

How can community nurses help to combat food insecurity?

Shaping and promoting the future of community nursing

RCN Bladder & Bowel Forum: what are our plans for 2022?

Healing skin with zinc oxide

Optimising nutritional care of patients with cancer

In plain sight: the untapped potential of district nurses

Assessment of chronic oedema

Lymphovenous disease and fibrosed wound beds: adjuvant therapies

Importance of peristomal skin protection

Assessment and management of faecal incontinence

Dementia and end of life: providing good quality palliative care

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**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

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

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e: mail@jcn.co.uk

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# Tackling food poverty



Due to recent energy price increases, fuel cost rises and hikes in the general cost of living, healthy eating may not be at the forefront of everyone's thoughts — simply eating may be a serious and very real issue for many. This issue's 'Community matters' piece (pp. 8–12) offers extensive information about the potential struggles our patients may have and how we can support them in a sensitive and compassionate way. It gives us ideas and demonstrates the importance of holistic patient

assessment, while also providing some advice and solutions. Working within the community and being invited into patients' homes is such a privilege, as it offers the opportunity actually to see how our patients live and identify appropriate support mechanisms.

There is no doubt that community nursing is becoming ever more complex and varied to align with the changing needs of the patient population, with increasing challenges and demands being placed on the nursing workforce. So, with the imminent launch of the National Community Plan 2021–2026, do read how you can get involved and have your voice heard by joining the National Community Nursing Practitioners Network, which offers a range of resources for development and learning (p. 13).

As I am sure you will agree, wound and skin care are 'part and parcel' of community nursing caseloads. Developing practice and exploring new treatments is vital and none more so than for those with lymphovenous disease, as Julie Stanton and colleagues highlight in their article on fibrosed wound beds and adjuvant treatments (pp. 34–43). This issue also looks at stoma skin care, discussing common peristomal complications and how to assess and prevent skin damage, as well as educating ostomy patients and their families about risks, and thus helping to improve quality of life (pp. 44–50).

As always, I hope you enjoy reading the journal and find the clinical articles helpful for your day-to-day practice. If you have any ideas for features, please get in touch, as it is always great to hear from our readers. And finally, don't forget to check when the JCN exhibition and study days are coming to your area — [www.jcn.co.uk/events/series/roadshow-study-day](http://www.jcn.co.uk/events/series/roadshow-study-day).

Annette Bades, editor-in-chief, JCN

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**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*

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

**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*

**Gail Goddard**, *mobile district nurse team manager, Hounslow and Richmond Community Healthcare; associate lecturer, Bucks New University*

**Sharon Holroyd**, *retired lead continence nurse*

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

**Melanie Lumbers**, *freelance tissue viability nurse*

**Debbie Myers**, *head of clinical and professional development, Quality and Professional Development Team, Leeds Community Healthcare NHS Trust*

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

**Georgina Ritchie**, *deputy director of education, Accelerate*

**Hattie Taylor**, *district nurse lead (Purbeck), Dorset Healthcare University NHS Foundation Trust; Queen's Nurse*

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

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



I am a district nurse, nurse teacher in practice, associate lecturer and Queen's Nurse who believes that excellent community nursing is vital and that community nurses should be more visible. Care should be available to everyone who wishes to remain at home. I have an interest in dementia, end-of-life care and teaching in practice to support newly qualified nurses. I am very pleased to be a part of the JCN editorial board, an accessible journal for all community nurses to inform their practice and strive for excellent care.  
*Gail Goddard*

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*

I've been working in district and community nursing for 20 years. My particular passion is for continuity of care in community nursing, which encourages healthy behaviour, builds trusting relationships, can reduce healing times, and makes people feel more positive about their healthcare experience. We have a responsibility to prepare for the future by continuing to develop leadership and clinical skills. The JCN is a great resource for support, education and to share best practice.  
*Hattie Taylor*

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In each issue of the Journal of Community Nursing, we investigate a topic affecting our readers. Here, we ask...

# How can community nurses help to combat food insecurity?

Considering we live in one of the richest countries in the world, it is interesting quite how many colourful words and phrases the English language has for being hungry – ‘I’m starving’, ‘I’m absolutely ravenous’, ‘I could murder a ... [fill-in blanks with favourite fast-food].’

This language of extreme hunger is especially bizarre given our easy access to food, evidenced by the supermarkets on our high streets and the stacks of takeaway leaflets that clog up our letter-boxes, offering anything from pizza to curry to vegan sushi, all at the click of a button.

Unlike many people who live in developing nations and who face an ongoing struggle against poor diet and malnutrition, in the UK most of us have little idea what it must be like to go without food for even a day, let alone to exist in a constant state of hunger.

Unfortunately, however, the rise of Covid-19 has heralded a perfect storm that has had a disastrous effect on food insecurity in the UK. As well as the isolation caused by the pandemic, the past few years have seen rising supply costs in part brought on by Brexit, and more recently, a squeeze on people’s household budgets due to increasing fuel prices. As a result, food insecurity and initiatives such as food banks have become much more commonplace.

Food insecurity is an issue that is relevant for community nurses, many of whose patients are



*It is incredibly sad that we are publishing an article on food poverty, but recent reports have suggested that the number of people unable to pay their energy bills is expected to treble by April 2022 and food poverty is inextricably linked to fuel poverty. It is unacceptable in 2022 to have to choose whether you will eat or heat your home. People will often go without food themselves in order to feed their children and the embarrassment and stigma associated with poverty needs to be addressed.*

*District nurses are well placed to explore this with older people sensitively. Many older people will never admit to having no food in the house, yet you can see they have lost weight, are pale and have no energy. Making an excuse to wash my hands in their kitchen, I would open the fridge door to see exactly what they had and there were times I would shop and cook something while I was there. You cannot leave someone knowing they are hungry or cold. The value on building up the trust and relationship takes time, but cannot be taken lightly or seen as trivial. A person’s overall health and wellbeing is a fundamental part of what it means to be a nurse.*

*If nothing else, the pandemic has shown us the value of communities, of keeping in touch and looking out for vulnerable neighbours, of knowing what assets the community has and the opportunities that Primary Care Networks and Integrated Care Systems bring to our population’s health.*

**Sue Boran**  
Director of nursing programmes, Queen’s Nursing Institute

elderly or live alone with chronic conditions and have struggled to maintain adequate nutrition through repeated lockdowns, as well as finding it increasingly challenging to afford a healthy diet.

## WHAT IS FOOD INSECURITY?

According to the Trussell Trust, a charitable organisation that supports a UK-wide network of food banks, the term ‘food insecurity’ can be



understood as 'a household-level economic and social condition of limited or uncertain access to adequate food' ('Our vision for a future without food banks' — [www.trusselltrust.org/about](http://www.trusselltrust.org/about)).

Food insecurity can have a devastating effect on families and individuals, with children particularly vulnerable to issues such as delayed physical development and diseases such as asthma and anaemia. Older people are also disproportionately affected by food insecurity, particularly those who do not qualify for social care or cannot access help with shopping or cooking — a combination of circumstances that can result in malnutrition as well as exacerbating chronic health conditions ('More than 1m UK older people risk "withering away" from hunger' — [www.theguardian.co.uk](http://www.theguardian.co.uk)).

From a nursing perspective, in a recent blog post for the *British Medical Journal*, one former community nurse, Lindsay Graham, relates how she would often visit older people in their homes and find them cold and with little food in their cupboards. Graham writes about how she would often end up going 'to the local shop to get bread or milk, or a tin of soup and some cheese, and make them something warm to eat' (Lindsay Graham: 'Eradicating food poverty — it is our duty to care and to advocate' — [blogs.bmj.com](https://blogs.bmj.com)).

While this may not be every nurse's experience, many of you will have older patients, in particular, who are ill-equipped to fend for themselves. Community nurses do not need any lessons on the importance of a healthy diet, for example, to aid recovery from wounds or maintain bone strength and prevent falls. However, with the advent of Covid-19, ensuring patients have access to adequate nutrition has become more important than ever.

## HOW HAS COVID-19 AFFECTED FOOD INSECURITY?

Covid-19 itself, as well as the



*Following a healthy diet on a tight budget has never been easy, but now seems harder than ever. We had a lively debate as pre-reg students at the University of the West of England (UWE) in the '90s; it was clear then from our discussions that some of us coped on a minimum food budget in the past, and some really didn't appreciate how difficult it can be. In Jack Monroe's (writer and food poverty campaigner) recent piece in 'The Guardian', one of her observations was that while many luxury items such as pricey ready meals haven't increased by much, the basic staples used for filling and calories such as rice, pasta and potatoes have recently increased a lot, sometimes by 150% plus. While to many, this increase is noticeable but not crippling, for others this will be enough to force them into the 'heat or eat' bracket.*

*As community nurses, people welcome us into their home. This is part of why many of us love this role, for the different perspective and relationship this affords. Often, we may be the only person stepping over the threshold. Skills in assessing our patient's food insecurity can stem from personal experience as well as our education around diet and health inequalities. An essential part of our nursing assessment is nutrition and food accessibility, risk of malnutrition, providing advice on diet or weight loss and enriching food. MUST or MUAC or other scores of risk can be built into health and social care screening templates.*

*What happens after that is key. Raising awareness for the safety of individuals among other key professionals, interagency discussions and planning, appropriate referral (dietician or swallow assessment), and planning of reassessment is essential. Community nurses continued visiting people in their own homes during lockdowns. In tandem, local communities were mobilised to provide delivery services, as well as many other types of initiatives to ensure that people had access to the food they need. We are in a position to see what is happening to people, how some are struggling, as well as to help keep the debate on the table for reducing food insecurity.*

**Hattie Taylor**

District nurse lead (Purbeck), Dorset Healthcare University NHS Foundation Trust; Queen's Nurse

government measures introduced to halt the spread of the pandemic, such as lockdowns and self-isolation, have had a significant negative effect on food insecurity. Repeated lockdowns have meant that many older people were simply unable to shop, while the foodbanks

that often supply vulnerable people with regular nutritious food found it increasingly challenging to operate due to a lack of supplies from supermarkets and falling volunteer numbers ('Coronavirus (COVID-19): Supporting foodbanks' — [www.london.gov.uk](http://www.london.gov.uk)).

With many people unable to work during lockdowns, the strain on the finances of poorer families heightened the risk of conditions such as malnutrition and obesity, as people cut back on healthy food perceived as expensive in favour of a 'basic sustenance' diet that relied more on items such as tinned foods, rice and pasta ('UK's poorest "skip meals and go hungry" during coronavirus crisis' — [www.theguardian.co.uk](http://www.theguardian.co.uk)).

Another much-overlooked consequence of the pandemic was that internet access became far more important, particularly in terms of ordering and scheduling supermarket deliveries. However, many older and vulnerable people also experience digital poverty and do not have access to the internet or a smartphone, and as such were unable to order groceries online or order from fast-food 'apps' during Covid-19 ('How the digital divide affects older adults' use of technology during Covid-19' — [aging-better.org.uk](http://aging-better.org.uk)).

Children were particularly hard-hit by food insecurity brought on by Covid-19. Having originally started a campaign to extend free-school meals across the summer holidays for those children at risk of poor nutrition, in September 2021, the Manchester United footballer and social justice campaigner, Marcus Rashford, claimed that child food poverty was 27% higher than before the start of the pandemic, and asked the government to consider the '2.5 million children that are struggling to know where their next meal might be coming from today' ('Marcus Rashford reboots campaign to end child food poverty and urges people to write to their MPs' — [versus.uk.com](http://versus.uk.com)).

Rashford's comments were backed-up by government figures showing that between January and October 2020, almost 200,000 more children had registered for free school meals in England due to the economic effects of the pandemic, meaning that 1.63 million out of 8.2 million state school children were eligible for



*Food insecurity has been highlighted in a variety of arenas, geographical regions, and patient populations. It is far more common than originally considered and recent events, including the pandemic, Brexit and price rises has further increased this insecurity.*

*As nurses, being aware of this issue increases our opportunity to promote public health and offer integrated person-centred care. Being the curious, enquiring practitioner can enhance our ability to improve a patient's diet. One father said he had just given his toddler a good lunch as he was going to nursery, I enquired what it was he had eaten and it was half a sausage roll and for another family it was a packet of crisps for their toddler — it was what the families had in, they knew their toddler would eat and they could afford to buy.*

*Discussion and education is a key role of the nurse in this arena and health promotion should be fundamental to all of our our interactions with the individuals and families we work with. This may include healthy eating discussions and appropriate referral, for instance to the food bank or Citizen's Advice, who have people trained to discuss finances, and maybe reviewing their outgoings, talking to their energy provider will enable them to have more money to spend on money for food.*

*The initial dialogue is key, including building rapport, being non-judgemental and supportive, as many individuals are in this position through no fault of their own and find it difficult to admit what is happening to them. They wish to improve this food insecurity for themselves and their family, but have been hit by a set of circumstances that have sent their family finances into a downward spiral with a significant impact on the individual's physical and mental health.*

**Teresa Burdett**  
Principal academic, Bournemouth University

free lunches ('Food poverty: rising number of children in England eligible for free school meals' — [www.theguardian.co.uk](http://www.theguardian.co.uk)).

### RISING PRICES

As well as the ongoing Covid-19 pandemic, Brexit and a global fuel supply crisis have had a knock-on effect on food insecurity, with goods being more expensive to import. Also, rising heating costs this winter mean that many vulnerable people are having to make stark choices between food and keeping themselves warm.

Caroline Abrahams, charity director at Age UK, says: 'Rising energy bills are filling pensioners on low fixed incomes with absolute dread... it is clear that as things stand, some fully expect to have to choose between cutting down on food or turning down their heating' ('Without more Government financial help, fuel poor older households will top a million by the spring, new analysis shows' — [www.ageuk.org.uk](http://www.ageuk.org.uk)).

Similarly, Sustain, an alliance of organisations dedicated to improving food production and distribution,



*The community nurse is one of the few healthcare professionals in the privileged position of being invited into their patients' homes. They are provided with a unique insight into the true health and wellbeing of their patient; as it is much harder to mask the truth when in the family home surrounded by personal belongings. This in itself often supports them to approach subject matters that perhaps other healthcare professionals would be unaware of. Using prompts within the home to start conversations; whether this is around support from family and friends (seen in photos), or access to kitchen and equipment as observed when in the room.*

*A variety of screening tools can be utilised in helping to gain insight into the nutritional habits of patients. Any assessment tool should be used as an aide memoir, encouraging conversation to help answer some probing questions; not used as a tick box exercise. Therefore, screening tools, such as Waterlow or those attached to your wound care care plan, may provide a greater understanding to areas of concern. When the healthcare practitioner sits and talks to their patient about the need for nutrition to help support wound healing (and the extra calories required to achieve this), or its role in preventing pressure area damage; often you will find the patients will then explain their difficulties in access to appropriate food and drink. It is widely accepted that a malnourished person can just as easily present as obese as they can underweight. Honest and open conversations often result in great discoveries, leading the professional into ways to offer support and signpost.*

*Once issues and concerns are identified, solutions and approaches to addressing these areas can be openly shared; taking away the patient's potential sense of shame. The pandemic has brought great advances in technology and access to health and wellbeing services. While it is acknowledged that technology may be a direct barrier to some patients (particularly those in advancing years); we shouldn't assume there is not a solution. Many of our patients may have friends and relatives who have online access. Public libraries are open again, providing a social community where the internet can be accessed, and support in using it offered. The NHS have created a site entitled 'Better Health', bringing together a vast array of topics to help support mental and physical health. This includes nutrition. Menus and shopping lists can be easily accessed. The headline may state weight loss, further reading leads you to menu planning offering ideas on improving nutritional status — [www.nhs.uk/better-health/](http://www.nhs.uk/better-health/). As healthcare professionals, we need to identify areas of concern and help find solutions — our patients' health will then improve.*

*The pandemic has seen increases in cases of domestic violence and abuse (DVA). Sadly we are aware that DVA does not discriminate, happening to any age. Issues associated with DVA can also lead to food deprivation.*

**Melanie Lumbers**  
Freelance tissue viability nurse

noted some time ago that a no-deal Brexit would see widespread price rises affecting those 'most in need', which it defined as 'children, hospital patients, people living in care homes or in detention, recipients of meals on wheels, lunch clubs or charitable meals, people in crisis who are being referred to food banks, and those experiencing household food insecurity due to low income' ('Brexit food resilience for the people who need it most' — [www.sustainweb.org](http://www.sustainweb.org)).

In other words, many of the patients that nurses in primary care see on a daily basis.

### IS A PATIENT'S DIET MY RESPONSIBILITY?

While many nurses might not see the provision of food as their primary role, the effect of poor nutrition on health means that a holistic view of general community nursing must include food insecurity. Crystal Oldman, chief executive of the Queen's Nursing Institute (QNI), recently wrote that nurses and health visitors are ideally placed to identify and act on food insecurity because they are the people that are most likely to see it in 'their daily work with families'.

Writing about her own experience of receiving free school meals and the effects on children of food insecurity, Oldman adds that, 'as nurses, we see the impact of poverty on children every day and we cannot remain silent on this issue' ('Free school meals: nurses cannot remain silent on child food poverty' — [www.rcni.com](http://www.rcni.com)).

In its nutrition guidelines for nurses, the Royal College of Nursing (RCN) makes it clear that it is a nurse's duty to investigate any patient they suspect of being malnourished ('Nutrition essentials'



*As community nurses we have a unique opportunity to make every interaction count in addressing food insecurity. Many community nurses will have experienced opportunistically discovering people with poor nutrition, and limited access to adequate food due to either financial constraints or the physical ability to buy food themselves. Formal carers have limited time to assist with shopping and then have limited time to cook food, so many rely on ready meals or sandwiches of poor nutritional value. Often, these individuals have been surviving with poor nutrition for a long time and it quickly becomes their norm. The people we discover in this position are probably in truth the tip of the iceberg.*

*Raising your own awareness of food insecurity, knowing what is available to help in your area and how to signpost to this help is vitally important. Holistic assessment has always been the benchmark of high quality community nursing, including nutritional assessment. Nutrition impacts on so many aspects of an individual's health and well being, but at a time of increasingly high workloads and lower staffing capacity where staff are resisting task orientation of care on a daily basis, it may not be always prioritised. The use of nutritional assessment tools may assist with this, but only if there are resources available if action is needed and community nurses continue to champion the importance of good nutrition as part of their care.*

**Gail Goddard**

Mobile district nurse team manager, Hounslow and Richmond Community Healthcare; associate lecturer, Bucks New University

— [www.rcn.org.uk](http://www.rcn.org.uk)). Some of the recommended steps nurses can take include:

- ▶ Understanding the effects of ageing on nutritional needs
- ▶ Understanding how ill-health and medicines affect appetite
- ▶ Becoming food aware, for example, that meals are as important as medicines
- ▶ Learning to assess patients for signs of, or risk of malnourishment in health and social care settings and in the community
- ▶ Ensuring that the appropriate diet is being provided in community care settings, such as residential homes.

## HOW CAN COMMUNITY NURSES RAISE ISSUES OF FOOD POVERTY?

Unfortunately, one of the challenges of food insecurity is stigma, which is one of the reasons that it is such a difficult issue to eradicate. Stigma is a significant issue for people who are accessing services such as food banks, with the associated shame meaning they will often not want to discuss their

own food insecurity or even refuse help ('Food banks: I hung around outside, embarrassed to go in' — [www.bbc.co.uk](http://www.bbc.co.uk)).

Similarly, food insecurity is often associated with people on low incomes, which can also be a source of shame and embarrassment, which may prevent people from wanting to discuss the issue.

Much work has been done into how nurses and other healthcare staff can tackle food insecurity with their patients sensitively, with one extensive study in the journal, *Health and Social Care in the Community*, making various recommendations ('Health professionals' experiences and perspectives on food insecurity and long-term conditions' — [www.ncbi.nlm.nih.gov/pmc/articles/PMC7027877](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC7027877)), namely:

- ▶ Nurses can use a protocol or screening tool to bring up the issue of food insecurity — this lends the discussion a clinical aspect, rather being a judgement on the patient personally. A simple two-question tool has been

developed for use in children: [childrenshealthwatch.org/public-policy/hunger-vital-sign](http://childrenshealthwatch.org/public-policy/hunger-vital-sign)

- ▶ Using communication skills, such as active listening, to signal respectfully that you are aware that the person may be having food insecurity issues
- ▶ Gently signpost the person to local resources, such as charities that distribute excess food from businesses
- ▶ Consider incorporating nutritional screening into your service's admission or assessment procedures — again, this reduces the personal nature of any enquiries about food insecurity, instead making them seem routine.

With the Covid-19 pandemic, impact of Brexit and rising energy costs, food insecurity is an issue that is not going away any time soon. For community nurses, it is essential to identify food insecurity in patients, and most importantly, learn the techniques to bring it up sensitively. After all, while not all of us may experience hunger on a daily basis, we should all have the appetite to do something about it. **JCN**



Neesha Oozageer Gunowa (top) and Karen Bareham (bottom), both community nursing fellows, Nursing Directorate, NHS England and NHS Improvement

The National Community Nursing Plan 2021–2026 is coming. If you have not heard about this exciting opportunity to use your voice as a highly skilled nurse working in the community, you should get involved. Community nursing is widely recognised as central to delivery of the *NHS Long Term Plan* and high-quality person-centred care. Yet, the needs of the population are changing due to increases in age, complexity, successes in long-term condition management, which require increased complex plans of care and intervention. While there are talks of upskilling the ‘out-of-hospital workforce’, this narrative fails to recognise the diverse experiences, knowledge and skills current community nurses already hold. Therefore, it is vital that the National Community Nursing Plan showcases the workforce and reflects the needs of the populations.

The pivotal role of community nursing is now becoming increasingly

# Shaping and promoting the future of community nursing

recognised. To reflect this, the recruitment and retention of nurses into the community is now one of Ruth May’s (Chief Nursing Officer for England) priorities (NHS England, 2019). The launch of the National Community Nursing Plan in the Spring of 2022 is eagerly awaited and to support this work, 14 experienced and skilled senior community nurse leaders have been commissioned as community nursing fellows across three themes to support the co-design and delivery of this plan. These themes came from engagement visits where three priority ‘wishes’ for community nursing were collated from nurses across a number of organisations, including:

- ▶ Attractive, fulfilling and flexible careers in community nursing
- ▶ Community nursing working collaboratively to improve patient outcomes and experiences
- ▶ Community nursing getting the full profile and recognition it deserves.

These themes are further divided into seven action areas, which have been allocated to pairs of community nurse fellows to facilitate engagement with key stakeholders and develop a strategic road map for delivery. Each pair of community nurse fellows has been sponsored by a local NHS regional team. NHS regional teams support local systems to provide more joined up and sustainable care for patients.

The seven action areas and sponsors are:

- ▶ Action area 1 — South West: Deliver diverse career pathways
- ▶ Action area 2 — South East: advance research and innovation
- ▶ Action area 3 — North West: build capacity of integrated care systems

- ▶ Action area 4 — North East and Yorkshire: drive use of digital and data
- ▶ Action area 5 — London: expand role in population health management
- ▶ Action area 6 — Midlands: raise the profile and celebrate success
- ▶ Action area 7 — East of England: demonstrate value and understand the economics.

The authors look forward to sharing the outcomes of this work in future editorials.

The National Community Nursing Plan needs to be thoroughly inclusive, therefore it is important that the diversity of voices within the community nursing family is represented to shape this plan and services so that they reflect the needs of communities and families. Nurses who work in the community are able to become directly involved in this work by joining the National Community Nursing Practitioners Network, where there are a wide range of resources for development and learning. As nurses, you can register to join the network, which meets at least every two weeks and provides access to senior national community nursing leaders. **JCN**

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## FOR MORE INFORMATION...

... about the National Community Nursing Practitioners Network, visit: <https://bit.ly/3tqrzQq>



Fiona Le Ber, clinical nurse specialist for bladder and bowel; chair, RCN Bladder & Bowel Forum; Queen's Nurse

The Royal College of Nursing (RCN) Bladder & Bowel Forum has become aware that continence nursing is facing some serious challenges. Following yearly strategy day discussions with the committee, concerns were shared that nurses in general seem to have lost confidence in bladder and bowel care and continence assessment. Two committee members are lecturers of student nurses and qualified nurses and have both found a definite lack of confidence in continence care. This loss of confidence raises a great many questions which the Forum needs to address in the coming year, such as:

- ▶ As continence specialists, we have been busy promoting our specialism and expertise. Has this raised continence to a level where general nurses now believe they 'cannot do continence', as it is a specialism and not basic nursing care?
- ▶ Is the lack of certainty we have all been dealing with due to the pandemic, with staff being redeployed into different areas, affecting confidence in abilities?
- ▶ Is continence taught and discussed during nurse training?
- ▶ Are student nurses and newly qualified nurses understanding the importance of appropriate continence care?
- ▶ If so, where is the missing link between learning and delivering?
- ▶ As nurses, are we still performing holistic assessments of our

# RCN Bladder & Bowel Forum: what are our plans for 2022?

patients. Are we still assessing our patients using the Roper, Logan and Tierney's activities of daily living?

- ▶ Are nurses embarrassed to ask patients about bladder and bowel issues?

A recent round table discussion between Essity, leaders in continence, and women's health, found that it is common for healthcare professionals to feel as embarrassed, if not more embarrassed, when asking questions about bladder and bowel issues. Indeed, Nikki Cotterill, associate professor in continence care at the University of the West of England, and a Bladder & Bowel Forum committee member, stated that her recent research shows that healthcare professionals do not know how to manage conversations about continence and then if patients disclose symptoms, clinicians are not confident in giving advice or treatment. Continence assessment has become a tick-box exercise (Agnew, 2021).

Reflecting on these issues, the committee have decided to go 'back to basics' and 'get continence out there'.

My day-to-day role is clinical nurse specialist for continence and stoma care in the community. In Jersey, community nursing is delivered by Family Nursing and Home Care, a local charity which provides children's nurses, school nurses, health visitors, district nurses, a tissue viability nurse and me. Despite regular training sessions and developing guidelines and competencies, there is still a distinctive lack of confidence and decision-making where bladder and bowel care is concerned. When asking my colleagues what the problem is, I'm often told that time is an issue — the workload is high and continence

is not seen as a priority, whereas pressure trauma is reportable and leg ulcer care is measurable.

The RCN Bladder & Bowel Forum's plan for this year is to speak at nursing conferences around the country — not just conferences about continence as specialist conferences are 'preaching to the converted'. We believe we need to be getting to the ear of healthcare professionals from all areas of health and social care. We also plan for each member of the committee to write an article for nursing journals on continence basics.

To end the year, we are planning an online conference, which will be shared on our forum page and social media. This event will reflect the RCN's Bladder and Bowel Learning Resource and will include ([www.rcn.org.uk/clinical-topics/bladder-and-bowel-care/RCN-Bladder-and-Bowel-Learning-Resource#assessment](http://www.rcn.org.uk/clinical-topics/bladder-and-bowel-care/RCN-Bladder-and-Bowel-Learning-Resource#assessment)):

- ▶ How the bladder works and bladder problems
- ▶ How the bowel works and bowel problems
- ▶ Fundamentals of continence assessment
- ▶ Catheter care essentials.

We collectively hope that as a forum of like-minded bladder and bowel nurses, we can promote the importance of continence care and reduce embarrassment felt by healthcare professionals and the general public when taking about issues with continence. **JCN**

## REFERENCE

Agnew T (2021) How do we talk to patients about embarrassing health problems? *Nurs Times* 2 Nov. Available online: <https://bit.ly/3qIjNEW1>

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# Healing skin with zinc oxide

*This piece reviews common skin complaints and discusses zinc oxide, its clinical properties and role in wound healing, looking at how ZIPZOC medicated stocking can support a patient's journey to full healing.*

Healthy skin is important — but, as the largest organ of the body and with its external aspect, it can be vulnerable. We can protect skin from the sun, and avoiding smoking and stress and eating a well-balanced diet may delay premature ageing of the skin and prevent various skin complaints (American Academy of Dermatology Association [AAD], 2022). However, it still requires great care.

The skin acts as a barrier against potential infection. Each layer contains skin cells, water and fats, all of which help to maintain the skin's integrity (Lawton, 2019). But, for some people, chronic skin complaints or ulcerations can occur, and thus a good skin care regimen should never be underestimated.

Common skin manifestations include eczema, erythema, dermatitis, pruritis, and lichenification, typically seen in conjunction with venous leg ulceration, lymphoedema and where there is chronic oedema and inflammation (Flour, 2013). The terms eczema and dermatitis may be confused, but tend to mean the



Janine Davies, independent clinical product specialist, Evolan Pharma

same thing (British Association of Dermatologists [BAD], 2020).

## SKIN AND AGEING

The elderly population are more at risk of dermatological conditions, due to epidermal thinning (WoundSource, 2019). As glandular activity declines, the skin can become drier and scaly, and thus more friable. This can make this group more prone to skin tears (Campbell et al, 2018). The elderly also tend to have less efficient thermoregulation through the skin, and it is well documented that the ageing process causes reduced dermal thickness, a reduction in elastic fibres, and a loss of tensile strength (Brown, 2019), in addition to a diminished blood supply. This means that where there is tissue damage, delayed healing may occur along with an inability to repel infection (Armstrong, 2017).

## ECZEMA MANAGEMENT

Eczema is thought to be caused by a combination of genes and triggers (Van Onselen, 2020). Individuals with eczema tend to have an over-active immune system and when exposed to certain triggers outside or inside the body, an inflammatory response is created, which plays a part in worsening eczema or causing flare ups (National Eczema Association, 2022). At present, although eczema cannot be cured, it can be managed so that individuals have a good quality of life, sleep well, and the inflammation does not damage their skin (British Skin Foundation, 2022).

The skin of people with eczema does not produce enough fat and oil and may not retain adequate water content, making it less effective as a barrier. It is more at risk of cracking, inflammation, and potential infection

(Eczema.Org, 2022a). One of the worst and most uncomfortable problems for patients with eczema is itch, which can also be difficult to treat (Eczema.org 2022b). Itch can significantly affect a person's quality of life, disturbing sleep and altering mental well-being (Flavell, 2015). Scratching usually damages the skin, which, in turn, can worsen eczema. The skin eventually thickens into leathery areas because of chronic scratching. Scarring or infection may occur as a result of deep scratching which causes bleeding (British Skin Foundation, 2022). Thus, it is important to manage the problem and follow a good skin care regimen, which may include regular washing, drying, the application of emollients or topical steroid treatments, and sometimes dressing with medicated bandages, stockings or wet wraps (British Skin Foundation, 2022). Left untreated, a flare up can spiral out of control, making it more difficult to restore skin to its previous condition (Eczema.Org, 2022c).

## VENOUS LEG ULCER MANAGEMENT

Skin changes are commonly seen with venous leg ulcer management, and so skin care is as important as wound management to maintain tissue integrity and prevent further breakdown (Bianchi, 2012). Examples of skin changes include (Bianchi, 2012):

- ▶ Hyperkeratosis
- ▶ Varicose eczema
- ▶ Red leg syndrome
- ▶ Contact dermatitis
- ▶ Maceration
- ▶ Extreme dryness.

Clinicians should take care to select dressings, applications and bandages which do not contain frequent sensitizers. Examples of such products include paraffin gauze,



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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.

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**Contra-indications:** Arterial leg ulcers. Known hypersensitivity to zinc oxide or the excipients in the ointment. **Special Warnings and Special Precautions:** None known. **Interactions:** None known. **Pregnancy and Lactation:** There is no evidence to suggest ZIPZOC should not be used during pregnancy. **Undesirable Effects:** The skin of leg ulcer patients is easily sensitised to some topical medications. ZIPZOC contains no preservatives thereby reducing the risk of skin reactions. Reported reactions include, rash, erythema, itching and maceration of the wound edge. If the outer bandage is inappropriate or the medicated stocking is not changed with sufficient frequency it can cause the stocking to dry out. **Excipients:** Liquid Paraffin Ph. Eur. White Soft Paraffin BP. **Incompatibilities:** None reported. **Shelf Life:** 3 years. **Storage:** At or below 30°C. Keep all medicines out of the reach of children. **Packaging:** Polyethylene aluminium foil laminated pouches, each pouch containing a single medicated stocking. The outer carton will contain either 4 or 10 pouches. **Legal Category:** P **Market authorization number:** PL44616/0002 **Date of first authorisation/renewal of the authorisation:** 01 October 2006 **Date of revision of text:** 26 October 2018 Trade Mark of Evolan Pharma AB **Date of preparation:** October 2018

zinc paste, alginates, and paraffin-based emollients — all of which are considered to be low risk (Scottish Intercollegiate Guidelines Network [SIGN], 2010).

## MAINTAINING SKIN INTEGRITY WITH ZINC OXIDE

Zinc is an essential metallic trace element which is required for health, second only to iron as the most abundant in the human body (Lansdown et al, 2007). Around one-fifth of total zinc content is contained within the skin, with the epidermis containing five to six times more than the dermal layer (Maher, 2015). Zinc is important for many functions in the body, including:

- ▶ Growth
- ▶ Immune function
- ▶ Antibody production
- ▶ Tissue maintenance
- ▶ Wound healing (Kogan, et al, 2017).

From a wound and skin healing perspective, zinc is important for cell structure and integrity as it is a co-factor for many metalloenzymes required for cell membrane repair, cell proliferation, and growth (Lin et al, 2018). It is located intracellularly and in the extracellular matrix (ECM) of the skin in the form of protein complexes, where its role is to stabilise cell components. In summary, zinc aids cell division, migration and maturation — all a vital part of the wound healing trajectory (Lansdown et al, 2007).

Topical zinc oxide also plays a part in the synthesis of the extracellular matrix within the wound (Lin et al, 2018), and can assist with autolytic debridement by donating moisture to the affected area. Indeed, dressings that optimise a moist wound environment by adding moisture to the wound bed or removing excess fluid aid the process of autolysis, where the body's enzymes break down non-viable tissue (Atkin, 2014). However, one of the more common reasons for clinicians to choose zinc oxide is for its well-known anti-inflammatory effects, which are widely documented (Agren, 1990; Lansdown et al, 2007; Kogan et al, 2017).



Agren (1990) identified that when zinc oxide is applied to an open wound, it is slowly but continuously solubilised, with absorption through human skin increasing zinc levels in the epidermis, interstitial fluid, and the dermis, thereby not only correcting a local zinc deficit and enhancing wound healing, but also acting pharmacologically.

Studies have also shown that the application of topical zinc oxide:

- ▶ Soothes red and irritated skin
- ▶ Reduces wound debris
- ▶ Improves healing rates
- ▶ Promotes epithelialisation
- ▶ Provides antioxidant, antifungal and antibacterial actions (Fincham Gee, 1990; Stacey et al, 1997; Eagle, 1999; Lansdown et al, 2007; Pasquet et al, 2014; Maher, 2015; Kogan et al, 2017).

## ZIPZOC MEDICATED STOCKING

ZIPZOC is a single-use medicated stocking, which is indicated for venous leg ulcers and associated skin conditions, e.g:

- ▶ Varicose eczema
- ▶ Hyperkeratosis
- ▶ Cellulitis/red leg syndrome
- ▶ Dermatitis.

It is also suitable for dermatological conditions, e.g:

- ▶ Atopic eczema
- ▶ Dermatitis.

(Evolan Pharma, 2022)

ZIPZOC is a pharmaceutical product which is impregnated with a paste containing 20% zinc oxide (Evolan Pharma, 2022). The stocking is made from a cotton rayon

fabric, which has elastic fibres and is therefore stretchy. It can be cut to size or simply folded back on itself before applying a secondary dressing. In the author's clinical opinion, one of the advantages of ZIPZOC is its ease of application.

ZIPZOC is quickly pulled onto the limb in a similar way to a sock, which can save time at dressing changes for clinicians. Anecdotal evidence shows that patients report a high degree of acceptance with ZIPZOC, as it empowers them to self-care with activities of daily living, such as routine hygiene, and to carry out dressing changes which fit with their personal lifestyle. Furthermore, as ZIPZOC is potentially less bulky than bandages, everyday concerns such as suitable footwear become less of an issue.

Figures 1–3 show how to apply ZIPZOC medicated stocking.

An important consideration when choosing ZIPZOC is in relation to its preservative-free formula (Evolan Pharma, 2022). When patients are required to wear dressings for a protracted period, it is thought that they can easily become sensitised to various ingredients within the products, with the antagonists often thought to be preservatives (Torfs and Brackman, 2021). ZIPZOC removes this potential problem with its preservative-free formula, providing comfort for the patient over a seven-day wear time (Evolan Pharma, 2022).

Steroid, antibiotic, retinoid preparations etc may be used in conjunction with ZIPZOC, but clinicians need to be mindful that the topical medicament may absorb more quickly due to the occlusive nature of the stocking, therefore reducing the period of effectiveness of the added topical preparation (Evolan Pharma, 2022).

ZIPZOC can be used either under simple retention bandaging or under compression therapy systems (Evolan Pharma, 2022) — vascular



Figures 1–3.  
Applying ZIPZOC.

assessment should always be carried out before applying compression therapy. ZIPZOC medicated stocking may be selected to support full healing for wounds and skin conditions.

Remember, patch testing for 48 hours is always recommended before initial use.

## CONCLUSION

Topical zinc oxide provides a protective barrier, reduces inflammation, and offers a moist healing environment when skin integrity has been lost (Williams, 1999; Lansdown et al, 2007). ZIPZOC medicated stocking is soothing and cooling when *in situ*, applying zinc oxide to the wound or skin surface, which may correct a local zinc deficit and aid healing (Agren, 1990). **JCN**

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*Dr Anne Holdaway, consultant dietitian, chair of the Malnutrition Pathway panel*

# Optimising nutritional care of patients with cancer

The Malnutrition Pathway has developed a new online resource focusing on the nutritional needs of patients with cancer ([www.malnutritionpathway.co.uk/cancer](http://www.malnutritionpathway.co.uk/cancer)), which aims to enable nurses to recognise nutritional issues and provide first-line advice. The resource is supported by downloadable patient fact sheets. It has been developed in response to a growing desire among patients and carers for information on diet and nutrition in cancer (European Cancer Patient Coalition, 2019; Sullivan et al, 2021), and includes specific information on dealing with common nutrition impact symptoms.

Nutrition is considered highly important by patients with cancer across their trajectory of care, from the period of diagnosis through treatment and beyond into survivorship and in palliation. Many patients will experience diet-related issues throughout the journey, which can remain untreated and persist well beyond the treatment phase (Sullivan et al, 2021). An estimated one in three patients with cancer attending out-patients are at nutritional risk (Bozzetti et al, 2021), and up to 83% of patients experience malnutrition during the course of their disease, depending on the type of cancer, treatment and nutritional assessment method used (Bauer et al, 2002; Isenring et al, 2003; Tong et al, 2009; Ravasco, 2019; Medical Nutrition Industry [MNI], 2020).

Nutritional issues and poor nutritional status can result from the local effects of the cancer itself, the metabolic response to the cancer, and the treatments used, such as chemotherapy, radiotherapy, immunotherapy and surgery. These issues not only contribute to the development of malnutrition, but also create distress and add to existing anxieties. Additionally, disease-related malnutrition, cachexia and sarcopenia (loss of muscle) result in poorer outcomes and increased mortality — hence, where possible, should be prevented, identified and treated (Arends et al, 2017).

Timely nutritional interventions can improve nutritional status, body composition, function, symptoms, quality of life, the patient experience, and ultimately survival (Holdaway et al, 2021).

Nutritional risk is associated with a number of common clinical issues, such as fatigue, anorexia, depression, pain, gastrointestinal symptoms, including nausea, constipation, vomiting, and mucositis (Khorasanchi et al, 2022). Such issues can interfere with the ability to eat and drink among those living with cancer. They are usually noted and recorded by the healthcare team, but should act to trigger further nutritional assessment, and where needed, referral for more detailed assessment by a dietitian or nutrition team (Bozzetti et al, 2012).

Nutritional issues can arise at any point in the cancer journey. Left uncontrolled they can impair dietary intake, compromise nutritional status and create diet-related anxieties. If we are to improve nutritional care in cancer, and the patient and family experience, it is crucial that regular nutrition screening and assessments are integrated into care to enable

early identification and timely management of nutritional issues and address patients' and families' nutritional concerns.

The 'Optimising Nutritional Care in Cancer' resource outlines the impact of malnutrition in cancer, advises on nutrition screening and assessment, and gives advice for both nurses and patients on ways to adjust the diet to prevent or manage common nutrition impact symptoms. It also includes information on diet in the prehabilitation phase before treatment, top-line information on nutrition support and diet therapy, the use of oral nutritional supplements (ONS) when indicated, and includes a summarised step-by-step guide.

The resource is available free to download at: [www.malnutritionpathway.co.uk/cancer](http://www.malnutritionpathway.co.uk/cancer). Patient information sheets providing top tips on managing nutrition impact symptoms, such as reduced appetite, dry mouth, taste changes, swallowing issues, altered bowel habit and fatigue are also available free to download within the resource.

*Production of the cancer resource materials has been made possible by an unrestricted educational grant from Nutricia.*

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<https://www.malnutritionpathway.co.uk>

## FATIGUE

The Royal College of Occupational Therapists provide some useful advice on conserving energy and pacing activity to manage fatigue:

[www.rcot.co.uk/conserving-energy](http://www.rcot.co.uk/conserving-energy)

If you are constantly tired, try some of the energy saving ways from the list below to help you eat a balanced diet with sufficient calories and protein:



- Eat softer foods that are easier to swallow
- Buy ready meals to reduce the amount of energy required to cook
- Consider buying items that lessen the burden of cooking - for example marinated chicken to which you just have to add the vegetables to the main part of the meal
- Prepare food when your energy levels are at their best, this might be in the morning. Keep a stock of frozen vegetables in the freezer to reduce the amount of preparation required for meal times
- Using a slow cooker or preparing a casserole means you can make meals ahead of when you might eat them. If you make extra amounts you can freeze portions that can be eaten another day
- If you find you tire over the day you might wish to swap your cooked meals and snack meals around for example try a cooked breakfast or have your main meal at lunchtime and have a snack or bowl of cereal in the evening
- Ask friends and family to stock the freezer or fridge with portioned meals
- Order your shopping online and get it delivered
- Keep a stock of foods in your cupboard so you know you have some items in store to use if you are too tired to shop or wish to shop less frequently. Useful store cupboard ideas can be found at <https://bit.ly/3GX2Vmm>
- Find out what assistance is available locally via social services such as meals on wheels, befriending services, help within the home, dining clubs

**Note: If you are diabetic, ensure your diabetes is managed as well as possible as poor blood glucose control can make fatigue worse**



<https://www.malnutritionpathway.co.uk>

## MOUTH, SORE MOUTH, CHEWING DIFFICULTIES, BREATHLESSNESS

If you have lost weight and have dentures, you may find the dentures no longer fit. In this case try and arrange a visit to a dentist as soon as you can. If your mouth is dry or sore, ask a healthcare professional to check that you don't have an infection. They may also be able to recommend a treatment to soothe the discomfort. Try easy to chew, moist foods with added sauces. For example casseroles, soups, meats, fish pie, Shepherd's pie, chopped chicken in a sauce, vegetable bakes, soups, fishes, soya based/Quorn mince dishes, risotto, softly cooked pulses in sauce. Try to eat soft and easy to eat but can be low in energy and nutrients. Creamy ones like soups, porridge, chicken, beans or pulses may be more nutritious. Add extra fat to boost the energy and protein content

Try mashed or stewed fruit, fruit compote with custard, evaporated milk, ice cream, sorbet, dairy or coconut milk shakes, panna cotta, creme caramel, milk jelly, custard and tiramisu

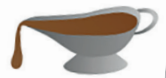
Try to eat smaller meals more frequently

Avoid spicy and hard crunchy foods

Soft drinks may be comforting e.g. chilled water, ice cream, ice lollies. Using a straw may help

Acidic foods such as vinegar, pickles, tomatoes, oranges and lemons may be best avoided. Try peach, blackcurrant or apple juice instead of citrus juices

Hot foods such as crisps, salted nuts and beef drinks, may irritate soreness. Avoid cool air blowing directly onto or across your face. Close an open window or use a small, handheld fan



<https://www.malnutritionpathway.co.uk>

## PREHABILITATION - GETTING READY FOR TREATMENT

Prehabilitation (prehab) is about getting your body ready for treatment, whether that is surgery, radiotherapy, chemotherapy or immunotherapy.

It can involve improving your nutrition, physical fitness and psychological wellbeing. At your diagnosis your healthcare team may screen you for any problems in these three areas. Taking action early to address any problems can help you tolerate your treatment, have fewer side effects or cope better. In turn this can get you through your treatment journey and help you recover.



This leaflet outlines some of the things you might wish to consider in relation to your diet in the weeks running up to treatment.

### The importance of a balanced diet

Being as well-nourished as possible before you start your treatment can help you deal with problems that might arise along the way. Enjoying what you eat is important too.

A balanced diet needs to include food from all the food groups to make sure your body works well, these include beans, pulses, fish, eggs, meat and other proteins, starchy foods, fruit and vegetables and dairy foods such as milk, yoghurt and cheese or dairy alternatives.

Ideally you should eat enough calories (energy) and enough protein to keep your weight steady and keep as strong as possible. If you are underweight or have lost weight unintentionally then you may be advised to try and gain a little weight.

Even if you are overweight, losing weight at this time may not be recommended but instead ensure you avoid gaining more excess weight.

### A balanced diet includes:

- enough calories to give you the energy to perform your everyday activities
- enough protein to keep your muscles strong and your immune system working. This is important before and during treatment - if you are wondering if you are eating enough protein see more information on high protein foods in the leaflet - 'Protein, why it is important and where to find it' [www.malnutritionpathway.co.uk/library/proteinideas.pdf](http://www.malnutritionpathway.co.uk/library/proteinideas.pdf)

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Professor John Unsworth, chair of council, Queen's Nursing Institute

# In plain sight: the untapped potential of district nurses

**'One thing is consistent over the decades of invention and reinvention of services, and that is the systematic failure by the NHS to use, develop, and expand its existing workforce.'**

with the skills, knowledge and competence to provide care at home for the same patients that these new services are designed for. These staff are in plain sight, they are not hiding, they are there with the skills the NHS needs. They require investment and increased staffing, but they can step up to provide the care people need at home.

In November 2021, the QNI published a report, 'Untapped Potential: District Nursing Services and the Avoidance of Unplanned Admission to Hospital'. This report describes how district nurse team leaders have advanced skills in assessment, diagnosis and patient management, which could be used to provide safe and effective care for people at home, preventing unnecessary hospital admissions, and that the NHS was failing to capitalise on this resource. One of the most shocking findings of the report was the increasing fragmentation of care at home, with a myriad of specialist teams for intravenous (IV) drug administration and other aspects of care. It does not take too much thought to see how a patient with class 2 cellulitis and leg ulceration who is having problems with mobility could be getting visited by three different teams of nurses for essentially the same problem.

The 'Untapped Potential' report highlighted how 60.4% of NHS commissioners in England have set out in contracts an expectation that district nurses reduce unnecessary admission to hospital and, despite this, many of the team leaders reported a lack of equipment to enable care to be provided. As one respondent remarked, 'A pathway would be a great advancement in the treatment of cellulitis within

Next year, I will have completed four decades in health care. One of the enduring things you learn with longevity in health care is that the NHS consistently 're-invents the wheel'. Introducing shiny new solutions which some of us know are not new and in some cases not that shiny. The latest of these are virtual wards in England, apparently first 'pioneered' in March 2020 to prevent emergency admission and to assist with early discharge from hospital. NHS England (2021) describes how 'virtual wards will allow patients to get the care they need at home, safely and conveniently, rather than being in hospital'. They describe how this innovation was set up with remote monitoring for Covid-19 and is now extended to other respiratory infections and for older people with frailty. Of course, virtual wards are just re-badged intermediate care services previously called hospital at home and rapid response. They are not new, and they were not pioneered in Watford in 2020 — in fact, they have existed since the 1990s (Leff et al, 2005).

The development of intermediate care grew from care models in Scandinavia from the 1990s onwards (Organisation for Economic Co-operation and Development [OECD], 2011). The Labour government at the time invested £120 million in the development of intermediate care services, including the development

of hospital at home and community matrons. Community matrons were implemented to provide structured proactive care to patients with long-term conditions, with the aim of reducing unnecessary admission to hospital.

One thing is consistent over the decades of invention and reinvention of services, and that is the systematic failure by the NHS to use, develop, and expand its existing workforce. Each time we develop a whole new service, new posts deplete existing services as people move from one role to another. Of increasing concern is that many of these services operate Monday to Friday day times only, leaving people without care or under the care of mainstream services outside of these hours. This begs the question about why not just invest in mainstream services in the first place?

The NHS in England currently has 115,000 vacancies (Health Foundation, 2020) and around 55,000 of these are vacancies for registered nurses (Royal College of Nursing [RCN], 2020). At the same time, existing district nursing, health visiting and school nursing services have seen sharp declines in the number of staff (Queen's Nursing Institute [QNI], 2019; Institute of Health Visiting [iHV], 2020). Yet, in the last 10 to 15 years, we have been educating and developing our district nursing team leaders





Photographs reproduced courtesy of the QNI and Kate Stanworth.

the home environment, preventing hospitalisation. We would need more training, but district nurses are capable of providing specialised care in the home setting.'

The failure of the health service to utilise its existing expertise is partly a failure of policy and partly a failure of leadership. Wignall and Mason (2022) describe how all too often nurses see policy as something imposed on them. Policy, of course, needs translation and implementation and it is possible for senior leaders in NHS organisations to decide how something is implemented. Take, for example, community matrons, as in 2005 each NHS trust was given a target number of posts (Department of Health [DH], 2004). At the time, I, as the nurse director of my trust, decided to bolster district nursing teams and make the team leaders community matrons, increasing their pay grade and providing additional education around chronic disease management and prescribing.

It is important to say that this situation is not unique to district nursing, it happens in every service across community health and primary care. One of the great successes of integration was the Sure Start Centres and their work with health visitors (Glass, 1999). Rather than duplicating services, the centres brought together family support under a single roof.

**'... in the last 10 to 15 years, we have been educating and developing our district nursing team leaders with the skills, knowledge and competence to provide care at home... . These staff are in plain sight, they are not hiding, they are there with the skills the NHS needs.'**

In summary, not only does the NHS need a detailed workforce plan, but it needs to look at its existing depleted and tired workforce and what it could achieve if it invested in and developed it. As the philosopher, author and poet, George Santayana said, 'Those who cannot remember the past, are condemned to repeat it'. **JCN**

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# TalkToUs

## The QNI Listening Service



The Queen's Nursing Institute (QNI) operates a listening service, TalkToUs, which offers emotional support by phone to registered nurses working in the community.

The service is operated by trained listeners who are available for any nurses working in community or social care, including those supporting care homes, and nurses working with people who are homeless. TalkToUs is intended as a friendly ear for nurses who would like to talk to someone in complete confidence about any aspect of their work or home life during the current pandemic.

### How to contact us:

- ✚ Please email [TalkToUs@qni.org.uk](mailto:TalkToUs@qni.org.uk) giving your first name, your phone number and a preferred date and time for a call. Call backs are usually made between 11am and 4pm Monday to Friday.

We aim to get back to you within 48 hours (72 hours at the weekend). This email inbox is only monitored during the working week. If you need to speak to someone urgently, please visit [www.samaritans.org](http://www.samaritans.org) or call them on 116 123.

“ We are delighted to offer this listening service which gives community nurses a safe space to share their experiences and gain emotional support from our trained listeners.

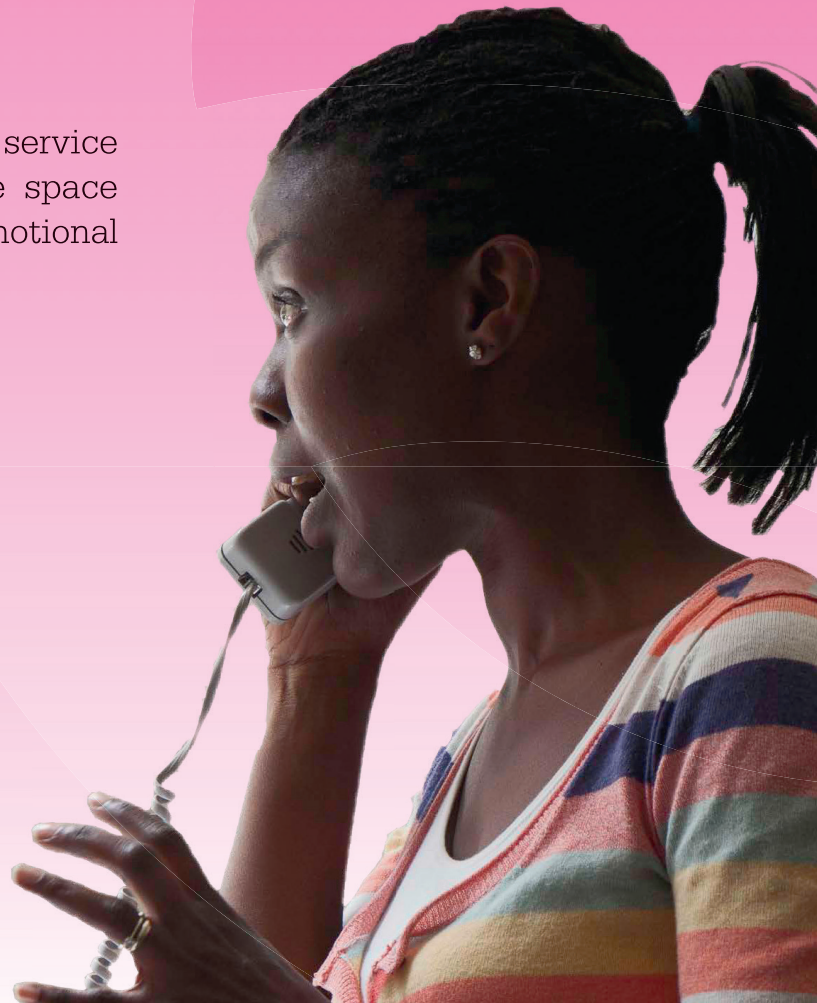
**Dr Crystal Oldman CBE, QNI Chief Executive**



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Charity number: 213128



This JCN clinical skills series provides a guide to the identification, assessment and management of chronic oedema of the lower limb and associated complications.

## Part 2: Chronic oedema: assessment

This clinical series aims to demystify and simplify approaches to assessment and management of chronic oedema in the community, including the promotion of self-care, with the aim of improving efficiency and delivering best evidence-based care for patients with chronic oedema. Part 2 looks at how to assess chronic oedema using the six S', discussing the first three — story, self-care and site (Wound Care People, 2019).

Chronic oedema is a challenging clinical problem (Figure 1), which will continue to increase and for which most healthcare professionals receive little formal training (Sneddon, 2019). This omission in training can lead to a lack of awareness, confidence and specialist knowledge regarding chronic oedema (Allen and Morgan, 2021). Unfortunately, patients with chronic oedema are often referred to community nurses too late when assessment and management can appear daunting (Sneddon, 2019).

The multiple different causes and complications that often coexist in the same patient with chronic leg oedema can make the assessment process appear complex in nature (Keast et al, 2021).

To develop a care plan, patient assessment should be comprehensive and holistic (Keast et al, 2021) and aim to identify factors which can contribute to the development of chronic oedema. If performed correctly, it should:

- ▶ Help to identify the cause(s) of chronic oedema
- ▶ Guide management

**'The multiple different causes and complications that often coexist in the same patient with chronic leg oedema can make the assessment process appear complex in nature.'**

- ▶ decisions, and highlight any contraindications to treatment
- ▶ Provide a baseline of information against which improvement/deterioration of the patient and their chronic oedema can be measured
- ▶ Help to overcome 'ritualistic' or inappropriate practice by indicating when management should be changed according to improvement/deterioration
- ▶ Optimise efficiency, ensuring that the patient gets the right treatment at the right time
- ▶ Help to develop a care partnership with the patient and promote a positive experience of care
- ▶ Identify the need for further investigations and referral
- ▶ Identify the patient's ability/willingness to self-manage
- ▶ Recognise any issues that may

affect the patient's ability to cope with their condition

- ▶ Set realistic treatment goals (Best Practice Statement [BPS], 2008; Fletcher, 2010).

### SIX SIMPLE STEPS TO CHRONIC OEDEMA ASSESSMENT

A systematic approach to assessment is recommended to ensure that all factors contributing to chronic oedema are identified. These can be varied and may include lifestyle choices and the patient's general and mental health. Oedema should never be ignored or viewed as part of the ageing process, and assessment should go beyond just examining the swollen limb, or just the swollen area, and take a full

#### Practice point

Simply put, lower limb chronic oedema assessment should involve:

- ▶ Taking a patient history
- ▶ Assessing lower limbs
- ▶ Assessing circulation
- ▶ Assessing skin

(Bianchi et al, 2012).

holistic approach. The assessment of people with chronic oedema can be approached using the six S' (Wound Care People, 2019). This article will discuss the first three, i.e. story, self-care and site.

## Story

It is essential to obtain the patient's background 'story' or history to identify the possible cause(s) of chronic oedema. Thorough history-taking can help to identify the known risk factors for the development of chronic oedema (Table 1), including underlying medical conditions, medication or lifestyle choices (Todd, 2016). Where possible, contributing issues should be addressed or their management optimised, to ensure that any care plan is successful (Atkin, 2014).

Patient history should include:

- ▶ Age: the prevalence of chronic oedema increases with age

**Table 1: Risk factors for chronic oedema** (adapted from BPS, 2008; Todd, 2016; Keast et al, 2021)

- ▶ Increasing age
- ▶ Lymphatic disorder (congenital malformation of the lymphatic system)
- ▶ Surgical removal of lymph nodes or trauma which has damaged lymphatics
- ▶ Radiotherapy
- ▶ Malignancy — radiation, lymphatic obstruction by a tumour
- ▶ Obesity
- ▶ Venous disease and deep vein thrombosis
- ▶ Heart failure or other volume overload conditions
- ▶ Cellulitis or other infections
- ▶ Prolonged dependency
- ▶ Immobility
- ▶ General frailty
- ▶ Medication, e.g. steroids, calcium channel blockers and gabapentin
- ▶ Chronic inflammatory conditions, e.g. rheumatoid arthritis
- ▶ Significant trauma to limb, e.g. burns/degloving
- ▶ Nutritional status
- ▶ Comorbidity, in particular, polymorbidity



**Figure 1.**  
*Chronic oedema of the lower limbs.*

**'Thorough history-taking can help to identify the known risk factors for the development of chronic oedema, including underlying medical conditions, medication or lifestyle choices.'**

- ▶ Presenting complaint: has the swelling been present for longer than three months? Does it resolve with elevation?
- ▶ History of the complaint: onset and duration of the swelling may indicate cause, e.g. if the swelling has followed recent surgical intervention
- ▶ History of past and current medication: certain medications are known to increase the risk of developing oedema (Table 2)
- ▶ Medical background: including previous surgery and any possible postoperative complications. Has the patient had a vascular assessment within the last six months? Does the patient have vascular insufficiency or peripheral arterial disease?
- ▶ Family background: could the cause of swelling be hereditary, e.g. primary lymphoedema or lipoedema?
- ▶ Nutritional status: protein deficiency can draw fluid into the tissues resulting in swelling

- ▶ Chronic medical conditions or comorbidities: for example, cardiovascular disease, diabetes or cancer are known to contribute to swelling
- ▶ Psychological status: how is the patient coping with the swelling and underlying cause(s)? How are they coping with pain, sleeplessness, etc?
- ▶ Socio-economic circumstances: does the patient need assistance/support with their care?
- ▶ Lifestyle choices: are these contributing to swelling, e.g. a sedentary lifestyle or obesity? Does the patient spend prolonged periods sitting or standing?
- ▶ Previous compression choices: the success or failure of previous management choices (if any) can guide future decisions (Grey et al, 2006; Eagle, 2009; Fletcher, 2010)

**Table 2: Medications that can increase the risk of oedema** (adapted from Todd, 2016)

- ▶ Calcium channel blockers, e.g. amlodipine, nifedipine
- ▶ Non-steroidal anti-inflammatory drugs (NSAIDs), e.g. ibuprofen, naproxen
- ▶ Gabapentin
- ▶ Hormones, e.g. oral contraceptives
- ▶ Steroids, e.g. prednisone
- ▶ Diabetes medication (thiazolidinediones), e.g. pioglitazone, rosiglitazone

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(Naik et al, 2019).



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**Table 3: Terminology used for self-care** (Hiskett, 2020)

- ▶ Self-management/shared care
- ▶ Self-care
- ▶ Supported self-care
- ▶ Shared decision-making
- ▶ Patient involvement
- ▶ Patient engagement
- ▶ Patient empowerment

- ▶ Previous education: what has the patient previously been told about their condition if anything?  
(Wound Care People, 2019)

Findings will highlight if further investigation or referral is needed. For example, referral back to the GP may be needed to discuss medications that can potentially result in, or worsen, oedema, e.g. calcium channel blockers (Raymond and Flanagan, 2017). If heart failure is suspected as a contributing factor to swelling, blood tests, such as B-type natriuretic peptide (BNP), may be required to confirm the diagnosis (levels are elevated in cases of heart failure and other cardiac conditions). If raised, a cardiac referral may be required. Remember, chronic oedema will not resolve if the underlying cause(s) is/are not addressed.

## Self-care

One solution that is gaining momentum is self-care — a concept that has been around for some time and called different things over the years (Table 3). Self-care can offer a means to maintain or even improve the

### Practice point

Promoting self-care to your patients who are able and willing to engage means that you may be able to reduce some of your workload. It can empower patients and free up your time. Self-management is not abandoning the patient to care for themselves, and support should be available if needed.

capacity to live well over time (Grady and Gough, 2014).

Self-management of long-term conditions is also a key component of the *NHS Long Term Plan* to improve efficiency, and free up valuable resources (NHS England, 2019).

Self-care is a dynamic and empowering method of long-term management. However, to engage with their own care, patients must be:

- ▶ Willing
- ▶ Health literate
- ▶ Central to decision-making
- ▶ Central to care delivery  
(Todd, 2014).

**'It is important to ensure that the patient does not feel abandoned with their condition and that they are supported in their self-care throughout their healthcare journey.'**

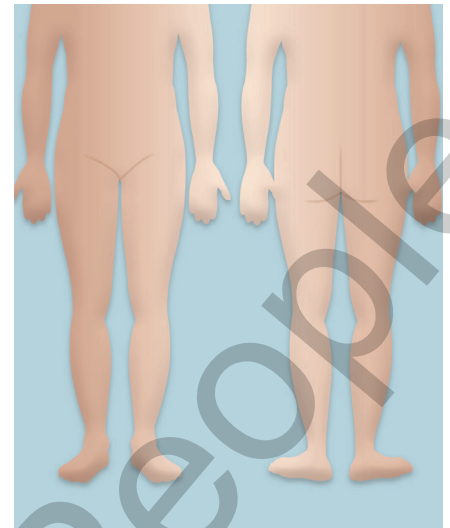
Self-care requires a collaborative approach from carers, family, volunteers and healthcare professionals (Todd, 2014). Resources must be made available to provide support.

It is important to ensure that the patient does not feel abandoned with their condition and that they are supported in their self-care throughout their healthcare journey. It should not be seen as leaving the patient 'to get on with it' and a cost-free option (Todd, 2014).

### Can the patient self-care?

During assessment, consider the following factors to determine if the patient is able to self-manage effectively:

- ▶ Overall health status of the patient, including comorbidities, dexterity and mobility: can the patient apply and remove compression garments/wraps? Are they able to reach their limb(s)?
- ▶ The patient's knowledge and beliefs about their condition: do they understand why self-care



**Figure 2.**

Full extent of swelling should be determined by examining the whole of the lower limb from waist to toes.

is beneficial?

- ▶ The patient's understanding of their treatment: can they understand the principles of care?
- ▶ How actively does the patient wish to be involved in their treatment? They must be willing to carry out some self-care for it to be successful in the long term
- ▶ Are there any social pressures, and, if so, how will they impact on treatment, for example, is the patient able to sleep in bed?
- ▶ The patient's desire to change: is the patient willing/able to modify lifestyle factors such as weight management, nutrition, lifestyle, smoking, drinking, etc?
- ▶ Cognitive ability and skills: is the patient mentally and/or physically able to engage in self-care?
- ▶ Previous treatment experience: a negative experience may influence their outlook on care and its effectiveness
- ▶ The role of friends, family and carers in care provision: is the patient dependent on community staff or family for care delivery at certain times of day?

(Wound Care People, 2019)

Factors known to adversely impact on the ability to self-care include:

- ▶ High levels of morbidity
- ▶ Financial constraints



Figure 3.  
Chronic oedema present in one leg.

- ▶ Depression
- ▶ Lower income (Bayliss et al, 2007).

In addition to supporting self-care, it is important to identify patients who are not concordant or are unable to take responsibility for their condition (Rich, 2007), so that ongoing care can be delivered.

### Site

The site of the swelling should be examined as part of initial assessment and then as part of ongoing care. Looking at the lower limbs can provide meaningful information as to the extent of the swelling and possible causes, depending on presentation.

The whole leg should be examined. Remember that the lower limb constitutes the leg from the groin down to the toes, not just below the knee. Both lower limbs should be examined for the presence of oedema and compared to each other. For example, if swelling is present above the knee, the abdomen, genitalia and sacrum should also be examined (Figure 2); if oedema extends to these locations, this may indicate heart failure or another medical condition. If present, the patient should be referred back to the GP for further investigations (Wound Care People, 2019).

Assessment of the site should aim to identify:

- ▶ If the swelling is acute or chronic
- ▶ If the swelling affects one (unilateral) or both (bilateral) limbs
- ▶ If the swelling is localised or more generalised? (Gorman et al, 2001).

### Oedema in both legs

Dependent oedema is a common cause of swelling in both legs, occurring when the patient sits or stands for too long. It is often seen in the community setting in people who sleep in a reclining chair or armchair (Evans and Ratchford, 2016).

Obesity may also result in

## KEY POINTS

- Assessment is crucial to identify the underlying cause(s) of chronic oedema.
- Assessment can be approached using the six S': story; self-care; site; skin; size; shape.
- Physical examination of both limbs is a crucial part of assessment; the affected limb can be compared to the unaffected to see the degree of swelling, shape alteration and if any skin changes are present.
- It is important to examine the whole of the affected lower limb, from the waist down to the toes, to establish the extent of swelling.
- Increased awareness of, and vigilance for, signs and symptoms of chronic oedema can help to identify the condition in its early stages, leading to early intervention and prevention of complications.
- Determining the patient's ability to self-care is important, as their involvement in management can improve outcomes.

oedema in both legs, due to the pressure of added weight on the veins in the stomach (Vasileiou et al, 2011; Atkin, 2014). Similarly, this coupled with hormonal changes may lead to oedema in pregnancy.

Bilateral swelling can indicate a central cause of oedema, such as chronic venous insufficiency (CVI), heart failure or nephrotic syndrome (Wound Care People, 2019).

Patients with heart failure may present with swelling in both legs that extends into the trunk, usually accompanied by breathlessness on exertion or when lying flat (Evans and Ratchford, 2016).

Kidney and liver conditions may result in bilateral swelling. Some medications (Table 2) can also result in bilateral oedema (Evans and Ratchford, 2016).

## Revalidation Alert

Having read this article, reflect on:

- How you currently carry out assessment of patients with suspected chronic oedema
- Which of your patients may be able and willing to be involved in their own care
- Some of your cases and if they have barriers to self-care which could be overcome?

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

## Practice point

Assessment should not just be performed at first presentation, but be ongoing with regular re-evaluations so that care plans can be changed as needed (Wound Care People, 2019).

Swelling in both legs that does not extend to the feet may indicate lipoedema, a chronic condition leading to accumulation of fat below the waist (Lipoedema UK, 2019).

### Oedema in one leg

Unilateral chronic oedema can indicate deep vein thrombosis (DVT), superficial thrombophlebitis, or cellulitis, all of which are accompanied by redness, pain and tenderness to touch, and require urgent intervention. It may also indicate primary lymphoedema, which would require specialist referral. Unilateral oedema may also be an indication of an underlying malignancy (Lymphoedema Framework, 2009; British Lymphology Society, 2022).

### One or both legs

Common vascular disorders, such as venous hypertension and chronic venous insufficiency, can cause swelling in one or both legs (Lymphoedema Framework, 2009; Atkin, 2014) (Figure 3).

Failure to examine the whole limb can result in the wrong treatment. For example, if only below the knee and above the ankle is examined, yet swelling extends to above the knee and foot, application of compression may force fluid into these areas, resulting in further swelling. This could cause the patient to lose confidence in the clinician's ability to make decisions and become non-concordant with treatment (Bianchi, 2012).

## CONCLUSION

Early intervention and management of chronic oedema is a key factor in reducing the risks to overall patient health, recovery, lifestyle and work (Keast et al, 2014). This

can only be achieved by undertaking a comprehensive assessment of each patient to facilitate effective oedema management (Atkin, 2014). It has been reported that not only is the recognition of chronic oedema too late, but the implementation of management is also too late, possibly due to a fear of the action required, i.e. compression, or limited or no access to treatment (Keast et al, 2014). **JCN**

*Part three in this series will discuss the final three S' in chronic oedema assessment — skin, size and shape.*

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# Let's Talk Veins: An Uphill Journey

## Programme for Wednesday 28<sup>th</sup> September

08.00 – 09.00 **Registration, coffee & exhibition**  
09.00 – 09.15 **Welcome and introduction: Mike Hoskins, LLCF Chairman**

### 09.15 - 15.30 Workshops (40 minutes each)

- International guidelines: recommendations & comparison among different nations
- Innovative practice
- How assertive are we to truly advocate for those in lower limb management care?
- Prevention and management of skin tears in the lower limb
- The importance of exercise in the management of venous and lymphatic disease
- Current investigations in venous disease
- The role of aesthetics of the lower limb

13.10 - 14.10 **Lunch & Exhibition**  
15.30 - 17.00 **Leg Club & LCIP Forum**



### On Request – Concurrent workshop

Meet the experts on the Social Prescribing Leg Club model of lower limb care

- Why you need a Leg Club
- How to set-up a Leg Club

## Thursday 29<sup>th</sup> September

08.00 – 09.00 **Registration, coffee & exhibition**  
09.00– 09.15 **Welcome:** Mike Hoskins, LLCF Chairman  
**Opening address:** Professor Keith Harding CBE, **Morning Chairperson:** Trudie Young  
09.15 – 09.50 **Dermatology problems related to venous disease**  
Professor Marco Romanelli, Professor and Consultant Dermatologist at the Division of Dermatology, Department of Clinical and Experimental Medicine, University of Pisa  
09.50 – 10.25 **Saving tomorrow's legs today**  
Professor Mark Whiteley, Professor and Consultant Venous Surgeon and Consultant Phlebologist, The Whiteley Clinic, London  
10.25 – 11.05 **Mid-morning coffee and exhibition**  
11.05 – 11.35 **Embedded inequality in the treatment of lower limb ulcers**  
Mr Adam Gwozdz, Clinical Lecturer / Vascular SpR Imperial College London  
11.35 – 12.10 **My legs are killing me!**  
Rebecca Elwell, Macmillan Lymphoedema Advanced Nurse Practitioner and Team Leader, NHS University Hospitals of North Midlands  
12.10 – 12.45 **Complex Revascularisation for Chronic Limb-Threatening Ischemia: state of the art & cutting-edge technologies**  
Mr Lukla Biasi, Consultant Vascular Surgeon Guy's and St Thomas' NHS Foundation Trust King's Health Partners and Tunbridge Wells Hospital  
12.45 – 13.30 **Lunch & exhibition, Afternoon Chairperson:** Mike Hoskins  
13.30 – 14.00 **The legs that did so much now need your help!**  
Dr Melanie Thomas, National Clinical Lead for Lymphoedema in Wales, NHS Wales & Karen Morgan, National Lymphoedema Education and Research Lead  
14.00 – 14.30 **Complexities in leg ulcer management: case study discussion**  
Dr Jemell Geraghty: Nurse Consultant Tissue Viability & Lecturer in Adult Nursing King's College London  
14.30 – 15.00 **Who's in charge of my wound?**  
Trudie Young, Director of Education and Training for the Welsh Wound Innovation Centre and Tissue Viability Nurse, Velindre NHS Trust  
15.00 – 15.45 **Looking through the key hole: the role of social models of care in addressing social isolation**  
Dr Anna Galazka, Cardiff Business School  
15.45 **Draw and Close**

## The 20th Annual Leg Club Conference Worcester Rugby Club, 28<sup>th</sup> & 29<sup>th</sup> September 2022

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# Lymphovenous disease and fibrosed wound beds: adjuvant therapies

Julie Stanton, John McRobert, Zoe Gocher, William John, Veronica Doody

Suboptimal management of leg ulcers has been identified as a UK-wide problem that is both costly to the NHS and a drain on nursing resources (Guest et al, 2020). The overall annual NHS cost of wound care has increased by 48% in real terms over the five years since Guest et al's (2015) original work. Guest et al's studies (2015; 2020) also found a common pattern with regard to a failure on the part of healthcare professionals to establish the underlying aetiology of a wound. This article highlights the importance of changing the way we treat leg ulceration in relation to identifying and managing patients with lymphovenous disease, and explores new treatments surrounding the care of leg ulceration to help break down fibrosis in complex wounds caused by lymphatic changes.

## KEYWORDS:

- Lymphoedema ■ Venous ulceration ■ Fibrosis
- Adjuvant treatments

According to a best practice statement (Wounds UK, 2019), wound complexity increases the likelihood of wound chronicity and can make a wound hard to heal. A 'complex' venous leg ulcer (VLU) has a number of indications that link to lymphovenous disease, namely:

- ▶ Wound present for more than six months
- ▶ Current infection and/or history of recurrent infections
- ▶ Wound has failed to reduce in size by 20–30% at four to six weeks despite best practice
- ▶ Fixed ankle or reduced range of motion
- ▶ Unmanaged pain
- ▶ Severe lymphoedema.

(adapted from Wounds UK, 2019).

These characteristics are usually seen in most patients who attend the authors' wound and lymphoedema clinics, with many having the added complication of fibrosed wound beds.

Patients that are seen across the authors' six clinics predominantly present with lymphovenous ulcers, with the majority of chronic non- or slow-healing ulcers having a degree of limb distortion, with either a subtle or pronounced inverted champagne-shaped leg (*Figures 1 and 1a*).

## FIBROTIC WOUND BED

Chronic venous insufficiency (CVI) will lead to the development of the inverted champagne bottle leg and is said to be caused by the fibrin cuff (Burnand et al, 1982; Mortimer and Browse, 2003; Williams, 2009). The tissues feel hard and 'woody', which is thought to be due to fibrin deposited around capillary beds which, in turn, leads to elevated intravascular pressure (Burnand et al, 1982; Mortimer and Browse, 2003; Williams, 2009). If the pressure is not treated, this leads to lipodermatosclerotic (LDS) changes,



Figure 1.

i.e. inflammation of the layer of fat under the epidermis. Patients with LDS also develop lymphatic changes, which reduce the capacity of the lymphatic system to function effectively (Williams, 2009). The 'fibrin cuff', which surrounds the capillaries in the dermis, decreases oxygen permeability and inhibits diffusion of oxygen and other nutrients, leading to impaired wound healing (Burnand et al, 1982; Williams, 2009).

In normal wound healing, the response to epithelial cell damage is

## Practice point

Fibrosis is the replacement of normal structural elements of the tissue with excessive accumulation of scar tissue, composed of distorted collagens (Artlett, 2012).

Julie Stanton, director of nursing, Pioneer Wound Telehealth; John McRobert, clinical director; Zoe Gocher, tissue viability/lymphoedema lead nurse; William John, tissue viability/lymphoedema nurse; Veronica Doody, tissue viability nurse consultant, all at Pioneer Wound and Lymphoedema Centres

to produce transforming growth and other factors, which together result in local inflammation and cellular activity essential for wound healing (Artlett, 2012). However, when tissues are subjected to persistent insult and injury, such as infectious pathogens or autoimmune reactions, this process of repair goes awry (Artlett, 2012).

This creates a chronic inflammatory environment where cytokines and growth factors are abundantly released, as well as other signalling molecules that act as the principal effectors of the fibrotic process. The resulting fibrotic scar tissue will eventually impede normal functioning of the skin (Artlett, 2012). This process is usually seen in patients with chronic wounds, in particular, those which have a continuous cycle of re-infection leading to the development of lymphatic changes (Figure 2). The greater permeability in CVI leads to haemosiderin staining, which results in further extravasation of proteins causing increased oncotic pressure (Farrow, 2010). This, in turn, can affect the nerves, causing pain and discomfort coupled with recurrent cellulitis (bacterial infection of the skin). Fibrosis can also lead to vascular problems and the debris, dead cells, and other by products of wound healing will cause stagnation of the wound environment and slow wound healing (Mortimer and Browse, 2003; Williams, 2009; Bjork, 2013).

In the authors' clinical experience, until the issue of fibrosis around the wound bed is addressed by clinicians and within the literature, it will be a challenge to promote adequate oxygenation of nutrients to the wound bed and improve lymphatic drainage.



Figure 2.

## MODIFIED TREATMENT

Morgan et al (2005) and Green (2007) believe that a modified approach to standard, evidence-based leg ulcer management is required when dealing with patients with chronic oedema and ulceration, rather than those with only the latter.

Simple compression will only concentrate the proteins further by removing some of the water. However, the remaining proteins will hold onto water molecules (Farrow, 2010), which is why, in the authors' clinical experience, treatment needs to be modified to improve lymphatic flow and reduce the effects of fibrosis.

Specific issues associated with managing patients with lymphoedematous ulceration include:

- ▶ Limb shape distortion
  - ▶ Care of skin creases and folds
  - ▶ Swelling of the toes and forefoot and potential swelling above the knee
  - ▶ Fibrosed wound beds
  - ▶ Hyperkeratosis
  - ▶ Papillomatosis
- (Green, 2007; Williams, 2009; Farrow, 2010; Ellis, 2015).

In response to these challenges, the authors' service has developed modified treatment regimens to deal with the specific issue of lymphovenous ulceration. Patients may require complex decongestive therapy (CDT). Those with large, swollen, distorted limbs with skin problems and fibrosis are usually treated with a course of multilayer lymphoedema bandaging (MLLB) and possibly manual lymphatic drainage (MLD), along with skin care, an exercise programme, psychosocial support and education (Foldi et al, 2000). This intensive therapy programme is used to 'decongest' the limb by removing fluid from the congested tissues, encouraging the movement of fluid through the lymphatic pathways, and reshaping the oedematous limb (Green, 2007).

One issue seen is chronic oedema

in the toes, knees and thighs caused by venous bandaging, which tends to exacerbate ulceration and prevent healing (Williams, 2003; Green 2007) (Figure 3).

To prevent this in the thighs, bandaging above the knee and to the thigh can be replaced by wrap systems, compression hosiery, or simple lymphatic drainage techniques, depending on the type and severity of the swelling.

Therefore, to achieve the goals related to lymphatic treatment, healthcare professionals need to incorporate stiffer levels of compression, exercise, manual and simple lymphatic drainage (SLD) techniques and the introduction of adaptive foams and fibrotic tissue softeners (Williams, 2003), including the use of kinesio tape, which is effective in the treatment of lymphoedema (Blanco and Gonzalez, 2020).

## ADAPTATIONS TO BANDAGING TECHNIQUES

The use of compression therapy aims to achieve different outcomes for venous and lymphatic disease (Williams, 2009; Charles 2013).

### Venous

For venous ulceration, compression bandaging and exercise aim to:

- ▶ Reduce venous reflux and improve venous return
- ▶ Reduce venous hypertension
- ▶ Maximise the calf muscle pump
- ▶ Reduce elevated matrix metalloproteinase (MMP) levels to promote healing of venous leg ulcers (Parsch and Mortimer, 2015).



Figure 3.

## Lymphoedema

For lymphoedema, compression therapy is used to:

- ▶ Reduce formation of excess interstitial fluid by opposing fluid filtration from blood capillaries into the tissue, thereby decreasing the lymphatic load
- ▶ Ensure that fluid is shifted into areas with functional lymphatics
- ▶ Increase lymphatic reabsorption and stimulation of lymphangion contractions
- ▶ Enhance the muscle pump, resulting in increased frequency and amplitude of lymph collector contractions
- ▶ Break down fibrosclerotic tissue (European Wound Management Association [EWMA], 2005).

Compression bandages are usually short-stretch, applied to the whole leg in a figure-of-eight rather than a spiral, to increase pressure and stiffness (toe-to-thigh if required) and prevent displacement of oedema into these areas (i.e. toes, knees and thighs). The high working pressures applied by bandages stimulate lymphatic pumping and reabsorption of lymph (Moffatt et al, 2005; Charles, 2013).

However, for patients with ulceration due to lymphoedema, where there is an area of fibrosis, bandages should be applied as a 'criss cross' or 'star', with a cohesive short-stretch bandage over the fibrosed tissue to add additional pressure to that area (Atkin and Sykes, 2015).

The authors' service has also introduced a strapping technique (Hopkins et al, 2011), which uses cohesive inelastic compression bandaging in narrow straps layered in a fan distribution over the ulcer and oedema. This allows higher compression to the retromalleolar area (Hopkins et al, 2013).

The Putter technique is also utilised for ulceration due to oedema, which is the application of a short-stretch bandage applied as usual and applied to fill any 'soft' spots (where fibrotic changes end in the skin, i.e. where the lymphatics are draining to [Wigg, 2016]).

## ADJUVANT TREATMENT OPTIONS

There are a variety of adjuvant treatments for fibrosis in lymphovenous disease, including:

- ▶ Creative foam applications, such as chip pads or custom-cut, flat foam pieces (Hodgson et al, 2011)
- ▶ Strapping techniques to manage areas of densely fibrotic tissue and retromalleolar fossa ulcers (Hopkins et al, 2013)
- ▶ MLD or SLD (Bertelli et al, 2013)
- ▶ Low level laser therapy (LLTT) (Wigg, 2009)
- ▶ Kinesio tape (Blanco and Gonzalez, 2020)
- ▶ Adapting bandaging techniques, such as applying inelastic compression bandages in a figure-of-eight application rather than a spiral for those with late-stage lymphoedema (Moffatt et al, 2005; Charles, 2013; Whitaker et al, 2015); utilising the Putter technique; or applying above the knee to the thigh bandaging (Elwell, 2015)
- ▶ Knee and thigh compression wraps (Mosti et al, 2015).

This article will now look at each method and how to implement in practice, with some case studies where the authors have used these techniques to reduce fibrosis and see what potential effect the treatments had on outcomes.

### Foam applications

These therapies help to maximise the effect of compression bandages by distributing consistent pressure over a greater surface area within the bandage structure (Hodgson et al, 2011).

They consist of chip pads, silicone pieces, cut foam and adapted cut foams. These are placed either around

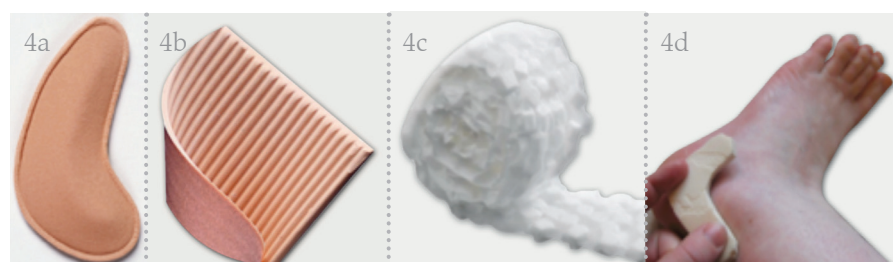


Figure 4.

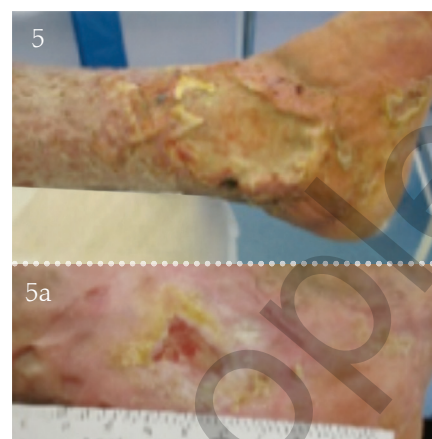


Figure 5.

the wound bed or over the area of fibrosis on top of a primary dressing. The bandages are then applied (Figures 4). Foam and compression is a technique used by many lymphoedema therapists to help reduce tissue fibrosis (Hodgson et al, 2011). Channeled foam can be used to help create tissue stretch and move lymphatic fluid along the lymphatic pathways, by pushing lymph from the high-pressure areas and allowing it to drain proximally through the low-pressure areas (Farrow, 2010).

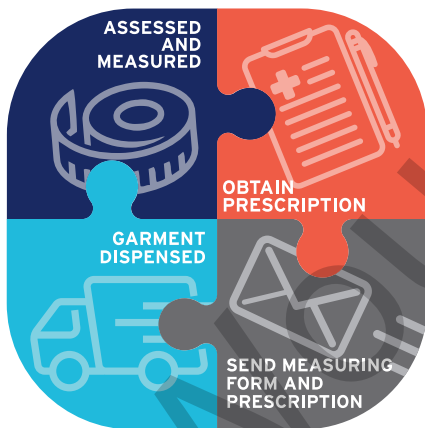
### Case studies for foam pads and strapping

Patient A had leukaemia and an ulcer of over six months' duration (Figures 5 and 5a). Treatment incorporated a short-stretch bandage applied in a figure-of-eight, retromalleolar strapping and a chip pad. The periwound area softened and the wound went on to heal within six months, despite the patient's multiple comorbidities.

Patient B had swelling to the toes and foot and fibrosed oedema to the retromalleolar area of the leg, with longstanding chronic venous hypertension which had resulted in lymphatic changes (Figures 6 and 6a). He was treated with a short-stretch bandage applied in a figure-of-eight



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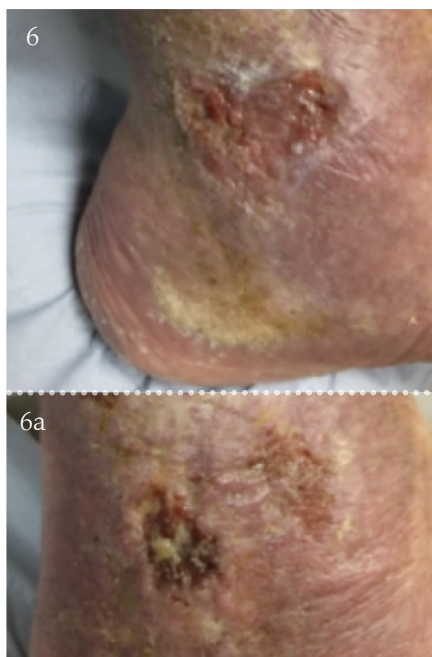


Figure 6.

and strapping. The patient had a fibrosed wound bed with atrophie blanche surrounding the periwound area. The area reduced in size by 1cm within a four-week period.

Patient C had mixed venous arterial disease and an ulcer present for two months, which had been treated with full compression therapy (Figures 7–7c). Her left leg had strapping applied over a double layer short-stretch bandage, which softened the fibrotic area and, as a result, the wound reduced in size by 0.5cm in four weeks and the pain the patient was experiencing at the wound bed reduced.

Patient C also had ulcers on her right leg, for which she was treated with a combination of strapping and Mobiderm foam padding (Thuasne). The ulcer size reduced by 15.5cm<sup>2</sup>, with softening of the periwound area within a four-week period.



Figure 7.

### Manual/simple lymphatic drainage (MLD/SLD)

Patients may require a degree of MLD. The technique employed by the authors is the FGMLD 'Fill and Flush' (Wigg, 2015). This is a research-based technique which moves fluid to drainage points on the limb, which are located using the skin pinch test. Skin around the wound site needs to be assessed by modifying the Stemmer's test to examine skin texture in affected areas (Bjork, 2013). If you can pinch and lift the skin, the test is negative, if you cannot, it is positive. This means that lymphatic drainage is



Figure 8.



Figure 9.

poor to the area and you need to find a 'soft spot' into which to drain fluid.

Skin that is positive for lymphoedema will be thickened, less pliable and produce limited or no 'bow tie' of wrinkles (Figure 8), which is indicative of chronic inflammation, tissue thickening and fibrotic soft tissue changes (Bjork, 2013; Wigg, 2015) (Figure 9).

As part of the treatment plan, the authors also teach patients and family members/carers how to administer SLD. Plans are developed based on lymphatic drainage pathways. If fluroscopy (a method of mapping and identifying superficial drainage pathways, which then allows clinicians to map drainage routes and target treatment — currently only available privately in the UK) cannot be accessed, the authors' service use the pinch test to identify potential drainage pathways to ensure when bandaging or kinesio taping can be used to push fluid to the draining areas of the leg (Farrow, 2010).

**Low level laser therapy (LLTT)**  
LLLT or photobiomodulation therapy is a laser or LED light

### Practice point

The psychological impact that chronic oedema/lymphoedema can have on patients should never be underestimated, as it can lead to depression, anxiety, fatigue, sleep problems, reduced social interaction, mobility restrictions and poor body image (Finlayson et al, 2017).

therapy, which is claimed to improve:

- ▶ Tissue repair
- ▶ Inflammation
- ▶ Oedema
- ▶ Pain (Pillar et al, 1998; Shubert, 2001; Carati et al, 2003; Kozanoglu et al, 2009; Minatel et al, 2009; Omar et al, 2012).

The aim of LLLT is to soften thickened and fibrosed tissues, reduce inflammation and therefore the risk of cellulitis, and lessen the viscosity of the lymph to improve lymph flow and overall limb volume reduction (Elisaka and Eliskova, 1997). Treatments typically take 1–10 minutes and should be applied two or more times a week. Combining LLLT therapy with other aspects of lymphoedema management, such as strapping techniques, bandaging and MLD, can help to reduce 'stubborn' swelling in the affected area.

LLLT has been shown to have an effect on lymphoedema secondary to cancer, with reported improvements including the reduction of tissue hardness and limb volume (Pillar et al, 1998; Kozanoglu et al, 2009; Omar et al, 2011), and softening of scar tissue and increased mobility (Carati et al, 2003; Wigg, 2009; Omar et al, 2011). Work in the UK has found

that patients with lymphoedema and fibrotic tissue have increased softening in comparison to standard treatment. When delivered as an adjunct therapy, it enhances the effect of MLD and compression (Wigg, 2009).

Studies investigating whether LLLT can be useful as an adjunct to conventional wound healing therapies have shown higher healing rates (Schubert, 2001), especially in wounds that have failed to respond to other forms of treatment (Minatel et al, 2009). Dyson et al (2001) found that the healing of acute wounds can only be stimulated by LLLT if they are healing sub optimally, as it encourages granulation tissue production and wound contraction.

Therefore, the evidence may highlight the benefit in cases where conventional treatment has not been successful, which links to the effects it has on fibrosis in lymphoedema, meaning that LLLT potentially warrants further study.

#### Case studies for LLLT

Figures 10 and 10a show patient D who presented with a mixed aetiology ulcer which had been present for over six months. The patient had not been responding to conventional therapies and was experiencing pain, which reduced the ability of the nursing team to apply optimal compression levels. It was thus decided to start LLLT. The patient's pain reduced within two weeks allowing the team to

apply appropriate compression. The periwound fibrosis subsequently reduced and softened and the ulcer went on to heal.

Patient E (Figures 11 and 11a) had a venous leg ulcer with atrophie blanche surrounding the periwound area. It was decided to treat with LLLT and foam padding. By week four, the periwound skin had softened and the wound was reducing in size.

#### Kinesio tape

Kinesio tape is a therapeutic taping technique to alleviate pain and facilitate lymphatic drainage by microscopically lifting the skin (Blanco and Gonzalez, 2020). This lifting effect forms convolutions in the skin, increasing interstitial space and decreasing inflammation in affected areas by allowing blood and lymph to dilate and drain. The tape increases the space in which lymphatic fluid flows, enabling it to move towards working lymph nodes. It can also help to facilitate the stretch response of the angions, with movement or muscle contraction (Blanco and Gonzalez, 2020).

Kinesio tape is applied with differing tensions to areas of oedema and fibrosis, following the identified lymphatic drainage pathways



Figure 10.

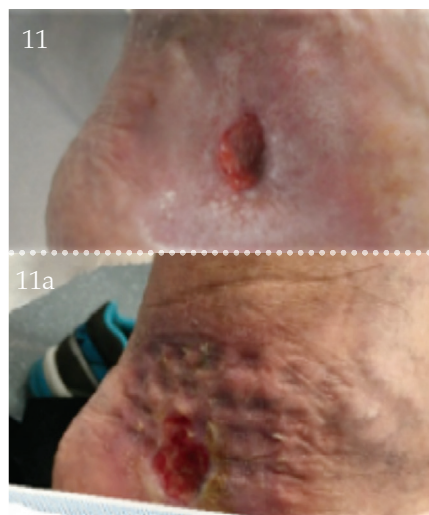


Figure 11.

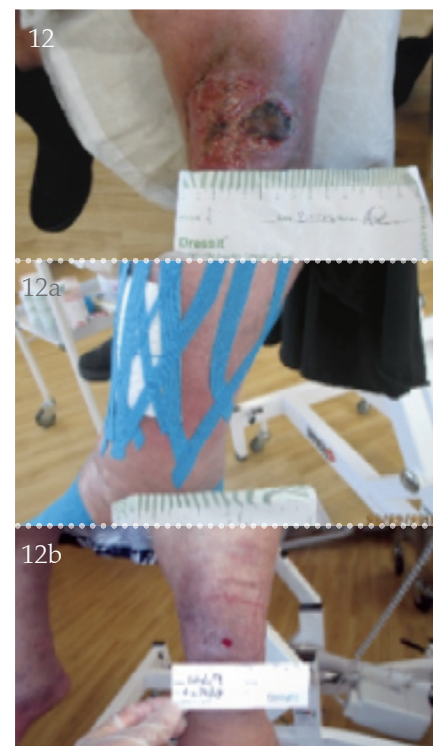


Figure 12.



Figure 13.

identified by the pinch skin test (Figure 8).

#### Case studies for kinesio tape

Patient F had a haematoma and was also morbidly obese and refused any form of compression. Kinesio taping was started following the lymphatic drainage pathways and the wound healed within three months (Figures 12–12b).

Patient D had lymphovenous disease with lymphorrhoea and recurrent fungal infections to the toes, which had not been controlled with conventional toe and stump bandaging techniques and appropriate antifungal treatments (Figure 13). Kinesio tape was applied following the drainage pathways, (Figure 13a) and then a short-stretch 8cm bandage was applied in a figure-of-eight to the ankle and a

### 'Management of chronic oedema and lymphoedema requires knowledge, understanding and skill in assessment, diagnosis and management, as well as knowledge of physical and psychological sequelae of the condition.'

10cm bandage applied in a figure-of-eight to below the knee, finishing with 10cm spiral toe-to-knee bandaging. This treatment regimen resulted in the lymphorrhoea and superficial ulcer healing within four weeks.

Patient G had a small retromalleolar ulcer which had not



Figure 14.



Figure 15.

been responding to conventional bandaging techniques or strapping. Kinesio tape was applied over the primary dressing to reduce the fibrosis and assist healing, which subsequently occurred (Figures 14–14b).

Patient H had a venous leg ulcer which had been present for six months with a fibrosed wound bed. A two-layer elastic/inelastic combination bandage system was applied along with kinesio taping to a draining soft spot on the patient's leg. The periwound fibrosis softened and the wound reduced in size after four weeks of treatment (Figure 15 and 15a).

The patients involved in these case studies were referred to the authors' specialist wound and lymphoedema service as they were non-healing at six weeks, despite receiving compression therapy. With the introduction of appropriate adjuvant treatment options, the wounds progressed to healing. In the authors' clinical opinion, the effect of modified therapies on the fibrotic wound bed and periwound skin needs further investigation.

## CONCLUSION

In the UK, many areas either do not have lymphoedema specialists or have been withdrawing services. This has passed the care onto generalist healthcare professionals, resulting in a failure to meet international standards for the management of lymphoedema (Macmillan Cancer Support, 2011). Management of chronic oedema and lymphoedema requires knowledge, understanding and skill in assessment, diagnosis and management, as well as knowledge of physical and psychological sequelae of the condition (Williams, 2009).

Specialist lymphoedema and wound care services need to educate and improve healthcare professionals' knowledge base and stop the delay in referral to appropriately trained clinicians (Harding et al, 2015), which increases severity of symptoms, leading to patients enduring





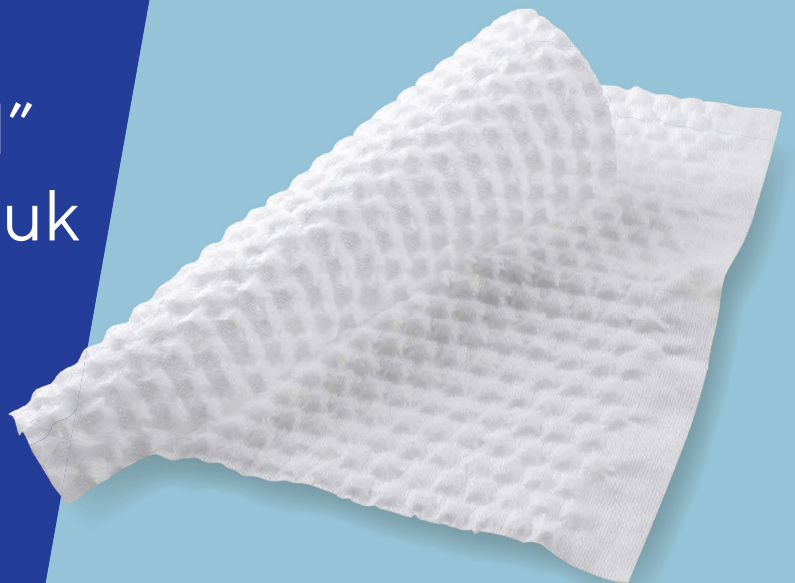
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(\*) Moffatt CJ, Gaskin R, Sykorova M, et al (2019) Prevalence and risk factors for Chronic Oedema in UK community nursing services. *Lymphat Res Biol* 17(2): 147-54.

(\*) Stanton J (2020) Development of the hybrid tissue viability nurse/lymphoedema nurse. *JCN* 34(4):46-51.

unnecessarily protracted intensive treatment packages that are more labour and resource intensive (Todd, 2019). Inappropriate disease management can also result in unnecessary complications, such as recurrent infection, pain, increased swelling, and poor outcomes for patients (Ellis, 2015).

The lymphatic system should be targeted to trigger an immune response to balance the bioburden of the wound and reduce the cycle of recurrent infection (White et al, 2014; Stanton, 2020). If the lymphatics are static, dead cells, debris and other by products of wound healing remain, causing stagnation of the wound environment and delayed wound healing.

The introduction and adaptation of CDP, consisting of MLD/SLD, compression bandaging, remedial exercises and skin care, mobilises accumulated oedema fluid and increases lymph flow, resulting in a beneficial therapeutic effect on fibrosclerosis (Foldi et al, 2000), as seen in the case studies presented here.

Adaptation of pathways to include treatment to break down fibrosis in the wound bed to improve lymphatic drainage (Elwell, 2015), and, ultimately, the microcirculation, is essential in wound care and, in the authors' clinical opinion, should be encouraged to improve outcomes in complex chronic leg ulceration caused by lymphovenous disease. Interventions to help prevent damage to lymphatic capillaries and techniques to facilitate lymphatic drainage and lymphangiogenesis need to be considered as part of routine wound management (Bjork and Hettick, 2018).

The introduction of tissue viability nurses with lymphoedema expertise should be encouraged within leg ulcer clinic settings to improve patient outcomes. Alongside this, controlled trials should be undertaken to look at evaluating these techniques to ascertain whether outcomes and healing times are improved, as well as which techniques or combinations are more effective. **JCN**

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## KEY POINTS

- Suboptimal management of leg ulcers has been identified as a UK-wide problem that is both costly to the NHS and a drain on nursing resources.
- Wound complexity increases the likelihood of wound chronicity and can make a wound hard to heal.
- Fibrosis is the replacement of normal structural elements of the tissue with excessive accumulation of scar tissue, composed of distorted collagens.
- Until the issue of fibrosis around the wound bed is addressed by clinicians and within the literature, it will be a challenge to promote adequate oxygenation of nutrients to the wound bed and improve lymphatic drainage.
- The use of compression therapy aims to achieve different outcomes for venous and lymphatic disease
- There are a variety of adjuvant treatments for fibrosis in lymphovenous disease.
- Management of chronic oedema and lymphoedema requires knowledge, understanding and skill in assessment, diagnosis and management, as well as knowledge of physical and psychological sequelae of the condition.

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## Revalidation Alert

Having read this article, reflect on:

- Your knowledge of lymphovenous disease
- The issue of fibrosis in the wound bed
- How you could adapt treatment to achieve better outcomes for patients with wound chronicity.

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

# Importance of peristomal skin protection

Valentine Lacey

It has been reported that one in 500 people in the UK are living with a stoma (Colostomy UK, 2022) and nearly three-quarters of people with a stoma experience skin problems. Therefore, skin assessment, prompt identification of risk and preventing skin problems is the cornerstone of peristomal skin care. This article introduces common peristomal complications, focusing on the assessment and prevention of two distinct groups of peristomal skin damage; peristomal moisture-associated skin damage (PMASD), one of the types of moisture-associated skin damage (MASD), and peristomal medical adhesive-related skin injuries (PMARSI).

## KEYWORDS:

- Stoma ■ Peristomal moisture-associated skin damage (PMASD)
- Peristomal medical adhesive-related skin injuries (PMARSI)

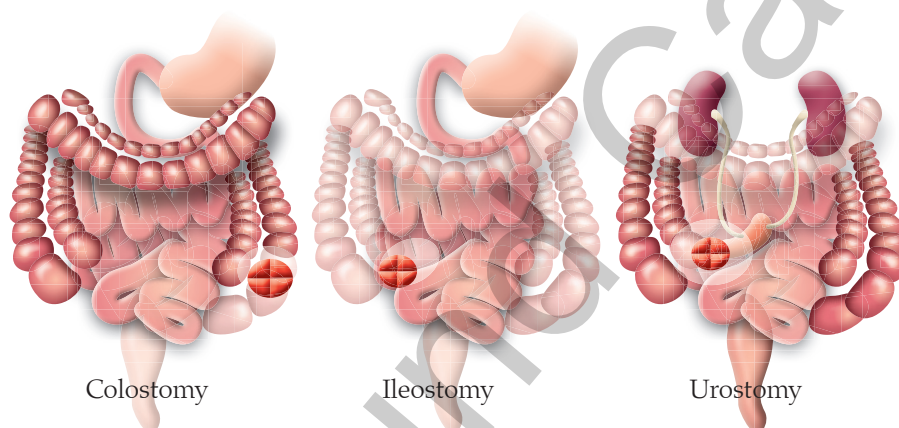


Figure 1.  
Types of stoma.

Derived from the Greek word for 'mouth' or 'opening', a stoma refers to a surgical opening onto the outside surface of the skin that has been formed to pass faeces or urine (Burch, 2010; Jones, 2016).

The StoMap Programme Baseline Report (2019; [www.eoecph.nhs.uk/stomap-baseline-report.htm](http://www.eoecph.nhs.uk/stomap-baseline-report.htm)) estimates that there are 176,824 people in the UK living with a stoma. Individuals of

all ages can have a stoma. It can either be temporary or permanent, depending on the reason for the stoma formation. The creation of an ostomy is a life-changing event resulting in alterations in body image (Nichols, 2018), with a lifelong effect on the outcomes of an ostomate's health quality.

In the author's clinical opinion, common medical conditions that might lead to a stoma are:

- ▶ An obstruction to the bladder or bowel
- ▶ Bowel cancer
- ▶ Bladder cancer
- ▶ Crohn's disease

- ▶ Diverticulitis
- ▶ Inflammatory bowel disease
- ▶ Ulcerative colitis.

## THE SKIN

The skin is the largest organ in the body and is made up of three layers, epidermis, dermis and subcutaneous layer. The outermost layer of the epidermis, the stratum corneum, is the most important layer in maintaining the pH-dependent barrier function of the skin (Jones, 2014).

The stratum corneum is a combination of lipids, keratins and protein. Its primary function is to act as a barrier between the deeper layers of skin and the outside environment, preventing toxins and bacteria from entering the body. Moisture is held in the stratum corneum preventing evaporation into the atmosphere via transepidermal water loss (TEWL) which, in turn, keeps the skin hydrated. This creates what is known as the natural moisturising factor (NMF). Cell turnover in the stratum corneum occurs every 28 to 30 days in young adults and 45 to 50 days in elderly adults (Menon et al, 2012).

If the skin is exposed to too much moisture, it becomes overhydrated and prone to maceration (Parnham et al, 2020). This makes it easier for irritants and microorganisms to penetrate the skin and impair its barrier function, and reduces the skin's integrity to mechanical forces such as friction and shear (Young, 2017; Parnham et al, 2020).

## Differentiating skin tones

It is important for community and general practice nurses (GPNs) to understand the differences in skin

tones to provide the best prevention and/or treatment of moisture-associated skin damage (MASD) and medical adhesive-related skin injury (MARS) (Table 1). Regardless of the type of stoma, 'the skin immediately surrounding the stoma should look like the skin on the rest of the abdomen' (Stelton, 2019) and should not have any discoloration. For example, ostomates with lighter skin tones should not have reddened peristomal skin, and ostomates with darker skin tones should not have darker discolorations on their peristomal skin. It is important to remember that a stoma is part of the patient, and the condition of their skin reflects their general health and might be affected by any health issues, such as hypoxia and anaemia (Stelton, 2019).

The need for clinical research into darker skin tones has led to articles that have highlighted evidence of inequity in relation to clinical care and patient assessment, leading to higher prevalence of severe injuries before detection of damage occurs in people with darker skin tones (Gunowa et al, 2020).

To avoid skin tone bias, clinicians should be encouraged to tailor skin assessment when it comes to assessing MASD and MARS (Table 1; Wounds UK, 2021).

## TYPES OF STOMA

There are three main types of stoma (Figure 1):

- ▶ Colostomy, which will pass formed faeces and flatus. Most commonly used in patients who have had rectal cancer
- ▶ Ileostomy, which will pass loose faeces and flatus. Created for patients with conditions such as ulcerative colitis
- ▶ Urostomy, which will pass urine. Formed from the ileum and most commonly used when the patient has bladder cancer (Jones, 2016; Burch, 2017).

The most common type of stoma formed in the UK is the colostomy, followed by the ileostomy, with the least common being the urostomy (Burch, 2017).

## COMMON PERISTOMAL SKIN COMPLICATIONS

Peristomal skin complications can be caused by a variety of factors, but the main ones are chemical and mechanical. For example, peristomal moisture-associated skin damage (PMASD) can occur as a result of the skin being exposed to effluent from the stoma (Salvadaleña et al, 2020), while peristomal medical adhesive-related skin injury (PMARS) happens during the removal of adhesive pouching systems. Salvadaleña et al (2020) found that, on average, peristomal skin complications started 64 days after undergoing stoma surgery, resulting in the three most common types of peristomal skin complications, namely:

- ▶ Acute or chronic irritant dermatitis (such as PMASD)
- ▶ Maceration
- ▶ Mechanical trauma.

Clinical research has found that skin injuries related to medical adhesives are prevalent but underreported (Le Blanc et al, 2013; Stelton, 2019).

Peristomal skin complications can be categorised according to the DET (discolouration, erosion and tissue) score, as mild, moderate, and severe (Salvadaleña et al, 2020), e.g:

- ▶ Mild (1–3): discolouration=3; no erosion or tissue overgrowth; total score=3
- ▶ Moderate (4–6): discolouration=3; erosion=2; no tissue overgrowth; total score=5

- ▶ Severe (7–15): discolouration=3; erosion=3; tissue overgrowth=2; total=8.

## PERISTOMAL SKIN CARE

One the biggest challenges following stoma surgery is maintaining skin integrity around the stoma. As said, regardless of the type of stoma, the surrounding skin should look like the skin on the rest of the abdomen. It should not be discoloured (Stelton, 2019). Unfortunately, most ostomates will experience peristomal skin problems at some point in their lives, making peristomal skin complications one of the most prevalent ostomy-related complications influencing an individual's health status and quality of life (Fellows et al, 2021).

Successful treatment in peristomal skin health, or skin health in general, can have a positive impact on an individual, and in the collective, provide an overall societal benefit (Nichols et al, 2019). Similar conclusions were drawn by LeBlanc et al (2019), who found that peristomal skin problems led to impaired physical function, poor quality of life, and higher costs.

Skin problems can be divided into two distinct groups — moisture-associated skin damage (MASD) and medical adhesive-related skin injuries (MARS) — requiring different approaches to prevention and management.

**Table 1: Assessing MASD and MARS in darker skin tones (adapted from Wounds UK, 2021)**

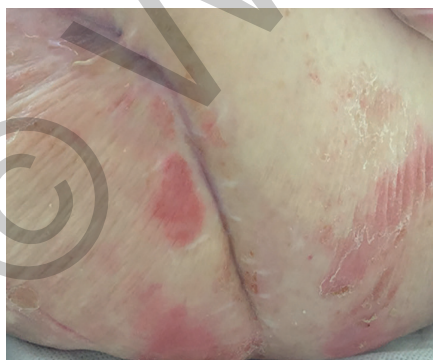
Type of skin damage	Possible presentation	Tips for practice
Moisture-associated skin damage (MASD)	Change in skin colour: this may present as redness, darkening, lightening or blue/purple tones	<ul style="list-style-type: none"> <li>▶ Inspect the skin thoroughly and regularly, and make sure that protective measures such as barrier products are used in at-risk patients before damage occurs</li> <li>▶ The skin should be checked for changes so that diagnosis can be made before maceration occurs if possible</li> </ul>
Medical adhesive-related skin injury (MARS)	Damage may be difficult to spot if clinicians are looking for 'redness'	<ul style="list-style-type: none"> <li>▶ Skin integrity and issues such as dryness should be considered when using adhesive products</li> <li>▶ Extra care should be taken to avoid MARS, and to identify it when it occurs in patients with dark skin</li> </ul>



**Figure 2.**  
*Peristomal skin complications.*



**Figure 3.**  
*Peristomal dermatitis.*  
*Photograph: iStock/pavlemarjanovic.*



**Figure 4.**  
*MARSII.*

### Moisture-associated skin damage (MASD)

MASD is an umbrella term adopted by healthcare professionals for skin damage of various aetiologies associated with prolonged or continuous exposure to moisture (Young, 2017; Parnham et al, 2020). The four clinical manifestations are:

- ▶ Incontinence-associated dermatitis (IAD)
- ▶ Intertriginous dermatitis
- ▶ Periwound moisture-associated dermatitis
- ▶ Peristomal moisture-associated skin damage (PMASD) (Figure 3) (Young, 2017), which this paper focuses on.

The difference between the four conditions is the type of moisture that induces the skin damage, such as effluent from a stoma coming into contact with the skin (Young, 2017).

Peristomal moisture-associated skin damage can happen quickly, causing distress, pain and difficulty in obtaining a good seal, and often results in the embarrassment of effluent leakage (Parnham et al, 2020).

Management of PMASD depends on the correct choice and application of the ostomy device and a structured skin care routine (Young, 2017).

### Medical adhesive-related skin injuries (MARSII)

MARSII (Figure 4) has recently been defined as: 'Skin damage related to the use of medical adhesive products or devices such as tapes, wound dressings, stoma products (referred to as PMARSII), electrodes, medication patches and wound closure strips' (Fumarola et al, 2020).

MARSII can be divided into three categories, namely:

- ▶ Mechanical (e.g. skin stripping, tension injury/blister, skin tear)
- ▶ Dermatitis (e.g. irritant contact and allergic dermatitis)
- ▶ Other (e.g. maceration and folliculitis) (Fumarola et al, 2020; Kelly-O'Flynn et al, 2020).

Intrinsic and extrinsic risk factors that make the skin more prone to MARSII include:

- ▶ Intrinsic: extremes of age (neonates and elderly), dehydration, malnutrition, dermatological conditions, underlying medical conditions (e.g. infection, diabetes), oedema
- ▶ Extrinsic: dry skin and harsh cleansers, prolonged exposure to moisture, medications (e.g. long term corticosteroids and anti-inflammatory agents, radiation therapy, photodamage or exposure to ultraviolet light, tape or removal of adhesive devices and itching (Fumarola et al, 2020).

Comprehensive skin assessment should be performed in all patients before applying a medical adhesive, and at each time a medical adhesive is removed (Hadfield et al, 2019; Fumarola et al, 2020).

There are four ways that PMASD and PMARSII can be prevented (Hadfield et al, 2019; Kelly-O'Flynn et al, 2020; Swift et al, 2021):

- ▶ Preparation of the skin by ensuring it is clean and dry and the application of a barrier film (e.g. MEDI DERMA-S Total Barrier Film, Medicareplus International), allowing it to completely dry before application of an adhesive device
- ▶ Selecting the appropriate medical adhesive ensuring that it flexes with the contours of the skin and movement
- ▶ Application of the adhesive product — ensuring there is no stretch or tension and it is in full contact with the skin
- ▶ Removal of the adhesive product — removing slowly while supporting the skin, utilising a silicone adhesive remover (e.g. LIFTEEZ Medical Adhesive Remover, Medicareplus International).

### Practice point

The S.M.A.R.T. Card is a convenient, wearable version of the S.M.A.R.T. Resource. Sign up to receive a free S.M.A.R.T. Card at:  
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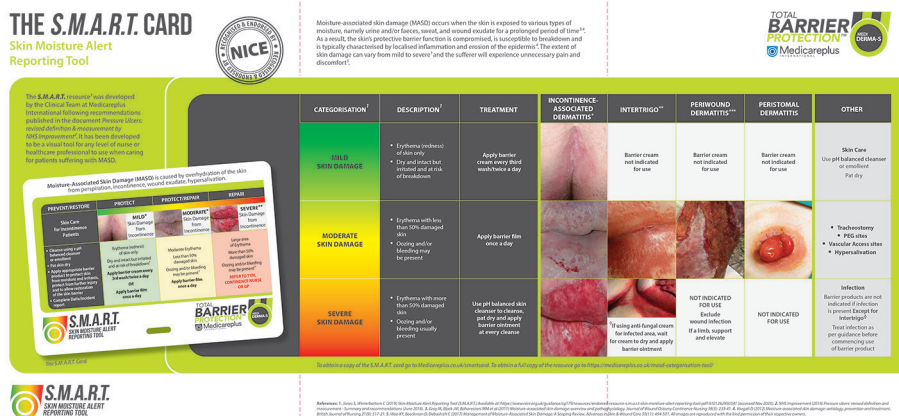


Figure 5. S.M.A.R.T. Card (adapted by S Jones and C Winterbottom for Medicareplus International Limited with kind permission from the National Association of Tissue Viability Nurses Scotland (NATVNS) 2014 — Scottish Excoriation and Moisture Related Skin Damage Tool).

### THE S.M.A.R.T. RESOURCE

The S.M.A.R.T. resource (Figure 5) was developed by the clinical team at Medicareplus International following recommendations in the document, *Pressure ulcers: revised definition and measurement framework* (NHS Improvement, 2018).

It has been developed to be a visual tool for any level of nurse or healthcare professional to use when caring for patients suffering with MASD. The S.M.A.R.T. resource is endorsed by the National Institute for Health and Care Excellence (NICE, December 2019).

### PRODUCT FOCUS

This paper will now look at two products which provide a skin care solution for both PMASD and PMARSI.

#### MEDI DERMA-S Total Barrier Film

Using a protective barrier film can help protect damaged and intact skin from the harmful effects of moisture and irritants, as well as from potential skin damage that may be caused by the application of adhesive ostomy products. Medi Derma-S Total Barrier Film (Figure 6) has been found to provide protection from PMASD on intact and moderately damaged peristomal skin in adults and

paediatric patients (Southgate and Bradbury, 2016; Copson and De Freitas, 2021). The film is available in several formats, such as wipes, aerosol or pump spray, 1ml or 3ml film applicators and dries within seconds for ease of use.

It is a silicone-based medical grade liquid, which forms a thin, transparent, protective film when evenly applied to the skin. It gives protection from bodily fluids (i.e. urine and faeces), from adhesive products, and friction-related trauma for up to 72 hours (Huish and Walters, 2016; Hadfield, 2017). To help minimise the risk of skin sensitivities, Medi Derma-S Total Barrier Film is alcohol, fragrance,

latex, parabens and phthalates free and is not made with natural rubber latex.

To help improve patient comfort, the film has a non-sting formulation (Dykes et al, 2012; Huish and Walters, 2016; Hadfield, 2017) and does not need to be removed between applications. It is indicated for the prevention and management of MASD and is suitable for mild-to-moderate skin damage (Copson and De Freitas, 2021).

However, a different approach is needed to prevent MARS. As a result of the lack of awareness of and education on MARS, proactive prevention is key in avoiding pain and skin damage (Kelly-O'Flynn et al, 2020).

Figure 7 shows the results from a 14-patient evaluation in a neonate intensive care unit of the skin barrier film conducted over a one-to two-day period (Hadfield, 2017). All the patients had intact skin both before and after the evaluation, with only one neonate having slight erythema following adhesive device removal. There was no change in the level of skin damage, with no skin damage being seen following dressing removal in all the patients involved. It was also noted that no pain or stinging was vocalised when the barrier film product was applied. The clinicians and patients/



Figure 6. MEDI DERMA-S Total Barrier Film 30ml Pump Spray, 50ml Aerosol, Sterile 1ml and 3ml Applicators and Wipes.



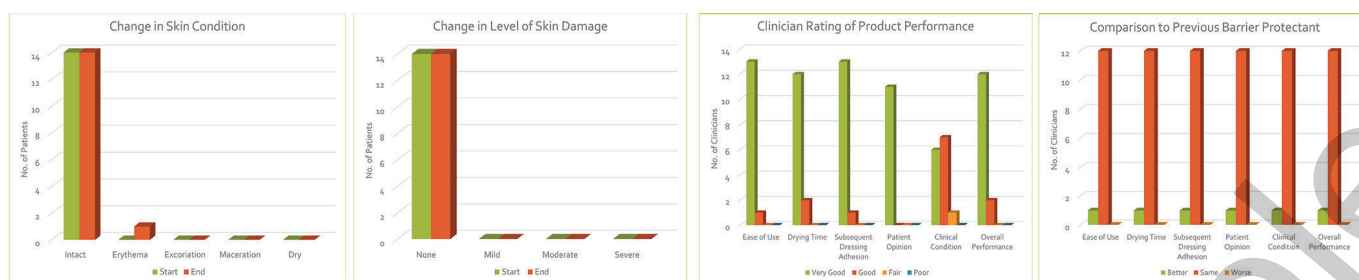


Figure 7.

Results of a clinical evaluation of MEDI DERMA-S Total Barrier Film for preventing MARS (Hadfield, 2017).

carers rated the barrier film as either very good or good across all the evaluation domains, and either better than (n=1) or the same as (n=12) the previously used barrier film. The product was considered to be clinically acceptable and suitable for inclusion on the local formulary to replace an existing product.

### LIFTEEZ Medical Adhesive Remover aerosol and wipe

LIFTEEZ Medical Adhesive Remover aerosol and wipe (Figure 8) is a non-sting, no-rinse formulation which can be used to help prevent PMARS by dissolving the adhesives used in stoma or ostomy appliances while also being gentle on the skin (Jones et al, 2018).

It has several benefits to patients and clinicians (Table 2) and should be used as part of a structured approach in the total management of a patient's skin (Kelly-O'Flynn et al, 2020).

Table 2: Clinician and patient benefits of using LIFTEEZ (Jones et al, 2018; Hadfield et al, 2019)

Clinician benefits	Patient benefits
▶ Fast and easy removal of stoma appliance with no skin stripping	▶ Reduced pain during stoma appliance change
▶ No effect on adhesion of replacement stoma appliance	▶ Reduced erythema and skin trauma to fragile skin
▶ Increased patient comfort	▶ Reduced or no analgesia requirements
▶ Increased patient compliance	▶ Reduced anxiety around stoma appliance removal
▶ Increased patient engagement in their own care	▶ Reduced time needed for appliance change

### CONCLUSION

Peristomal skin damage is a common problem for ostomy patients and so education on risks and prevention is vital. Skin care should be high on the agenda for any healthcare professional who provides clinical care to ostomy patients and, in particular, protecting the skin from the harmful effects of moisture and the removal of adhesive products. Importantly, care needs to be taken when assessing different skin tones. Skin tone bias should be avoided and clinicians should

be encouraged to tailor skin assessment when it comes to assessing PMASD and PMARS (Table 1; Wounds UK, 2021). **JCN**

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Figure 8.

LIFTEEZ Medical Adhesive Remover 50ml Aerosol and Wipes.

## Remember...

The role of the stoma specialist nurse is varied and encompasses aspects of care, such as:

- ▶ Preoperative assessment and education of the patient and their significant other
- ▶ Stoma siting
- ▶ Stoma training in hospital and community setting (Burch, 2017).

Patients with a newly formed stoma should receive continuity of care for up to three months after discharge from hospital (Association of Stoma Care Nurses UK, 2015). Support and guidance for healthcare professionals and patients should be available as a matter of routine. Many stoma nurses run patient groups or clinics where patients can discuss any problems and talk to other stoma patients.

Stoma organisations include:

- ▶ Colostomy UK: [www.colostomyuk.org/](http://www.colostomyuk.org/)
- ▶ Ileostomy and Internal Pouch Association: <https://iasupport.org/>

Information for the general public:

- ▶ NHS UK: [www.nhs.uk/conditions/colostomy/](http://www.nhs.uk/conditions/colostomy/)  
[www.nhs.uk/conditions/ileostomy/](http://www.nhs.uk/conditions/ileostomy/)
- ▶ Bladder and Bowel Community: [www.bladderandbowel.org/bowel/stoma/what-is-a-stoma/](http://www.bladderandbowel.org/bowel/stoma/what-is-a-stoma/)
- ▶ Find stoma support services (England): [www.nhs.uk/service-search/other-services/Stoma%20support/LocationSearch/388](http://www.nhs.uk/service-search/other-services/Stoma%20support/LocationSearch/388)

Information for healthcare professionals:

- ▶ The Association of Stoma Care Nurses UK: [www.ascnuk.com](http://www.ascnuk.com)

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# Assessment and management of faecal incontinence

Jane Young

Faecal incontinence (FI) has a huge impact on patient quality of life. It can lead to feelings of shame and degradation and affect relationships, self esteem and body image. Its causes are multi-factorial, but so much can be done to improve or cure this embarrassing symptom. Despite this, it can take many years for patients to open up and admit to friends, relatives or healthcare professionals that they are suffering. FI should never be accepted as normal — all too often in the author's experience this is seen to be the case. There are treatment options even for those patients who are bedbound. This article reviews the latest research and highlights the need for sensitive and supportive consultations with this patient group.

## KEYWORDS:

■ Faecal incontinence ■ Causes and diagnosis ■ Treatment

Faecal incontinence (FI), always has an underlying cause (Harari, 2009). It is defined as any involuntary loss of faeces that is a social or hygiene problem (National Institute for Health and Care Excellence [NICE], 2007). Faecal incontinence occurs in approximately 50% of nursing home residents and up to 10% of older people living at home (Potter et al, 2007). In the world of bladder and bowel management, FI is considered the most underreported due to the shame and embarrassment associated with it (Sbeit et al, 2021). It is reported to be linked to depression, low self-esteem and restriction of normal daily activities (Camilleri-Brennan, 2020). It leads

**'In the world of bladder and bowel management, FI is considered the most underreported due to the shame and embarrassment associated with it (Sbeit et al, 2021).'**

to increased care home admissions, urinary tract infections (UTIs) and skin issues (Potter et al, 2007; Harari, 2009; Norton et al, 2010).

Despite a plethora of management options, some bladder and bowel nurses feel inadequately trained to manage FI (Leo et al, 2017). A recent survey of 250 general practitioners in the United Kingdom also found 75% lacking in adequate skills to assess and manage FI (Shinkwin et al, 2021). Several national audits of continence care in the United Kingdom have persistently highlighted poor continence care and gaps in provision. A national audit specifically focusing on FI in 2007 found deficiencies in carrying out basic

assessments and a lack of integrated working, as well as poor management options (Potter et al, 2007). The *NHS Long Term Plan* aims by 2024/25 to reduce Gram-negative bloodstream infections (GNBSIs) by 50% and promotes tackling faecal incontinence as a key driver to achieving this target (NHS Improvement, 2017; NHS England, 2019). *Escherichia coli* (E.coli) originates from the gut and when patients are faecally incontinent, this increases the risk of E.coli bacteraemia.

This paper explores the causes and treatments of FI, as well as the barriers that can lead to sub-standard management of the condition. In the author's opinion, it is sometimes considered normal and not managed effectively, if at all. Indeed, an audit of care homes in the author's workplace found that up to 97% of residents in one care home suffered with faecal incontinence.

## CAUSES AND DIAGNOSIS

Basic requirements to maintain bowel continence include a compliant rectum with adequate capacity, intact internal and external anal sphincters, puborectalis muscle of the levator ani complex, normal rectal distension, anal sensation, reflex contractions and coordination of central and peripheral nervous systems. According to Bliss et al (2017), there are three types of faecal incontinence, namely:

- ▶ Passive incontinence, when there is the involuntary loss of stool or flatus without awareness
- ▶ Urge incontinence, when there is loss of faecal matter, even with rectal sensation and an intact pelvic floor and faecal soiling resulting in staining of underwear
- ▶ Sudden FI, with symptoms consistent with cauda equina

syndrome (a rare but serious condition which occurs when nerves at the bottom of the spinal cord are compressed), which requires urgent assessment and intervention (Shaw and Wagg, 2016).

There is also functional incontinence, where the patient may be continent but unable to toilet themselves.

In 2007, NICE produced guidance for managing FI based on systematic reviews of the evidence available at that time. The guidance highlighted the profound effect FI has on physical and mental health, leading to patients remaining undiagnosed, caregiver fatigue and admission to 24-hour care facilities. To get an accurate diagnosis, all possible contributory factors should be considered. Several conditions are linked to FI, such as anal sphincter dysfunction, rectal disorders, such as anismus and rectocele, malignant diseases, neurological disease, and psychiatric conditions (Duelund-Jakobsen et al, 2016).

Causes of FI are usually categorised as non-traumatic or traumatic. Non-traumatic causes due to anal sphincter or evacuatory dysfunction are most prevalent. These are seen commonly in neurological diseases, where there can be abnormal anorectal reflexes and/or reduced or absent anorectal sensation. Patients with central nervous system dysfunction often experience constipation, FI and evacuatory issues (Scott et al, 2021). Widely used are the clinical recommendations of the Neurologic Incontinence Committee 2013 consultation document, which provide clear pathways for the management of FI (Cotterill et al, 2018). More recent expert consensus was produced by Abrams et al in 2018, in the 6th International Consultation on Incontinence.

Others factors include neuropathy related to conditions such as diabetes, obesity, rectal surgery, overflow incontinence, congenital abnormalities and radiotherapy (Kim et al, 2021). One study of 256

morbidly obese women found 67% suffered with FI, suggesting an increased stress on the pelvic floor musculature associated with obesity (Wasserberg et al, 2008). A recent systematic review of obese patients suffering with FI found a significant reduction in FI episodes post bariatric surgery (Mohamed et al, 2021).

Traumatic causes of FI are related to obstetric trauma during childbirth and reconstructive ano-rectal surgery, and, as Potter (2007) states, it becomes more common with disability and advancing age. In the literature, the prevalence of FI varies widely due to populations sampled and different definitions. In a study with 71,000 American participants, Menees et al (2018) found that one in seven had suffered with bowel incontinence and that there was an increased prevalence associated with ageing. They also found little difference in gender, suggesting that childbirth-related trauma causing FI could be overestimated. Concomitant diarrhoea and constipation, inflammatory bowel disease and diabetes were other high-risk factors. Another recent, large cross-sectional study of 4,027 patients, 83% of whom were female, found that

41% of patients reported coexistent symptoms, such as constipation, using established international diagnostic (Rome) criteria (Drossman et al, 2016), meaning that constipation was diagnosed and not necessarily picked up on before referral into the study (Vollebregt et al, 2020).

According to Norton et al (2007), holistic baseline assessment should cover a detailed medical history, as well as abdominal and rectal examination to assess any ano-rectal abnormalities. It should also differentiate between urge, passive or functional incontinence. Objective evidence should be obtained using a week-long bowel diary using the Bristol Stool scale (Figure 1). Consideration of diet and fluid consumption should be noted, along with which medication is prescribed and or bought over the counter. Cognition and mobility status are also important factors. Aside from a digital rectal examination, investigations may include a plain film X-ray to rule out impaction, stool cultures, or faecal immunochemical tests (FIT).

Specialist diagnostic centres may perform endo-anal ultrasound,








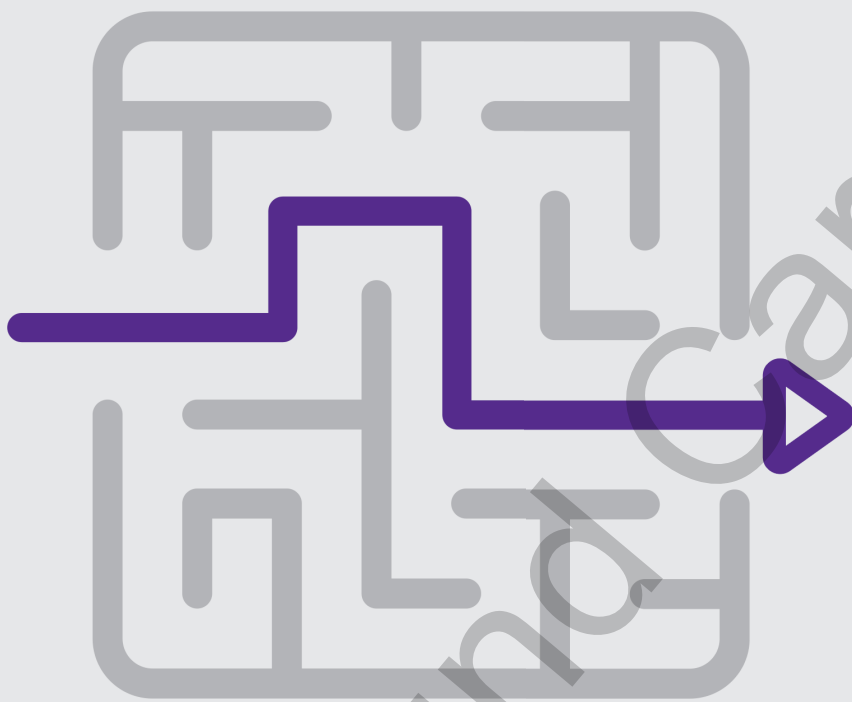
Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces Entirely liquid

Figure 1. Bristol stool chart.

# GUIDANCE CHOICE STRUCTURE



*"Is not biased to any one system approach; this is about getting transanal irrigation right for the patient and optimising their bowel independence and management" - Nurse*

The decision guide is a five-step approach, developed by experts, to guide you through your decision making when initiating rectal irrigation. It includes:

- ✓ Assessment for appropriate selection
- ✓ Choosing the optimal equipment and volume of water for any bowel condition, including Low Anterior Resection Syndrome (LARS)
- ✓ Valuable training for safe and effective use

**It includes assessment with continued use of medication in conjunction with rectal irrigation.**

Emmanuel A, Collins B, Henderson M, Lewis L, Stackhouse K (2019) Development of a Decision Guide for transanal irrigation in bowel disorders. *Gastrointestinal Nursing*, 17(7): 24-30

which assesses the anatomy of the anal canal to look for structural and or sphincter abnormalities and offer biofeedback. Biofeedback consists of anal exercises and manometry. Norton and Cody (2012) found biofeedback using computer equipment or rectal balloon to be more beneficial than exercises alone. Anorectal manometry allows the assessment of resting and squeeze anal pressures, which represent the function of the external and internal anal sphincters.

According to NICE in their clinical guideline of 2007, multiple randomised controlled trials (RCTs) using biofeedback have elicited few statistically significant results. Despite clear guidance, a national audit looking at adherence to national guidance showed clear deficits in the diagnosis and management of adults with FI (Harari et al, 2014).

The diagnostic criteria for FI were made more restrictive in the latest Rome IV questionnaire, and a large virtual study of nearly 6,000 adults in three countries by Whitehead et al (2020) showed that this dramatically affected prevalence rates. They concluded that regardless of the frequency of FI, impact on quality of life was the same. This was echoed in another study in 2017 by Helewa et al, who measured success in improvement in quality of life, not a reduction in incontinence episodes.

## MANAGEMENT

There may be many specialists involved in treating patients with FI, including bladder and bowel teams, surgeons, physiotherapists and specialist units. Ultimately, the aim

of treatment is to improve subjective symptoms and quality of life. Once any red flags have been ruled out and a cause found, a management or care plan should be created with the patient.

In the author's clinical experience, initial management should aim to regularise stool frequency and consistency and maintain skin integrity and personal hygiene. Reversible factors, such as toilet access, toileting programmes, or medication side-effects, should be addressed. Management strategies in FI should start with conservative management, including lifestyle and behavioural interventions (Norton et al, 2010).

In the author's experience, controlled bowel movements with suppositories can improve continence in bedbound patients who are unable to be toileted. If this fails to improve and/or cure, pharmacological and then surgical management options should be considered. Lifestyle interventions include avoiding osmotic agents, e.g. fatty foods, artificial sweeteners and caffeine (Shaw and Wagg, 2016).

Herbert (2019) outlines several first-line conservative approaches aside from pelvic floor muscle training (PFMT) that can be used, including patient education about how the bowel functions, bowel habit training, advice about diet and eating pattern changes and dietary fibre supplements, and the use of medications such as loperamide to firm the stool.

Where available, containment products should be provided for the patient's dignity and they should be advised on coping strategies, such as locating toilets, carrying spare clothes and cleansing kits. Pelvic floor muscle training has been widely researched in relation to urinary incontinence, but less so in the case of FI. A Cochrane review in 2012 of biofeedback and/or sphincter exercises to treat FI concluded that the limited number of trials did not elicit a definitive outcome of their role in treating FI (Norton and Cody, 2012). This was also found to be the

case in a more recent review in 2020 of pre and post-natal FI (Woodley et al, 2020). Despite this, in the author's clinical experience, PFMT is widely suggested in the literature as a conservative treatment.

Medications for FI do not treat the underlying cause, they merely alter the stool consistency to reduce the risk of incontinence. In 2002, Cheetham et al published a Cochrane review of drug treatments for FI comparing randomised trials available at the time. They found that most of the included trials rather than looking at faecal incontinence, focused on the treatment of diarrhoea and called for more rigorous trials in patients with FI, not necessarily associated with diarrhoea. They found little evidence with which to assess the use of pharmacological preparations for the management of faecal incontinence.

Omar and Alexander (2013) published a later Cochrane review of drug treatments for use in the management of FI and found again there was limited evidence that anti-diarrhoeal drugs, such as loperamide, and drugs that enhance anal sphincter tone, such as sodium valproate, reduce faecal incontinence in patients with liquid stools. Moreover, loperamide was found to be associated with significant side-effects, such as headache and abdominal pain. The review found the study sample sizes to be small and called for larger and more rigorous trials.

The synthetic opioid, loperamide hydrochloride, has been shown to be more effective than placebo at controlling FI episodes (Omar and Alexander, 2013), but if the side-effects of loperamide are intolerable, patients should be offered codeine phosphate or co-phenotrope (NICE, 2007). Some patients will be sensitive to the sedative side-effects of the opioid codeine. The active ingredient of co-phenotrope, diphenoxylate, shares the same side-effect profile as loperamide and should be used in caution due to the potential effects on the central nervous system (Ede, 2014). Other studies have found the use of synthetic fibre gives similar results in terms of firming stools,

### Red flag symptoms

Red flag signs suggestive of bowel cancer require urgent investigation. These include:

- ▶ Unexplained weight loss
- ▶ Nausea
- ▶ Recent and persistent change in bowel habit
- ▶ Abdominal pain
- ▶ Anorexia.

(NICE, 2011)

with less constipating side-effects compared to loperamide (Markland et al, 2015). Synthetic fibre can be helpful for patients whose dietary fibre intake is low.

Skin care and hygiene are important factors for patients with FI, with containment products, barrier creams and sprays being crucial for dignity and skin protection. Anal plugs have been on prescription for many years and studies as far back as 1991 have found that their use stopped FI in 82% of the periods during which the plug was in place (Mortensen and Humphreys, 1991). Anal plugs provide a barrier to prevent stool leakage and, if there is no rectal sensation, are well tolerated (Norton and Kamm, 2001).

Newer inserts sit in the anal canal rather than the rectum, thus they do not mimic stool which can cause anorectal discomfort and irritation. A recent review paper by How et al (2021) found that, when tolerated, anal inserts significantly improved continence, quality of life and in some cases bowel function. They highlight the need for longer term studies to assess compliance.

Should these conservative measures fail, transanal irrigation (TAI) is the next non-surgical intervention to aim to cure according to a best practice consensus review of transanal irrigation in adults (Emmanuel et al, 2013). There are several TAI kits on prescription, i.e. Peristeen® (Coloplast, which is supported by NICE guidance [2018]). During TAI, water is instilled into the rectum using a lubricated cone or rectal catheter. This facilitates emptying of the recto-sigmoid, with some studies showing the whole of the descending colon being cleared of stool. One of the first academic papers on TAI published by Christensen et al in 2003 proved this with scintigraphic assessment.

Mekhael et al's (2021) systematic review looked at the clinical effectiveness of TAI in patients with neurogenic bowel disease, faecal incontinence, constipation or low anterior resection syndrome. It found TAI to be beneficial in terms of

relieving FI and improving quality of life, but the authors acknowledged that a limitation to the studies reviewed was the missing reporting of clinical significance.

Patients may need assistance to perform TAI if unable to do so independently, and healthcare professionals should be competent to assess suitability, teach and monitor compliance and effectiveness. Community nursing teams, however, can often be too stretched to take on this role, even though it takes only 15 minutes approximately. In the author's experience, most care agencies will decline to perform TAI, but are often needed to assist community nursing teams with hoist transfers etc, and therefore coordinating visits can be challenging. Specialist carers looking after tetraplegic clients will usually be competent in all aspects of bowel care, including irrigation. Emmanuel et al (2013) reported that it can take up to 12 weeks to establish an effective irrigation regimen. Supporting the patient through the early stages of TAI is crucial, as there can be high discontinuation rates of up to one-third of patients (Juul and Christensen, 2017).

More recent innovation in the gastroenterology world is the use of probiotics, the composition of gut microbiota, and how it influences those with neurogenic bowel dysfunction (NBD). A 2021 systematic review by Faber et al found that most of the 14 studies excluded aspects such as diet and antibiotic use, and only a few studies assessed the gut microbiota. They concluded that more research is needed in larger data sets with multiple samples taken over a prolonged period of time to assess how microbial composition alters, and how changes in diet, bowel function and antibiotic use affects this.

Sacral neuromodulation (SNM), the stimulation of the S2–S3 nerve root, can be achieved via the sacral nerve or peripherally via the tibial nerve. There are limited studies in its use in the management of FI, as most have focused on the bladder. A

landmark multi-centre prospective study of 120 patients by Wexner et al (2010) who were treated with SNS found it to be effective and safe. Forty percent of patients achieved complete continence, and FI episodes decreased from nine to two per week. A more recent study looking at long-term outcomes reported a sustained response to SNS (Varghese et al, 2020).

Posterior tibial nerve stimulation (PTNS) is electrical stimulation of the tibial nerve at the ankle. Randomised controlled studies have shown that for some patients who have not responded to conservative treatment, there is a modest benefit (Ferri-Morales, 2018).

Surgical interventions are second line. These include sphincteroplasty and the creation of an artificial anal sphincter. However, while initial continence is achieved, results worsen over time (Glasgow and Lowry, 2012). As a last resort, formation of a colostomy or ileostomy can be a reasonable option for symptoms of FI, as the procedure reduces time spent with bowel care and can provide independence, improving quality of life for patients (Preziosi et al, 2018).

## IMPACT ON THE PATIENT

The All-Party Parliamentary Group for Continence Care in 2011 stressed how crucial it is to reduce the negative impact and improve quality of life for patients with bladder and bowel dysfunction.

Continence care has been under scrutiny for many years. Last year, it was highlighted by the Pelvic Floor Society that across the UK patients are presented with an inequality of access to care resulting from the patchy nature of services for continence and functional pelvic conditions — thus, there is work to do here.

Some studies have found that up to 50% of patients do not disclose their FI with anyone, not even a close relative, let alone a healthcare professional (Bharucha et al, 2005). Feelings of shame, repulsion, embarrassment, and in some cases,

denial, are common. To understand why a patient would suffer for so long in silence, it is important to consider how belief systems create a barrier and delay in patients seeking help and explore the research in terms of patient-centred care for patients with FI.

According to Cichowski et al (2014), patient-centred care can be defined as care that considers the patient's preferences, needs, and values and ensures that patient values guide all clinical decisions. Driven by the *NHS Five Year Forward View*, NHS England (2014) has made a commitment to improving patient-centred care through involving patients and giving them the power to manage their own health and allowing them to make informed decisions about their care and treatment, relying on healthcare professionals to work collaboratively with patients who use the services. Thus, in practicing patient-centred care with patients with FI, it is vital to consider the implementation of management strategies from the patient's point of view, as well as the healthcare professional's clinical point of view.

Barriers to patients seeking treatment for FI have been identified consistently in the literature, including gender, ethnicity, culture, understanding of illness, health, financial status, psychology and personal experience of healthcare provision (Rizk, 2017). Many surveys have shown that several years will pass before patients admit they are suffering with FI to a healthcare professional, sometimes because they think it is a normal part of ageing or are too embarrassed and do not know what treatments are available (Taylor et al, 2014). Interestingly, Taylor et al's (2014) small pilot of care home residents with FI found 80% did not think of themselves as being incontinent, as if that word only applied to bladder leakage.

In the case of the frail and elderly population in nursing or care homes, FI is often accepted as a normal part of the ageing process and not seen as a chronic long-term condition. As Norton et al (2010) state, FI

in this group is socially isolating and associated with increased dependency, morbidity and mortality. Frailty, described as having multiple chronic illnesses and physical limitations, is itself a risk factor for FI.

Dementia is known to have a negative impact on sphincter control. A 62-paper synthesis of the evidence of how FI should be managed in people with dementia in care homes was published in 2017 by Goodman et al. They concluded that dementia was a well-known risk factor for FI, yet staff working with patients with FI lacked the skills and knowledge needed to improve and manage the condition. They stressed the importance of care home staff understanding their responsibilities with regard to intimate and personal care, and the challenges continence aids can bring. In the author's clinical opinion, the concept of patient-centred care with clinician-led assessment from general practitioner's, community nurses, matrons or bladder and bowel teams is vital to reduce FI in this patient group.

Studies have also looked at the way screening for FI is performed or not, citing lack of physician knowledge as an issue alongside patients not wanting to discuss their FI face to face, preferring to use questionnaires (Brown et al, 2018). A small qualitative study conducted by Brown et al in 2017 found 12 barriers to seeking help when suffering with FI, including lack of knowledge of the condition, its treatments, denial, fear of tests and provider barriers. Many similar barriers are found in patients with urinary incontinence, but a common theme in the study was a lack of knowledge that many others suffer with FI too, highlighting the sense of isolation people with FI can feel.

## CONCLUSION

Although treatments and strategies exist for FI, systematic reviews agree that there is no consensus on the best treatment strategy, with RCTs producing contradictory results and many finding no significant differences between treatments

## Practice point

Developing a relationship with the patient, educating and motivating them to aid concordance with conservative measures is key.

(Lal et al, 2019). According to Lal et al (2019), there is an element of placebo effect in the treatments for FI. The outcome of another systematic review concluded that to permit comparison between FI treatments, it is imperative to standardise the inclusion criteria, methodology, follow-up period, and outcome measures across studies in the field (Simillis et al, 2019). Bliss et al (2017) called for more awareness of FI, citing a lag compared to other long-term conditions. By doing so, it could reduce the stigma and isolation which so many patients feel.

Healthcare professionals should be skilled in assessment and management of FI and have the knowledge to know when to refer on. Patients with FI should be supported with self-management tools. It is important that healthcare professionals help patients to make decisions, set goals, start and modify treatment options and thus empower them to improve their condition. Much of the research focuses on the reduction of the physical symptoms of FI and fails to highlight its psychological impact on the patient.

The concept of patient-centred care with clinician-led assessment from general practitioner's, community nurses, matrons or bladder and bowel teams is vital to reduce FI, particularly for those with frailty or dementia. The same multidisciplinary approach must also apply to acute trusts.

The stigma of faecal incontinence needs to be replaced with well-researched treatment options delivered with compassion, empathy and respect. **JCN**

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## KEY POINTS

- Faecal incontinence (FI) has a huge impact on patient's quality of life. It can lead to feelings of shame and degradation and affect relationships, self esteem and body image. It's causes are multi-factorial but so much can be done to improve or cure this embarrassing symptom.
- Despite a plethora of management options, some bladder and bowel nurses feel inadequately trained to manage FI.
- It is important that healthcare professionals help patients to make decisions, set goals, start and modify treatment options and thus empower them to improve their condition.
- The stigma of faecal incontinence needs to be replaced with well-researched treatment options delivered with compassion, empathy and respect.

# Dementia and end of life: providing good quality palliative care

Karen Harrison Dening, Zena Aldridge

Dementia has not traditionally been conceptualised as a terminal or life-limiting condition. Yet, dementia can significantly reduce a person's survival time from the onset of symptoms and has been shown to be similar to that of some cancers. Alongside this, with the growing number of cases of dementia expected over the coming decades, we can also expect to see the number of people dying with or from dementia increasing. Supporting good quality palliative care for people with dementia will be required by all clinicians in all care settings. This final paper in the series follows the case studies of two people with dementia as they reach the end of their lives.

## KEYWORDS:

■ Dementia ■ Palliative care ■ End-of-life care ■ Support

The population of the UK, as with other developed nations, is ageing. Estimates show that in 50 years' time, there are likely to be an additional 8.6 million people aged 65 years and over living in the UK (Office for National Statistics [ONS], 2018a). The increased ageing and morbidity of our population is driven by several factors. Improvements in life expectancy where the number of deaths in early life from infectious disease has decreased and the management of other conditions has improved, such as cardiovascular disease (ONS, 2018b). Treatment and survival rates of some cancers is

**'... people with advanced dementia suffer a range of symptoms, similar to those found in the terminal stages of cancer. For example, pain and dyspnoea, pressure ulcers, agitation, and eating problems are very common as the end of life approaches, but are often poorly assessed and managed.'**

improving, thus a higher proportion of the world's population is living to old age. This has led to an increase in the numbers of people living long enough to develop the multiple comorbidities associated with old age, in particular neurodegenerative diseases such as dementia (Sampson and Harrison Dening, 2021) and many of these will have pain as one of their most significant symptoms (Litchner et al, 2016).

## DYING WITH AND FROM DEMENTIA

Dementia has not traditionally been conceptualised as a 'terminal' or

'life-limiting' syndrome. However, Xie et al (2008) reported a median survival time from symptom onset of dementia to death of 4.5 years following analysis of a longitudinal population-based cohort study, concluding that one in three people (30%) over the age of 65 years will die with, or from dementia.

Similarly, Rait et al (2010) found that the median survival time from the diagnosis of dementia was 3.5 years. However, with a median survival time of 1.3 years, advanced dementia (as defined by a Functional Assessment Staging Tool [FAST] [Reisberg, 1988] score of 7c and higher) is associated with a life-expectancy similar to that of well-recognised terminal diseases such as metastatic breast cancer (Mitchell et al, 2009). Similarly, people with advanced dementia suffer a range of symptoms, similar to those found in the terminal stages of cancer. For example, pain and dyspnoea, pressure ulcers, agitation, and eating problems are very common as the end of life approaches, but are often poorly assessed and managed (Sampson and Harrison Dening, 2021).

## RECOGNISING WHEN A PERSON WITH DEMENTIA IS DYING

Identifying when a person with dementia is reaching the end of their life can be challenging. Numerous studies have attempted to identify prognostic indicators or indices that may guide clinicians in adopting a more palliative approach to care, but these tools are more reliable at identifying people with dementia at low risk of dying rather than those at higher risk of death (van der Steen et al, 2005; Sampson and Harrison Dening, 2021). Clinical judgment, discussion with families and carers, and taking the opportunity

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

to reassess, or shift the goals of management towards palliative care at times of intercurrent illness (such as pneumonia, urinary tract infections [UTIs], etc.), or transitions in care may be a more practical and reliable approach (van der Steen, 2010). It is essential to consider that people can both die with or from dementia. Some people may have dementia and no other conditions, yet others will have other multiple conditions in addition to their dementia, such as cancer or heart failure, that may be the primary cause of any decline and subsequent death (Sampson and Harrison Dening, 2021). Van der Steen et al (2014) undertook a Delphi study of experts in the field of dementia and palliative care to develop a set of recommendations for optimal palliative care in older people with dementia.

This paper will now consider the palliative and end-of-life care needs of families affected by dementia through the lens of the two ongoing case studies in this series. Previous articles follow the stories of Dhriti Singh and Gregory Brewin (Harrison Dening and Aldridge, 2021a; 2021b; 2021c; Aldridge and Harrison Dening, 2021a; 2021b; 2022).

### PATIENT STORY ONE: DHRITI SINGH

A systematic review conducted by Shepherd et al (2019) found that people with dementia were at 1.42 times higher risk of being admitted to hospital compared to those without dementia, with those at highest risk being those people with dementia who were older and living with physical comorbidities. A hospital admission for a person with dementia can be both confusing and distressing; they are very hectic and noisy places at the best of times and not an ideal environment for anyone with a cognitive impairment. People with dementia who are admitted to hospital have a known higher risk compared to those without dementia or cognitive impairment of:

- ▶ Developing delirium
- ▶ Functional decline
- ▶ Fall-related injuries
- ▶ Hospital-acquired infections
- ▶ Mortality

Dhriti Singh is now 67 years old and was diagnosed with vascular dementia eight years ago. She also has heart failure and hypertension and is now incontinent of both urine and faeces. Thus far, her husband Arjun has been her main carer, with the support of paid carers who visit their home four times a day across the entire week to help him provide personal care to Dhriti. Dhriti and Arjun have three adult children who have, over the years of their mother's dementia, slowly and incrementally increased their support to their father in caring for their mother. The family's aim has been to care for Dhriti in her own home for as long as possible.

### Patient story one

Two years ago their youngest daughter, Prisha, moved into the family home and gave up her job as a nurse to provide care for her mother who, they were told by her GP, was approaching the end stages of dementia. However, she is concerned that she has spent so long out of the nursing workforce now that she may be unemployable.

Arjun can no longer hold a conversation with Dhriti as she rarely speaks, only uttering small grunting noises when moved, and rarely opening her eyes. Arjun is very distressed witnessing the deterioration in his wife. In the last six months, Dhriti has had pneumonia twice, each time resulting in a hospital admission which caused her and the family a great deal of distress. Arjun has asked the GP if they can avoid any further hospital admissions.

- ▶ Longer length of stay
- ▶ Reduced quality of life (Fogg et al, 2017; Afonso-Argilés et al, 2020).

There is evidence to suggest that acute physical illness requiring emergency hospital admission, such as pneumonia or UTIs, may be an indicator that a person with advanced dementia is approaching the end of their life (Sampson and Harrison Dening, 2021). Moreover, there is a lack of evidence to suggest that many active medical interventions, for example, artificial hydration and nutrition (Davies et al, 2021), or hospital admission (Sampson et al, 2009) prolong or improve the quality of life in people with advanced dementia (van der Steen, 2010). It is therefore understandable that Arjun is starting to question the purpose and benefits of a hospital admission in his wife's case. In response to these issues, there is increasing interest in how a palliative approach may be beneficial for frail older people with advanced dementia (Livingston et al, 2017).

### Palliative care in dementia

The World Health Organization (WHO, 2016) defines palliative care as:

*An approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment of physical, psychosocial and spiritual symptoms and in their treatment.*

(Gomez- Batiste et al, 2007)

The European Association of Palliative Care (EAPC) published a consensus statement defining the principles of palliative care for people diagnosed with dementia (van der Steen et al, 2014). While the many definitions of palliative care share a common philosophy, a central goal is to maintain the quality of life and so also the quality of dying and the concept of a good death (Read and MacBride-Stewart, 2018). Clearly, Arjun's priority now is

to maintain his wife’s quality of life, although she is dying, by avoiding any undue distress.

It is important that we consider the goals of care for Dhriti, who is in the advanced stages of dementia, and weigh up the costs and benefits of any treatments. As discussed earlier, although it is difficult to prognosticate when a person is dying with dementia, there are signs which are indicative of the final stages of life. Reisberg (1988) suggests that the advanced stage of dementia can be identified by a person presenting with features of stage 7 on the FAST scale — the person with dementia cannot dress themselves, is doubly incontinent, and speaks at most only a few words (Table 1).

*The Gold Standard Framework Proactive Identification Guidance* (PIG) (Thomas et al, 2016) advises clinicians to ask themselves the ‘surprise question’ – ‘for patients with advanced disease or progressive life-limiting conditions, would you be surprised if the patient were to die in the next year, months, weeks, days?’ An understanding of a person’s presentation on the FAST scale (Reisberg, 1988) or the Gold Standards Framework (PIG) (Thomas et al, 2016) could be helpful in determining their goals of care and to facilitate communication and understanding about serious illness with families, such as Arjun and his children (Secunda et al, 2020).

However, there are some signs and symptoms that might require further consideration, rather than

### Reflective points

Would you be surprised if Dhriti was to die in the next year, months, weeks, days? Using the GSF PIG, how would you record the signs and symptoms Dhriti is displaying? As noted in the case study, how might you assess the significance of Dhriti’s grunting response to when she is being moved? What support and information might you offer to Arjun and Prisha about Dhriti’s stage of illness?

**Table 1: Functional assessment staging tool (adapted from Reisberg, 1988)**

Stage 1	▶ No difficulty either subjectively or objectively
Stage 2	▶ Complains of forgetting location of objects. Subjective work difficulties
Stage 3	▶ Decreased job functioning evident to co-workers. Difficulty in travelling to new locations. Decreased organisational capacity
Stage 4	▶ Decreased ability to perform complex tasks (e.g. planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc)
Stage 5	▶ Requires assistance in choosing proper clothing to wear for the day, season or occasion (e.g. may wear same clothing repeatedly)
Stage 6	▶ 6a Difficulty in putting clothes on properly without assistance ▶ 6b Unable to bath without assistance ▶ 6c Inability to handle mechanics of toileting ▶ 6d Urinary incontinence, occasional or more frequent ▶ 6e Faecal incontinence, occasional or more frequent
Stage 7	▶ 7a Ability to speak is limited to approximately six intelligible words or fewer ▶ 7b Speech is limited to the use of a single intelligible word in an average day ▶ 7c Ambulatory ability is lost (cannot walk without personal assistance) ▶ 7d Cannot sit up without assistance ▶ 7e Loss of ability to smile ▶ 7f Loss of ability to hold up head independently

simply determining a score on a measure. Arjun notes that Dhriti makes a grunting noise when being moved during care interventions. This may not be an automatic response, but due to pain and discomfort so require specific assessment for pain using an appropriate behavioural pain assessment tool, such as the Abbey (Abbey et al, 2004) or Pain Assessment in Advanced Dementia Scale (PAINAD) (Warden et al, 2003) measures.

The overall and declining functioning of the person with dementia as end-of-life approaches can lead to high levels of carer burden (Boogaard et al. 2019; Cohen-Mansfield and Brill 2020; Mo et al, 2021). Thus, as well as good care for the dying person, it is crucial to support family members.

### PATIENT STORY TWO: GREGORY BREWIN

People with dementia often have a range of other comorbidities (Aldridge and Harrison Denning, 2021a), including frailty. Frailty is found in 25–50% of people over 85 years of age and is associated with increased vulnerability to physiological stressors (Clegg et al, 2013). Frailty has been defined as a distinctive health state related to the ageing process in which

multiple body systems gradually lose their in-built reserves (Turner, 2014), and can also be considered to have a life-limiting effect (Clegg et al, 2013). Some of the risk factors for developing frailty are similar to those for dementia, such as, smoking, obesity, lack of physical activity, depression and increased age (Sampson and Harrison Denning, 2021).

There is a sequential association between frailty and increased risk of developing cognitive impairment. Furthermore, increased frailty will accelerate cognitive decline in those with dementia (Clegg et al, 2013), and thus have the effect of a downward spiral. As we can see in Gregory’s case, he was not considered to be in the very advanced stages of dementia, but his health status was compounded by frailty.

The presence of frailty is associated with poor health outcomes, yet there is often a lack of understanding that adverse events such as falls or infections can trigger disproportionately negative changes and decline in the health status of frail residents due to their lack of homeostatic resilience (Clegg et al, 2013; Barclay et al, 2014; Clegg et al, 2015). As a result, being frail can lead to increased risk of unplanned

Patient story two

Gregory Brewin has a mixed diagnosis of Alzheimer’s and vascular dementia. Through the support of his sons, James and Ian, and a close neighbour and friend, Brenda, Gregory was able to continue living in his own home for several years. The local community and primary care services continued to monitor his comorbid conditions of diabetes and chronic obstructive pulmonary disease (COPD). Gregory’s GP had recently carried out his annual health check and considered Gregory to be in the moderate to advanced stage of dementia. However, Gregory developed acute breathlessness and was admitted to the acute hospital and from there he was transferred into a care home as it was felt that he was now unable to live alone. During the admission, he was assessed and diagnosed with frailty.

As James and Ian both held Lasting Power of Attorney for their father, it was agreed that Gregory’s home would be sold as it was considered impossible for him to return. Gregory adapted well to the care home life, despite his sons’ misgivings. However, Gregory’s GP advised them that given their father’s multimorbidity and advancing dementia he would not have long to live.

hospital admissions, morbidity, and mortality (Turner and Clegg 2014; WHO, 2016).

As was the case for Dhriti and her family, it is important for healthcare professionals to be able to consider the goals of care for Gregory and discuss these with his family. The GP has recognised that Gregory is approaching the end of his life but, similar to prognostication for people with dementia, there are challenges in identifying a deteriorating frail patient. In Gregory’s case, as well as considering the FAST scale (Reisberg, 1988), and Gold Standard Framework PIG (Thomas et al, 2016), the Clinical Frailty Scale can be used to stage frailty in people with or without dementia (Rockwood et al, 2005).

although there are some prognostic indicators and guides to help clinicians.

People dying with dementia can often have complex physical and mental health needs that require impeccable assessment, not just of their physical symptoms, but also their spiritual and emotional needs. Furthermore, families and carers of people with dementia and the staff that work with them, in a range of settings from community to the acute hospital, need support and guidance. An holistic, family-centred approach, in keeping with the core values of palliative care, is required to provide good quality end-of-life care, comparable to other conditions for frail, older people who are dying with or from dementia to reduce current inequalities. **JCN**

CONCLUSION

Determining when a person with dementia is dying is not easy,

Reflective points

- Consider patients on your caseload — what proportion might have both dementia and frailty?
- What support and information might you offer to Gregory’s two sons, James and Ian, about his illnesses?

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KEY POINTS

- Identifying when a person with dementia is reaching the end of their life can be challenging.
- The overall and declining functioning of the person with dementia as end of life approaches can lead to high levels of carer burden.
- Families and carers of people with dementia and the staff that work with them need support and guidance.
- An holistic, family-centred approach is required to provide good quality end-of-life care for frail, older people who are dying with or from dementia to reduce current inequalities.

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Useful resources

- ▶ **Abbey Pain Scale available online:** [www.apsoc.org.au/PDF/Publications/APS\\_Pain-in-RACF-2\\_Abbey\\_Pain\\_Scale.pdf](http://www.apsoc.org.au/PDF/Publications/APS_Pain-in-RACF-2_Abbey_Pain_Scale.pdf)
- ▶ **Clinical Frailty scale — available online:** <https://bit.ly/3tfe9hS>
- ▶ **Toolkit for general practice in supporting older people living with frailty — available online:** [www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty-1.pdf](http://www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty-1.pdf)
- ▶ **Pain Assessment in Advanced Dementia Scale (PAINAD) — available online:** <https://geriatrictoolkit.missouri.edu/cog/painad.pdf>

# Reflections on the changing face of community nursing

*Community nursing is a crucial part of the UK's healthcare system. In the future, the NHS wants more patients to be treated in the community and outside a traditional hospital setting, which will see community and district nurses playing an increasingly vital role. Here, Bridget Kearns, district nursing sister/advanced nurse practitioner (ANP), Northamptonshire Healthcare NHS Foundation Trust, looks at and dispels the many myths still surrounding community nursing, so as to encourage and attract more community nurses.*

The 'NHS Long Term Plan' outlines how the NHS plans to cope with the growing pressures on primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health professionals and social care staff (NHS England, 2019).

New expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes.

This commitment — an NHS 'first' — creates a ring-fenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24 (NHS England, 2019).

But, just as in other parts of the NHS, there is a shortage of community nurses. A report published in December 2020 from the Health Foundation shows a decade of decline in the number of specialist mental health, community and learning disability nurses — which the authors say will make recovering from the Covid-19 pandemic particularly challenging (Royal College of Nursing [RCN], 2020).

*Northamptonshire Healthcare NHS Foundation Trust is part of the 'Best of Both Worlds' recruitment campaign that brings together the University of Northampton, Northamptonshire Healthcare NHS Foundation Trust, Northampton General Hospital, Kettering General Hospital (KGH), St Andrew's Healthcare and Northants GP and aims to recruit nurses, doctors and healthcare professionals to live and work in Northamptonshire.*

**'New expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes.'**

While overall nursing numbers have risen by 8% since 2010, the number of health visitors and nurses working in community nursing, mental health and learning disability services are all lower than in June 2010 (RCN, 2020).

The number of mental health nurses dropped by 8% in the 10 years to June 2020, health visitors dropped by 15%, there was a 12% drop in the number of community health nurses and a 39% fall in learning disability nurses (RCN, 2020).

The author works for Northamptonshire Healthcare NHS Foundation Trust (NHFT), which provides NHS community and mental health care services, and is trying to address this and encourage younger nurses into the profession. Most of the team are under 40, with many newly qualified nurses coming straight from university.

The trust is keen to change the perception that community nursing is for older nurses looking to slow down, or that community nurses do not have the high skill set needed in an acute hospital setting. Indeed, this could not be further from the truth in the author's experience.

## CHANGING PERCEPTIONS — THE AUTHOR'S EXPERIENCE

I'm 54-years-old and qualified as a nurse in 1987. I was inspired by my grandmother, who had been a district nurse in Kettering. I remember being taken in the back of her car when she went on her community rounds, and I developed a passion for nursing at a young age.

But, it wasn't until I returned to nursing in 1998, having taken time off to get married and start a family that I decided to become a community nurse. I did my return to practice qualification and needed to find a nursing role which I could fit around child care.

I found a nursing opportunity where I could work 20 hours a week at what later became NHFT, which I thought sounded ideal to work around family life. I've been there ever since.

One of the best things about working for NHFT is that it is supportive and encourages professional development. When I first joined, I completed a conversion course to become a staff nurse, and later I did the DNSPQ (district nurse specialist practitioner qualification) to become a band 7 district nurse.

This degree level course combined academic study at the University of Northampton with practical learning within NHFT's district nursing teams. I then did a prescribing course to become an independent nurse prescriber.

As a band 7 district nurse/advanced nurse practitioner (ANP)



my role is slightly unusual because I still get to spend a great deal of time with patients, as well as doing managerial tasks. For me, this is important, as I originally went into nursing to care for people and want to continue doing this.

Some nurses can be put off progressing to senior roles because they believe that they will spend less time caring for patients. Luckily at NHFT this is not the case, and we still get to be hands-on. I have quite a large caseload and spend most of my time with patients. But, I'm also the clinical lead for advice and guidance for the rest of the team.

During my time as a district nurse, the perceptions about the role have changed. Community nursing is no longer seen as a place for nurses returning to practice or who are nearing retirement. The role comes with a great deal of responsibility and requires skills for prescribing and delivering intravenous (IV) care. This would not have been the case in the past.

## SKILLS TO TREAT COMPLEX HEALTH NEEDS

Community nurses are a highly skilled workforce which is taking on more roles that would previously have been handled by GPs and other services. For example, the management of long-term conditions and peripheral central lines, such as peripherally inserted central catheters (PICCs) for patients having long-term IV antibiotics or chemotherapy. The author's trust also runs a weekly catheter and PICC clinic for non-housebound patients, as these services are not provided by their GP surgery.

Increasingly, younger nurses are coming into community nursing. Many are surprised by the range of clinical skills needed to deliver the services to meet patients' needs. It is demanding work where many different skills are required as patients often have complex health issues and so community nurses need to have confidence in their abilities because of the degree of autonomy that they have.

The role is fast-paced and varied, and nurses need to have confidence to work independently as they go into patients' homes alone. Although they always have support of the team, when they are in someone's home, they are on their own, unlike in a hospital setting.

## COVID-19 PANDEMIC

The pandemic has shone a spotlight on nursing, and attracted more people into the profession. The number of people applying for nursing courses has risen by almost a third (32%), according to statistics from the Universities and Colleges Admissions Service (BBC News, 2021).

In May 2021, the Queen's Nursing Institute (QNI) also said it is on track to see the 'largest' annual increase in district nurses across the UK since its records began (Ford, 2021). This is all positive news. But, the pandemic has also brought additional challenges.

Unlike many other NHS services, it was business as usual for all district nursing teams, but the author's caseload also increased due to other services pausing face-to-face appointments.

A good example of this in Northamptonshire was the setting up of a Care Home Task Force made up of community nursing staff from all localities across the county. This task force went into care homes who required additional nursing support to ensure that patients continued to receive appropriate treatments and assistance.

At the author's trust, many services, such as GPs and podiatry, had paused face-to-face appointments, so the community nursing caseload increased to cover extra wound care visits for podiatry patients, assessing unwell patients in residential homes, and being the link between the patient, their family and carers — thus demonstrating how community nurses came to the fore at this crucial time. It also highlights how important the service is, and how it

adapted to the changing healthcare landscape. Also, by raising the community nursing profile, it is hoped that more nurses will be encouraged into this area.

## ATTRACTING NEW GRADUATES

For nurses studying for their nursing degree, doing the community pathway can open their eyes to what the role entails. Shanice Fletcher, for example, is one of the community nursing sisters in the Corby and Kettering team. She began her nursing training at the University of Northampton in 2016 when she was 23 and graduated in 2019.

She started her job as a community nurse with the author's trust straight afterwards and was soon promoted to a band 6 sister in June 2020. Shanice had always wanted to be a nurse, but when her mother and grandfather were diagnosed with cancer, she was determined to pursue her dream.

She helped care for her mother and attended all her hospital appointments, so she got to see first-hand what nursing was like. However, it was not until university that she learnt more about community nursing. She did some placements in the community, which led her to choosing the community pathway in the third year at university.

Having decided on the community pathway, the university organised for her to do placements at NHFT in her final year. This resulted in her being offered a job eight months before she finished.

Shanice was attracted to community nursing because it is an autonomous role with a great deal of responsibility, while also working as part of a supportive team. She enjoys the variety of the job and building relationships with patients. She was surprised at first at the skill set required, and believes that often community nursing is seen as being easier and less skilful, although this is not the case.

In community nursing, there

are growing numbers of end-of-life and palliative care patients. The population is ageing and with age often comes ill health. Increasingly, these patients are being cared for in the community. Consequently, in the author's clinical opinion, nurses need more skills than they did before to deal with a wide variety of conditions.

Many of Shanice's caseload are end-of-life and palliative care patients, including some younger palliative care patients, ranging in age from 20 upwards, who can have complex care needs.

As well as dealing with the clinical side of their condition and ensuring that they have the right treatment, she also supports them psychologically. For younger people, this can mean helping them and their families come to terms with their diagnosis.

This can be challenging, but the community nursing team at NHFT support each other. Every fortnight there is a debrief meeting where they can talk about their cases and how they are coping. Shanice says they are a close-knit team and being able to share how they are feeling is helpful.

They also have time each day to hand over to ensure that they can safely manage their afternoon visits. From this, they can escalate up to senior management if they require more support.

Even in Shanice's short career to date, she has seen the role of a community nurse change significantly. When she first did her placements in 2016, the nurses did not take a laptop out with them. The morning was spent out with patients, and the afternoon back in the office writing up notes.

Now, nurses have laptops and can access all patient case histories. Furthermore, they can write up their clinical records while they are still with patients, which is a more efficient way of doing things. It has, however, meant that they are dealing with more patients.

In the author's clinical experience, whereas a few years ago the usual caseload would have been six or seven a day, now nurses are out most of the day and can see double that. On top of the scheduled visits, they may also receive emergency same-day call-outs which they need to prioritise first. This requires effective time management and leadership to ensure patient safety.

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**'Community nursing is evolving and is becoming an increasingly important part of the healthcare system in the UK. As a result, it offers nurses a truly rewarding career where "the sky is the limit" as regards progression.'**

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Also, Shanice says community nurses are no longer based in doctor's surgeries as area teams are now based in one office. This is great for teamwork; however, it has meant that they do not have such easy access to the GPs as before.

The view of the community nurse being an older person that wants to slow down and move out of acute nursing has changed in her time too. She is seeing community nursing getting younger, with more newly qualified nurses choosing to start their careers in the community.

## SUPPORTING COMMUNITY NURSES

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Like myself, Shanice has been fully supported to develop her skills and progress in her career. NHFT invested in her even before she joined, as during her final months at university they supported her to ensure that she had all the necessary skills and competencies ready for when she joined.

Shanice is currently doing her district nursing qualification, which she started in January 2021 and takes a year. Her career aspiration is to do her non-medical prescribing

course, with the hope of eventually becoming a band 7 district nurse.

For people choosing to start their nursing career with NHFT, all new starters are supported with a period of supernumerary and in-house training to develop all the clinical skills required, and there is ongoing support from the district nursing team to develop their competencies.

The author believes that community and district nursing is one of the most exciting and satisfying areas of nursing in which to work, especially with the NHS focusing on offering more care in the community and developing services.

It is an area where nurses can hone their skills in a fully supported environment. There are great opportunities for career advancement, as can be seen with NHFT, which actively encourages staff to do training and qualifications throughout their careers.

Community nursing is evolving and is becoming an increasingly important part of the healthcare system in the UK. As a result, it offers nurses a truly rewarding career where 'the sky is the limit' as regards progression. **JCN**

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