Absorb. Retain. Maintain optimal microclimate^[1,2]



Versatile:

Simple to choose, simple to use



Patient-friendly:

Atraumatic dressing changes^[3]

BE PREPARED
and prevent exudate-related complications



Product Illustration

Product	Size/Wound pad	Product Code	PIP Code	NCP Code	Pack size
Zetuvit® Plus Silicone Border	10 × 10 cm / 5 × 5 cm	413910	4137071	EJA254	10
	12.5 × 12.5 cm / 7 × 7 cm	413920	4137055	EJA255	10
	17.5 × 17.5 cm / 11.5 × 11.5 cm	413930	4137063	EJA256	10
	15 × 25 cm / 9 × 19 cm	413940	4137048	EJA257	10
	20 × 25 cm / 14 × 19 cm	413950	4136030	EJA258	10

For more information contact your local HARTMANN representative or contact our customer services team
HARTMANN UK & Ireland +44 (0) 1706 363200
Email: info@uk.hartmann.info | www.hartmann.co.uk

Never miss an update from HARTMANN UKI -
Join www.hartmannmarketing.com online now



HARTMANN UKI Healthcare Professionals



HARTMANN GROUP

Transfers efficiently Removes cleanly



Exufiber® and Exufiber® Ag+

The next generation in
Gelling Fibers driven by
Hydrolock® technology



5 reasons to switch to Exufiber® and Exufiber® Ag+

- 1 Efficiently transfers exudate*** away from the wound bed to the secondary dressing^{1,2}
- 2 Locks up to 23% more** of the exudate** absorbed than Aquacel® Extra^{TM 3}
- 3 Promotes autolytic debridement** to support a **clean wound bed upon dressing removal**⁴
- 4 Exufiber® Ag+ prevents biofilm reformation***** as part of a biofilm management approach^{5,6}
- 5 98% of clinicians rated Exufiber** as 'easy' or 'very easy' to remove in one piece⁷

Extensive size range available: 5x5cm, 10x10cm, 15x15cm, 20x30cm, 4.5x10cm, 4.5x20cm, 4.5x30cm
Plus cavity wound ribbons: 1x45cm (Exufiber only) or 2x45cm

Take the 14 day Exufiber® challenge



See for yourself how making a small change can make a big impact. Request clinical product samples by scanning the QR code or go to www.molnlycke.co.uk/exufiberchallenge

* For Exufiber® Ag+, when exposed to a flow rate of 0.6ml/h at 40 mmHg pressure for up to seven days (Mölnlycke Health Care. Exufiber Ag+; Physical properties over time. Mölnlycke Health Care. Data on file. [2019].)

** When comparing lab test results for retention under pressure with Aquacel®, Aquacel® Extra™, Durafiber® and UrgoClean® dressings. *** As part of a holistic biofilm management approach as per international guidelines (i.e. cleansing, debridement and reassessment) [Bjarnsholt T, Eberlein T, Malone M, Schultz G. Management of wound biofilm Made Easy. London: Wounds International 2017]

1. Mölnlycke Health Care. Data on file. [2018]. 2. Mölnlycke Health Care. Data on file. [2020]. 3. Surgical Materials Testing Laboratory BS EN 13726-1:2002. Test methods for primary wound dressings. Mölnlycke Health Care. Data on file. [2014]. 4. Smet, S., Beele, H., Saine, L., Suis, E., Henrickx, B. Open, non-comparative, multi-centre post market clinical follow-up investigation to evaluate performance and safety on pressure ulcers when using a gelling fibre dressing as intended. Poster Presentation at European Pressure Ulcer Advisory Panel Conference, 2015, Ghent, Belgium. 5. Gil et al. 2017. Evaluation of a Gelling Fiber Dressing with Silver to Eliminate MRSA Biofilm Infections and Enhance the Healing. Poster presented at the Symposium on Advanced Wound Care Spring meeting/Wound Healing Society (WHS) Annual Meeting 2017, Apr 05 - 09, 2017, San Diego, CA, USA. 6. Davis, S. C., Li, J., Gil, J., Head, C., Valdes, J., Glinos, G. D., Solis, M., Higa, A. and Pastar, I. (2019). Preclinical evaluation of a novel silver gelling fiber dressing on Pseudomonas aeruginosa in a porcine wound infection model. Wound Rep Reg. 27: 360-365. 7. Davies, P., McCarty, S., An in-use product evaluation of a gelling fibre dressing in wound management. E-poster presentation at Wounds UK Conference, 2017, Harrogate, United Kingdom.

Find out more at www.molnlycke.co.uk. Mölnlycke, Unity House, Medlock Street, Oldham, OL1 3HS. Phone 0161 621 3900. The Mölnlycke trademarks, Exufiber, names and logos are registered globally to one or more of the Mölnlycke Health Care group of companies. © 2021 Mölnlycke Health Care. All rights reserved. UKWC1018a

Aquacel and Aquacel Extra are registered trade marks of ConvaTech. Durafiber is a registered trade mark of Smith and Nephew. UrgoClean is a registered trade mark of Urgo medical Ltd

