

How can community nurses improve their leadership skills?

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Hyperlocal recruitment key to future nursing pipeline

Role of male nurses: breaking down the stereotypes

Does digital healthcare revolutionise medical practice?

Supported self-care for venous leg ulcers: nicety or necessity?

Effects of chronic cough on urinary incontinence

Detecting frailty and unintentional weight loss

Recognising, assessing and managing pain in a person with dementia

Intermediate care for young, frail, marginalised patients

Mediterranean diet: what's all the hype?

Integrated and coordinated care: what it means

The time is now to keep children with asthma safe

SKIN CARE

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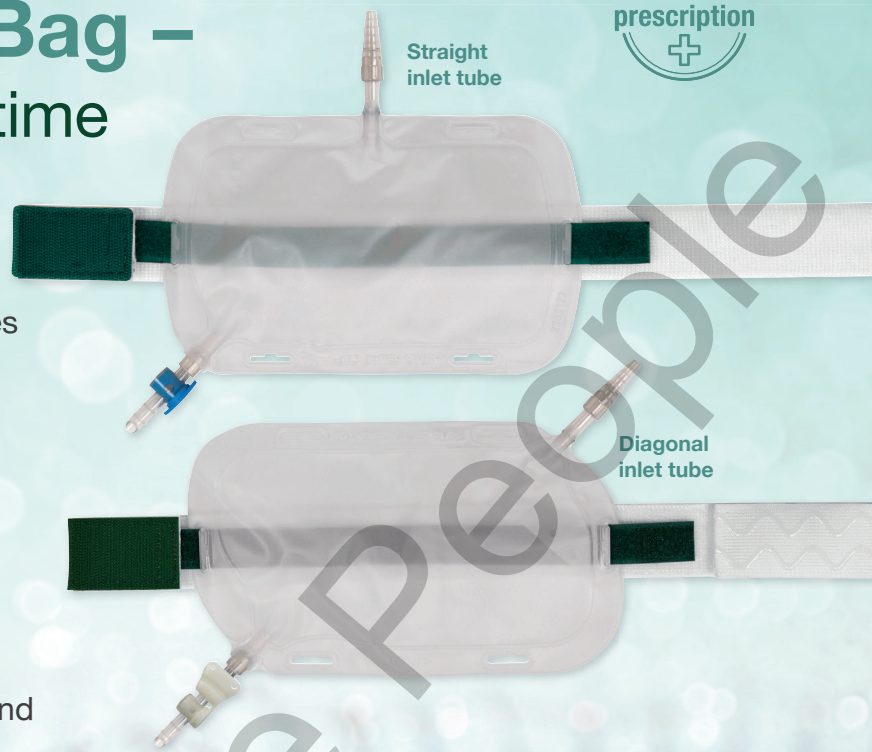


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Everyone has the potential to be a leader



On the 5th of July we celebrated 75 years of the NHS. It was an ideal opportunity for us all to reflect on how the NHS has evolved and adapted over the years, and to remember how fantastic and transformative the NHS really is. I hope that everyone celebrated in some way, and had the opportunity to attend some of the many events organised by the NHS and your places of employment. It is difficult to really comprehend how health care has changed since 1948, but I am so appreciative that it has and

of the advances and opportunities that it has brought us all. Similarly, it is also challenging to envisage the future and the sustainability of the NHS, although a key factor to this is leadership. Leadership within the community is discussed within our 'community matters' piece (pp. 8–12), and I would urge you all to read it and take some time to reflect on leadership within your own teams and your organisation. The culture of any organisation is significantly determined by its leaders and changing a culture takes time and a great deal of effort, but our teams need to have a culture that is compassionate, inclusive and collaborative. This is vital for us to move forward and face the forthcoming challenges within the NHS. It is necessary both to attract new staff and retain the staff we already have. Please remember that everyone can be a leader, no matter what your role.

It is always great to hear about new projects that are going on in our communities, such as the five gardens which nurses have developed as part of this year's National Garden Scheme (NGS) Elsie Wagg innovation scholarship programme. Community initiatives like this, developed in partnership with the Queen's Nursing Institute (QNI), have the potential to make a significant positive impact on local people's health and wellbeing (pp. 14–15). I was also heartened to read about the work going on in Leeds to provide intermediate care for the young, frail population experiencing homelessness who might be excluded from other areas of care — such community work is crucial for addressing health disparities and promoting social inclusion (pp. 51–54).

Here at JCN we are keen to support you in your day-to-day practice by covering a range of clinical areas within each issue to equip you with valuable information, gain new insights and improve understanding of health concerns. So, I hope that the diverse topics covered in this issue, such as chronic cough and its impact on continence, pain in people with dementia, why now is the time to be addressing asthma in children, as well as the benefits of the Mediterranean diet, to name but a few, go some way to help you provide the best possible care for your patients. I also hope that you get some time for yourselves over the summer — after all, it's important to prioritise your self-care and wellbeing too.

Annette Bades, editor-in-chief, JCN
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References: 1. Agren M (1990) Studies on Zinc in Wound Healing. Linköping University Medical Dissertations No. 320. Department of Pathology II, Faculty of Health Science, Linköping, Sweden. 2. Boyd AS (2010) Ichthammol revisited. Int J Dermatol 49: 757–60 3. Evolan Pharma AB (2020) Data on file. Danderyd, Sweden. 4. Gayko G, Cholcha W, Kietzmann M (2000) Anti-inflammatory, antibacterial and anti-mycotic effects of dark sulfonated shale oil (Ichthammol). Sonderdruck aus Berl. Munch. Tierarztl. Wochenschr. 113, Heft 10. 5. Kogan S, Sood A, Granick MS (2017) Zinc and wound healing: A review of zinc physiology and clinical applications. Wounds 29(4): 102–6 6. Lansdown ABG, Mirastschijski U, Stubbs N et al (2007) Zinc in wound healing: Theoretical, experimental, and clinical aspects. Wound Repair Regen 15: 2–16

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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 and an academic with a passion for end-of-life care, older people and nurse education. I believe that care at home gives people the best opportunity to remain in control of their own health and wellbeing. It is a privilege to be a guest in a person's house and to help them achieve their goals. It is also a privilege to train nurses of the future to adopt this personalised care approach to really make a difference. I am excited to join the editorial board of the JCN where I can see the hard work that community nurses undertake.
Amanda Young



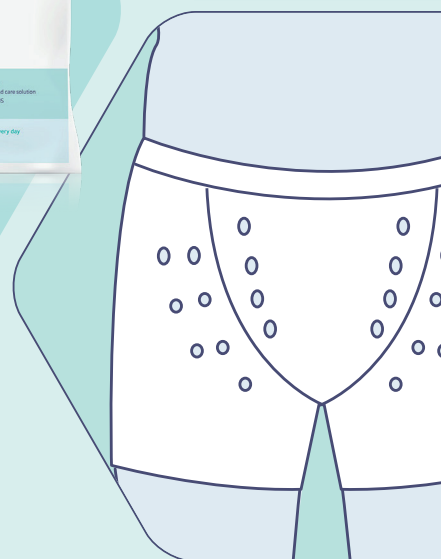
I am a freelance tissue viability nurse (TVN) and health visitor. My true passions are in pressure area care and moisture-associated skin damage. I sit as a registrant panel member on the NMC Fitness to Practice Hearings, and work with the Institute of Health Visiting (IHV), where I have recently supported 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 improve their leadership skills?

There have been many renowned leaders throughout history. Alexander the Great. Cleopatra. Winston Churchill. Liz Truss... OK, maybe the last one is a bit of a stretch, but many civilizations have been defined by a single inspirational leader who was able to bend circumstances to their will.

To a much lesser extent, the same is true in any workplace. Someone has to make decisions and drive strategies or ideas, otherwise nothing would get done. But what is it that makes a great leader? What qualities make people follow one person and not another?

In terms of healthcare where snap clinical decisions can often mean life or death, the ability to lead others is crucial. However, not all leadership comes from the top, and achieving goals can also be about inspiring others, not necessarily giving out orders.

You may be a leader of a community team; you may work in a GP surgery; or you might be a district nurse who wants to mentor students or newly qualified colleagues. All of these roles require leadership skills.

But apart from remembering your colleagues' birthdays and offering to organise the off-duty rota, what are the characteristics that are going to enable you to reach your goals and those of your team?

IT'S JUST THE WAY WE DO THINGS...

Traditionally in the NHS, leadership was in the hands of a select few,



Historically, it has been difficult for nurses to be able to play a steady leadership role in the working world. As this article accurately describes, in times gone by we were often thought of as 'doctors' handmaidens'. This is something, unfortunately, even now colleagues and myself still come across in certain places. Although I must admit in recent years I have seen a shift in this for the better, which is a promising sign for nurses of the future to be able to grow and lead within their roles and be encouraged to do so. Nurses are being acknowledged for their skills and high levels of experience and extended training, with more opportunities coming available to advance further in our careers than ever before.

I am lucky in my current practice as the nursing team are encouraged to develop leadership as part of their role — taking on more highly skilled levels of work and completing more training to enhance skill sets. However, I have experienced work environments where I haven't felt seen as a clinician and, with a wide variety of experience and training, at times felt very frustrated feeling that my thoughts/ideas were often brushed off, which can be very disheartening. My advice to anyone feeling this way is not to be afraid to explore other opportunities — nurses are in short supply all over the country (and even worldwide).

One of the keys to leadership in practice is good communication between all members of the team, and being mindful to maintain positive relationships with members of the whole team — this makes such a difference when in a leadership role. Indeed, being approachable and compassionate with team members and not just with patients is imperative.

Cheryl Crawford
Practice sister, Braehead Medical Practice, Renfrew

usually medical consultants and to a lesser extent matrons and charge nurses. Most staff nurses and even junior doctors were not expected to express clinical opinions, much less act on their own initiative.

Decisions about care were handed down from on high, often with little more justification than because 'that is the way it's always been done', or because a consultant had once decided that they preferred a

particular type of medication, or a matron liked the patients to be up and dressed by an appointed time in the morning.

As recently as 2001, there were still ongoing power struggles between doctors and nurses, with research suggesting that nurses could perform many clinical tasks just as well as their medical colleagues, but that a lower value was placed on any task they performed ('Doctor and nurse rivalries undermine NHS reform' — www.the-guardian.com).

Historically, gender has also played a part in how leadership was apportioned in the NHS, with nurses often derogatorily referred to as 'doctors' handmaidens'. Writing in the *British Medical Journal*, Braithwaite et al note how 'gender divides existed within healthcare roles, with male doctors being hierarchically dominant compared with the traditionally submissive nature of female nurses' ('The basis of clinical tribalism, hierarchy and stereotyping: a laboratory controlled teamwork experiment' — bmj.com).

This resulted in power imbalances, which meant that nurses and doctors were often working against each other, rather than for the benefit of patients. Not to mention that the expertise of nurses was disregarded.

Another issue with clear leadership in any healthcare organisation is the range of specialties that exist, even within demarked professional groups. Take a typical patient with a chronic diabetic foot ulcer. At any one time, they may be under the care of a wound care specialist, general practice nurse, visiting community nurse, carers, a GP, podiatrist, and in the worst-case scenario, a surgeon. Each one of these may have their own ideas and preferred way of doing things, which can cloud decision-making and make treatment goals harder to achieve.

LEADING US INTO DANGER

The historical interprofessional issues that had dogged the NHS came to a head a decade ago, when various scandals highlighted the role of



Leadership in the community arena takes many formats dependent upon a number of variables, including the working environment, individual nurse leaders themselves, their team content and skill mix, and the patient populations they are caring for. Due to multiple complexities, including the competing needs of different patient populations and vagaries of working in the community, nursing leaders need to be adaptable, with their leadership styles taking a variety of configurations, including, but not exclusively, being compassionate, relational and collective leaders in differing compositions dependent upon the context in which they are working.

Nurse leaders also need to be role models, providing and supporting person-centred, integrated quality care with the individual at the heart of everything. Community nurse leaders should be able to see the wider picture, being aware of patient needs, team needs, as well as the social and political context, with a view to moving forward in an increasingly complex world. A community nurse leader not only leads, but is also part of their team, which is a fine balancing act — being too autocratic is rigid but too little may be 'laissez faire' and can lead to a lack of direction for the team and compromised care for individuals.

In the community, leadership is not just at a certain grade or level, as community practitioners by the very essence of their work lead on care and lead teams, and colleagues demonstrate this by, for instance, taking a lead with particular groups of patients or on particular projects. This is increasingly happening in the larger teams, which are being formed due to the integrated care agenda.

Student nurses on placement in the community have the chance to lead on particular topics and learn about a variety of conditions. They also have the unique opportunity to offer care to an individual patient or group of patients in their own home. The community setting provides a plethora of learning opportunities for the student nurse with the support and supervision of their experienced community colleagues.

Leadership in the community has undoubted challenges, some obviously exclusive to the community setting itself. But, there are unique opportunities for leadership in a variety of guises and areas. Support and time are valuable commodities in today's nursing world but are required to enhance leaders. Developmental opportunities and resources for current and future leaders are vital, not only to encourage recruitment and retention, but also to promote excellent standards of care, improve patient outcomes and enhance the service offered to patients — all of which are the undoubted aims of community practitioners. Appropriate community nursing leadership clearly supports these aims.

Teresa Burdett
Principal academic, Bournemouth University



Leadership comes from feeling powerful, sharing power, and giving others a platform even when we may feel insecure ourselves. Some years ago, when I was a specialist practitioner qualification (SPQ) student, I was told by my mentor that 'true power is the sharing of knowledge, not the hoarding of knowledge, and admitting when it's an area where we have no knowledge!' This simple sentence has resonated with me throughout my years in district and community nursing practice.

Historically within NHS leadership 'training' programmes, we have learned about leadership styles and been offered tool kits with attributes and behaviours that, as individuals, we must adopt to be effective leaders — but, while this makes us knowledgeable about styles of leadership and able to recognise styles being used around us, does it give us the ability to lead? Leadership comes from competence and confidence to speak out; knowing that we are competent in what we are talking about, perhaps a clinical issue or the need to challenge suboptimal health care, and confident that we are in an environment where we will be supported by our own leaders, peers and followers when we do put our head above the parapet.

So, why is power important and, traditionally, have we felt afraid to embrace terms such as power and powerful? Perhaps there are negative connotations to the terms, and thus we have stuck with the softer terms of 'empower' and 'empowerment'? But, maybe the time has come for us to stop waiting to be empowered, perhaps it's time for district and community nurses to start to feel more powerful and recognise how we can use power to affect care for our community.

Power can be subdivided. Heimens and Timms (2014) first introduced the concepts of new power and old power some years ago. Recognising old and new power, the differences, and how each can be used to effect change is a powerful tool for community nursing practice. Old power is positional, linked to hierarchy and a top-down approach. A classic example of this is the current what 'band it is' I witness everyday in NHS practice and which seems to be a habit we have fallen into to describe each other, regardless of role, specialism, skills or abilities, leading to an over focusing on pay scales rather than the leadership that an individual brings to clinical practice. For example, 'I'm off to the 8a matrons meeting', or 'ask the band 5 to do it...'. In certain healthcare situations this is useful, for example in the resus department of ED there is little opportunity for discussion or debate and thus old power may be an effective way to direct the best care for the patient. But, aside from these types of situations, it's time to start to challenge the inappropriate use of old power.

New power is more useful for most. New power means the power of collaboration, it's made by many and shared — what better group of nurses than those working in district and community nursing could there be to share power. By working together as a collective voice we can cause change across the bigger systems. So, let's connect, collaborate and make each other feel competent, confident and ultimately powerful.

Georgina Ritchie
Director of education, Accelerate

leadership, or lack of it, in multiple care failures.

In 2013, the Francis Report detailed widespread abuse at Mid Staffordshire NHS Foundation Trust. Patients were subjected to shocking treatment, such as being left in soiled bed linen, denied food and water, and not administered prescribed medicines. The report blamed poor nursing care, fuelled by an overly confident leadership obsessed with

meeting government targets ('Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry?' — assets.publishing.service.gov.uk).

Another 2015 report into the care at the University Hospitals of Morecambe Bay NHS Foundation Trust, found serious failures of care in a maternity unit that ultimately led to unnecessary deaths. Again, poor leadership was found to have a significant role ('The Report of the

Morecambe Bay Investigation' — assets.publishing.service.gov.uk).

While individual nurses and doctors were to blame for some of the poor care seen in both cases, the lack of clear leadership and clinical direction was cited as a significant contributing factor.

Writing about the care failures in the Francis report, the King's Fund noted that 'it is essential that

leadership in clinical teams, NHS boards and national organisations is aligned around meeting the needs of patients, and quality and safety of care' ('Patient-centred leadership: rediscovering our purpose' — www.kingsfund.org.uk).

STYLING IT OUT...

Talking about leadership is one thing, actually putting it into practice is another. What does good leadership actually look like?

Historically in the NHS, leaders often operated with autocratic or transactional leadership styles. An autocratic style typically involved one leader, often a doctor, who made all the decisions with limited input from other members of the team. While this could be demotivating for nurses, it did have some positive implications for patient care, for example where clear decisions were required in an emergency ('Leadership styles in healthcare' — www.ijsrp.org).

With the transactional style, leadership was again top-down and task-focused, with staff being rewarded for good performance with bonuses or promotion. Again, it is possible to see how this leadership style flourished in the past, where care was often measured by targets, such as the number of free beds rather than the quality of patient experience ('Leadership styles and leadership outcomes in nursing homes' — biomedcentral.com).

Since the Francis report, however, these traditional styles of leadership have begun to fall out of fashion and instead, what's known as relational leadership styles, such as transformational and compassionate leadership, have come to the fore.

Transformational leadership focuses on the leader's ability to motivate and empower team members. Its core themes include:

- ▶ Inspirational motivation
 - ▶ Intellectual stimulation
 - ▶ Individualised consideration
- ('Transformational leadership, knowledge sharing and reflection, and work teams' performance' — onlinelibrary.wiley.com).



Community nurses demonstrate leadership abilities at local, regional and national level, with skills in communicating effectively at all levels for the benefit of their patients and teams. In addition to being compassionate leaders, they also practice distributive leadership, including the innovative and creative ideas of the people they work with.

This is especially important as teams evolve to become multidisciplinary and solutions to problems may not always be 'nurse' focused.

Distributive leadership allows for nurse leaders managed by non-nurses to contribute to the community nurse voice, addressing inequalities, workforce issues, concerns with care and professional differences — all of which can assist in improving integrated working for the benefit of people requiring support or care in the community.

Amanda Young

Director of nursing programmes, Queen's Nursing Institute (QNI)

Transformational leadership seeks to promote teamwork and collaboration between staff members through techniques such as developing rapport and treating staff with respect to create a sense of 'working together' ('Supporting newly qualified nurses to develop their leadership skills' — rcni.com).

Similarly, compassionate leadership involves the leader focusing on relationships between team members with an emphasis on empathy and mutual support, thereby enabling colleagues to reach their full potential. According to the King's Fund, the compassionate leader attempts to understand the challenges their team members face and is committed to supporting them to cope with work challenges. Crucially, the compassionate leader does not pretend to 'have all the answers', but rather seeks to collaborate with colleagues to arrive at shared decisions ('What is compassionate leadership?' — www.kingsfund.org).

LEADING IN PRACTICE

All these theories may look good on paper, but when it comes to leading a team of nurses working in primary care, what are the key skills required?

According to Felicia Sadler

writing in Nurse.com, nurse leaders can nurture both resilience and emotional well-being in their staff by mixing so called 'hard' and 'soft' skills. Hard skills include clinical knowledge and expertise and are vital to being respected and trusted by your colleagues. However, these technical nursing skills are of little use if your team members are not listening to you. This is where soft skills will enable you to collaborate with other team members, and to 'bring them along' with you to achieve your goals ('How nurse leaders cultivate resilience with soft skills' — www.nurse.com).

Using soft skills does not simply mean inviting your colleagues to a pub quiz or letting them go off-shift early. Soft skills include demonstrating empathy, active listening, encouraging your team members to take responsibility and being honest. Being a relational leader does not mean demonstrating that you have all the answers; instead, showing that you can ask for others' opinions will encourage them to trust you.

Another review of leadership strategies for frontline nurses found that modelling shared values such as compassion for patients and ensuring nurses had access to formal education were key to 'getting the best out of' nursing colleagues. For

all the research into leadership styles, the review found that overall, nursing leadership worked best when nurse leaders were accessible, used open communication, and took a personal interest in their staff ('Leadership strategies to promote frontline nursing staff engagement' — journals.lww.com).

Of course, we don't all possess the unique qualities of historical leaders like Florence Nightingale, Gandhi or Napoleon (although some of your managers may act like the latter). And in any practice it can be tough to manage the competing priorities of our multidisciplinary colleagues, whether they be GPs, pharmacists or physiotherapists. But, when it comes to leadership in community nursing, being able to listen to our peers is a strength rather than a weakness, and, whatever the challenges, it is important to remember that the team is always greater than the sum of its parts. **JCN**

REFERENCES AND WEB LINKS

Doctor and nurse rivalries undermine

NHS reform. Available online: www.theguardian.com/society/2001/jul/31/nhsstaff.health

Francis report. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

How nurse leaders cultivate resilience with soft skills. Available online: www.nurse.com/blog/how-nurse-leaders-cultivate-resilience-with-soft-skills/

Leadership strategies to promote frontline nursing staff engagement. Available online: https://journals.lww.com/nursingmanagement/fulltext/2020/02000/leadership_strategies_to_promote_frontline_nursing.11.aspx#:~:text=Not%20only%20should%20frontline%20nurses,a%20personal%20interest%20in%20staff

Leadership styles for healthcare. Available online: <https://www.ijssrp.org/research-paper-0919/ijssrp-p9308.pdf>

Leadership styles and leadership outcomes in nursing homes. Available online: <https://bmjhealthservres.biomedcentral.com/articles/10.1186/s12913-020-05854-7>



Not every nurse wants to lead teams, yet leadership is everyone's responsibility. Successful modern nursing teams require a 'collective leadership' culture. In community nursing, there's great potential for collective leadership to flourish and consequently for individual careers to develop and thrive.

As the relaxing of hierarchy in nursing continues, opportunities are increasing for individuals to embrace the threading of leadership through their careers from early on. Student nurses have been encouraged to identify areas for development, and use change management theories to implement quality improvement projects in their practice area. Indeed, future leaders can shine at early career level and we sometimes see their careers take off at speed when these skills are cultivated.

If incivility or poor practice exists, then ideally everyone needs the confidence and skills to speak up and instigate change; these are skills that can be developed through learning about leadership theories, so everyone can benefit.

A compassionate leader with strong ethics and who is a good role model creates a culture of psychological safety to ripple throughout their teams and encourages other team members who show leadership skills to develop them. You could argue that teams with collective leadership would have an advantage on recruitment and retention, as they have a positive reputation for being such.

From a practical sense, how can community nurses improve their leadership skills? An abundance of options; literature, ask the nursing community on social media for recommendations, the NHS Leadership Academy courses, other esteemed organisations offering a range of options to study and transform — the world is your oyster.

Hattie Taylor

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

Morecombe Bay report. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Patient-centred leadership: Rediscovering our purpose. Available online: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/patient-centred-leadership-rediscovering-our-purpose-may13.pdf

Supporting newly qualified nurses to develop their leadership skills. Available online: <https://journals.rcni.com/nursing-management/cpd/supporting-newly-qualified-nurses-to-develop-their-leadership-skills-nm.2022.e2031/full>

[leadership-skills-nm.2022.e2031/full](https://journals.rcni.com/nursing-management/cpd/supporting-newly-qualified-nurses-to-develop-their-leadership-skills-nm.2022.e2031/full)

The basis of clinical tribalism, hierarchy and stereotyping: a laboratory controlled teamwork experiment. Available online: <https://bmjopen.bmj.com/content/bmjopen/6/7/e012467.full.pdf>

Transformational leadership, knowledge sharing and reflection, and work teams' performance: A structural equation modelling analysis. Available online: <https://onlinelibrary.wiley.com/doi/full/10.1111/jonm.13118>

What is compassionate leadership. Available online: www.kingsfund.org.uk/publications/what-is-compassionate-leadership

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Matthew Bradby, head of communications, Queen's Nursing Institute (QNI)

The Queen's Nursing Institute (QNI) and the National Garden Scheme (NGS) have announced five new gardens and health projects led by nurses taking place in 2023.

The five projects are all led by nurses working in community settings and seek to improve the health of local people. Many projects supported by the QNI go on to become part of mainstream services. All this year's projects will run until early 2024 when they will submit their final reports.

'SANCTUARY' — A GENDER SPECIFIC SAFE OUTSIDE SPACE TO BE ENJOYED, GLOUCESTER

This project seeks to provide a safe space for women with serious mental health illness in Gloucester. The garden will provide an area for women to relax, meet, and for therapy to take place within a designated area that is peaceful and designed with them in mind.

Project leader, Angela Willan, said:

This garden will provide a fantastic area for women to relax, meet, and for therapy to take place within an area that is peaceful and designed with them in mind. Engagement in gardening has been shown to have both immediate and long-term effects on mental health outcomes, such as reductions in depression and anxiety symptoms, while gardening daily is associated with reduced stress and increased

New gardens and health projects for 2023

life satisfaction. Selecting and planting specific plants/herbs/flowers, with community volunteers, will aim to support menopause and other health issues specific to women. Having a safe space outside, in which to expand the discussion and activity, such as planting of herbs, vegetables or wildflowers, will help enhance this approach in a creative and purposeful way.

GREENER CARE HOME PROJECT, STAFFORDSHIRE

This project aims to introduce health clinics and post-Covid rehabilitation sessions in care homes using gardening as a focus. The project aims to support people's mental health and wellbeing and provide the opportunity for early identification of deteriorating patients. The project also aims to increase mobility and dexterity, providing early health promotion messages, good nutrition, hydration and exercise. It supports the objective of enhancing health in care homes following the Covid pandemic.

Project leader, Carolyn Fleurat, said:

I have a passion for service improvement, sustainability and transformation. The project incorporates the NHS Green Plan into our care home network using social prescribing, offering well-being sessions and empowering care coordinators to provide green space and facilitate gardening sessions. This will encourage residents' hobbies and interests, as well as improving their mood and supporting the reduction of hospital admissions and GP visits. In addition, it will provide opportunities for clinicians to identify early deterioration in residents and will involve therapy and use a non-pharmacological approach.

NEW LONGTON WELLBEING GARDEN SCHEME, LANCASHIRE

This project aims to transform wasteland at the back of a GP surgery into a garden that can be used by patients and the local community. The objective will be to create an environmentally friendly garden of three raised beds and a small greenhouse to grow fruit and vegetables. Nurses will lead gardening groups for those with long-term conditions, working together on a garden that can be tended and used all year round to improve physical and mental wellbeing.

Project leader, Corrie Llewellyn, said:

This project will provide a sustainable raised bed vegetable garden that all the practice community can get involved in and provide some sustainable healthy food year on year. The nurses in the practice are well-placed to hold educational working groups for our long-term condition patients who can help tend the garden, where physically possible, as well as benefit from fresh air, fresh produce and socialising outdoors, with an emphasis on healthy eating. The development of the garden will also benefit the staff, providing a quiet reflective space which will improve mental wellbeing. Our social prescriber can utilise the new garden for all patients, bringing the community together to help tackle some of the loneliness we have in our ageing patient population. We are planning for diversity among those who will use the garden, for example scented and textured plants for people living with dementia or who are visually impaired. Our garden will be wheelchair/walking frame friendly.

BOTANICAL BROTHERS, EAST LONDON

The project aims to improve the mental health of fathers in the community. The gardening project will connect with fathers to support their emotional health, providing an environment of calmness, tranquillity, and safety to raise awareness about mental health and improving access to mental health services. Fathers will be able to access a range of professional support, safe and confidential conversation, breaking down some existing barriers that hinder client engagement.

Project leader, Fawn Bess-Leith, said:

The new project will encourage interest, commitment and focus in the fathers' group. The project is intended to foster an atmosphere of self-care, enhance awareness and accessibility to emotional wellness services. The prevalence of paternal perinatal depression is well documented and highlights the need at national and local level for high quality holistic support for men, in particular from an ethnically diverse community. The evidence suggests that the prejudice and stigma around mental health in these groups impacts

negatively on men's mental health, in addition to poorer outcomes for their children and partners in the long term. I anticipate the growth and development within the garden environment will bring excitement and surprise to many. The calm, exhilarating and relaxed atmosphere will encourage socially isolated fathers to meet. We hope that the project will encourage an interest in gardening for fathers and promote inclusivity, to create a sense of belonging and acceptance.

GROW TOGETHER — SHARE TOGETHER, SURREY

This project aims to redesign and rejuvenate the garden at Dorking Community Hospital. The focus of this garden project is intergenerational and cross-cultural interaction; through talking in a relaxed space, sharing memories and stories; growing food to learn about nature and encouraging conversation about the environment; sharing the food, sharing break times, memories, time and space by bringing children and older people together to create a sense of community.

Project leader, Simon Littlefield said:

The vision is to use the space

for patient rehabilitation, bringing them to the outdoors, into a therapeutic space. The garden adjoins the community rehabilitation ward, allows interaction on a different level, in a different space to keep the mind, body and spirit energised for longer. Health benefits include using the space for conversation/health promotion as a space to talk about health and prevention of ill health. The garden will be a space for children, for teaching and education, learning and growing. There is the opportunity for life-long learning — engaging children in social and developmental opportunities. The garden will also be a space for staff to relax and unwind, where they feel they can switch off and recharge their batteries. JCN

More information

The NGS Elsie Wagg Scholarships are awarded annually. Applications to run projects in 2024 will be advertised in late summer 2023 on the QNI's website.



Before and after: Grow Together — Share Together, Dorking Community Hospital.



Greener care home project, Staffordshire.

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Hannah Cressey, senior HR business partner — resourcing, Leeds Community Healthcare NHS Trust

Hyperlocal recruitment key to future nursing pipeline

In an exceptionally challenging labour market for healthcare workers, Leeds Community Healthcare NHS Trust recruited over 100 local people for local jobs, reaching deep into communities to tap into a diverse talent pool and tackle unemployment. The trust innovated new ways to recruit, engaging with local people to overcome barriers in the recruitment process.

Leeds Community Healthcare has traditionally relied on the NHS jobs website to attract candidates to vacancies, particularly within healthcare support worker and nursing roles. With unemployment levels reaching record lows over the last two years, the volume of candidates applying for positions through NHS jobs has decreased significantly. The candidates that were applying were from similar socio-economic backgrounds and were generally already in employment, often already working within the Leeds Health and Social Care System.

The trust focused on building a pipeline of the next generation of nurses by introducing the first band 2 clinical apprenticeship in the organisation. This has opened the door for many people who want to become nurses, but did not know where to start. The ambition is that the trust will support these people to develop through their career

and eventually train to be nurses or allied health professionals.

Leeds Community Healthcare did not wait for candidates to come to them, they took the vacancies into the community close to where the vacancies were based and transformed the recruitment process. Holding sessions in high traffic areas and local hotspots across the city, such as the White Rose Centre and Churches in Harehills, as well as posting flyers through doors in areas of high deprivation, the trust was able to attract a more diverse candidate pool and reduce socio-economic inequalities via employment.

The trust encouraged referrals from local third sector organisations, such as Gipton Independent Supported Living, and supported those furthest from the labour market into work, adapting the recruitment process to meet the individual needs of those people applying. Partnering with a third sector body who supports homeless people to find housing and employment, the trust has been able to support some of the most marginalised people to access employment.

The benefits have been staggeringly effective. The trust has improved the lives of people across Leeds and offered a true career pathway in the NHS. For example:

- ▶ 33% of the people appointed were previously unemployed with a further 6% being on zero-hour or agency contracts
- ▶ 29% of people appointed are from black, Asian and minority ethnic backgrounds, which supports the trust's equality and

diversity ambitions of having a workforce that is representative of the communities served

- ▶ 25% of people appointed live in the most deprived areas within Leeds which provides a wider socio-economic benefit to the city and supports the environmental aims of providing local work for local people. Many of the new staff members can walk or cycle to work, having a positive impact on their health as well as retention
- ▶ Supporting people into work who are in or have left the criminal justice system
- ▶ 10% of roles offered as apprenticeships.

With this cohort of staff, there has been less than 10% turnover in the first 12 months, which is lower than the trust-wide average. One of the new healthcare support workers said:

I can see myself being here for a very, very long time. I wouldn't have got the job without the support I have had.

Testimonials about the impact on patient care from leaders within patient services include this one from our palliative (end-of-life) service:

Filling vacancies enables the service to be staffed to its fullest without having to lean on agency services to cover the unfilled shifts. This means that patients are able to achieve their preferred place of death and to support this to happen is very important and rewarding.

And from our Wharfedale Hospital inpatient service:
Increase in our staff by 35% will improve quality of care

for patients, call bells will be answered in a timelier manner. New staff bring new ideas.

The key takeaways from the first 12 months are that when engaging with different communities, individuals will have differing needs; there is not a one size fits all approach to adapting the recruitment process. Some candidates have needed support with accessing technology, whereas other people have needed financial support to get to interviews. Other barriers include a lack of understanding of NHS terminology, job titles and job descriptions that are overly complicated when compared to the skill level of the role that is being advertised.

The ambition for this approach to recruitment in the trust is to expand on this offer and recruit to more vacancies in this way, making vacancies accessible for those who would like to work in their local community while maintaining an excellent pipeline of candidates to support workforce requirements.

This work encapsulates the trust's vision to be an excellent provider, which works with children, adults and families to deliver high quality care, to be a good partner, develop and value our staff and use our resources wisely and efficiently. This work offers a new road to hear our communities, build bridges of engagement and help local people become part of the nursing and health workforce for the future. **JCN**



Hannah Cressey (left) and Jessica Harrison (right), HR advisor, Leeds Community Healthcare NHS Trust.



Hannah Cressey (left), Emily Day (middle), resourcing coordinator and Janet Lightfoot (right), resourcing advisor, all at Leeds Community Healthcare NHS Trust.

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Stanley Blunt, student nurse,
University of Northampton

Role of male nurses: breaking down stereotypes

providing high-quality care to babies and children up to the age of 18, while also supporting their families.

Although most students enrolled in UON's 'Children & Young People's Nursing degree' are still female, the 2020–2022 cohort is bucking this trend with a 'bumper crop' of seven male students. Through our shared commitment to providing exceptional care, we hope to inspire other men to consider nursing as a rewarding and fulfilling career path.

My decision to become a nurse stems from an interest in science and my natural affinity for working with people. However, it was a pivotal moment when my younger brother broke his arm and was hospitalised that made me realise my calling. I remember visiting him and seeing how hard the nurses worked and how well they interacted with my brother and the family.

From this moment, I knew I wanted to do something medical in a role helping people, but it was a bit later that I opted to become a nurse. At first, I was not sure as no one in my family was a nurse so I did not have anyone to talk to about it and gain an idea as to what it involved. However, I wanted to work with children and realised that children's nursing was the ideal role and enrolled on the degree.

It is a shame that nursing is not usually promoted as a career option for men at school, as it is still perceived as a female profession. This is something that needs to change, with much more awareness that men can be nurses too. Unless men have someone in the family who is a nurse, it is not something that most young men would have on their radar as a career option.

Men can make great children's and young people's nurses, but working together in the profession alongside female nurses is where patients benefit most by bringing different experiences, skills and abilities to the ward. Half the population is male, so it makes sense that half the nursing population should be male.

Some male patients may feel more comfortable when in hospital being treated by a male nurse. Having this option could make the experience easier in what is often a stressful situation for people when they end up in hospital.

A common misconception is that children's and young people's nursing is all about working with babies, but this is not the case. We also work with a lot of older people, sometimes up to 18 years of age. During my course I did a placement in A&E and saw a few young people with mental health issues — it was rewarding to see the difference that I could make to their mental wellbeing.

Overall, nursing is an incredibly rewarding and fulfilling career, and the NHS and healthcare industry at large stand to benefit from having more male nurses. Do not let outdated stereotypes or apprehension hold you back from pursuing your passion for caring for others. The UON nursing degree provides an excellent pathway to a bright future in nursing. **JCN**

REFERENCE

Nursing and Midwifery Council (2022) *The new register 1 April 2021– 31 March 2022*. Available online: www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2022/nmc-register-march-2022.pdf

In the UK, nursing remains a predominantly female profession, with only 11% of registered nurses identifying as male (www.nurses.co.uk/blog/stats-and-facts-uk-nursing-social-care-and-healthcare/). This disparity is even more pronounced in specialties focused on children and young people (Nursing and Midwifery Council, 2022). However, the University of Northampton has observed that there is growing recognition of the valuable contributions male nurses can make to the field, leading to efforts to increase their representation throughout the nursing workforce.

Despite the many rewards of a career in nursing, some men may be discouraged from pursuing this path due to the perception that it is traditionally a female role, particularly given the nurturing nature of the job.

However, the University of Northampton (UON) is actively working to challenge this stereotype and encourage more men to consider nursing as a profession. By bringing together the unique strengths and qualities of male and female nurses, UON believes that the quality of care provided to children and young people can be enhanced.

I am proud to be part of a small but growing group of male nursing students at UON, all of whom are currently training to specialise in

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Abdul Seckam, head of research and academia, Health Business Solutions UK (HBSUK)

Does digital healthcare revolutionise medical practice?

'Use of technological-based solutions for healthcare specialities has become favourable worldwide and digital healthcare is revolutionising the medical arena.'

highest productivity and efficiency levels for the NHS, clinicians and patients. HBSUK also considers the importance of personalised care and delivery of this service in a timely manner. The patient is considered at the heart of the management plan with evidence-based links and support to aftercare. Additionally, the patient reported experience measures (PREMs) and net promoter scores (NPS) data which the author has captured reflect the better outcomes delivered among 30,000 patients seen (Seckam, 2023).

As the CMO of HBSUK, Dr Mark Emerton comments:

At HBSUK, through our Virtual Lucy® (LUCY — Let Us Connect You) platform, we can identify the most appropriate clinician and offer a remote assessment within three days for over 99% of patients.

Our patient initiated follow-up (PIFU) model allows each patient to be offered an agreed duration of follow-up with specific triggers to return. Each patient has clear actions and the ability to arrange appropriate follow-up either through a case review, remote video consultation, or face-to-face, and an agreed plan for what happens next.

In our MSK service, 41% of patients experience an entirely digital service with fewer than 3% of those returning with the same problem within six months. Our dermatology service reduces the number of first new patient appointments by up to 66% with one-third of all patients offered a definitive treatment plan within 48 hours of completing their clinical information. In our recent gastroenterology pilot, a

Use of technological-based solutions for healthcare specialities has become favourable worldwide and, in the author's opinion, digital healthcare is revolutionising the medical arena.

DOES DIGITAL HEALTHCARE REVOLUTIONISE MEDICAL PRACTICE?

With the advent of Covid-19, use of digital platforms has become favourable for communication in various professional services, especially in the medical arena (Vargo et al, 2021). But, what is the digital revolution and how is it embodied in healthcare? What technologies have been developed, are useful and how will these impact healthcare? The list of questions is endless. Machine learning, in particular, artificial intelligence (AI) is taking on cognitive roles, i.e. Brainomix, in the prediction of large vessel occlusions, e.g. stroke, (Murray et al, 2020). However, societal factors are not being considered. While digital transformation has been improved due to the Covid-19 pandemic, such as digital consultations in outpatient clinics for musculoskeletal (MSK) services, technologists need to consider accessibility to digital platforms, connectivity and digital literacy (Steinhubl et al, 2015; Topol, 2019; Ibrahim et al, 2021; Seckam and Hallinberg, 2022; Mistry and Jabbal, 2023) and develop digital programmes in line with patient needs.

Healthcare is dynamic and complex and requires an evidence-based approach. Indeed, the NHS Long Term Plan (NHS England, 2019) encompasses holistic, prudent care, self-care, outcome-based models, integration, prevention and, importantly, digitisation to mention but a few constructs (NHS England, 2019).

In a presentation by Liam Cahill (2022a; b), supported by the Florence Nightingale Foundation, it was suggested that digital plays an important role in the shift and is the impetus to drive better outcomes.

HOW DO WE EMBED DIGITAL HEALTHCARE SOLUTIONS FOR OUR POPULATION WITH LESS MONEY AND STAFF?

The author's organisation works alongside NHS trusts to provide cost-effective insourcing solutions, as well as capacity solutions, resourcing, triage services, pathway redesigns, and digitisation through the use of Virtual Lucy (HBSUK, 2023). HBSUK delivers surgical treatment services from the patient entering the hospital to leaving post-surgery. This extends to day-case and in-patient surgery and clinics — end-to-end solutions (E2E). Although HBSUK covers all surgical specialties, its focus is on MSK, ophthalmology and dermatology services. It uses its own pathway designs to find the best possible solutions that will have the

diagnosis made from reviewing the patient completed clinical information was the same as that after their face-to-face appointment in 88% with 30% potentially discharged back to the GP with reassurance and advice. Half of the patients requiring investigation could have been directed straight to test before their consultation.

(Emerton, 2023).

This meets the NHS *Outpatient Recovery and Transformation Programme* (NHS England, 2023) elements for outpatient services, including:

- ▶ PIFU
- ▶ Remote/hybrid consultations
- ▶ Specialist advice
- ▶ Reduction in 'Did Not Attends, (DNAs)' (NHS, 2023), as the VL service is tailored to the patient.

The Topol review (2019) and other authors also highlighted the most impactful technologies for healthcare, including:

- ▶ Telemedicine
- ▶ Smartphone apps
- ▶ Wearables and sensors
- ▶ Genome engineering
- ▶ Speech recognition and natural language processing
- ▶ Artificial intelligence
- ▶ Robotics (Steinhubl et al, 2015; Torkamani et al, 2017; Topol, 2019; Cahill a; b, 2022).

In the author's experience, digital healthcare solutions are revolutionising medical practice and have an important place in healthcare alongside many other tools, which clinicians and the healthcare world can employ for better outcomes. Indeed, digitalisation has potentially positive beneficial fiscal and psychosocial implications on patients, families, carers and the clinical workforce. For example, if implemented correctly, remote appointments save patients and their families/carers travel time and costs by attending appointments

online at their convenience and in their own homes. This also reduces the stigma of sitting and waiting anxiously in GP surgeries. Additionally, this also reduces the patient, family and carer carbon footprint. Patients can personalise and take ownership of their healthcare plans.

EMPOWER, ENGAGE, AND IMPLEMENT

It is also important to note that clinicians and patients need to be empowered and engaged to implement digital technological advances (Risling et al, 2017). However, barriers to both clinicians and patients who implement and advocate for digital advances need to be considered, such as internet connectivity, digital literacy, acceptance of technology, familiarisation and accessibility of technology, to mention but a few. Once these issues have been addressed, patients and the workforce can be empowered and engaged to embed digital technologies and solutions in clinical practice and personal healthcare respectively. **JCN**

REFERENCES

- Cahill L (2022a) What does the future of digital hold for the clinical workforce? *J General Practice Nurs* 8(1): 16–17
- Cahill L (2022b) *What does the future hold for the clinical workforce?* Available online: https://youtu.be/u72w_7gtZQM.
- Emerton M (2023) *Outpatient recovery and transformation — could it be that digital is better than face-to-face.* Available online: www.linkedin.com/pulse/outpatient-recovery-transformation-could-digital-better-than-face
- HBSUK (2023) Available from NHS Insourcing services | Digital Triage | Remote specialist assessments. Available online: www.hbsuk.co.uk
- Ibrahim H, Liu X, Zariffa N, Morris AD, Denniston AK (2021) Health data poverty: an assailable barrier to equitable digital health care. *Lancet Digital Health* 3(4): e260–e265
- Mistry P, Jabbar J (2023) *Moving from exclusion to inclusion in digital health and care.* King's Fund, London. Available online: www.kingsfund.org.uk/publications/exclusion-inclusion-digital-health-care
- Murray NM, Unberath M, Hager GD, Hui FK (2020) Artificial intelligence to diagnose ischemic stroke and identify large vessel occlusions: a systematic review. *J Neurointerv Surg* 12(2): 156–64
- NHS England (2019) *The NHS long term plan.* Available online: www.longtermplan.nhs.uk/
- NHS England (2023) *Outpatient Recovery and Transformation Programme.* Available online: www.england.nhs.uk/outpatient-transformation-programme/
- Risling T, Martinez J, Young J, Thorp-Frosli N (2017) Evaluating patient empowerment in association with eHealth technology: scoping review. *J Med Internet Res* 19(9): e329
- Seckam A (2023) Placing patients at the heart of digital solutions to care. *J General Practice Nurs* 9(2): 22–3
- Seckam A, Hallingberg B (2021) The experiences and perceptions of stroke survivors engaging in a virtual choir during COVID-19: a thematic analysis. *Br J Neurosci Nurs* 17(Sup5): S18-S25.
- Steinhubl SR, Muse ED, Topol EJ (2015). The emerging field of mobile health. *Sci Transl Med* 7(283): 283rv3
- Topol E (2019) *The Topol Review. Preparing the healthcare workforce to deliver the digital future.* Available online: www.topol.hee.nhs.uk
- Torkamani A, Andersen KG, Steinhubl SR, Topol EJ (2017) High-definition medicine. *Cell* 170(5): 828–43
- Vargo D, Zhu L, Benwell B, Yan Z (2021) Digital technology use during COVID-19 pandemic: A rapid review. *Human Behav Emerg Tech* 3(1): 13–24

HBSUK mission: making healthcare better

HBSUK aims to help healthcare providers reduce their waiting times by providing online outpatient services and on-site clinical capacity. To find out more, visit: www.hbsuk.co.uk/

Supported self-care for venous leg ulcers: nicety or necessity?

Andrew Kerr, Laura Hallas-Hoyes

Lower limb ulceration continues to be a common cause of suffering and its management places a significant burden on the NHS, with venous leg ulcers (VLUs) being the most common hard-to-heal wound in the UK. It is estimated that over one million patients in the UK have lower limb ulceration, of which 560,000 were categorised as VLUs at a cost of over £3 billion each year. Although self and shared care in chronic disease management is not new, historically wound care and specifically lower limb management has been undertaken solely by healthcare professionals. This article outlines the results of implementing a lower limb wound pathway (Wounds UK, 2016), and a lower limb self-care delivery model measuring clinical outcomes and the impact on workforce pressures through limiting face-to-face healthcare professional contact up to one appointment every six weeks, when capacity and capability criteria are met. A suitability assessment was conducted and, when appropriate, patients were managed using a self-care delivery model. Patient data were collected, anonymised and independently analysed, comparing time to healing against data on file from a previous audit using the lower limb wound pathway (Wounds UK, 2016). This highlighted VLUs in 84 of the 95 patients selected for the self-care model had healed by week 24 and a further 10 patients had healed by week 42, with only one remaining patient reaching 42 weeks without healing. These results support the hypothesis that when suitable, patients with a VLU can self-care and deliver clinical effectiveness without compromise.

KEYWORDS:

- Care pathway ■ Delivery model ■ Self-care ■ Service evaluation
- Venous leg ulcer ■ Workforce sustainability ■ Cost-effectiveness

The need to reduce variations in care, improve healing outcomes and reduce costs in the management of venous leg ulcers (VLUs) has been well documented (Guest et al, 2015; Guest et al, 2020; Dowsett, 2022). However, more recently, healthcare professional time coupled with the ambition of the NHS to reduce its emissions to net zero by 2040 has highlighted the need for a national

strategy to improve standards and delivery of wound care in the NHS (Browning, 2016; NHS England, 2019). Through advances in product innovation, national guidance, including financial targets, and a new 2022 best practice statement, there is improved understanding to help facilitate self-management for some individuals and/or their carers if they are supported and educated to do so (National Wound Care Strategy Programme [NWCSP], 2020; Wounds UK, 2022).

SELF AND SHARED CARE MANAGEMENT

Hopkins and Narasimhan (2022) define self-care as the ability to

maintain health, prevent disease and manage illness and disability, both with and without a healthcare worker. Self-care is not new; many chronic conditions are managed through shared and supported care, including respiratory disease and diabetes (NHS England, 2019). Effective management using a self-care model can be a complex process and will require patient involvement and/or support from their families. The success of managing chronic conditions such as VLUs through shared responsibilities will depend on capacity to learn and capability to perform certain tasks (Bayliss et al, 2003; Wounds UK, 2022). However, when suitability has been established, there are many reasons why empowering a patient to self-help can generate effective and efficient outcomes for both the patient and service provider (Table 1).

Delivering effective long-term self-care is one of many strategies that can enhance the delivery of effective and efficient lower limb management (Hallas-Hoyes et al, 2021). Furthermore, understanding the impact of an evidence-based leg

Table 1: Positive effects of patient empowerment (Kapp and Santamaria, 2020)

▶ Encourages concordance, compliance and adherence to short and long-term management plans
▶ Self-treatment can improve physical wellbeing
▶ Improves pain management
▶ Enhances emotional wellbeing, helping to manage worry about infection and resolve dissatisfaction with professional care
▶ Enables patients to maintain their lifestyle and minimise the disruption of making time to receive professional care
▶ Reduces financial cost of wound dressings and expense associated with receiving professional care

Andrew Kerr, director, Lower Limb Consultancy Services Ltd; honorary tissue viability clinical nurse specialist, Sandwell and West Birmingham Hospitals NHS Trust; Laura Hallas-Hoyes, lead tissue viability nurse specialist, South West Yorkshire Partnership Foundation Trust

ulcer pathway alongside a self-care delivery model for the management of VLU can improve both structural service redesign and patient outcomes (Hallas-Hoyes et al, 2021).

SERVICE REVIEW

In 2018, the South West Yorkshire Partnership Trust (SWYT) tissue viability leg ulcer service reviewed their current lower limb pathway. This review highlighted that 76% of their patients were seen weekly, with the remaining 24% being seen twice weekly. During the review, the total cost of care per patient was estimated to be approximately £4,300 from initial assessment to wound closure. The majority (70%) of this cost was attributed to healthcare professional time (£3,010). The review concluded that the care pathway had become onerous with clear service limitations and lacked scope to support self-care management. As a result, the tissue viability team made the decision to introduce an evidence-based best practice leg ulcer algorithm adapted from the Atkin and Tickle lower limb wound pathway (Wounds UK, 2016), which has subsequently been updated (Wounds UK, 2022). The main differences between the two pathways were improved clarity around delivery and the use of the right product for the right patient at the right time (Figure 1).

As part of this service redesign, the tissue viability service also hypothesised that it would be possible to introduce a self-care delivery model (Figure 2), which would reduce the burden on their health service and improve patient empowerment with no reduction in patient healing outcomes or an increase in the risk of infection.

SERVICE EVALUATION AND REDESIGN

The service evaluation aimed to observe changes in clinical delivery and monitor patient outcomes following the implementation of the lower limb wound pathway (Wounds UK, 2016) and a self-care delivery model. This would investigate how a self-care delivery model could

enhance resource allocation and VLU management without compromising outcomes.

The evaluation set out to recruit 100 self-care patients from the community leg ulcer caseload, following a capacity and capability assessment. Patients were required to have a differential diagnosis of a VLU, a recorded ankle brachial pressure index (ABPI) measurement, and be on the lower limb wound pathway (Wounds UK, 2016). Patients were then considered clinically suitable for self-care if they had capacity and capability to use either a leg ulcer hosiery kit, such as an Activa® or ActiLymph® compression hosiery kit (L&R, UK), or an adjustable compression wrap, such as ReadyWrap® (L&R, UK).

As highlighted within the 'Best Practice Statement: Holistic management of venous leg ulcers' (Wounds UK, 2022), due to the cost-economic benefits and the potential positive implications for the patient, hosiery kits should be used as a first-line option except in those patients who do not meet the select criteria for a hosiery kit (Table 2). Patients who present with exudate that is not controlled within a topical dressing, and/or there is a large amount of reducible oedema/limb distortion are not suitable for self-care. However, this should be reassessed regularly and when suitable, self-care can be considered utilising a self-care solution, such as compression hosiery kits or adjustable compression wraps (Wounds UK, 2022).

To be considered suitable, the patient and/or named carer also had to be clinically and functionally able to self-care in compression. To guide the team, a self-care support plan was used to assess clinical awareness, social capacity, functional capability, and the patient's understanding of their condition (Figure 2). If suitable, the patient/named carer was issued a patient-specific self-care plan booklet, which included when and how to contact their named healthcare professional. Self-care compression, suitable dressings and emollients were prescribed for the agreed period of self-care and reviewed at the

next healthcare professional face-to-face contact point. The patient or named carer subsequently followed an agreed plan of care, which was reviewed at six weekly intervals. If the patient required additional support, they would be triaged virtually by a clinician before a face-to-face meeting took place. Also, if the patient needed additional dressings, they were able to contact the team and, if suitable, these would be provided.



While the majority of the self-care cohort followed a six weekly face-to-face cycle, approximately 20 to 30 patients used a telephone review service and provided photographs by email (especially if they were shielding). The patient or their carer would report any changes to the lower limb, including whether the wound was improving and reducing in size. However, only one face-to-face visit was ever missed for these patients to ensure the plan of care remained appropriate and to monitor their progress effectively. If any of the key suitability criteria changed, where the patient was not able to meet the criteria for self-caring, the healthcare professional and patient followed the adapted version of the lower limb wound pathway (Wounds UK, 2016) until the patient's suitability was reassessed and self-care was considered appropriate.

Safety should always be at the heart of all care given and patient and staff safety were paramount throughout this evaluation. Therefore, additional education was provided to staff around correct implementation and audit, as well as education to all patients and named carers in the form of an informative patient/carer-friendly guide, 'My leg ulcer treatment plan'. This included information on the causes of leg ulceration, treatment, the signs of deterioration/infection, and long-term care requirements. The patient's management record and healthcare professional's contact details were also provided at initiation of the self-care delivery model.

CHANGE MANAGEMENT

Although many patients with a chronic condition such as diabetes,

Table 2: Right product, right patient, right time (adapted from Wounds UK, 2022)

Product	Evidence of VLU healing	Advantages	Considerations	Patient perspective	Best practice
 <p>Compression hosiery kit</p>	<p>Multi-centre randomised control trial (RCT) included 457 patients. Proven to be as effective as multicomponent bandaging in healing venous ulceration</p> <p>Additional advantage as less expensive and reduced risk of recurrence of ulceration (Ashby et al, 2014)</p>	<p>Does not require a high level of skill to apply. Delivers known consistent compression levels. Allows for patient self-care</p> <p>Cost-effective</p> <p>Delivers compression to the foot</p>	<p>Not suitable for rapidly decreasing limb sizes or unusual limb profiles</p> <p>Exudate needs to be contained within the dressing</p>	<p>Low profile and no limits to footwear/clothing</p> <p>Facilitates supported self-management (i.e. can be removed for showering/bathing)</p>	<p>First-line option when exudate is controlled within the dressing and there is no reducible oedema/limb distortion</p>
 <p>Compression wrap system</p>	<p>Over 65 articles published but only one RCT (Blecken et al, 2005) that the authors concluded was of low quality</p> <p>VenUS 6 is an ongoing RCT, one of the aims being to compare compression wraps with evidence-based compression in terms of time to healing of VLUs (Arundel et al, 2023)</p>	<p>Compression value adjustable — value dependent on application technique</p> <p>Allows for easy adjustment as limb volume decreases</p> <p>Facilitates supported self-management</p> <p>Can deliver compression to the complete limb using foot, calf, knee and thigh pieces</p>	<p>Not practical if VLU is highly exuding</p> <p>Not useful if ulcer site is behind the malleolus</p>	<p>Can be adjusted to adapt to limb circumference changes and improve comfort</p> <p>Low profile with minimal impact on footwear/clothing</p> <p>Allows self-care/family care</p>	<p>Until the VenUS 6 study data is published, it is recommended that compression wraps are used as a second-line option when exudate is managed within a primary dressing, or for supported self-management (Wounds UK, 2022)</p>

heart disease and arthritis are managed through shared and supported care (Grady and Gough 2014), historically wounds have been treated using a paternalistic model (Lusher, 2020).

This approach typically involves a healthcare professional assessing the aetiology and condition of the wound, managing associated factors which may affect wound healing, and implementing an evidenced-based plan of care, either in the patient's own setting or through attending a clinic. However, if the care for all patients with a wound continues solely to use a traditional paternal approach, it is likely that the patient will continue to feel disempowered and overwhelmed (Joseph-Williams et al, 2017). Adopting a parental role can often lead to patients developing a state of learned helplessness, which can instigate low self-esteem and poor confidence regarding their ability to help themselves. This can result in reduced quality of life, with patients being more likely to become

dependent on clinicians for wound management (Palmer, 2022).

To adopt shared decision-making and facilitate self-care involves a shift in attitude and can be a key challenge for any change programme (Joseph-Williams et al, 2017). To successfully implement shared decision-making, advocate patient choice and deliver self-care needs structural change. This requires revised pathways alongside cultural and attitudinal changes among clinicians and patients. In the author's clinical experience, all too often clinicians feel that they already involve the patient and carers in planning and implementing care, and, as such, do not see how shared decision-making is any different. A key barrier to attitudinal change can be their indwelling belief that they are doing what is perceived to be the best for their patients (Joseph-Williams et al, 2017). Although with the best of intentions, this can result in a lack of patient empathy and failure to appreciate and understand fundamental values, opinions and

preferences and how these may be dissimilar to their own.

Another challenge identified by Joseph-Williams et al (2017) is the assumption by healthcare professionals that patients do not wish to share decision-making. This may be the case for some patients and their preference should be respected. However, this is more common among older patients who are more familiar with the paternalistic approach to health care, where the patient is expected to do as they are told (Say et al, 2006; Lifford et al, 2015). As a result, some older patients feel that they will upset healthcare professionals if they do not agree with the decisions made by the clinicians and wish to be perceived as a 'good' patient, thus avoiding potential conflict (Elwyn et al, 2012).

To overcome this, an element of coaching and letting go is required — something not familiar with some historical models of care. In order to

Driving workforce and clinical transformation with L&R

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- Projections by the Kings Fund estimate **that NHS staff shortages will reach 250,000 by 2030**?³

THE SOLUTION*

THE **BIG**
SQUEEZE

L&R's 3-Step approach - to deliver workforce transformation

RELEASING UP TO

95%

In nursing hours per patient back to care

SAVING UP TO

83%

In total cost of care per patient

SAVING UP TO

72%

In product costs per patient

Scan the QR Code to **access the study and view the outcomes in full**



1. Guest et al (2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013, BMJ V10.11

2. Guest J (2021) Burden of wounds to the NHS: what has changed since 2012/13? Guest editorial, Wounds UK, Vol 17, No 1

3. Staffing shortfall of almost 250,000 by 2030 is major risk to NHS long-term plan, experts warn | The King's Fund (kingsfund.org.uk)

* Hallas-Hoyes et al. (2021). An advanced self-care delivery model for leg ulcer management: a service evaluation. JWC

Lower Limb Wound Pathway

Immediate Care
Leg Ulcer Assessment
Ongoing Treatment

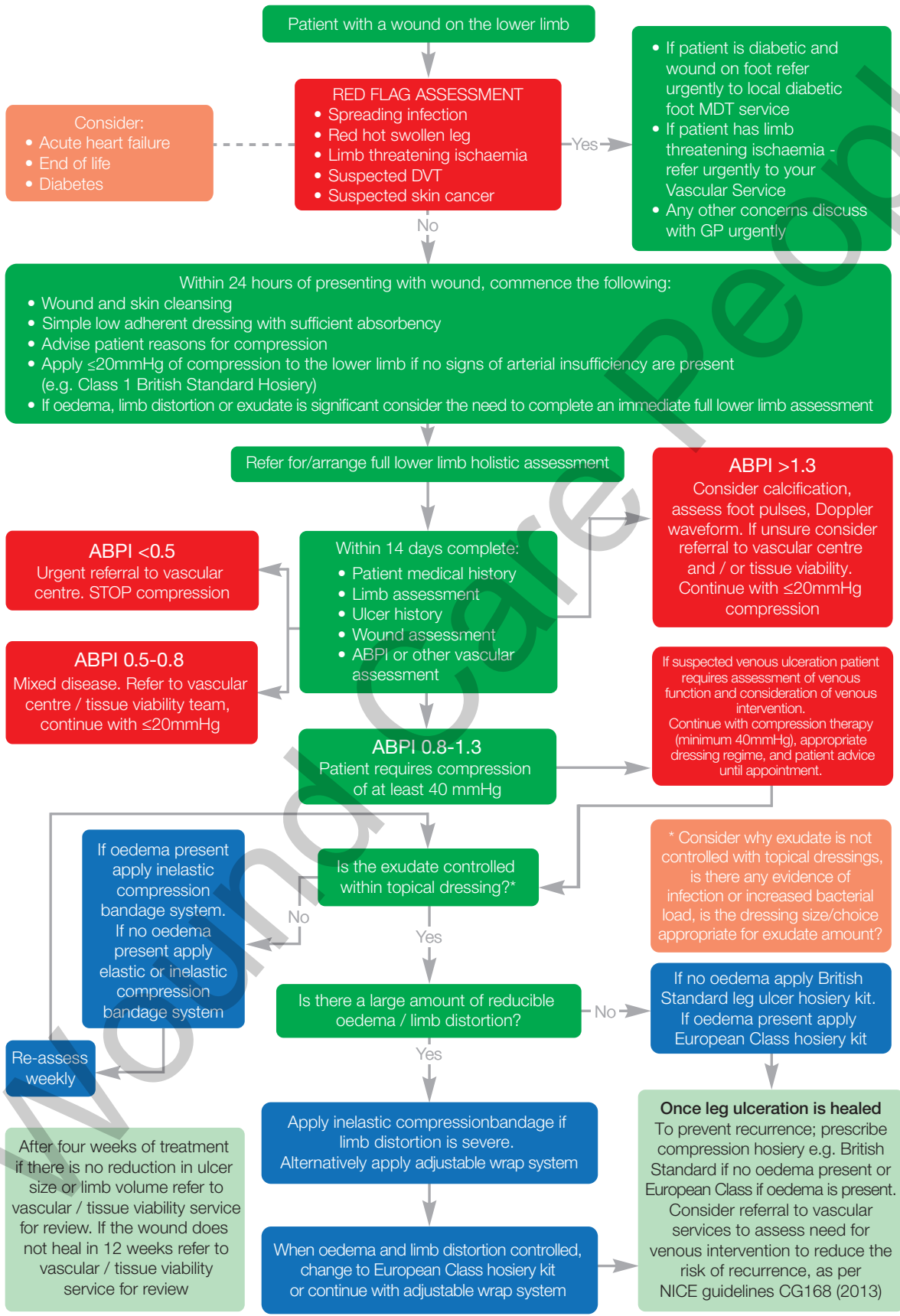
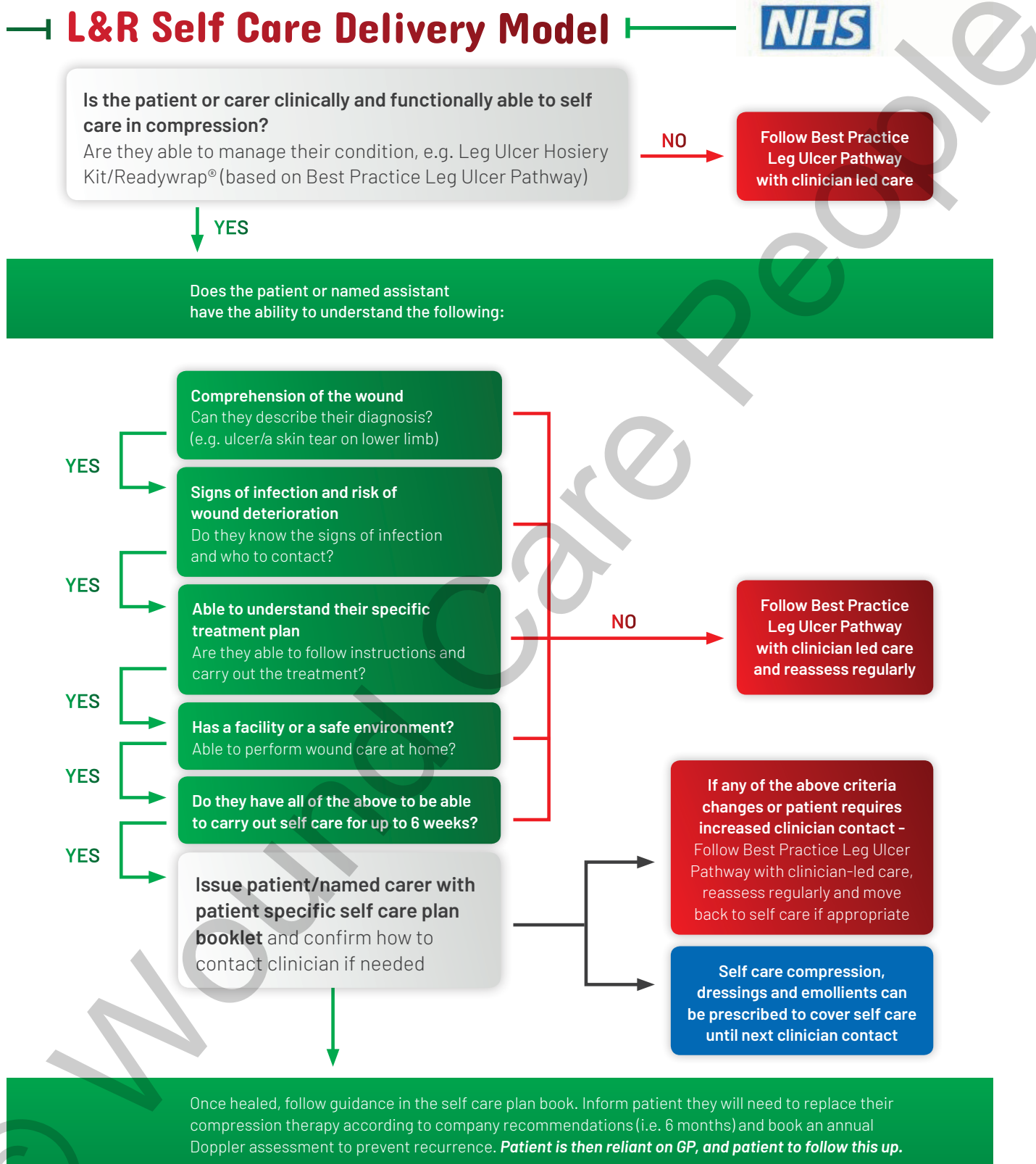


Figure 1. Lower limb wound pathway.



SQUEEZE IN

LEADING THE SELF-CARE REVOLUTION



Figure 2. Self-care delivery model.

Box 1 Study parameters

- ▶ Resource reallocation
- ▶ Staff motivation and work satisfaction
- ▶ Staff wellbeing and ergonomics
- ▶ Productivity
- ▶ Timely documentation
- ▶ Healthcare professional time
- ▶ Product cost

establish a therapeutic relationship, it is important to:

- ▶ Establish the patient’s level of understanding into their condition
- ▶ Establish the patient’s service and practitioner expectations
- ▶ Establish the level of social support needed/provided
- ▶ Outline the model of care being considered
- ▶ Emphasise the importance of patient/carer involvement
- ▶ Set realistic and achievable goals alongside effective communication and support (Wounds International, 2016).

Enabling a more active stakeholder role for patients and their carers is referred to as ‘patient empowerment’, ‘patient engagement’ or ‘patient involvement’ (Wounds International, 2016). However, the term ‘involvement’ is not clearly understood by either patients or clinicians and can often mean different things to different people. As highlighted in the Eurobarometer Qualitative Study (2012), for both practitioners and patients, ‘involvement’ is often used simply

to understand medical compliance and whether a patient is able to follow a plan of care. The difference between what we believe the patient experience to be and the actual experience should be explored and better understood (Palmer, 2022).

Healthcare providers should explore and develop models of care in line with patients’ capability and capacity to learn, not just through historic, entrenched and ritualistic practice. Indeed, patients who have access to support and education, who have previous treatment experience or already live with a chronic disease have an increased likelihood of being able to be more actively involved in their care (Eurobarometer Qualitative Study, 2012). When willing and able, working in partnership with patients has significant benefits. Embracing self-care can improve patients’ physical, emotional, and mental health, reduce stress and anxiety, manage chronic conditions effectively, develop a sense of self-awareness and improve their overall quality of life (Kapp and Santamaria, 2020). Additionally, self-care can lessen healthcare costs by reducing the need for medical interventions (Hallas-Hoyes et al, 2021).

Self-care can also positively impact clinicians as it helps them to maintain their own health and well-being, essential for providing high-quality care to their patients. Clinicians who engage in self-care are better able to manage stress, prevent burnout, and maintain a positive work-life balance (Hallas-Hoyes et al, 2021). This, in turn, can improve job satisfaction and increase the quality of care they provide to their patients.

PATIENT OUTCOMES

Within the first five months, 110 patients were assessed as suitable for self-care and were recruited onto the service evaluation following the patient recruitment pathway (Figure 3). Of these 110 patients, 12 exited the self-care pathway and so were withdrawn from the evaluation and data were collected on the remaining 98 patients. The reasons for exit broadly fit into the following categories:

- ▶ Declined further treatment or neglected wound hygiene (n=3)
- ▶ Patient no longer able to self-care (n=4)
- ▶ Change of living situation/ personal circumstances (n=3)
- ▶ Patient death or crisis (n=2).

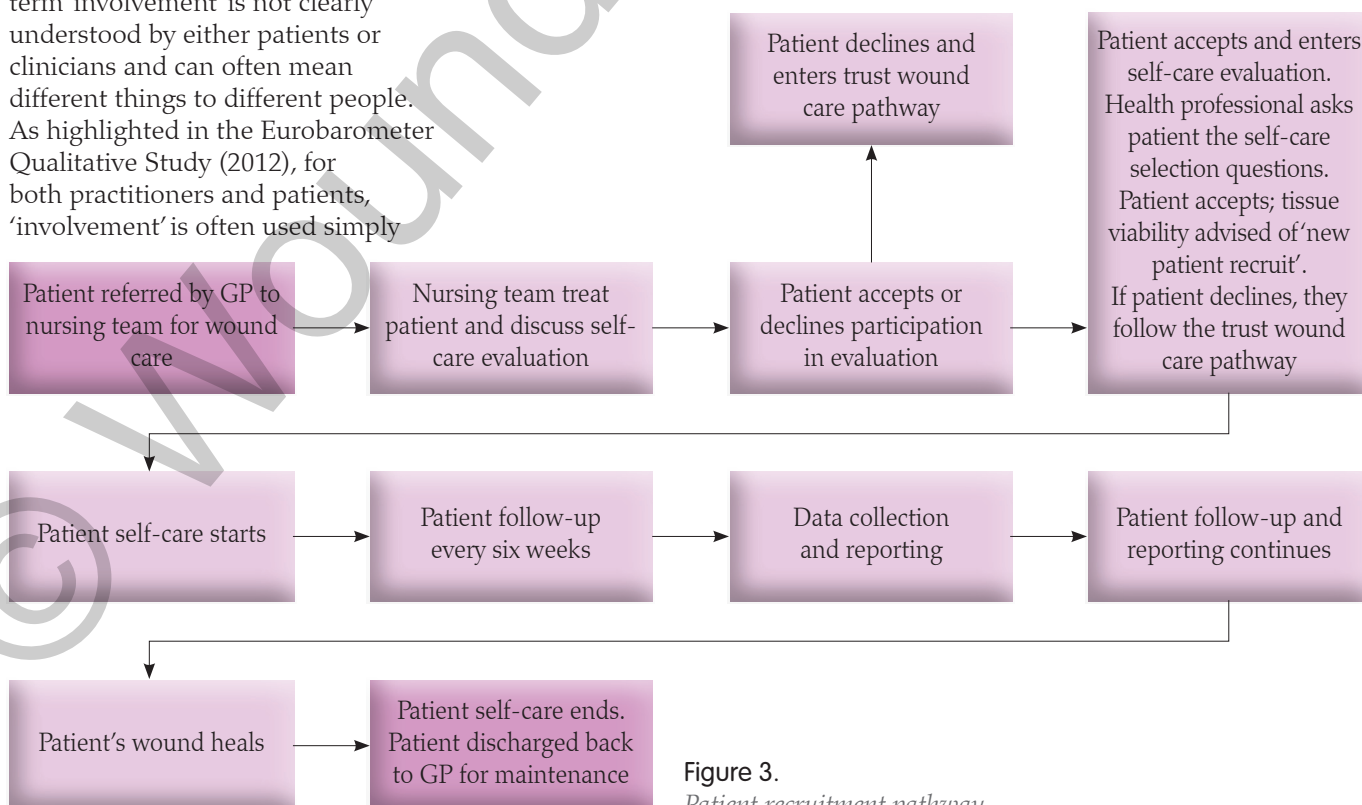


Figure 3. Patient recruitment pathway.

Further to this, three patients had inconsistent data entries and were subsequently withdrawn from the final data analysis, leaving a total of 95 patients. Of the 95 remaining patients following the self-care pathway:

- ▶ 84 patients healed by week 24
- ▶ An additional 10 patients healed by week 42
- ▶ The remaining patient reached week 42 without healing.

By week 42, VLU healing rates were 99% for the self-care delivery model (Figure 4), compared with 98% using the conventional best practice leg ulcer treatment pathway. This suggests healing outcomes for the self-care delivery model are similar to those treated using a conventional best practice leg ulcer treatment pathway in isolation. This confirmed SWYT's original premise that when suitable, patients with a VLU can use a self-care delivery model using less resource and continue to maintain equivalent healing rates. Table 3 illustrates 68 (72%) patients were healed at week 18, increasing to 84 (88%) at week 24.

Due to the stigma that age and gender can have a negative impact on clinical outcomes and associated time, nursing time per patient data were analysed. This recorded the mean nursing time in minutes required to achieve full wound closure across the patient cohort. This highlighted that neither age nor gender was necessarily a barrier to self-care and nursing time does not rise as patient age increases.

Table 3: Healing rate of all self-care participants (n=95)

Point on pathway	Patients healed	
	(%)	(No.)
Assessment	3.4	3
6 weeks	29.0	28
12 weeks	47.3	45
18 weeks	72.2	68
24 weeks	88.2	84
30 weeks	91.7	86
36 weeks	96.4	91
42 weeks	98.8	94

Table 4: Overall cost for patient

Pathway of care	Health professional time	Product	Total	Saving per patient	Saving
Traditional pathway	£3078.56	£1257.44	£4336.00	Traditional pathway cost minus self-care delivery model cost of £361	£3975.00
Best practice leg ulcer pathway	£1539.28	£628.72	£2168.00	Best practice leg ulcer pathway cost minus self-care delivery model cost of £361	£1807.00
12 weeks	£184.11	£176.89	£361.00		

Table 5: Overall cost for patient across product and healthcare professional time

Cost data from Southwest Yorkshire Trust (SWYT)	Cost per patient pathway	Product spend apportionment percentage	Health professional spend percentage	Product spend per patient	Health professional spend per patient
Traditional	£4336.00	29%	71%	£1257.00	£3079.00
Best practice leg ulcer pathway	£2168.00	29%	71%	£629.00	£1539.00
Self-care delivery model	£361	49%	51%	£177.00	£184.00

INFECTION CONTROL

Lower limb leg ulcer healing times are often compromised by wound infection (International Wound Infection Institute [IWII], 2022; Wounds UK, 2022). This service evaluation closely monitored infection rates following the introduction of the self-care delivery model, where medical records stated whether infection had increased, decreased or remained static. The data found infection rates did not increase following the introduction of the self-care model and generally reduced from 5% at the initial assessment to 0% at week six. However, throughout the evaluation, two patients did experience infection at 12 weeks and one patient at 30 weeks, leading to an overall infection rate of 2% and 3% retrospectively.

CLINICIAN SATISFACTION

Changing the way health care is delivered can present challenges to both staff and patients (Craig and Dowding, 2019). To understand the impact a self-care delivery model had across the service, the tissue viability team requested feedback through an online questionnaire. This survey was sent to 150 members of staff across several community nursing bases. The survey sought to understand the

effect of the self-care delivery model on the individuals and the service as a whole, and was anonymised and collated to provide clinical validation (Box 1).

The results unanimously supported the self-care delivery model and its ability to steer both the team's work practice and the care delivered to their patients. The feedback also suggests implementation of the model had improved job satisfaction through being able to provide care in a more thoughtful and timely manner. Furthermore, the model has potential to benefit staff wellbeing by reducing the ergonomic impact of lower limb management, such as that caused by kneeling and bending while attending patients' wounds.

RESOURCE EFFICIENCY

Based on unpublished data held on file by L&R, on average, the number of nursing hours needed to treat a patient's VLU through to complete closure was 24.5 hours, or 1,470 minutes. This is also supported through data published by Guest et al (2018). When use of the self-care delivery model was implemented, the recorded mean number of nursing hours required to achieve complete closure was 1.3 hours. This time

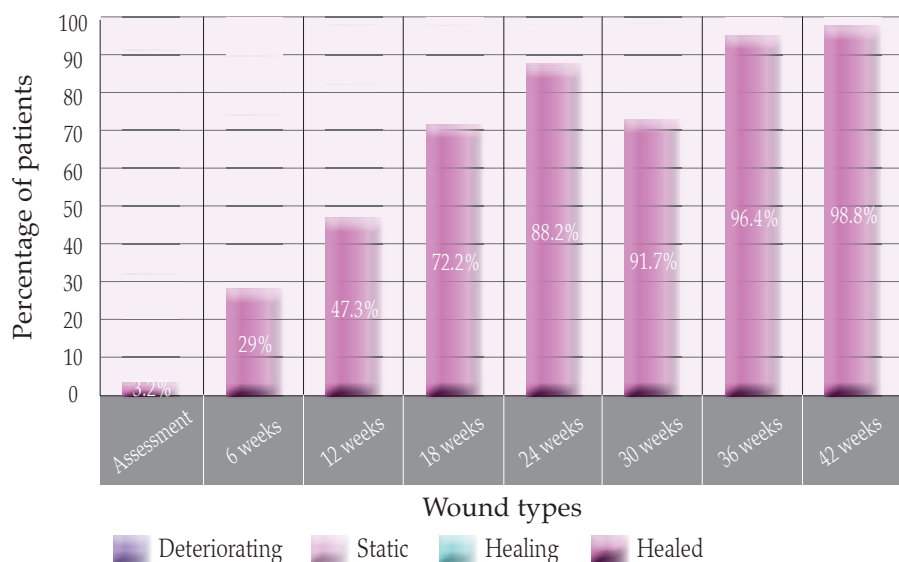


Figure 4. Healing rates for completed care using the self-care delivery pathway and healing status based on the last data entry.

efficiency equates to >90% reduction in healthcare professional contact time, representing a mean saving of 23.2 nursing hours per healed patient. This reduction in time was mainly due to 83 of the 95 patients being able to self-care for six weeks and the majority healing within 18–24 weeks.

COST-EFFECTIVENESS

To evaluate the cost-effectiveness of the self-care delivery model, the tissue viability service conducted a cost audit to understand the potential efficiency savings across Barnsley. This audit utilised all healthcare professional costs, including nursing time and total wound care product spend (Table 4). Healthcare professional time included initial patient assessment costs at a standard unit cost of £50 per hour and was based on patient appointment times of 20 minutes.

Wound care product use was driven by the number of dressing changes needed and, as product use did not vary significantly per patient, an average cost per patient was calculated.

A service cost analysis compared the new self-care delivery model against the original traditional pathway and the currently used best practice leg ulcer pathway, which is implemented when self-care is not suitable. The mean total cost using

‘When a patient and/or their carer is capable and accepting of self-care, the required healthcare professional input needed for a patient with a VLU can be reduced by over 90%.’

the self-care model was £361, with an overall reduction of £3975 when compared to the original traditional pathway and a saving of £1807.00 when compared against the best practice leg ulcer pathway. This cost reduction was mainly due to less nursing time needed to implement effective care, as to that in both the original traditional and best practice leg ulcer pathways where the ratio for distribution of healthcare professional cost to wound care product spend was approximately 70:30. (Table 5). The self-care delivery model however, reduced health professional cost and wound care product spend to 51% and 49% respectively. This highlights both a decrease in healthcare professional time and in product spend.

‘NHS LONG TERM PLAN’ (<CO2 EMISSIONS)

Travel time, either by the healthcare professional visiting a patient or a patient attending clinic, is significant in terms of cost, associated time (Table

6), and the environmental impact. Although not a primary objective, this service evaluation explored travel and its associated time per journey as it may be possible to avoid some travel and save more time if a self-care delivery model is followed. As this data were not independently analysed and was based on estimated data, it was not included within the total cost of patient management. However, as expected, the implementation of the self-care delivery model did result in a reduction in travel (mileage + time), fuel costs and carbon dioxide emissions and this is estimated to equate per 100 patients to:

- ▶ 1471kg saving in carbon dioxide
- ▶ £535 saving in fuel costs
- ▶ 60% reduction in miles driven using the self-care delivery model).

CONCLUSION

In SWYT, there are up to 2,000 new patients referred into the tissue viability service per annum. This could equate to a visit schedule of over 20 clinical visits per day, per healthcare professional. With an estimated 144,000 visits per year, this represents a significant workforce challenge and as stated within the Burden of Wounds study (Guest et al, 2020), one that is potentially unsustainable. When a patient and/or their carer is capable and accepting of self-care, the required healthcare professional input needed for a patient with a VLU can be reduced by over 90%. This reduction in resource input could relieve the burden on service delivery and the overall cost of managing an individual with a VLU. This service evaluation has demonstrated how implementing a self-care delivery model could reduce the overall treatment costs of following the leg ulcer pathway from £2168.00 to £361 per wound, with no negative impact on healing outcomes.

Based on these findings, if a clinical team has a caseload of 2,000 new patients per year, and a service provider enrolls ≥40% of new patients

Table 6: Travel time

Total time	Actual travel time in hours	Travel time avoided in hours
418	160	258

into a self-care delivery model, it could allow the capacity of nearly two full-time equivalents (FTEs) to be assigned to other essential healthcare duties. It may not be possible to fully release this time saving, but it will enable the service provider to prioritise and deliver other necessary care, especially to patients with multiple comorbidities or more complex presentations. It is therefore recommended that service providers explore the possibility of introducing a self-care model for VLU care. **JCN**

REFERENCES

- Arundel CE, Welch C, Saramago P, et al (2023) A randomised controlled trial of compression therapies for the treatment of venous leg ulcers (VenUS 6): study protocol for a pragmatic, multicentre, parallel-group, three-arm randomised controlled trial. *Trials* 24(1): 357
- Ashby RL, Gabe R, Ali S, Adderley U (2014) Clinical and cost-effectiveness of compression hosiery versus compression bandages in treatment of venous leg ulcers (Venous leg Ulcer Study IV, VenUS IV): A randomised controlled trial. *Lancet* 383(9920): 871–9
- Bayliss EA, Steiner JF, Fernald DH, Crane LA, Main DS (2003) Descriptions of barriers to self-care by persons with comorbid chronic diseases. *Ann Fam Med* 1(1): 15–21
- Blecken SR, Villavicencio JL, Kao TC (2005) Comparison of elastic versus nonelastic compression in bilateral venous ulcers: a randomized trial. *J Vasc Surg* 42(6): 1150–5
- Browning P (2016) The House of Lords debates wound care strategy. *J Wound Care* 26(12): 707–11
- Craig J, Dowding D (2019) *Evidence-based practice in nursing*. 4th edn. Elsevier Limited
- Dowsett C (2022) Reducing variation in venous leg ulcer management: a focus on compression. *Wounds UK* 18(4): 58–64
- Elwyn G, Frosch D, Thomson R, et al (2012) Shared decision making: a model for clinical practice. *J Gen Intern Med* 27: 1361–67
- Eurobarometer Qualitative Study (2012) *Patient involvement. Aggregate report, May 2012*. Available online: https://health.ec.europa.eu/system/files/2016-11/eurobaro_patient_involvement_2012_en_2.pdf
- Grady PA, Gough LL (2014) Self-management: a comprehensive approach to management of chronic conditions. *Am J Public Health* 104(8): e25–31
- Guest JF, Ayoub N, McIlwraith T, et al (2015) Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 5(12): e009283
- Guest J, Fuller G, Vowden P (2018) Venous leg ulcer management in clinical practice in the UK: costs and outcomes. *Int Wound J* 15(1): 29–37
- Guest JF, Fuller GW, Vowden P (2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. *BMJ Open* 10: e045253
- Hallas-Hoyes L, Williamson S, Kerr A, Andrews T, Calladine L (2021) An advanced self-care delivery model for leg ulcer management: a service evaluation. *J Wound Care* 30(9): 751–62
- Hopkins J, Narasimhan M (2022) Access to self-care interventions can improve health outcomes for people experiencing homelessness. *BMJ* 376: e068700
- International Wound Infection Institute (2022) *Wound Infection in Clinical Practice*. Wounds International, London
- Joseph-Williams N, Lloyd A, Edwards A, Stobart L, Tomson D, Macphail S, et al (2017) Implementing shared decision making in the NHS: lessons from the MAGIC programme. *Br Med J* 357: 1–6
- Kapp S, Santamaria N (2020) The effect of self-treatment of wounds on quality of life: a qualitative study. *J Wound Care* 29(5): 260–8
- Krist AH, Tong ST, Aycock RA, Longo DR (2017) Engaging patients in decision-making and behaviour change to promote prevention. *Stud Health Technol Inform* 240: 284–302
- Lifford KJ, Witt J, Burton M, Collins K, Caldon L, Edwards A, et al (2015) Understanding older women's decision making and coping in the context of breast cancer treatment. *BMC Med Inform Decis Mak* 15: 45
- Lusher J (2020) Who's wound is it anyway? *Int Wound J* 17(4): 1092–93
- National Wound Care Strategy Programme (2020) *Recommendations for Lower Limb Ulcers*. Available online: www.nationalwoundcarestrategy.net/wp-content/uploads/2021/04/Lower-Limb-Recommendations-WEB-25Feb21.pdf
- NHS England (2019) *NHS Long Term Plan*. Available online: www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (accessed 29 March, 2023)
- Palmer JS (2022) Shared decision making for efficacious wound care. *Br J Community Nurs* 27(Sup6): S8–S10
- Say R, Murtagh M, Thomson R (2006) Patients' preference for involvement in medical decision making: a narrative review. *Patient Educ Couns* 60(2): 102–14
- Wounds International (2016) *International Best Practice Statement: Optimising patient involvement in wound management*. Wounds International, London
- Wounds UK (2016) *Best practice statement: holistic management of venous leg ulceration*. Wounds UK, London
- Wounds UK (2022) *Best Practice Statement: Holistic management of venous leg ulceration (second edition)*. Wounds UK, London
- Zahra S; Arundel C; Jones K, Davill T; Roberts G; Dunville J (2022) VenUS 6 — A randomised controlled trial of compression therapies for the treatment of venous leg ulcers: Study design and update. *J Wound Management* 23(1): 13–17

KEY POINTS

- Lower limb ulceration continues to be a common cause of suffering and its management places a significant burden on the NHS, with venous leg ulcers (VLUs) being the most common hard-to-heal wound in the UK.
- Delivering effective long-term self-care is one of many strategies that can enhance the delivery of effective and efficient lower limb management.
- To adopt shared decision-making and facilitate self-care involves a shift in attitude and can be a key challenge for any change programme.
- This article outlines the results of implementing a lower limb wound pathway and a lower limb self-care delivery model measuring clinical outcomes and the impact on workforce pressures.

Effects of chronic cough on urinary incontinence

Ann Yates

A chronic cough is often a symptom of respiratory illness, but it can be brought about by many factors, i.e. smoking, being female, abdominal obesity, low income, environmental factors, allergies, medication and increased age (Colak et al, 2017). Unfortunately, a frequent side-effect of chronic coughing is urinary incontinence (UI) — mainly stress urinary incontinence (SUI). Although quite prevalent within this cohort of individuals, there seems to be little professional knowledge with regards to interventions to prevent or treat UI. This article looks at the causes of chronic coughing and how it impacts on UI. It also identifies how professionals can recognise at-risk patients and start treatment options.

KEYWORDS:

■ Urinary incontinence ■ Stress urinary incontinence ■ Chronic cough
■ Assessment ■ Treatment options

Urinary incontinence (UI) has long been associated with respiratory symptoms and, in the main, a chronic cough. A chronic cough has been defined as a cough presenting as the only or predominant symptom and lasting for more than eight weeks with no obvious abnormalities on chest imaging (Yang et al, 2022). Chronic cough accounts for up to 10–38% of patients attending respiratory clinics (Yang et al, 2022) and has several complications associated with it, e.g. sleep disruption, headaches, and dizziness. Furthermore, the effects of a chronic cough can also lead to UI. Urinary incontinence is defined by the International Continence Society as the involuntary loss of urine (Abrams et al, 2010).

The main type of UI associated with chronic coughing is stress urinary incontinence (SUI), which

is the involuntary leakage of urine from the urethra associated with effort, physical exertion, sneezing or coughing (Haylen et al, 2010). The incidence of UI in females with chronic cough is higher than in males (Yang et al, 2022). This is mainly due to females having a higher risk of UI due to pregnancy, childbirth and the menopause (Haukeland-Parker et al, 2021). However Burge et al (2017) and Salman et al (2022) recognised in both studies of men with chronic cough/respiratory illness that prevalence of SUI and UI in this group is higher than men without respiratory/chronic cough symptoms.

Complications of urinary incontinence can have a severe negative impact on quality of life. It is common for individuals to have higher levels of depression, anxiety and stress, and poor sleep quality (Haukeland-Parker et al, 2021). UI may also contribute to absences from work, avoidance of social activities and isolation, as well as financial implications including increased health costs (Haukeland-Parker et al, 2021).

Thus, UI associated with chronic cough has been demonstrated as a significant clinical problem that professionals should have the knowledge to be able to identify and address.

CAUSES OF CHRONIC COUGH

To understand the impact of a chronic cough on UI, individual risk factors and the most common and less common causes responsible for chronic cough should be considered.

Individual risk factors for a chronic cough are varied according to a study undertaken by Colak et al (2017). In this study of 14,669 individuals, prevalence of chronic cough in the general population was:

- ▶ 4% overall
- ▶ 3% in never smokers
- ▶ 4% in smokers
- ▶ 8% in current smokers.

These figures identify smoking as a risk for respiratory conditions and a factor in chronic coughing. Other associated risks were being female, abdominal obesity, low income, environmental factors, allergies and increased age (Colak et al, 2017).

The most common and less common causes contributing to a chronic cough are identified in *Table 1*. Some of the most common causes are now described in further detail.

Asthma is a chronic respiratory disease that affects the airways by causing inflammation of the inside walls which become sore and swollen causing constriction of the passage of the lungs and making it difficult to breath (Barrie, 2023). There are numerous triggers for asthma, including:

Table 1: Causes of chronic cough (adapted from NHS Inform Scotland, 2023a; Mayo Clinic, 2019)

Most common	Less common
Asthma — cough can be exacerbated when exposed to cold air, certain chemicals or vary with seasons	Heart failure
Postnasal drip — when nose or sinuses produce extra mucous, which then drips down the back of the throat and triggers cough reflex	Bronchiectasis — damaged, dilated airways
Gastro-oesophageal reflux disease (GORD) — where the throat becomes irritated by leaking stomach acid	Bronchiolitis — inflammation of the small airways of the lungs
Infections — can linger after symptoms of pneumonia, flu, Covid, fungal infections or tuberculosis	Cystic fibrosis
Chronic obstructive pulmonary disease (COPD) — a chronic inflammatory lung disease that causes an obstructed airflow from the lungs	Lung cancer
Medication, i.e. blood pressure drugs, e.g. angiotensin-converting enzyme (ACE) inhibitors	Non-asthmatic eosinophilic bronchitis — airway inflammation not caused by asthma
Allergy	Sarcoidosis — collection of inflammatory cells in the lungs

- ▶ Animal/pet hair
- ▶ Dust mites
- ▶ Certain medication including aspirin/non-steroidal anti-inflammatory drugs (NSAIDS)
- ▶ Changes in weather
- ▶ Chemicals in air/food
- ▶ Exercise
- ▶ Mould
- ▶ Pollen

(Barrie, 2018).

Postnasal drip is when more mucus than normal gathers and drips down the back of your throat. You may feel like you have a tickle in the back of your throat. Postnasal drip can be a bothersome condition that can lead to a chronic cough. Usual cause of postnasal drip is allergies (Mayo Clinic, 2019; NHS Inform Scotland, 2023a).

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. Symptoms include difficulties breathing, mainly due to narrowing of airways (NHS Inform Scotland, 2023b). The main cause is smoking and the likelihood of developing COPD increases the more you smoke and the longer you have been smoking (NHS Inform Scotland, 2023b). This is because smoking irritates and inflames the lungs, which results in scarring. This inflammation leads to permanent changes in the

lungs walls. Damage to the delicate walls of the air sacs in the lungs causes emphysema and the lungs lose their normal elasticity (NHS Inform Scotland, 2023b). The smaller airways also become scarred and narrowed. These changes cause the symptoms of breathlessness, cough and phlegm associated with COPD.

Medications used for both the treatment of respiratory conditions and other conditions, i.e. oral medication, can cause chronic coughing leading to SUI. These can include:

- ▶ Angiotensin-converting enzyme inhibitors (ACE inhibitors)
- ▶ Opioids, which can account for an incidence rate of between 28–66% causing a chronic cough
- ▶ Statins
- ▶ Other drugs, e.g. omeprazole, interferon and ribavirin

(Hongmei et al, 2020).

However, a study by Battaglia et al (2019) on inhaled drugs for treatment of respiratory conditions concluded that the probability of these drugs causing or having an effect on urinary problems was very low.

EFFECTS OF A CHRONIC COUGH ON THE PELVIC FLOOR

There are many reasons for pelvic floor weakness (Table 2), however this article will concentrate on the effects of chronic coughing.

It is commonly accepted that chronic coughing is a contributory cause for SUI and this has been supported by a plethora of scientific evidence (Battaglia et al, 2019). Studies have shown the presence of symptomatic cough were statistically significantly higher in both men and women with UI, thus the chronic cough is suggested as being the main cause of SUI in this cohort of individuals (Battaglia et al, 2019).

The question is why does a chronic cough have such a devastating effect on the pelvic floor? To understand this, an understanding of the anatomy and pathophysiology of the pelvic floor is needed.

The pelvic floor is made up of muscles and connective tissue that form a 'sling' or 'hammock' across the base of the pelvis. It is designed to keep all pelvic organs in place, namely bladder, bowel and in females uterus, and support spinal and pelvic stability (Yates, 2019a). These muscles control the opening of the bladder and maintain sphincter pressure. When working correctly and intra-abdominal pressure is increased, i.e. coughing, they react by contracting around the urethra to prevent leakage. However, anything that repeatedly or continuously raises abdominal pressure will put added strain on the pelvic floor muscles and risks damaging them, i.e. chronic cough (Yates, 2019a).

Table 2: Pelvic floor weakness — risk factors (Abrams et al, 2017; Yates, 2019a)

▶ Pregnancy and childbirth
▶ Chronic constipation
▶ Factors raising intraabdominal pressure, including chronic coughing due to respiratory illness, smoking or medication, heavy and/or repeated lifting, high impact exercise, being overweight/obese
▶ Ageing and menopause
▶ Surgery — this can cause trauma to the pelvic floor
▶ Neurological illness, especially connective tissue conditions as these can weaken pelvic floor
▶ Sexual abuse can cause trauma to pelvic floor
▶ Ethnicity — Hispanic and Caucasian women are at greater risk of pelvic floor weakness compared to African/Asian women

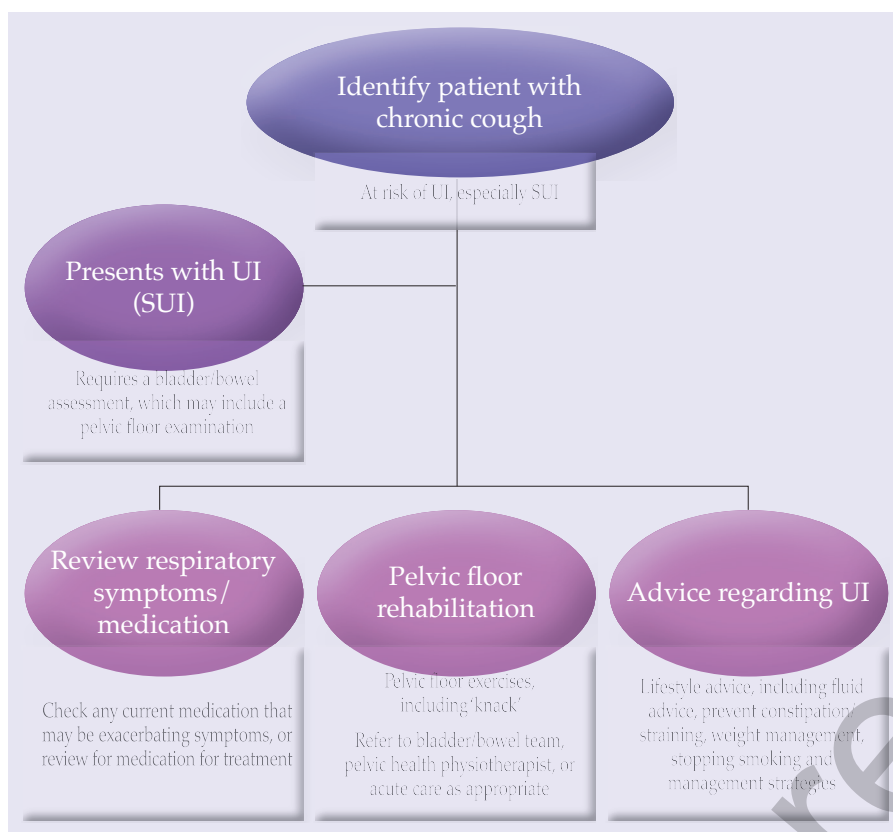


Figure 1. Sample flow chart to indicate pathway for individuals with chronic cough presenting with UI.

ASSESSING CONTINENCE FOR AN INDIVIDUAL WITH CHRONIC COUGH

It has been identified that healthcare professionals are not familiar with UI in men or women who suffer with respiratory conditions and exacerbation of chronic cough (Battaglia et al, 2019). Individuals who have UI due to chronic cough may also not mention the condition to a professional due to shame, embarrassment or low perception of the importance and consequences of the condition compared to presenting respiratory symptoms. Professionals should identify at-risk individuals and urinary assessment should be included within clinical assessment (Battaglia et al, 2019; Hennessey, 2023).

A continence assessment should include (Colley, 2020; Yates 2019b):

- ▶ Complete medical, surgical, obstetric, neurological and mental health history, details of any allergies, mobility, dexterity, and cognitive or social issues
- ▶ Body mass index (BMI)
- ▶ Information about the onset,

duration and current presentation of the symptoms and whether related to a specific event (i.e. coughing)/condition, effect on current quality of life and current management

- ▶ Details of all medication, including over-the-counter medication, herbal remedies and recreational drug use
- ▶ A completed bladder diary (usually three days)
- ▶ Details of fluid intake (including amount and type of fluids)
- ▶ Dipstick urinalysis — which is used on an initial continence assessment only as a screening rather than a diagnostic test. This helps to rule out dehydration and other medical issues including renal problems, diabetes and potential urinary tract infections (UTIs)
- ▶ Bladder scans — if presenting with symptoms of poor flow, feelings of incomplete emptying and recurrent UTIs, or have an underlying neuropathy
- ▶ Examinations (vaginal/rectal/abdominal/neurological), if required, but only performed by a competent professional.

It is vitally important to assess the individual before initiating any form of treatment or management plan.

TREATMENTS AND MANAGEMENT

Prevention is the primary aim of treating UI associated with chronic cough (Figure 1).

This can include reviewing and possibly removing medication aggravating the chronic cough which has an impact on UI. For example:

- ▶ Treating asthma-related coughing with appropriate inhaled steroids (as these have a low impact on UI)
- ▶ Allergies can be treated by avoiding allergens and taking antihistamines to dampen down allergic reactions
- ▶ Treating bacterial infections with antibiotics (when clinically required)
- ▶ GORD can be treated with antacids to neutralise stomach acid and medication to reduce the amount of acid the stomach produces (but be aware that omeprazole may have an impact on coughing)
- ▶ COPD can be treated with bronchodilators to widen airways (NHS inform Scotland, 2023a).

One of the best ways to improve SUI is the instruction of pelvic floor exercises and pelvic floor rehabilitation. Pelvic floor exercise is well evidenced and documented for reducing SUI in other populations

KEY POINTS

- Chronic cough can have a significant impact on an individual's bladder control.
- The causes of chronic coughing should be reviewed regularly to prevent UI complications.
- At risk individuals should be identified and advice/treatment/preventative measures initiated.
- Professionals treating respiratory conditions associated with chronic cough should be able to access relevant pelvic floor experts to treat patients.

but there is a sparsity of evidence with regards to its implementation within individuals who suffer SUI from chronic cough (Haukeland-Parker et al, 2021).

A study by Button et al (2019) explored if pelvic floor exercises would benefit to women with respiratory disease compared to women without respiratory disease. All participants underwent a three-month treatment programme, had assessments at baseline, treatment completion (three months) and three months following treatment by a specialist pelvic floor physiotherapist. Treatment comprised pelvic floor muscle training, including the knack, contraction of pelvic floor on exertion, sneezing, coughing etc and a daily pelvic floor exercise regimen (Button et al, 2019). The study indicated that the initiation of pelvic floor exercises did improve SUI outcomes for this group of individuals and should be promoted as a treatment.

An example of a pelvic floor rehabilitation programme is identified in *Box 1*. Initial assessment and instruction should always be undertaken by a professional competent in pelvic floor assessment and rehabilitation.

CONCLUSION

Many individuals suffer with UI due to a chronic cough. However, healthcare professionals who treat respiratory conditions are unaware of the bearing that a chronic cough can have on UI and the negative impact this causes on quality of life. Individuals who are at risk, or already suffer with UI due to their condition, should be identified and treated. Review of their current treatments should be undertaken and advice given to see if minimising the cough would have an impact. If they already have SUI, referral to an appropriate professional for pelvic floor instruction should be considered. At present, these individuals are having a raw deal when it comes to UI presentation, which, in the author's clinical opinion, needs to be addressed. **JCN**

Patient story

Violet (name changed for confidentiality), a 30-year-old, was a self-referral into the author's bladder and bowel service (BABS) with symptoms of urinary leakage on coughing, sneezing and exertion.

She had suffered with asthma since childhood, had no other relevant previous history and was nulliparous, non-smoker, with a BMI of 24. Previously, her medication had included a reliever inhaler (salbutamol, a preventative inhaler) and budesonide, and she stated that she had been prescribed steroids on numerous occasions. However, over the past five years symptoms of coughing and urinary leakage have got significantly worse. She has discussed her respiratory symptoms with her consultant and her medication is currently being reviewed. But, Violet felt too embarrassed to bring up her urinary problem, as she thought that she was the only one suffering with this even though the symptoms were affecting her quality of life greatly. She finally heard of BABS through a friend and eventually plucked up the courage (after two months) to contact the service.

All of this information was taken during her initial assessment, when her presenting symptoms were also assessed. These included frequency of urination seven times in 24 hours, no urgency, hesitancy or straining to void, but urinary leakage five to six times daily, usually no night time leakage (apart from when having an exacerbation of her asthma, usually a small-moderate amount and always associated with coughing, sneezing or exertion). She currently purchases her own pad products to manage the situation. She found the whole situation extremely humiliating and degrading, especially for a young working lady — it has affected her working and social life, her emotional wellbeing, as well as her finances.

Continuing the assessment her bowel pattern was checked which was usually daily, type 3–4 on the Bristol Stool Chart (BSC), no straining or bleeding noted.

She consented to a pelvic floor examination, which identified that she had a very weak pelvic floor, grade 1 on the Oxford grading (flicker only). She could only hold for three seconds and only repeat twice, and only achieved two fast muscle contractions. There was also some descent and slight urinary leakage noted on coughing. She thus had a differential diagnosis of stress urinary incontinence.

A treatment plan was discussed in depth, which included lifestyle advice and referral to a pelvic floor physiotherapist, as this would be the gold standard for improving outcomes. She was advised that she would not see any improvement for up to three months.

Violet was happy that she had contacted the service and realised that she was not alone and something could be done, her only regret was that she had not come forward sooner.

REFERENCES

- Abram P, Cardozo L, Fall M, Griffiths D, Rosier P, Ulmsten U, et al (2010) The standardisation of terminology of lower urinary tract function: report from the Standardisation Sub-committee of the International Continence Society. *Neurourol Urodyn* 29: 213–40
- Abrams P, Cardozo L, Wagg A, Wein A, eds (2017) *Incontinence*. International Continence Society, Bristol
- Barrie M (2018) Respiratory conditions and urinary incontinence. *J Community Nurs* 32(1): 20–6
- Battaglia S, Benfante A, Principe S, Basile L, Scichilone N (2019) Urinary incontinence in chronic obstructive pulmonary disease: a common co-morbidity or a typical adverse effect. *Drugs Aging* 36(9): 799–806
- Burge AT, Lee AL, Kein C, Button BM, Sherburn MS, Miller B, Holland AE

(2017) Prevalence and impact of urinary incontinence in men with chronic obstructive pulmonary disease: a questionnaire survey. *J Physiother* 103: 53–8

Button BM, Holland AE, Sherburn MS, Chase J, Wilson JW, Burge AT (2019) Prevalence, impact and specialised treatment of urinary incontinence in women with chronic lung disease. *Physiotherapy* 105: 114–19

Çolak Y, Nordestgaard BG, Laursen LC, Afzal S, Lange P, Dahl M (2017) Risk factors for chronic cough among 14,669 individuals from the general population. *Chest* 152(3): 563–73

Colley W (2020) *Colley Model. Supporting the assessment of bladder symptoms in adults*. Available online: www.continenceassessment.co.uk (accessed 21 March, 2023)

Dorey G (2003) *Clench it or drench it! A self-help guide for ladies who lurch, laugh and leak*. Grace Dorey, Barnstaple

Haukeland-Parker S, Frisk B, Spruit MA, Stafne SN, Johannessen HH (2021) Treatment of urinary incontinence in women with chronic obstructive pulmonary disease — a randomised controlled study. *Trials* 22(1): 900

Haylen BT, de Ridder D, Freeman RM, Swift SE, Berghmans B, Lee J, et al (2010) An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction. *Neurourol* 29: 4–20

Hennessey S (2023) A urinary incontinence service for patients with chronic cough. *Nurs Times* 119: 4

Hongmei D, Cuiqui S, Xianghuai X, Li Y (2020) Drug-induced chronic cough and the possible mechanism of action. *Ann Palliat Med* 9(5): 3562–70

Mayo Clinic (2019) *Chronic cough — symptoms and causes*. Available online: www.mayoclinic.org/syc-20351575 (accessed 20 March, 2023)

NHS Inform Scotland (2023a) *Cough*. Available online: www.nhsinform.scot/illness-and-conditions/lung-and-airways/cough (accessed 20 March, 2023)

NHS Inform Scotland (2023b) *Why does COPD happen?* Available online: www.nhsinform.scot/illness-and-conditions/

Box 1

Example of a pelvic floor rehabilitation programme

Rehabilitation comprises exercises in three positions — lying down, sitting and standing.

Slow muscle contractions

Lying down: lie down on your back on your bed with your knees bent and feet slightly apart. Tighten your pelvic floor as if trying to stop wind escaping. Hold contraction for ____ seconds. Relax for four seconds. Avoid holding your breath or tensing buttock muscles.

Sitting: sit on the edge of a chair or bed with your knees apart and feet facing forward. Tighten your pelvic floor and hold contraction for ____ seconds. Relax for four seconds. Avoid holding your breath or tensing buttock muscles.

Standing: stand with weight evenly distributed, and feet apart and facing forward. Tighten your pelvic floor and hold contraction for ____ seconds. Relax for four seconds. Avoid holding your breath or tensing buttock muscles. Perform three contractions to maximum strength three times daily in each position, building up to 10 three times daily.

Fast muscle contractions

In the same three positions as above, tighten pelvic floor as if trying to stop wind escaping but do not hold. Relax and repeat. Perform three contractions to maximum strength twice daily in each position, building up to 10 three times daily

Other activities

50% lift: contract your pelvic floor to 50% of the maximum strength only while walking, climbing stairs and so on. This will increase endurance.

The knack: tighten your pelvic floor strongly and quickly before coughing, sneezing, getting up from a chair, lifting, and so on. This will help prevent leakage.

After urinating: tighten your pelvic floor strongly to 'squeeze out' the last few drops before leaving the toilet.

After defecating: tighten your pelvic floor to 'push back' any faecal matter left in the anal canal into the bowel.

During sexual activity: tighten the pelvic floor, as this will help enhance sexual intercourse.

(Adapted from Pelvic Obstetric and Gynaecological Physiotherapy, 2018; Yates, 2019c; Dorey, 2003)

lung-and-airways/copd/chronic-obstructive-pulmonary-disease (accessed 21 March, 2023)

Pelvic Obstetric and Gynaecological Physiotherapy (2018) *The Pelvic Floor Muscles: A Guide for Women*. Available online: <https://pogp.csp.org.uk/publications/pelvic-floor-muscle-exercise-women>

Salman Q, Majeed R, Shafee I, Arif S, Waris M, Ayyub A (2022) Frequency of stress urinary incontinence with chronic obstructive pulmonary disease in men; a cross sectional survey. *Multicultural Education* 8(12): 110–14

Yang C, Feng Z, Chen Z, et al (2022) The risk factors for urinary incontinence in female adults with chronic cough. *BMC Pulm Med* 22(1): 276

Yates A (2019a) Female pelvic floor 1: anatomy and pathophysiology. *Nurs Times* 115(5): 18–21

Yates A (2019b) Basic continence assessment: what community nurses should know. *J Community Nurs* 33(3): 52–5

Yates A (2019c) Female pelvic floor 2: assessment and rehabilitation. *Nurs Times* 115(6): 30–3

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Detecting frailty and unintentional weight loss

Rona Dury

The UK has a population of approximately 11 million adults, 18.6% aged 65 and over (Centre for Ageing Better, 2022). Indeed, the demographic profile of the population of England and Wales and primary care records indicate that one in five people are over the age of 65 in England (Office for National Statistics [ONS], 2018; Robards, 2020). The condition of frailty is more prevalent in the older person, and estimates provided by various studies suggest that 3% of people over the age of 65 in England have the condition (Clegg et al, 2016; Sinclair et al, 2021). Community nurse caseloads are representative of the ageing population of the UK and frailty has been recognised as a clinical condition of the older person (Leary and Bushe, 2022). Early detection of frailty by experienced nurse practitioners can assist in developing a management strategy for the patient in order to inhibit progression of the condition (Ruiz et al, 2020).

KEYWORDS:

- Frailty ■ Weight loss ■ Assessment and screening
- Identification ■ Frailty tools

The implications of an ageing population affect the role of community nurses who, as a service, care for older people in their own homes. Community nurse caseloads are representative of the ageing population of the UK, with patient activity increasing significantly over recent years (Leary and Bushe, 2022). This has not only been seen in patient numbers, but also in the complexity of care required by patients (Britton, 2017). Although not all patients on a district nurse caseload are elderly, as there are those who due to health issues are unable to leave their home to seek healthcare/nursing (Queen's Nursing Institute [QNI], 2014), the 'State of Ageing report' (Centre for Ageing Better, 2022) concluded that for many older people, living in health is becoming more unlikely.

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'Frailty has been described as a multi-dimensional clinical condition in the older person. It results in increased vulnerability to external stresses and illness, which affects physical reserves and recovery and increases susceptibility to falls, fractures, and even death.'

There are increasing numbers of people living into old age with the condition of frailty, which may also be coupled with multiple long-term health conditions, such as heart failure, depression, dementia and chronic obstructive pulmonary disease (COPD) (Mangin et al, 2022). Treating people with comorbidities adds to community nursing teams' caseloads (Maybin et al, 2016). A report published by the independent research body, Christie & Co (2017), revealed an increase in the older population being admitted

to hospital, claiming that the key factor was due to a reduction in district and community nurses at a time when hospitals are already dealing with capacity challenges. This had previously been expressed by the Royal College of Nursing (RCN) in its report which identified a 47% reduction in district nurses in England (RCN, 2014). The QNI (2014) has also stated that district nursing in England is in a state of decline, with numbers falling by 48% since 2010. These points were supported again in the QNI's 2020 report (QNI, 2014; 2020), where an emphasis was placed on increasing district nursing service numbers in recognition of the growing demand to provide high-quality care to meet the needs of the ageing population.

FRAILITY

The condition of frailty is variable regionally, with the highest rates being in coastal and urban areas in the UK (Sinclair et al, 2021). There is a predominant rate of between seven and 10% in older adults, which increases to over 25% in those over 85 years of age (Collard et al, 2012; Gale et al, 2015).

Frailty has been described as a multidimensional clinical condition in the older person (Lacas and Rockwood, 2012). It results in increased vulnerability to external stresses and illness, which affects physical reserves and recovery and increases susceptibility to falls, fractures, and even death (Kim

Practice point

There is a high prevalence of frailty among people in the community (O'Caoimh et al, 2021).

and Choi, 2013). This definition differentiates frailty as a biological syndrome, rather than a disability (Rodriguez-Manas et al, 2013).

Although there does not appear to be one definitive model to detect frailty, physical deterioration appears to be the issue most identified and frequently mentioned in its assessment. This is not surprising, as the concept of frailty was originally described by Fried et al (2001; 2004) as a medical concept, with emphasis on physical functioning of older people. Fried's frailty tool (Fried et al, 2001) focuses on deficits in five physiological domains, including:

- ▶ Muscle weakness
- ▶ Slowness
- ▶ Exhaustion
- ▶ Reduced physical activity
- ▶ Slow walking speed.

This approach does not always take into account cognitive function, although frail elderly people have an increased risk of cognitive decline (Markle-Reid and Browne, 2003; Mitnitski et al, 2011).

The Rockwood and Mitnitski (2007) frailty tool, however, is expressed in terms of the frailty index or cumulative deficit model. This model concentrates on the level of frailty risk with regard to the number of health deficits in a person. It includes not only physical indicators of weakness, but also issues such as polypharmacy, cognition and mental health, as well as activities of daily living (Moorhouse and Rockwood, 2012). The Rockwood and Mitnitski tool also mentions unintentional weight loss in those with frailty.

This paper focuses on some of the physiological factors affecting changes in body mass index (BMI) and weight loss in the older person (Fried et al, 2001; 2004; 2021).

FRAILITY AND WEIGHT LOSS

Frailty can be defined as multi-system impairment associated with increased vulnerability to stressors, with the lowest frailty levels being in those with a BMI between 25 and 29.9 (Hubbard et al, 2010). The condition of sarcopenia, which

includes a reduction in skeletal muscle mass in the older adult, is a contributory factor to the development of frailty (Cawthon et al, 2009). Indeed, there is an overlap between the two conditions of frailty and sarcopenia, especially in terms of the physical aspects of the frailty phenotype, which includes low grip strength, gait speed and reduction of lean muscle mass (Dodds and Sayer, 2016). The similarities between sarcopenia and frailty include reduced muscle strength. Older people with a BMI below 25 are considered at greater risk of developing frailty (Curtis et al, 2023).

Frailty is viewed as a wasting disease with weight loss and malnutrition being one of its criteria (Kim and Choi, 2013). Malnutrition in the older person has been attributed to a range of issues, including alterations in appetite and gradual decline in sensory function (Britton and McLaughlin, 2013). If left unrecognised or untreated, this can affect cognitive and physical function. In the UK, 78% of men and 71% of women aged 65–74 years are considered to be overweight or obese, and obesity can mask malnutrition (Barrazoni et al, 2020). In addition, increasing numbers of the elderly are being diagnosed with coeliac disease, which is linked to a heightened risk of micronutrient deficiencies (Collin et al, 2018). These deficiencies may arise because people with coeliac disease avoid fortified wheat products, or because of malabsorption of micronutrients, which may occur due to the average time of diagnosis which is 14 years (Fuchs et al, 2018). This is coupled with low muscle mass and function (particularly strength), which almost invariably occurs in old age (Van Ancum et al, 2018).

In older adults, including unintentional weight loss in the definition of frailty may not be completely accurate, as this measure may not be sensitive enough to reflect the reasons for changes in nutritional intake (Amarya et al, 2015; Asamane et al, 2019). A decline in the olfactory receptors due to the ageing process may affect the senses of smell and taste, leading to reduced

Practice point

Malnourished individuals are more likely to develop frailty (Kim and Choi, 2013).

appetite (Fukunaga et al, 2005; Boyce and Shone, 2006). Nutritional factors that influence the development of malnutrition include eating ability, which can be compromised by poor dental health as well as dysphagia.

Dysphagia can affect nutritional intake due to personal fears of choking, which is also associated with a significant risk of aspiration pneumonia (Fukunaga et al, 2005). The ageing gut has a slower peristaltic action due to motor and sensory changes within the structure of the digestive system (Bitar et al, 2011). This, in turn, leads to gut distension which provides a feeling of fullness and affects the appetite (Britton and McLaughlin, 2013).

A study by Qui et al (2017) identified that a poor appetite is associated with reduced protein intake, but a higher consumption of dairy foods which could exacerbate sarcopenia and frailty. The recommended protein intake per day for an adult is between 1.2–2.0kg (Wolfe, 2012), and the diet should include fruit and vegetables. The importance of good quality food in the older person with adequate protein levels, as opposed to foods that are energy dense but low in micronutrients, is essential. Indeed, diet composition and increased calorie intake is suspected to influence frailty (Ramsay et al, 2015). Studies have also indicated that malnutrition and vitamin D deficiency further influence the development of frailty (Chang et al, 2010).

Older people with a high BMI have also shown signs of frailty (Donini et al, 2019). Although the reason for a raised BMI could be attributed to diets high in calories with a low nutrient intake, the unique physiological aspects of ageing mean that lean muscle mass decreases and is replaced by increased deposits of fat cells (Ponti et al, 2020). However,

fat loss is reduced in the older person which can mask reductions in muscle mass, and increase BMI score. A high BMI may also lead to reduced mobility, loss of independence, increased risk of disease and poorer quality of life (Boutari et al, 2017).

In the older adult, changes in the gastrointestinal (GI) microbiome results in less diversity and richness of microorganisms, which can lead to inflammatory processes in the gut potentially affecting absorption levels and efficiency of the natural functioning of the GI tract. This has been described as ‘inflamm-ageing’ affect (Ferrucci and Fabbri, 2018). It has also been noted that these changes can contribute to the risk of depression (Claesson et al, 2012; Kohler et al, 2016).

A decline in cognitive function is considered a central feature of depression, while consuming a balanced and healthy diet has been associated with a lower risk of cognitive decline in older adults (Gardener and Rainy-Smith, 2018; Tamura et al, 2018). Late-life depression is considered to be a frequent problem in the frail individual, with contributing factors most consistently associated with frailty including lack of support and social isolation (Chamberlain et al, 2016). Older people who are socially isolated often experience reduced appetite and therefore eat fewer meals or less nutritionally substantial food in a day (Ramic et al, 2011). However, although loneliness is associated with a lower quality of life in the older person, it is not always included in the assessment of frailty (Gobbens et al, 2010).

There are other factors that can add to a person’s susceptibility to frailty and weight loss, such as environmental and social issues. For example, people in a lower socioeconomic bracket with deprived backgrounds and those who are poorly educated are at the highest risk of frailty and pre-frailty (Langlois et al, 2012; Maharani et al, 2023). A recent Age UK report identified that two million older households had insufficient income to cover their essential spending costs, almost half of

whom (960,000) are living in poverty or just above the poverty line (Age UK, 2022). All these aspects could contribute to late life depression and feelings of hopelessness about the future (Luppa et al, 2012; ONS, 2022).

‘The importance of holistic assessment by community nurses to determine patient needs cannot be minimised. Indeed, it is an essential part of the role of the community nurse.’

The advantage of frailty tools to detect the condition is that they act as a guideline to support the use of further tools to assess identified physical problems in more detail. To be fully effective, the frailty tool should be used to identify not only those who are already frail, but also to establish therapeutic options for those people who develop early symptoms of frailty to prevent progression of the condition.

However, there have been reports of nurses not feeling fully confident in using the tools. This needs addressing (Coker et al, 2019), as a lack of understanding has implications for patients and the implementation of appropriate care (Warnier et al, 2021). Assessment for frailty in the older adult is complicated and screening requires community nurses not only to receive training to equip them with the skills to recognise frailty, but also to identify symptoms of pre-frailty to develop a management strategy for the patient (Ruiz et al, 2020).

CONCLUSION

Management of the frail, elderly individual is complex. Timely recognition of frailty by experienced nurse practitioners can assist in inhibiting the progression of the condition and enhance quality of life (Clegg et al, 2013). The importance of holistic assessment by community nurses to determine patient needs cannot be minimised. Indeed, it is an essential part of the role of the community nurse. However, the combination of a reduction in

community nurse staffing numbers and an increase in the older population causes time challenges for nurses, which could ultimately affect the quality of patient assessment and subsequent implementation of care (Britton, 2017). Indeed, despite the increased demand for community nursing services, the number of community nurses and those in senior ‘district nurse’ posts has fallen over a sustained period (QNI, 2022). This comes at a time of an ageing UK demography, with an increased population with long-term conditions and disability. Indeed, many people are living longer lives and are in need of community nurses’ care (Maybin et al, 2016; Fanning, 2019; Centre for Ageing Better, 2022). **JCN**

REFERENCES

Age UK (2022) *Research briefing: estimating the impact of rising prices on older households in the UK in 2022–23*. Available online: www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/safe-at-home/estimating-the-impact-of-rising-prices-on-older-households-in-the-uk-in-2022-23-may-2022.pdf

Amarya S, Singh K, Sabharwal M (2015) Changes during aging and their association with malnutrition. *J Clin Gerontol Geriatrics* 6(3): 78–86

Asamane EA, Greig CA, Aunger JA, Thompson J (2019) Perceptions and factors influencing eating behaviours and physical function in community-dwelling ethnically diverse older adults: A longitudinal qualitative study. *Nutrients* 11(6): 1224

Barazzoni R, Gortan Cappellari G (2020) Double burden of malnutrition in persons with obesity. *Rev Endocr Metab Disord* 21(3): 307–13

Bitar K, Greenwood-Van Meerveld B, Saad R, Wiley JW (2011) Aging and gastrointestinal neuromuscular function: insights from within and outside the gut. *Neurogastroenterol Motil* 23(6): 490–501

Boutari C, Mantzoros CS (2017) Decreasing lean body mass with age: challenges and opportunities for novel therapies. *Endocrinol Metab (Seoul)* 32(4): 422–5

Boyce JM, Shone GR (2006) Effects of

- ageing on smell and taste. *Postgrad Med J* 82: 239–41
- Britton H (2017) What are community nurses' experiences of assessing frailty and assisting in planning subsequent interventions? *Br J Community Nurs* 22(9): 440–5
- Britton E, McLaughlin J (2013) Ageing and the gut. *Proc Nutr Soc* 72(1): 173–7
- Cawthon PM, Fox KM, Gandra SR, et al (2009) Do muscle mass, muscle density, strength, and physical function similarly influence risk of hospitalization in older adults? *J Am Geriatr Soc* 57: 1411–19
- Centre for Ageing Better (2022) *Summary report: The state of Ageing*
- Chamberlain AM, St Sauver JL, Jacobson DJ, Manemann SM, Fan C, Roger VL, et al (2016) Social and behavioural factors associated with frailty trajectories in a population-based cohort of older adults. *BMJ Open* 6(5): e011410
- Chang CI, Chan DC, Kuo KN, Hsiung CA, Chen CY (2010) Vitamin D insufficiency and frailty syndrome in older adults living in a Northern Taiwan community. *Arch Gerontol Geriatr* 50(Suppl 1): S17–S21
- Christie & Co (2017) *Adult Social Care 2017 Funding, Staffing & The Bed Blocking Challenge*
- Claesson MJ, Jeffery IB, Conde S, et al (2012) Gut microbiota composition correlates with diet and health in the elderly. *Nature* 488: 178–84
- Clegg A, Young J, Iliffe S, Rikkert MO, Rockwood K (2013) Frailty in elderly people. *Lancet* 381(9868): 752–62
- Clegg A, Bates C, Young J, et al (2016) Development and validation of an electronic frailty index using routine primary care electronic health record data. *Age Ageing* 45(3): 353–60
- Coker JF, Martin ME, Simpson RM, Lafortune L (2019) Frailty: an in-depth qualitative study exploring the views of community care staff. *BMC Geriatr* 19(1): 47
- Collard RM, Boter H, Schoevers RA, Oude Voshaar RC (2012) Prevalence of frailty in community-dwelling older persons: a systematic review. *J Am Geriatr Soc* 60: 1487–92
- Collin P, Vilppula A, Luostarinen L, Holmes GKT, Kaukinen K (2018) Review article: coeliac disease in later life must not be missed. *Aliment Pharmacol Ther* 47: 563–72
- Curtis M, Swan L, Fox R, Warters A, O'Sullivan M (2023) Associations between body mass index and probable sarcopenia in community-dwelling older adults. *Nutrients* 15(6): 1505
- Dodds R, Sayer AA (2016) Sarcopenia and frailty: new challenges for clinical practice. *Clin Med (Lond)* 16(5): 455–8
- Donini LM, Busetto L, Bauer JM, Bischoff S, Boirie Y, Cederholm T, et al (2019) Critical appraisal of definitions and diagnostic criteria for sarcopenic obesity based on a systematic review. *Clin Nutr* 39(8): 2368–88
- Fanning A (2019) *Outstanding Models of District Nursing. A joint project identifying what makes an outstanding district nurse service*. RCN/QNI. Available online: www.qni.org.uk/wp-content/uploads/2019/05/Outstanding-Models-of-District-Nursing.pdf
- Ferrucci L, Fabbri E (2018) Inflammageing: chronic inflammation in ageing, cardiovascular disease, and frailty. *Nat Rev Cardiol* 15(9): 505–22
- Fried LP, Cohen AA, Xue QL, et al (2021) The physical frailty syndrome as a transition from homeostatic symphony to cacophony. *Nat Aging* 1: 36–46
- Fried LP, Ferrucci L, Darer J, Williamson J D, Anderson G (2004) Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. *J Gerontol A Biol Sci Med Sci* 59(3): 255–63
- Fried LP, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, et al (2001) Frailty in older adults: evidence for a phenotype. *J Gerontol A Biol Sci Med Sci* 56(3): M146–56
- Fuchs V, Kurppa K, Huhtala H, Mäki M, Kekkonen L, Kaukinen K (2018) Delayed celiac disease diagnosis predisposes to reduced quality of life and incremental use of health care services and medicines: A prospective nationwide study. *United European Gastroenterol J* 6(4): 567–75
- Fukunaga A, Uematsu H, Sugimoto K (2005) Influences of aging on taste perception and oral somatic sensation. *J Gerontol A Biol Sci Med Sci* 60: 109–13
- Gale CR, Cooper C, Sayer AA (2015) Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing. *Age Ageing* 44(1): 162–5
- Gardener SL, Rainey-Smith SR (2018) The role of nutrition in cognitive function and brain ageing in the elderly. *Curr Nutr Rep* 7: 139–49
- Gobbens RJ, Luijckx KG, Wijnen-Sponselee MT, Schols J (2010) Toward a conceptual definition of frail community dwelling older people. *Nurs Outlook* 58: 76–86
- Horner RL (2022) The role of the district nurse in screening and assessment for frailty. *Br J Community Nurs* 27(5): 226–30
- Hubbard RE, Lang IA, Llewellyn DJ, Rockwood K (2010) Frailty, body mass index, and abdominal obesity in older people. *J Gerontol A Biol Sci Med Sci* 65A: 377–81
- Kim TN, Choi KM (2013) Sarcopenia: definition, epidemiology, and pathophysiology. *J Bone Metab* 20(1): 1–10
- Kohler O, Krogh J, Mors O, et al (2016) Inflammation in depression and the potential for anti-inflammatory treatment. *Curr Neuropharmacol* 14: 732–42
- Lacas A, Rockwood K (2012) Frailty in primary care: a review of its conceptualization and implications for practice. *BMC Med* 10: 4
- Langlois F, Tuong Minh Vu T, Kergoat M J, Chassé K, Dupuis G, Bherer L (2012) The multiple dimensions of frailty: physical capacity, cognition and quality of life. *Int Psychogeriatr* 24(9): 1429–36
- Leary A, Bushe D (2022) *Workforce Standards for the District Nursing Service*. Queen's Nursing Institute
- Luppa M, Sikorski C, Luck T, Ehreke L, Konnopka A, Wiese B, et al (2012) Age- and gender-specific prevalence of depression in latest-life — systematic review and meta-analysis. *J Affect Disord* 136(3): 212–21
- Maharani A, Sinclair DR, Chandola T, Bower P, Clegg A, Hanratty B, et al (2023) Household wealth, neighbourhood deprivation and frailty amongst middle-aged and older adults in England: a longitudinal analysis over 15 years (2002–2017). *Age Ageing* 52(3): afad034
- Mangin D, Lawson J, Risdon C, et al (2022) Association between frailty, chronic conditions and socioeconomic status in community-dwelling older adults attending primary care: a cross-sectional study using practice-based research network data. *BMJ Open* 13: e066269
- Markle-Reid M, Browne G (2003) Conceptualizations of frailty in relation to older adults. *J Adv Nurs* 44: 58–68

Maybin J, Charles A, Honeyman M (2016) *Understanding quality in district nursing services. Learning from patient carers and staff*. King's Fund, London. Available online: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quality_district_nursing_aug_2016.pdf

Mitnitski A, Fallah N, Rockwood MR, Rockwood K (2011) Transitions in cognitive status in relation to frailty in older adults: a comparison of three frailty measures. *J Nutr Health Aging* 15(10): 863–7

Moorhouse P, Rockwood K (2012) Frailty and its quantitative clinical evaluation. *J R Coll Physicians Edinb* 42(4): 333–40

O'Caomh R, Sezgin D, O'Donovan MR, Molloy DW, Clegg A, Rockwood K, et al (2021) Prevalence of frailty in 62 countries across the world: a systematic review and meta-analysis of population-level studies. *Age Ageing* 50(1): 96–104

Office for National Statistics (2022) *Consumer Price Inflation, UK: April 2022*. Available online: www.ons.gov.uk/economy/inflationandpriceindices/bulletins/consumerpriceinflation/latest

Office for National Statistics (2018) *Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland, mid-2018*. Available online: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2018

Ponti F, Santoro A, Mercatelli D, Gasperini C, Conte M, Martucci M, Sangiorgi L, Franceschi C, Bazzocchi A (2020) Aging and imaging assessment of body composition: from fat to facts. *Front Endocrinol* 10: 861

Queen's Nursing Institute (2014) *The District Nursing Workforce Planning Project*. QNI, London. Available online: https://qni.org.uk/wp-content/uploads/2016/09/workforce_planning_literature_review.pdf

Queen's Nursing Institute (2020) *2020 Vision 5 years on: reassessing the future of district nursing*. QNI, London. Available online: <https://qni.org.uk/resources/2020-vision-five-years/>

Qiu R, Cao WT, Tian HY, He J, Chen GD, Chen YM (2017) Greater intake of fruit and vegetables is associated with greater bone mineral density and lower osteoporosis risk in middle-aged and elderly adults. *PLoS One* 12(1): e0168906

Ramic E, Pranjic N, Batic-Mujanovic O, Karic E, Alibasic E, Alic A (2011) The effect of loneliness on malnutrition in elderly population. *Med Arh* 65(2): 92–5

Ramsay SE, Arianayagam RE, Whincup DS, et al (2015) Cardiovascular risk profile and frailty in a population-based study of older British men. *Heart* 101: 616–22

Robards J (2020) *National population projection: 2020 based interim Office of National Statistics*. Data from Census 2021

Rockwood K, Mitnitski A (2007) Frailty in relation to the accumulation of deficits. *J Gerontol A Biol Sci Med Sci* 62(7): 722–7

Rodríguez-Mañas L, Féart C, Mann G, Viña J, Chatterji S, Chodzko-Zajko W, et al (2013) Searching for an operational definition of frailty: a Delphi method based consensus statement: the frailty operative definition-consensus conference project. *J Gerontol A Biol Sci Med Sci* 68(1): 62–7

Royal College of Nursing (2014) *London Safe Staffing Report 2014*. Available online: www.rcn.org.uk/publications

Ruiz JG, Dent E, Morley JE, et al (2020) Screening for and managing the person with frailty in primary care: ICFSR Consensus Guidelines. *J Nutr Health Aging* 24: 920–7

Sinclair DR, Maharani A, Chandola T, Bower P, Hanratty B, Nazroo J, et al (2021) Frailty among older adults and its distribution in England. *J Frailty Aging* 11(2): 163–8

KEY POINTS

- The demographic profile of the population of England and Wales and primary care records indicate that one in five people are over the age of 65 in England.
- Community nurse caseloads are representative of the ageing population of the UK and frailty has been recognised as a clinical condition of the older person.
- Although there does not appear to be one definitive model to detect frailty, physical deterioration appears to be the issue most identified and frequently mentioned in its assessment.
- Frailty can be defined as multi-system impairment associated with increased vulnerability to stressors, with the lowest frailty levels being in those with a BMI between 25 and 29.9.
- There are other factors that can add to a person's susceptibility to frailty and weight loss, such as environmental and social issues.
- The importance of holistic assessment by community nurses to determine patient needs cannot be minimised.

Revalidation Alert

Having read this article, reflect on:

- Tools you would use to detect frailty
- The overlap between sarcopenia and frailty
- Factors that increase an individual's susceptibility to frailty.

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

Tamura Y, Ishikawa J, Fujiwara Y, et al (2018) Prevalence of frailty, cognitive impairment, and sarcopenia in outpatients with cardiometabolic disease in a frailty clinic. *BMC Geriatr* 18: 264

Van Ancum JM, Pijnappels M, Jonkman NH, et al (2018) Muscle mass and muscle strength are associated with pre- and post-hospitalization falls in older male inpatients: a longitudinal cohort study. *BMC Geriatr* 18(1): 116

Warnier RMJ, van Rossum E, Du Moulin MFMT, van Lottum M, Schols JMGA, Kempen GJIM (2021) The opinions and experiences of nurses on frailty screening among older hospitalized patients. An exploratory study. *BMC Geriatr* 21(1): 624

Wolfe RR (2012) The role of dietary protein in optimizing muscle mass, function and health outcomes in older individuals. *Br J Nutr* 108: 88–93

Recognising, assessing and managing pain in a person with dementia

Karen Harrison Dening

Due to its progressive nature, dementia is now the leading cause of death in England and Wales, so a palliative approach to care is beneficial because of its emphasis on supportive care. Many people with dementia also have other comorbid health conditions common in older age, that in themselves may induce pain. However, people with dementia may have difficulty in understanding what they are feeling and in describing and locating the pain due to having issues with communicating their needs as their dementia progresses. This paper considers the recognition, assessment, treatment and management of pain in older people with dementia. It introduces the learner to what is known about the subject and why it is important to know the person's past history and previous ways of self-managing pain and discomfort using information gained from their family, carers and friends.

KEYWORDS:

- Dementia ■ Pain ■ Recognition of pain in dementia
- Pain assessment ■ Pain management

Dementia is an umbrella term used to describe a group of signs and symptoms characterised by behavioural changes and a loss of cognitive and social functioning brought about by progressive neurological disorders (Barber, 2020). There are more than 200 subtypes of dementia, but the most common are Alzheimer's disease, vascular dementia and Lewy body dementia. They also include mixed dementia, which is often a combination of Alzheimer's disease and vascular dementia, and frontotemporal dementia (Sandilyan and Dening, 2019).

'When the person is viewed only through the "lens" of their dementia, this can lead to the risk of other comorbid physical or mental health conditions, apart from their dementia, being overlooked.'

There are an estimated 944,000 people currently living with dementia in the UK and it is estimated that this will increase to one million by 2025 and two million by 2051 (Wittenberg et al, 2019). The greatest risk factor for dementia is old age, however, 70,800 of the estimated 944,000 people living with dementia are living with young onset dementia (YOD), where the onset of symptoms occurs under the age of 65 (Carter et al, 2022).

Due to its progressive nature, dementia is now the leading cause of death in England and Wales,

accounting for 12.5% of all deaths registered in 2019 (Office for National Statistics [ONS], 2020), so a palliative approach is seen as beneficial because of its emphasis on supportive care, including support for the family (De Vries, 2014; Van der Steen et al, 2014).

DEMENTIA AND OTHER COMORBID CONDITIONS

Many people with dementia also have other comorbid health conditions common in older age. On average, people with dementia are likely to have 4.6 chronic conditions besides dementia (Tonelli et al, 2018). Many of these conditions, such as osteoarthritis, genitourinary infections, constipation and pressure ulcers can cause pain (Corbett et al, 2014), but in a person with advanced dementia, their distress may be exacerbated when health and social care professionals have difficulty in recognising when a person with dementia is experiencing pain. This is often when a person with dementia has difficulty in communicating their needs (Banovic et al, 2018). When the person is viewed only through the 'lens' of their dementia, this can lead to the risk of other comorbid physical or mental health conditions, apart from their dementia, being overlooked. This can then result in

Practice point

Diagnostic overshadowing can lead to untreated symptoms and concerns, avoidable distress and behavioural changes in people with dementia.

Table 1: Possible indicators of pain in a person with dementia (adapted from De Vries, 2014)

▶ Facial grimacing	▶ Increased or decreased vocalisations
▶ Gestures that indicate distress	▶ Withdrawn social behaviours
▶ Guarding or reluctance to move a particular body part	▶ Lethargy or increased sleep
▶ Moaning with movement	▶ Decreased appetite and nutritional intake
▶ Limited range of motion or slow movement	▶ Increased confusion
▶ Increased heart rate, blood pressure or sweating	▶ Anger, aggression, irritability
▶ Restlessness	▶ Crying or distress

misdiagnosis or delay in appropriate treatment, or to not receiving care at all (Shefer et al, 2014), causing diagnostic overshadowing because the dementia diagnosis has taken precedence above other conditions (Voss et al, 2017).

PAIN IN OLDER PEOPLE AND IN PEOPLE WITH DEMENTIA

Pain is a unique and personal experience. McCaffery (1968) defined it as ‘whatever the experiencing person says it is, existing whenever the experiencing person says it does’. A definition that is still relevant today, particularly in dementia care nursing where person-centred care is at the core of practice (Cox, 2022). However, how older people experience pain is also affected by social and psychological factors, with many older people and their families and carers thinking that pain is a natural or inevitable part of ageing and something to be stoically borne and tolerated. This form of stoicism presents a risk of under-reporting pain and delays in their seeking help and pain relief (Abdulla et al, 2013).

As the experience of pain is unique to an individual, so is the way they react to their pain. Some people become quiet and withdrawn, while others may want to keep on the move — this may be to lessen the discomfort or as a form of distraction. Opinion is divided about how much is known about the experience of pain and dementia. Some researchers claim we have come a long way in the past two decades in understanding pain in dementia (Corbett et al, 2014), whereas others think that there is

still a dearth of high-quality research exploring pain assessment and treatment for people with dementia (Bullock et al, 2019).

In the author’s clinical experience, some nurses and clinicians still believe that people with dementia do not feel or remember their pain. However, many studies have found that people with dementia continue to feel pain but may have difficulty in understanding what they are feeling and in describing and locating the pain. They may also be unable to remember that they have been in pain and so may not report this at the time (Sampson, 2019), although may still experience the negative emotional effects of pain long after it abates but not understanding the basis for such feelings. There is little evidence to suggest that people with dementia experience less pain than others (Closs et al, 2016). Instead, they are less likely to report their pain due to the cognitive deficits they experience as their dementia progresses (Zwakhalen et al, 2009).

RECOGNISING WHEN A PERSON WITH DEMENTIA MAY BE EXPERIENCING PAIN

Undetected and undermanaged pain can significantly affect quality of life and increase morbidity (Sampson, 2019). In a person with dementia, pain can often lead to distressed behaviours (Table 1). Distressed behaviours can therefore be considered a person’s way of expressing an unmet need (Husebo and Achterberg, 2016) and, as the person deteriorates, they become less able to meet their own needs,

and have increasing difficulty in communicating these needs to others (Cohen-Mansfield et al, 2015).

Pain reduces a person’s ability to perform activities of daily living, but it can also reduce their appetite, induce low mood and depression and disturb sleep (DeVries 2014) (Table 1).

Pain in a person with dementia can trigger a cycle of distressing and critical events. For example, they may express their pain through behaviours that are perceived as aggressive and a symptom of their deteriorating dementia, resulting in their being prescribed antipsychotic or sedative medication, or they may become more restless and agitated, increasing their risk of falling and fractures.

ASSESSING PAIN

Many people with mild or moderate dementia may still be able to report pain verbally, and even those with more advanced dementia or whose speech is affected may still be able to do so when asked. For some however, loss of short-term memory may mean that they forget their pain and can only respond to an enquiry in the ‘here and now’ (Sampson, 2019). Nevertheless, this is no reason to ignore possible pain. A comprehensive and detailed assessment of pain in a person with dementia is essential to manage their pain.

Box 1
Four steps of pain assessment

- ▶ Always attempt to gain a self-report of pain in the first instance
- ▶ Consider any underlying causes of pain
- ▶ Observe the person with dementia for any behavioural indicators of pain
- ▶ Gain collateral information and history from those involved, i.e. families, carers and staff

(Herr et al, 2006).

There are several guides to support the recognition, assessment and management of pain in people with dementia. Herr et al (2006) recommend four steps (*Box 1*) to pain assessment in people with difficulties in communication (such as presents in dementia), whereas the Royal College of Physicians (RCP, 2007) suggests three dimensions to the assessment of pain. Whatever guidance you follow, good information is needed at every step or in every dimension, either from the person with dementia or corroborated by an informant, such as a relative or someone else who knows them well.

Applying the four-step process

Step 1. Always attempt to gain a self-report of pain in the first instance

Asking someone whether they are in pain is the first step in pain assessment and considered the 'gold standard'. For people with dementia, how you communicate and ask them the question 'are you in pain?' is important. You need to ensure their best possible understanding of your question, for example by:

- ▶ Being level and face to face with them to achieve good eye contact
- ▶ Asking them in a quiet room or space with minimal distractions
- ▶ Making sure that they are wearing their spectacles (if worn) so they can see you properly
- ▶ Making sure that their hearing aids are in place and working, so that they can hear you as well as possible
- ▶ Using an interpreter if English is not their first language
- ▶ Using your own body language, facial expressions and hand gestures to maximise communication, such as pointing or rubbing your own body (or theirs if not too intrusive for them) in a particular place to indicate an area
- ▶ Using closed-ended questions, which can be answered with a 'yes' or 'no' or with other



Photograph: CGN089/Shutterstock

simple responses, rather than ones that are open-ended. These can be easier to respond to for people with moderate-to-advanced dementia. Similarly, incorporating into your closed-ended questions language that is more familiar to them can help: 'Is this sore?', 'Does that hurt?' 'Does that ache?', for example, when pointing to a body part you suspect is causing them pain.

Step 2. Consider any underlying causes of pain

If the person with dementia is unable to tell you about their pain and/or its location, consider any possible underlying condition(s) or injury that may be the root cause. It is always useful to know something about the person's medical history and/or any other comorbidities, such as osteoarthritis and vascular or circulatory problems in the legs, that may be associated with pain. You may also ask yourself the following questions: are there any signs of bruising or of injury? do they have a sore mouth or a urine infection? are they constipated? Also, be aware that pain may exist even though a physical examination shows nothing untoward.

Step 3. Observe the person with dementia for any behavioural indicators of pain

If a person with dementia cannot communicate their pain, their reaction to it may manifest as a distressed behaviour (*Table 1*). Expressions of pain and discomfort

in a person with advanced dementia may need to be witnessed and identified by someone else, such as a family member or care worker — observation is key.

Step 4. Gain collateral information and history from those involved — families, carers and staff

Past medical and care records of the person with dementia and a collateral history and information from family, carers and friends are crucial when building up a picture of a person's background and pain history. Family members can provide information about how the person with dementia usually reacts to pain, both before and after the diagnosis of dementia, and also how they would have normally alleviated or managed their pain and discomfort. Past behaviours to manage pain and discomfort may still play out as the person progresses into their dementia.

TOOLS FOR ASSESSING PAIN IN A PERSON WITH DEMENTIA

There are several pain assessment tools designed for use in dementia care, but it is important to select one that matches the person's abilities (including premorbidity, before the diagnosis of dementia), intelligence and education level as these will influence their ability to respond (De Vries, 2014). Similarly, some assessment tools have been developed with specific care settings in mind so, for example, using the Bolton Pain Tool (developed for use

Box 2

Observational pain assessment tools

- ▶ Abbey Pain Scale (APS) (Abbey et al, 2004)
- ▶ Assessment of Discomfort in Dementia (ADD) (Kovach et al, 2002)
- ▶ Bolton Pain Tool (BPT) (Gregory, 2017)
- ▶ Pain Assessment in Advanced Dementia (PAINAD) scale (Hadjistavropoulos et al, 2014).

in acute hospital care) (Gregory, 2017) in a long-term care setting may not be the most appropriate.

In the moderate-to-advanced stages of dementia, using an observational pain assessment tool can help families and care staff to identify pain in a person who lacks the communication abilities to alert healthcare professionals to their pain in the usual way (Achterberg et al, 2021). As discussed, they may express their pain and need in their behaviours. There are several assessment tools that are well validated and have a high reliability in pain measurement in dementia (Box 2). Two tools which are commonly used in many care settings are the Abbey Pain Scale (Abbey et al, 2004) and the Pain Assessment in Advanced Dementia (PAINAD) Scale (Hadjistavropoulos et al, 2014). Both are sensitive to whether the person with dementia is mobile or immobile. However, there is no perfect tool, as all have advantages and disadvantages (Lichtner et al, 2014). What is essential is that a nurse or care team use the same pain assessment tool, which has been specifically chosen for the person with dementia and the appropriate care setting. This allows for consistency of measurement and develops skill in using the tool, helping to observe behaviours and scoring and reporting pain.

If the person with dementia is immobile or bed bound, it is important to use the chosen pain assessment tool during a care intervention, such as a change of continence aid. The person may

not appear distressed or in pain while lying in bed or sitting in a chair, but may feel pain when required to be moved. In the author’s clinical experience, observational pain assessment tools increase the chance of recognising pain in a person with dementia, with some, such as the Abbey Pain Scale, having a score threshold that indicates pain. However, the value of pain assessment tools is that they enable the nurse and care team to ‘witness’ and record the person’s pain or distress and communicate this to others in their care team — importantly, to the prescriber of pain medications and treatments.

MANAGING PAIN IN A PERSON WITH DEMENTIA

Once pain is detected or even suspected, it is essential that it is effectively managed. Managing pain in people with dementia often requires a multifaceted approach, involving the input of other health and social care professionals. There are two approaches to pain management that can be considered alone or in conjunction, namely:

- ▶ Non-pharmacological
- ▶ Pharmacological.

Non-pharmacological approaches

Non-pharmacological approaches to managing pain in older people with dementia are often underused but can have a great impact, especially if taken alongside analgesia (Achterberg et al, 2021). Some of the physical measures we might all

take to managing our own pain may include rest, gentle movement, the use of heat or cold, music therapy, aromatherapy and massage, and therapeutic touch (Abdulla et al, 2013; De Vries, 2014). Some of these can also be used in combination, for example, music therapy and massage, or a heat pad applied locally while resting.

People with dementia may also benefit from the comfort and reassurance gained from the care staff member who, for example, gives them a gentle hand massage while playing soft music preferred by the person with dementia to provide comfort for osteoarthritic pain. The massage can also enable the person to rest and relax, which helps to reduce stress, tension and discomfort, but importantly, helps them feel safe and that their needs are appreciated and met (Achterberg et al, 2021).

Pharmacological approaches

The Analgesic Ladder (World Health Organization [WHO], 2018) (Figure 1) provides a framework for managing pain in palliative care, but it can also be used in managing pain in people with dementia (Sampson and Harrison Denning, 2021). The three principles of the WHO analgesic ladder are to give analgesics (i) by the clock, (ii) by mouth (orally) and (iii) by the ladder:

- ▶ (i) To maintain a person’s freedom from pain, analgesia should be given by the clock or around the clock rather than only on demand (PRN), so on a regular and scheduled basis. Using analgesia

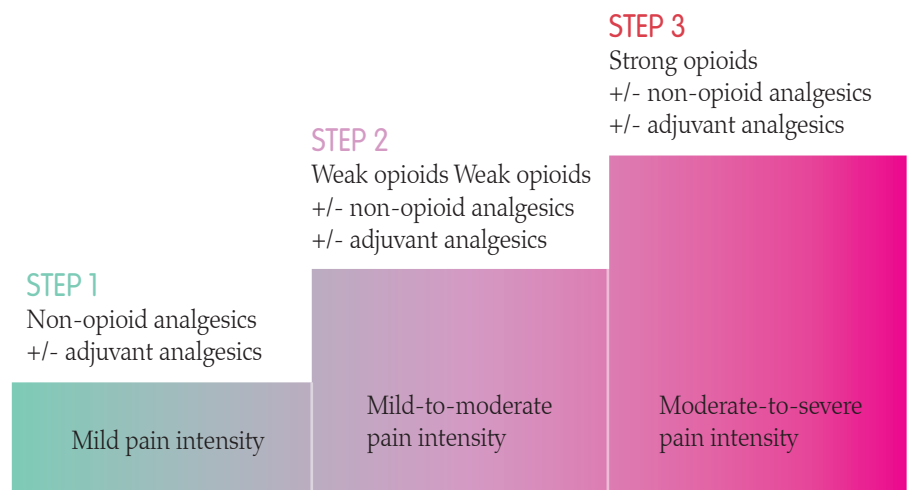


Figure 1. World Health Organization Analgesic Ladder (2018).

on a PRN basis in people with dementia, especially where they have difficulty in communicating their needs, can result in them receiving no or too little analgesia to keep them pain free and comfortable.

- ▶ (ii) The oral route is usually the preferred route in various care settings because it is often easiest. However, it may not be possible for all people with dementia, for example, where there are swallowing difficulties, so the least invasive route should be considered (Sampson and Harrison Denning, 2021). This might include using skin patches.
- ▶ (iii) If pain occurs, there should be prompt administration of medications according to the stepped approach detailed in the WHO's Analgesic Ladder (Figure 1).

As for anyone, paracetamol is recommended as the first step by most guidelines as an effective and safe analgesic, especially for musculoskeletal pain and osteoarthritis, both of which are common in older people with dementia (Horgas et al, 2007) and, as such, residents in care homes (Zwakhalen et al, 2009). Non-steroidal anti-inflammatory drugs (NSAIDs) include, for example, ibuprofen, but have a high risk of side-effects, including gastrointestinal bleeding and raised blood pressure, and should be used with caution in older people. Opioids can be prescribed for moderate-to-severe pain and can be effective in managing pain in people with dementia but, as for all medications, can cause side-effects. Larger doses can suppress respiration and in some older people can cause hallucinations and increase confusion (Achterberg et al, 2021). Opioids can also increase a person's risk of falls.

Successful management of pain requires regular review to ensure that medication is effective. The four-step assessment process (Herr et al, 2006) can be repeated and the management plan reviewed regularly. It is important to continue using the same behavioural pain assessment tool once treatment has started, so that:

- ▶ Progress can be monitored
- ▶ The effectiveness of medication or other treatment can be assessed
- ▶ Action taken if pain scores worsen, or indeed improve.

'Assessment involves developing an overall picture of pain and knowing the person with dementia as well as possible. Any assessment of pain should also involve family, carers and friends... '

CONCLUSION

It is important for nurses and care teams effectively to recognise, assess and manage pain in older people with dementia using a systematic and stepped approach. Assessment involves developing an overall picture of pain and knowing the person with dementia as well as possible. Any assessment of pain should also involve family, carers and friends to build a picture of their previous medical history and personal approaches to how the person with dementia managed their pain and discomfort before their diagnosis of dementia.

People with dementia experience the same types and degree of pain as any older person without dementia, but their pain may often go unrecognised or undertreated and managed due to their difficulties in communication. This places the responsibility on those around them to witness and consider the possibility of pain in people with dementia and to follow a process to undertake a comprehensive assessment and, if necessary, reassessment, which leads to effective treatment and management. **JCN**

REFERENCES

Abbey J, Piller N, De Bellis A, et al (2004) The Abbey pain scale: a 1-minute numerical indicator for people with end-stage dementia. *Int J Palliative Nurs* 10(1): 6–13

Abdulla A, Piller N, Adams N, et al (2013) Evidence-based clinical practice guidelines on management of pain in older people. *Age Ageing* 42(2): 151–3

Achterberg WP, Erdal A, Husebo BS, et al (2021) Are chronic pain patients with dementia being undermedicated? *J Pain Res* 14: 431–9

Banovic S, Zunic LJ, Sinanovic O (2018) Communication Difficulties as a result of dementia. *Matera Sociomedica* 30(3): 221–4

Barber R (2020) Clinical biomarkers and the diagnosis of dementia. In: Denning T, Thomas A, Stewart R, et al (Eds) *Oxford Textbook of Old Age Psychiatry*. 3rd edn. Oxford University Press, Oxford

Bullock L, Bedsona J, Jordana JL, et al (2019) Pain assessment and pain treatment for community-dwelling people with dementia: a systematic review and narrative synthesis. *Int J Geriatr Psychiatry* 34(6): 807–21

Carter J, Jackson M, Gleisner Z, et al (2022) Prevalence of all cause young onset dementia and time lived with dementia: analysis of primary care health records. *J Dementia Care* 30(3): 34–8

Closs SJ, Dowding D, Allcock N, et al (2016) Towards improved decision support in the assessment and management of pain for people with dementia in hospital: a systematic meta-review and observational study. *Health Services and Delivery Research*. <https://doi.org/10.3310/hsdr04300>

Cohen-Mansfield J, Dakheel-Ali M, Marx MS, et al (2015) Which unmet needs contribute to behaviour problems in persons with advanced dementia? *Psychiatry Res* 228(1): 59–64

Corbett A, Husebo BS, Achterberg WP et al (2014) The importance of pain management in older people with dementia. *Br Med Bull* 111(1): 139–48

Cox F (2022) An overview of pain assessment and management. *Nurs Standard*. doi:10.7748/ns.2022.e11936. Online ahead of print

De Vries K (2014) End-of-Life Care in Dementia. In: Coope B, Richards F, eds. *ABC of Dementia*. Wiley Blackwell, Oxford

Gregory J (2017) Initial testing of a behavioural pain assessment tool within trauma units. *Int J Orthopaed Trauma Nurs* 24: 3–11

Hadjistavropoulos T, Herr K, Prkachin KM et al (2014) Pain assessment in elderly adults with dementia. *Lancet Neurol* 13(12): 1216–27

Herr K, Coyne PJ, Key T, et al (2006) Pain assessment in the non-verbal patient: position statement with clinical practice recommendations. *Pain Manag Nurs* 7(2): 44–52

Horgas AL, Nichols AL, Schapson CA, et al (2007) Assessing pain in persons with dementia: relationships among non-communicative patient’s pain assessment instrument, self-report, and behavioural observations. *Pain Manag Nurs* 8(2): 77–85

Husebo BS, Achterberg WP (2016) Identifying and managing pain in people with Alzheimer’s disease and other types of dementia: a systematic review. *CNS Drugs* 30(6): 481–97

Kovach CR, Noonan PE, Griffie J, et al (2002) The assessment of discomfort in dementia protocol. *Pain Manag Nurs* 3(1): 16–27

Lichtner V, Dowding D, Esterhuizen P, et al (2014) Pain assessment for people with dementia: a systematic review of systematic reviews of pain assessment tools. *BMC Geriatr* 14: 138

McCaffery M (1968) *Nursing Practice Theories Related to Cognition, Bodily Pain, and Man — Environment Interactions*. UCLA Students’ Store, Los Angeles, CA

Office for National Statistics (2020) *Deaths registered in England and Wales: 2019*. Available online: www.ons.gov.

uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationssummarytables/2019 (accessed 8 January, 2023)

Royal College of Physicians, British Geriatrics Society, British Pain Society (2007) *The Assessment of Pain in Older People: National Guidelines*. Available online: www.britishpainsociety.org/static/uploads/resources/files/book_pain_older_people.pdf (accessed 8 January, 2023)

Sampson EL (2019) Pain in Dementia. In: Harrison Dening K, ed. *Evidence-based Practice in Dementia for Nurses and Nursing Students*. Jessica Kingsley Publishers, London

Sampson EL, Harrison Dening K (2021) Palliative and end-of-life care. In: Dening T, Thomas A, Stewart R et al (eds) *Oxford Textbook of Old Age Psychiatry*. 3rd edn. Oxford University Press, Oxford

Sandilyan MB, Dening T (2019) What is dementia? In: Harrison Dening K (ed) *Evidence-based Practice in Dementia for Nurses and Nursing Students*. Jessica Kingsley Publishers, London

Shefer G, Henderson C, Howard LM, et al (2014) Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms—a qualitative study. *PLoS One* 9(11): e111682

Tonelli M, Wiebe N, Manns BJ, et al (2018) Comparison of the complexity of patients seen by different medical subspecialists in a universal health care system. *JAMA Network Open* 1(7): e184852

Van der Steen JT, Radbruch L, Hertogh CM, et al (2014) White paper defining optimal palliative care in older people with dementia: a Delphi study and recommendations from the European Association for Palliative Care. *Palliat Med* 28(3): 197–209

Voss S, Black S, Brandling J, et al (2017) Home or hospital for people with dementia and one or more other multi-morbidities: what is the potential to reduce avoidable emergency admissions? the HOMEWARD project protocol. *BMJ Open* 7(4): e016651

Wittenberg R, Hu B, Barraza-Araiza L, et al (2019) *Projections of older people living with dementia and costs of dementia care in the United Kingdom, 2019–2040*. Available online: www.lse.ac.uk/cpec/assets/

KEY POINTS

- People with dementia may have difficulty in understanding what they are feeling and in describing and locating the pain due to having issues with communicating their needs as their dementia progresses.
- In a person with advanced dementia, their distress may be exacerbated when health and social care professionals have difficulty in recognising when a person with dementia is experiencing pain.
- Pain is a unique and personal experience. McCaffery (1968) defined it as ‘whatever the experiencing person says it is, existing whenever the experiencing person says it does’.
- There are several pain assessment tools designed for use in dementia care, but it is important to select one that matches the person’s abilities (including premorbidity), intelligence and education level, as these will influence their ability to respond.
- Undetected and under-managed pain can significantly affect quality of life and increase morbidity.
- It is important for nurses and care teams effectively to recognise, assess and manage pain in older people with dementia using a systematic and stepped approach.

documents/cpec-working-paper-5.pdf (accessed 8 January, 2023)

World Health Organization (2018) *WHO Guidelines for the Pharmacological and Radiotherapeutic Management of Cancer Pain in Adults and Adolescents*. Available online: www.who.int/publications/i/item/9789241550390 (accessed 8 January, 2023)

Zwakhalen SM, Koopsman RT, Geels PJ, et al (2009) The prevalence of pain in nursing home residents with dementia measured using an observational pain scale. *Eur J Pain* 13(1): 89–93

Revalidation Alert

Having read this article, reflect on:

- Why it is important to know the person’s past history and previous ways of managing pain and discomfort
- Different ways in which pain assessment can be undertaken
- Your knowledge of how to manage pain.



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

Intermediate care for young, frail, marginalised patients

Mark Denton, Rebekah Besford, Elizabeth Keat

People experiencing homelessness are generally not seen in traditional models of intermediate care. An out-of-hospital care model for those experiencing homelessness has been established in Leeds. This offers good quality accommodation in community settings with a multidisciplinary team to assess people's health and social care needs and offer step up or step down from hospital care. This has demonstrated a reduction in emergency department attendances and unplanned hospital stays, as well as an opportunity for people to be included in a home first model. Unexpected outcomes include a reduction in street sex work for the women who have been engaged on the project, less engagement with the criminal justice system, a place to facilitate prison releases, and an environment where end-of-life care can be delivered and achieve preferred place of death. Future investment is needed for out-of-hospital care to be an equitable offer in the city available to all.

KEYWORDS:

- Homelessness
- Out-of-hospital care
- Intermediate care
- Multidisciplinary team approach

If you search for intermediate care you will come across many definitions usually with key themes, such as community-based, often for older people, rehabilitation features strongly, receiving respite and remaining in their own home, usually accompanied by pictures of smiling older people with walking aids and adaptations.

So, what happens when you have a population of people who are excluded from home-based care as they do not have one? Who do not meet the requirements for frailty services as they are too young, and

their needs are often considered by services to be too complex and high risk to be met in traditional models of out-of-hospital care.

In 2021, Leeds was awarded funding from the Department of Health and Social Care for an out-of-hospital care model for people experiencing or at risk of rough sleeping. The project was to be externally evaluated along with other projects nationally.

Leeds is a city that has a commitment to reducing health inequalities and has strong partnerships across street support. It is a compassionate city where people and services work together to prevent and end homelessness (Leeds.gov.uk, 2023). Partner organisations in Leeds have committed to achieve the health and wellbeing strategy that 'Leeds will be a caring city for people of all ages, where people who are the poorest improve their

health the fastest' (Leeds Clinical Commissioning Group, 2021).

Targets for Leeds include reducing the number of people whose hospital discharge is delayed due to having no accommodation.

The national rough sleeping strategy is rooted in three pillars (Gov.UK, 2022):

- ▶ To prevent new people from starting to sleep rough
- ▶ To intervene rapidly to help them off the street
- ▶ To promote a person's recovery once they are off the street to build positive lives and not return to rough sleeping.

The national strategy emphasises the importance of strong relationships being at the centre of everything. Leeds has a strong vision and partnership to end rough sleeping with established partnerships between statutory health and housing and voluntary sector organisations as part of the Safer Leeds team.

The out-of-hospital care model was to build on the current in-reach into hospital service for patients who have been identified as experiencing or at risk of homelessness, working with the existing team to holistically assess health needs and work with patients on self-identified goals which could be achieved in an intermediate care setting. People could also be identified and referred for step-up care for hospital avoidance. The project aimed to expand the service, to enhance hospital liaison and multidisciplinary work across the city to deliver an outstanding service with both in-reach to and outreach from hospitals to provide continuity of care.

Mark Denton, social worker and homeless intervention project, Leeds City Council; Rebekah Besford, clinical lead homeless health inclusion team; Elizabeth Keat, homeless integration lead, both at Leeds Community Healthcare

An out-of-hospital team was established, including an integration lead, social worker, GP, two housing options officers, two senior support workers working in accommodation, a mental health practitioner, specialist nurse and a care navigator. In addition to the funded roles, other key professionals joined this multidisciplinary team (MDT). These included street-based health practitioner/paramedic and palliative care leads. The funding also invested in partnering the MDT with Pathway (www.pathway.org.uk; see box below).

Nine flats were offered by mental health accommodation services (MHAS) across three transitional housing units (THU) run by MHAS. Typically, referral criteria for THUs was for people with complex mental health difficulties referred by a mental health social worker or psychiatrist who needed support with daily living tasks. However, three flats were made available in each THU for the out-of-hospital team's patients, to live alongside regular THU residents with a personalised model of care.

The THUs were all situated outside the city centre in Care Quality Commission (CQC) registered buildings. The accommodation was of a good quality, with the flats being self-contained, each having a living room, bedroom, bathroom, and kitchen. Flats that were suitable for those with disabilities were also available. The THUs have gardens and outside spaces, communal areas for group work and patients are able to

Pathway

Pathway is the UK's leading homeless healthcare charity, which has helped 11 hospitals in England to create teams who take care of over 3500 homeless patients every year. Pathway also carries out research and provides training through the Faculty for Homeless and Inclusion Health, a network of more than 1700 people who are passionate about healthcare for excluded groups. People who have been homeless are included in every area of their work.

engage with any wellbeing activities or trips that are held for residents.

The following patient story highlights some of the benefits and ongoing challenges.

PATIENT STORY

Patient A was a 34-year-old lady. She had a long history of rough sleeping, often on the official street count and was part of a cohort of people identified by the city as needing priority. She also had a history of short-term placements in emergency or temporary accommodation. She had an extensive prison history and as a child was care experienced, recalling being placed in multiple children's homes. In addition, she had a history of street sex working and exploiting others for money for drug use and lived in squalid conditions and self-neglected. Her medical history included:

- ▶ Hepatitis C positive
- ▶ Paranoid schizophrenia
- ▶ Substance misuse — heroin, crack, amphetamines, pregabalin, benzodiazepines
- ▶ Malnourished, with a body mass index (BMI) of 14
- ▶ Significant wounds and scar tissue to arms from injecting and picking
- ▶ Bilateral full-thickness ulcers to groins and thighs.

Who did we engage with and what did they do?

Patient A was initially declined a health intervention flat in one of the THUs due to safeguarding concerns. This was mainly around how she had a history of targeting others for money for drugs, as the THUs are home to adults with mental health difficulties and vulnerable to being exploited. The authors discussed patient A in the MDT meeting, considering that if she could be settled on an opiate substitute prescription, she would have less need for trying to access money and exploiting others.

Over a period of weeks, partners in the city from street support teams, drug and alcohol services, and the outreach arm of the specialist primary care provision for the homeless (Bevan) continued to engage with

patient A and settled her on opiate substitute therapy and introduced her to the health intervention staff at the THU — i.e. a joint effort was made to facilitate her move into a flat. The authors discussed within the MDT that it was important to offer patient A a longer period of assessment, so as to evaluate her completely and offer safety and consistency. Thus, she was offered a six-month tenancy. Furthermore:

- ▶ Existing relationships continued throughout her stay at the health intervention flat with practitioners with whom she had an existing relationship to provide continuity
- ▶ Patient A was able to engage with the hepatitis C team now that she was settled in accommodation and was regularly seen in the community with a plan to complete treatment
- ▶ She was able to receive delivery of regular build-up drinks to improve her nutritional status
- ▶ Bevan primary care outreach team engaged with her more than before over her physical health, and outstanding outpatient appointments were organised
- ▶ Social workers were able to engage with patient A in the health intervention setting and build a relationship and complete a care act assessment
- ▶ A comprehensive risk management approach was undertaken
- ▶ Support workers were able to offer emotional as well as practical support, e.g. collecting benefits and prescriptions, budgeting, managing appointments, cleaning, shopping and cooking, and working with her to identify what she enjoys
- ▶ She was referred for palliative care — hoping for the best, while planning for the worst.

What was the impact?

The following outcomes have been achieved by having accommodation in the housing unit:

- ▶ Her health and presentation have become more stable
- ▶ She has not been admitted to hospital or ED while staying at the unit
- ▶ She has not returned to street sex work

- ▶ She has not had any interaction with the criminal justice system
- ▶ She has actively taken part in conversations around her own future
- ▶ She can identify things that interest her, such as baking, clothes and make up, and while she has not consistently engaged with all activities, some progress has been achieved
- ▶ Her flat has been clean and tidy on occasions. She has been proud of this and has been motivated to complete tasks in the flat, with her self-esteem improving. Although not always able to maintain this, support has been consistently offered
- ▶ Wounds have not deteriorated and there has been no active infection and she has been seen by the tissue viability nurse
- ▶ She has remained on the opiate substitute prescription
- ▶ She has demonstrated the ability to engage in discussions around her support needs
- ▶ Her confidence and communication skills have developed
- ▶ Her personal care has improved at times, with better personal hygiene and showing an interest in her appearance
- ▶ She has developed better relationships with professionals and a better attitude towards support work in general
- ▶ In her own words, she 'feels safe'
- ▶ She has become involved in engagement sessions and has contributed towards some co-production work on staff values.

What were the challenges?

It took several weeks to secure a flat for patient A, as the authors needed to establish safety and security for other residents.

Sadly, patient A has been declined future accommodation in other supported accommodation due to her high risks and substance misuse, and the authors have been unable to secure an acceptable move on option for her. However, the THU has offered a further six-month tenancy to continue therapeutic work, harm reduction and health interventions to avoid

return to temporary and emergency accommodation.

Substance misuse has been the main concern and all risks have led back to this. A trial of Buvidal was considered, but declined by patient A. Drug and alcohol services continue to make persistent efforts to engage with her to offer support and assistance.

'Often these individuals have been risk-managed out of other accommodation providers due to their multiple and complex needs... '

Throughout this project, there has been a great deal of reflection by the MDT as to what works well as an out-of-hospital model. The multidisciplinary approach from services that work together for a common outcome, while not working for the same organisation, has enabled personalised care with an emphasis on risk mitigation, therapeutic relationships, and case management that is creative and restorative, despite the challenges.

This project has allowed the authors to place people in homes, rather than just accommodation, i.e. a safe place where they can be assessed holistically and the MDT can learn what matters to them. Health and social care assessments and interventions are impossible to achieve without establishing safety and stability first. Feedback from patients is consistently that they feel this is home. It is also a reliable point of contact where health and social care services can actively engage the person in their treatment.

A continuing challenge is how this evolves from being a project into a sustained and funded system in the city. Although nine beds are a welcome improvement, this is a small resource for a cohort of people who are unable to access other intermediate care offers. Moving forwards with this model is also difficult due to limitations in securing private rental or local authority housing for patients.

As said, a key feature in enabling a flat to be offered under the project is risk management. Often these individuals have been risk-managed out of other accommodation providers due to their multiple and complex needs, and prior history with providers within the city. Access to risk management expertise is therefore essential in working with this cohort. In the authors' opinion, the MDT approach allows for effective, responsive and creative risk management plans to ensure the individual's safety and that of those around them. In this model, the social worker within the team leads on safeguarding and risk management.

Under the Care Act (2014), the local authority has a duty to lead on safeguarding responses. This lends itself to the social worker taking the lead on this within the MDT. This includes chairing risk management meetings, developing a holistic risk assessment and management plan, enacting it and then reviewing. This has reassured accommodation providers, who would previously have been stretched as to what they would have felt able to manage safely. In turn, this affords an opportunity for individuals to work with a service that provides assessment and support to maximise independence and achieve the best possible outcomes.

Indeed, a standout feature of the out-of-hospital model has been the in-depth, holistic assessment of needs over a period of time, in respect to both health and social care. A common challenge in providing this to the cohort in other settings, such as temporary/emergency accommodation or rough sleeping, is the ability and facilities to assess over a considered timeframe and the difficulty in, or the perceived non-engagement of these individuals when in transient circumstances. Having a flat of their own, with amenities and onsite support with care plans that are strengths-based and promote independence, gives greater insight into the individual's strengths and what they are capable of, while identifying areas where there is need for greater support or development. This provides individuals with a sense of security

and safety, supporting them not only to think about their immediate needs, but also to consider a future for themselves that they would like to achieve.

During their journey with the out-of-hospital care model, at the right time for them, a full assessment of needs under the Care Act 2014 is carried out for move-on planning, considering what eligible needs, if any, have been identified and working with the MDT to find services that will enable them to sustain the quality of life they have achieved with the service. This could be third sector services for tenancy support, health support or volunteering, or a commissioned service by adult social care as part of a package of care. In addition, those with needs that are assessed as requiring an enhanced level of ongoing care and support, are considered for more specialist supported living services or 24-hour care settings when appropriate.

In the authors' opinion, the integrated nature of working within this model facilitates higher quality assessments that enable better outcomes. The model of working to mitigate risks and working with the individual to promote improved management of behaviour that challenges and stretches boundaries for accommodation providers, is one that has supported the MDT to advocate on their behalf for onward planning with housing and care providers through an evidenced-based approach and personalised understanding of the person, their needs, and circumstances. Working in a psychologically and trauma-informed way creates the opportunity for individuals to have greater choice and control over their lives, promoting their autonomy and engagement as stakeholders in their own lives.

OUTCOMES

The authors are awaiting the formal national evaluation from King's College London. However, Stan Burrige, director of Expert Focus (www.expertfocus.co.uk/), commented:

The measured data from the Leeds out-of-hospital model

has reinforced the amazing service which has been delivered, but it is the unmeasured and unexpected positives which have come from this project which have not gone unnoticed. There has been a noticeable drop in sex-working and criminal activity, one person being very clear that it was the longest time they have been out of prison. Many of those who passed through the scheme had spent many years bouncing around inside or outside of different systems, this programme of work brought some stability to their lives and was often the longest time they had been accommodated in decades. There are no tick boxes that can reflect just how enormous this is.

As Simon Hodgson, head of community safety services, Leeds City Council said:

The ground-breaking, Leeds 'out-of-hospital project' provides a safe place, stable offer and support for people who are experiencing and/or at risk of homelessness. They deliver home-based care and assessment for people with exceptional quality, that truly delivers and retains a dignified compassionate response.

In the authors' experience, the project has delivered integrated, holistic, asset-based and personalised care, which has an emphasis on seeing the best in people, mitigating risk, promoting creative problem-solving and always holding people at the centre of their care. People have found safety, achieved health outcomes, found fun and joy in their life, reconnected with family and changed their lives.

Hospital data suggest that for the duration of the project a lower proportion of patients from this group were readmitted within 30 days of a previous admission, and the number of patients with many admissions was reduced.

The project has brought together several different professionals and teams and built positive relationships and a 'team Leeds' approach. Despite the mutual support of all

those involved in the model, there have been challenges in working collaboratively to change the lives of some of the highest risk and marginalised individuals in the city.

CONCLUSION

The National Institute for Health and Care Excellence guidance for homelessness (NICE, 2022) details the need for all areas to have a dedicated MDT around people experiencing homelessness and an equitable offer of intermediate care, which is bespoke for a younger population group with multiple disadvantages. In Leeds, a model has been developed which has resulted in a reduction in unplanned hospital admissions and emergency care attendances. It has also led to less chaotic lives with people being safe at home to consider their health and wellbeing, as well as facilitating advanced care planning for people to choose their preferred place of death. In addition, it enables positive risk taking and has fostered an integrated team to develop and work across systems to work creatively with the people they serve.

The authors continue to work within the city to be an established and securely funded out-of-hospital service that has equal value to other models of intermediate care, rather than just being a project. **JCN**

REFERENCES

- Gov.UK (2022) *Ending rough sleeping for good*. Available online: www.gov.uk/government/publications/ending-rough-sleeping-for-good
- Leeds Clinical Commissioning Group (2021) *Leeds left shift blueprint*. Available online: www.leedsccg.nhs.uk/publications/leedsleftshiftblueprint/
- Leeds.gov.uk (2023) *Homelessness strategy*. Available online: www.leeds.gov.uk/housing/housing-strategy/homelessness-strategy
- National Institute for Health and Care Excellence (2022) *Integrated health and social care for people experiencing homelessness*. NICE guideline [NG214]. Available online: www.nice.org.uk/guidance/ng214

Mediterranean diet: what's all the hype?

Gaynor Bussell

The Mediterranean Diet (MedDiet) is one that has been followed by certain populations from warmer climates for thousands of years. Many of these people seem to live in good health to an advanced age. Is this due to where they live and maybe a more laid-back lifestyle, or is their diet also responsible for this rude health? More recently, the popularity and publicity of the MedDiet seems to have grown exponentially. Will it end up being just another diet craze or is there something behind it so that we can be confident about advising patients to adapt their diet to being more Med like? This article explores what this diet actually is and whether there is any scientific proof for the claims made about it. From the research presented, it certainly seems that the MedDiet can offset many 'so-called' Western diseases. This paper also looks at which elements of the diet are likely to have this effect.

KEYWORDS:

- Mediterranean diet
- Polyphenols
- Inflammation
- Disease prevention

locally. In the 1950s, increasing trade made the food from these regions available worldwide. As it is a style of eating based on plants and using healthy fats, it has been shown to be one of the healthiest forms of diet with the ability to deter many 'so-called' Western diseases (Rishor-Olney, 2012). These benefits will be explored in this paper.

'As it is a style of eating based on plants and using healthy fats, it has been shown to be one of the healthiest forms of diet with the ability to deter many, "so-called", Western diseases.'



The Mediterranean diet (MedDiet) is a generic term used to describe the dietary pattern of individuals living in the olive growing countries along the coast of the Mediterranean sea, including Greece, Italy, southern

France, Crete, Spain, and parts of the middle east. It has been considered to be a poor man's diet, developed over the centuries, as people laboured in order to create sustenance in less hospitable terrain (Tuttolomondo et al, 2019). People in Mediterranean regions have eaten this sort of diet for thousands of years because it is based on the foods they can grow or source

The traditional MedDiet is typically made up of the following each day (taken from *Mediterranean Diet Pyramid: a lifestyle for today*):

- ▶ A variety of fruits and vegetables of different colours (more vegetables than fruit), a minimum of six portions
- ▶ Starchy food with each meal, such as bread, pasta, rice and couscous. Wholegrain is best.

Gaynor Bussell, freelance dietitian, nutritionist and life coach, specialising in women's health and weight issues

- ▶ Potatoes are not often used
- ▶ Two helpings of dairy, preferably low fat
- ▶ White meat about twice a week, fish/seafood twice a week, red meat less than two times a week, and processed meat less than once a week
- ▶ Two to four servings of eggs a week
- ▶ At least two helpings of legumes a week
- ▶ Less than two servings of sweet food a week
- ▶ Olive oil is the oil of choice
- ▶ Herbs, spices, garlic and onion are used extensively for flavouring rather than salt
- ▶ Wine is drunk in moderation, particularly red.

BIOLOGICAL EFFECTS OF THE MEDITERRANEAN DIET

Although not fully elucidated, the MedDiet seems to have the following biological effects, which enables it to offer numerous health benefits, such as:

- ▶ Lowering lipid levels
- ▶ Protection from oxidative stress
- ▶ Reduction of inflammation and platelet aggregation
- ▶ Inhibition of nutrient sensitisation pathways through specific restriction of amino acids
- ▶ Production of intestinal metabolites that are mediated by the microbiota (increase in genome stability)
- ▶ Attenuation of the genetic predisposition to present with hypercholesterolemia, hypertriglyceridemia, augmented fasting glucose and stroke incidence (Tuttolomondo et al, 2019).

WEIGHT MANAGEMENT

It was observed that people living in the south of Italy consumed a certain type of diet, now known as the MedDiet, and that these people were less obese and lived significantly longer (Corleo et al, 2020). Subsequent studies have further backed these observations. Indeed, there is now a body of literature suggesting that the MedDiet is effective in preventing

obesity (Corleo et al, 2020). However, surveys have indicated that adherence to the MedDiet in Italy has decreased in the past 50 years. At the same time, the prevalence of obesity in the Italian population has significantly increased, especially in the south, reaching alarming proportions (Corleo et al, 2020; Finicelli et al, 2022).

National initiatives were thus promoted to recover the nutritional habits inspired by the MedDiet, and recent data show a slight decrease in the prevalence of obesity over the last 15 years, particularly among children and adolescents (D'Innocenzo et al, 2019). Although obesity is still a matter of concern in Italy, the effectiveness of nutritional programmes based on the MedDiet suggests that preserving the traditional Mediterranean dietary habits may contribute to prevent obesity, with beneficial effects on health (Buscemi et al, 2020). Aspects of the MedDiet that help with weight include encouraging the consumption of a variety of nutrient-rich foods, rather than energy-dense sugary, fatty and processed ones (Healthline, 2019).

HEART HEALTH

Large cohort studies have shown that a high adherence to the MedDiet is associated with decreased markers of vascular inflammation (Dontas et al, 2007). This is not only due to the overall benefits of the diet, but also specifics such as consuming virgin olive oil, tree nuts and walnuts (Dontas et al, 2007).

A recent study showed that, in secondary prevention, the MedDiet was superior to a low-fat diet in preventing major cardiovascular events (Delgado-Lista et al, 2022). Similarly, the PREDIMED study showed that the incidence of major cardiovascular events was lower among those assigned to the MedDiet supplemented with extra virgin olive oil or nuts, compared to those assigned to a reduced-fat diet (Tuttolomondo et al, 2019).

In general terms, current studies indicate that the MedDiet has favourable effects in reducing blood pressure in both hypertensives and those with normal blood pressure (De Pergola and D'Alessandro, 2018). A further study showed that a strict MedDiet significantly decreased the likelihood of hypertension by 36% in people who were overweight and obese (Magriplis et al, 2020). The author of this article points out that carrying extra weight is known to be a risk factor for hypertension.

METABOLIC SYNDROME

Metabolic syndrome (MetS) is defined as the co-occurrence of metabolic risk factors, including insulin resistance, hyperinsulinemia, impaired glucose tolerance, type 2 diabetes mellitus, dyslipidaemia, and visceral obesity (NHS, 2019). Clinical and scientific studies pinpoint lifestyle modification as an effective strategy to reduce several features accountable for the risk of MetS onset (NHS, 2019). Among healthy dietary patterns, the MedDiet emerges in terms of beneficial properties associated with reducing MetS. It seems that the anti-inflammatory effect exerted by polyphenols in this diet (such as in olive oil, red wine, and nuts) is particularly accountable for the beneficial properties (Finicelli et al, 2019).

INFLAMMATION

Polyphenols are natural substances produced by plants to protect themselves from bugs. They help reduce inflammation when ingested; they also give plants their colours (Farzaei et al, 2019). Thus, the polyphenols in the MedDiet are believed to make it a low inflammatory diet. Low inflammatory foods in the MedDiet include:

- ▶ Fish
- ▶ Nuts
- ▶ Olive oil (virgin)
- ▶ A little red wine
- ▶ Wholegrains
- ▶ Tomatoes
- ▶ Fruit (especially berries) and vegetables, including beans (Bussell, 2021a).

RHEUMATOID ARTHRITIS

Emerging data has suggested that following a Mediterranean dietary pattern may be of benefit for both inflammatory and osteoarthritis. Specifically, research has identified beneficial effects of the MedDiet in reducing pain and increasing physical function in people living with rheumatoid arthritis. This is thought to be due to the diets anti-inflammatory effect (Forsyth et al, 2017).

The updated National Institute for Health and Care Excellence (NICE) guideline suggested that people with rheumatoid arthritis 'could be encouraged' to follow this eating pattern (NICE, 2018).

CANCER PREVENTION

Consuming a MedDiet is considered to be a powerful and manageable method to fight cancer due to its protective effects, such as in reducing oxidative and inflammatory processes of cells and avoiding DNA damage and cell proliferation (Mentella et al, 2019).

Apart from providing protective compounds, adherence to the MedDiet pattern decreases exposure to potential carcinogens by omitting intake of detrimental food items, for example, extensive consumption of red and processed meat is associated with an increased risk of cancer, especially colorectal. These foods are a potential source of N-nitroso compounds, polycyclic aromatic hydrocarbons, and heterocyclic amines, which are known to be cancerogenic (National Cancer Institute, 2017). A recent meta-analysis suggested that the above mentioned chemicals are associated both with increased risks of colorectal and gastric cancers (Morze et al, 2020).

WOMEN'S HEALTH ISSUES

Women's health seems often neglected and/or over medicalised; yet women are often desperate to find an answer to distressing symptoms such as menopause, polycystic ovary syndrome (PCOS)

and premenstrual syndrome (PMS) (Bussell, 2021b). It is now thought that many of these symptoms are due to inflammation, therefore the MedDiet should help (Bussell, 2021b).

NON-ALCOHOLIC FATTY LIVER DISEASE

Non-alcoholic fatty liver disease comprises a wide spectrum of hepatic disorders, from simple steatosis to hepatic necro-inflammation, leading to non-alcoholic steatohepatitis. As well as weight loss, treatments that work include a plant-based diet rich in polyphenols, so a MedDiet approach has been shown to work well (WebMD, 2022).

'Apart from providing protective compounds, adherence to the MedDiet pattern decreases exposure to potential carcinogens by omitting intake of detrimental food items... .'

A HEALTHY GUT MICROBIOTA

Polyphenols in the diet seem to boost the health effects of the intestinal microbiota; boosting the population of healthy gut bacteria and keeping down the more harmful ones (Filosa et al, 2018). It is also known that the right sort of gut bacteria can protect against many illnesses as well as boost mental health through the gut/brain link (Anderson, 2017).

ATOPIC ILLNESSES

There is evidence for a strong and inverse association between the level of adherence to the MedDiet and the occurrence of asthma and allergic rhinitis symptoms (Antonogeorgos et al, 2022). Promoting the MedDiet could be an efficient lifestyle intervention that could help to reduce the burden of these atopic diseases in adolescents (Antonogeorgos et al, 2022). It is the author's opinion that here, as with many of the illnesses protected against by this diet, it is the

diet's anti-inflammatory effect that is acting as the protective agent.

COGNITIVE DECLINE AND ALZHEIMER'S DISEASE (AD)

Anti-inflammatory dietary patterns, such as the MedDiet, may also be neuroprotective. Several components of such a diet, e.g. omega-3 fatty acids, antioxidants and polyphenols, can inhibit neuroinflammation associated with AD (McGrattan et al, 2019).

Anti-inflammatory diets may also attenuate neuroinflammation via indirect immune pathways from the gut microbiome and systemic circulation, as alluded to above (McGrattan et al, 2019). A recent study showed that following a healthy diet, especially at a younger age, may help to maintain a healthy brain (Song et al, 2022). Another recent study demonstrated that blood metabolites were associated with cognitive function and that certain dietary habits could potentially influence the levels of these metabolites and subsequently cognitive performance. The study suggested that the MedDiet, in particular, could lower metabolites associated with cognitive decline (Granot-Hershkovitz et al, 2022).

QUALITY OF SLEEP

Studies indicate that greater adherence to the MedDiet is associated with adequate sleep duration, with indicators of better sleep quality. This dietary pattern has a healthy profile of fat, proteins, carbohydrates, and abundant vitamins, mainly provided by the moderate-to-high intake of fruits, vegetables, nuts, olive oil, cereals, and fish. Mechanisms associated with these foods and nutrients and their possible combinations might explain the benefit of the MedDiet on sleep. On the other hand, a high consumption of red meat, saturated fat, and sugar-rich foods and beverages that are eaten only occasionally in the Mediterranean-style diet is associated with negative effects on sleep quality and quantity, and with insomnia symptoms (Scoditti et al, 2022).

Tracy had been diagnosed with PCOS and her blood sugars were creeping up to the pre-diabetic range. She had been told that her symptoms would ease if she lost weight. She had tried all sorts of diets, such as the keto-diet, low fat, calorie counting, but none had worked. She liked her food and enjoyed preparing tasty meals for her family. She told her dietitian that she loved the food when she went on holiday to the Mediterranean and seemed to lose some weight; she thought this was due to the fact that she was exercising more. Her dietitian suggested she try living and eating more as if she was abroad, i.e. more vegetables, pulses, some nuts and fish and swapping all her oil to olive oil, eating less red meat, cheese and processed food, and taking a little more exercise.

Her weight did start coming down slowly, but the good thing was that she enjoyed what she was eating and felt better in herself. Her blood pressure and low-density lipoprotein (LDL) cholesterol fell and she was told she was no longer pre-diabetic.

Tracy's story

'... the MedDiet pattern has been shown to have a better ecological footprint than current dietary habits in industrialised countries...'

planetary well-being (Serra-Majem et al, 2020)

CONCLUSION

Nutritional research has focused in recent decades more on food combination patterns than on individual foods/nutrients due to the possible synergistic/antagonistic effects of the components in a dietary model. Various dietary patterns have been associated with health benefits, but the largest body of evidence in the literature is attributable to the traditional dietary habits and lifestyle followed by populations from the Mediterranean region.

It seems that certain aspects and the overall effect of the MedDiet can offset many 'so-called' Western diseases. The diet ranks highly for being easy to follow, delicious, sustainable and healthy. Many authorities and charities for health, such as those for cancer, arthritis and mental health, suggest that this diet is adopted as a 'cure' and prevention for several diseases. Those who come from countries that traditionally ate this food need to be encouraged to return back to some of the old ways (shunning fast food habits), and those who have not eaten this sort of diet should be encouraged to try it. **JCN**

REFERENCES

- Anderson A (2017) *The Psychobiotic Revolution*. National Geographic
- Antonogeorgos G, Mandrapiya M, Liakou E, et al (2022) Hierarchical analysis of Mediterranean Dietary pattern on atopic diseases, prevalence in adolescence: The Greek Global Asthma Network study. *Allergol Immunopathol (Madr)* 50(5): 114–120
- Berry EM (2019) Sustainable food systems and the Mediterranean diet. *Nutrients* 11(9): 2229
- Buscemi S, Corleo D, Galvano F, De Lorenzo A (2020) The Mediterranean diet and its individual components: Linking with

LONGEVITY

The Seven Countries Study was key in bringing to light the health significance of the MedDiet and how it was associated with longer life due to the way it reduces life-threatening diseases (Menotti and Puddu, 2015). Since then, many prospective observational studies and trials in diverse populations have reinforced the beneficial effects associated with a higher adherence to the MedDiet in reference to the prevention/management of age-associated non-communicable diseases (Dominguez et al, 2021).

Age-related non-communicable diseases which can be reduced by following the MedDiet and hence extend longevity, include:

- ▶ Cardiovascular disease
- ▶ Metabolic disorders
- ▶ Neurodegenerative disorders
- ▶ Cancers
- ▶ Depression
- ▶ Respiratory diseases
- ▶ Fragility fractures, i.e. osteoporosis (Dominguez et al, 2021).

WHY IT HAS THE ADVANTAGE OVER OTHER DIETS

In the author's clinical opinion, as well as being healthy, the MedDiet is also tasty and simple to prepare.

It has more fat than traditional Western diets, giving the diet its taste

(flavonoids in foods give the taste and are fat soluble). Fats in the diet also help the fat-soluble vitamins and phenolic substances, such as leptin, to be absorbed.

It is a sustainable diet (Berry, 2019) — in particular, the more traditional form of the diet. Indeed, the MedDiet pattern has been shown to have a better ecological footprint than current dietary habits in industrialised countries, particularly when compared to the Western dietary pattern. This is mainly due to the higher consumption of local and in-season plant-derived foods and lower consumption of animal products.

However, unfortunately, the current dietary pattern in many Mediterranean countries has shifted from the traditional diet. A return to the latter would be beneficial for human health and the natural environment, as the MedDiet is not only a model of cultural food choices, cooking methods, meal patterns and, more broadly, a lifestyle, but is also a sustainable framework that attenuates the environmental pressure of food production and consumption (Corleo et al, 2020; Serra-Majem et al, 2020; Dominguez, 2021; Delgado-Lista et al, 2022). A broader adherence to this dietary model would make a significant contribution to greater sustainability of the food system (from producer to consumer), with a myriad of benefits for human and

- obesity in Italy. In: *The Mediterranean Diet* (2nd edn). Chap 26: 285–92
- Bussell G (2021a) Diet, lifestyle and inflammation. *J General Practice Nurs* 7(4): 38–42
- Bussell G (2021b) Can diet and Lifestyle changes help women's health conditions? *J General Practice Nurs* 7(1): 53–60
- Corleo D, Fabio G, De Lorenzo A (2020) The Mediterranean diet and its individual components: Linking with obesity in Italy. In: *The Mediterranean Diet (Second Edition) An Evidence-based Approach* Chapter 26: 285–92
- Delgado-Lista J, Alcalá-Díaz JF, Torres-Peña JD, et al (2022) Long-term secondary prevention of cardiovascular disease with a Mediterranean diet and a low-fat diet (CORDIOPREV): a randomised controlled trial. *Lancet* 399(10338): 1876–85
- De Pergola G, D'Alessandro A (2018) Influence of Mediterranean Diet on blood pressure. *Nutrients* 10(11): 1700
- D'Innocenzo S, Biagi C, Lanari M (2019) Obesity and the Mediterranean diet: a review of evidence of the role and sustainability of the Mediterranean diet. *Nutrients* 11(6): 1306
- Dominguez LJ, Di Bella G, Veronese N, Barbagallo M (2021) Impact of Mediterranean Diet on chronic non-communicable diseases and longevity. *Nutrients* 13(6): 2028
- Dontas AS, Zerefos NS, Panagiotakos DB, et al (2007) Mediterranean diet and prevention of coronary heart disease in the elderly. *Clin Interv Aging* 2(1): 109–15. Erratum in: *Clin Interv Aging* 3(2): 397
- Farzaei MH, Singh AK, Kumar R, et al (2019) Targeting inflammation by flavonoids: novel therapeutic strategy for metabolic disorders. *Int J Mol Sci* 20(19): 4957
- Filosa S, Di Meo F, Crispi S (2018) Polyphenols-gut microbiota interplay and brain neuromodulation. *Neural Regen Res* 13(12): 2055–59
- Finicelli M, Squillaro T, Di Cristo F (2019) Metabolic syndrome, Mediterranean diet, and polyphenols: Evidence and perspectives. *J Cell Physiol* 234(5): 5807–26
- Finicelli M, Di Salle A, Galderisi U, Peluso G (2022) The Mediterranean Diet: an update of the clinical trials. *Nutrients* 14(14): 2956
- Forsyth C, Kouvari M, D'Cunha NM, et al (2017) The effects of the Mediterranean diet on rheumatoid arthritis prevention and treatment: a systematic review of human prospective studies. *Rheumatol Int* 38(5): 737–47
- Granot-Hershkovitz E, He S, Bressler J (2022) Plasma metabolites associated with cognitive function across race/ethnicities affirming the importance of healthy nutrition. *Alzheimers Dement*. Sep 16. Epub ahead of print
- Healthline (2019) *Mediterranean Diet Review: Does It Work for Weight Loss?* Available online: www.healthline.com/nutrition/mediterranean-diet-review-scored (accessed September, 2022)
- Magriplis E, Panagiotakos D, Kyrou I (2020) Presence of hypertension is reduced by Mediterranean Diet adherence in all individuals with a more pronounced effect in the obese: the Hellenic National Nutrition and Health Survey (HNNHS). *Nutrients* 12(3): 853
- McGrattan AM, McGuinness B, McKinley MC, et al (2019) Diet and inflammation in cognitive ageing and Alzheimer's disease. *Curr Nutr Rep* 8(2): 53–65
- Menotti A, Puddu PE (2015) How the Seven Countries Study contributed to the definition and development of the Mediterranean diet concept: a 50-year journey. *Nutr Metab Cardiovasc Dis* 25(3): 245–52
- Mentella MC, Scaldaferrì F, Ricci C, et al (2019) Cancer and Mediterranean Diet: a review. *Nutrients* 11(9): 2059
- Morze J, Danielewicz A, Przybyłowicz K, et al (2021) An updated systematic review and meta-analysis on adherence to Mediterranean diet and risk of cancer. *Eur J Nutr* 60(3): 1561–86
- National Cancer Institute (2017) *Cancer causes and prevention*. Available online: www.cancer.gov/about-cancer/causes-prevention/risk/diet/cooked-meats-fact-sheet (accessed October, 2022)
- NHS (2019) *Metabolic syndrome*. Available online: www.nhs.uk/conditions/metabolic-syndrome/#:~:text=Metabolic%20syndrome%20is%20the%20medical,that%20affect%20the%20blood%20vessels (accessed October, 2022)
- National Institute for Health and Care Excellence (2018) *Rheumatoid arthritis in adults: management*. NICE, London. Available online: www.nice.org.uk/guidance/ng100
- Rishor-Olney CR, Hinson MR (2022) *Mediterranean Diet*. In: StatPearls [Internet]. Available online: www.ncbi.nlm.nih.gov/books/NBK557733/
- Scoditti E, Tumolo MR, Garbarino S (2022) Mediterranean diet on sleep: a health alliance. *Nutrients* 14(14): 2998
- Serra-Majem L, Tomaino L, Demini S, et al (2020) Updating the Mediterranean Diet Pyramid towards sustainability: focus on environmental concerns. *Int J Environ Res Public Health* 17(23): 8758
- Song S, Gaynor AM, Cruz E (2022) Mediterranean Diet and white matter hyperintensity change over time in cognitively intact adults. *Nutrients* 14(17): 3664
- Tuttolomondo A, Simonetta I, Daidone M (2019) Metabolic and vascular effect of the Mediterranean Diet. *Int J Mol Sci* 20(19): 4716
- WebMD (2022) *Diet, Lifestyle tips to reverse fatty liver disease*. Available online: www.webmd.com/hepatitis/fatty-liver-disease-diet

KEY POINTS

- As the MedDiet is a style of eating based on plants and using healthy fats, it has been shown to be one of the healthiest forms of diet with the ability to deter many, 'so-called', Western diseases.
- This dietary pattern has a healthy profile of fat, proteins, carbohydrates, and abundant vitamins, mainly provided by the moderate-to-high intake of fruits, vegetables, nuts, olive oil, cereals, and fish.
- Large cohort studies have shown that a high adherence to the MedDiet is associated with decreased markers of vascular inflammation.
- Consuming a MedDiet is considered to be a powerful and manageable method to fight cancer.
- A broader adherence to this dietary model would make a significant contribution to greater sustainability of the food system (from producer to consumer), with a myriad of benefits for human and planetary well-being.

Integrated and coordinated care: what it means

Diane Burns

Several crucial documents have identified the need for integrated care to meet patient requirements in the current financial climate, developed from the concepts of self-care and joining up care to improve health outcomes. These include the *Five Year Forward View* (2014), *Next Steps on the Five Year Forward View* (2017), *NHS Long Term Plan* (2019) and now the introduction of the Health and Care Act (2022) — all of which provide a contextualised approach to care. Integrated care is aimed at the way that organisations work together to support self-care (which incorporates the principles of holistic care considering physical, emotional, social, spiritual and economic health [Mills, 2017]), with a commitment to improve patient outcomes by avoiding confusion and repetition. It enhances comprehensive care planning by listening to patients — perhaps best summed up by the phrase, ‘No decision about me, without me’ (Department of Health [DH], 2012).

KEYWORDS:

- Integrated care ■ Care Planning ■ Communication ■ Self-care
- Holistic assessment ■ Person-centred care

Integrated care is achieved by organisations, such as the NHS and allied health providers (i.e. local authorities as well as private care establishments), working together to avoid fragmented care where individuals have to explain their patient journey over and over again to different health and social care providers. According to Gov.UK (2013), integrated care also ensures that patients do not become a product of system failure, as services are aware of patient needs through a comprehensive assessment process that looks beyond health and social care and also considers wider social determinants of health.

‘... it is essential for healthcare professionals to understand the care planning process and give patients the opportunity to have their voice heard...’

A National Voices paper (2013) identified that it is essential for healthcare professionals to understand the care planning process and give patients the opportunity to have their voice heard, i.e. their thoughts and wishes, so that they feel empowered and involved in their own care. This is particularly important when working with vulnerable patients in their own communities and homes.

The Office for National Statistics (ONS, 2021) indicates that by 2026–2030, the UK population is set to rise to 69.2 million people, a projected rise of 2.1 million. This means that with healthcare demands being stretched through increased need, care should be delivered more smartly and effectively

through a fully coordinated approach. With increasingly complex caseloads, nurses need to take more considered approaches to tackling and meeting patient care (Health Education England [HEE], n.d. a and b).

DEVELOPMENT OF INTEGRATED CARE CONCEPTS THROUGH POLICY AND LAW

The timeline for this is as follows.

2001: National service framework: older people

This considered the implementation of the single assessment for older people (Department of Health [DH], 2001).

2006: ‘Our health, our care, our say: a new direction for community services’

A white paper that looked at joining up health and social care plans and greater cooperation between NHS, local government and multidisciplinary teams (MDT) working within a case management approach (Department of Health and Social Care, 2006).

2006–2009: Partnership for older people’s projects

DH funding of 29 projects linked to primary care bringing together primary care trusts and voluntary/independent sectors with the aim of moving resources out of institutions towards patients’ homes. This was pivotal according to Henwood (2010).

2007: ‘Putting people first: a shared vision and commitment to the transformation of adult social care’

Collaborative work between local and central government with the set vision for system-wide transformation, including joint strategic needs, commissioning and co-locating (HM Government, 2007).

2008: 'High quality care for all: NHS next stage review'

This document is committed to greater patient choice and control with the personalisation of care plans (Department of Health and Social Care, 2008). This was fundamental in putting integrated organisations into place under one budget, including NHS and social care providers.

2012 Health and Social Care Act

This introduced the duty to encourage integrated care and facilitate competition across the NHS to reduce health inequalities. Local health and wellbeing boards were established (Department of Health and Social Care, 2012).

2012–2013: 'Integrated Care: Our Shared Commitment'

The aim of this framework document was to share the DH vision with 12 partner organisations being chosen — the partner organisations wanted to make integration of care the norm (Gov.UK, 2013). This included information systems. Input from the Department for Communities and Local Government (2013) provided further expansion of pilot projects, such as the neighbourhood community project, which looked at service redesign and delivery of care. This document supported the pilots, helping with the scoping and implementation of neighbourhood budgeting, understanding of a wider range of vision, priorities, commissioning, budgets and working together to create a collaborative focus with clear partnerships within the community project sites that ran from April 2012–March 2013 (Gov.UK, 2013).

2014: 'Five Year Forward View'

This document provided a greater emphasis on integrated care with regards to a 'shake up' in the way in which care was delivered (NHS England, 2014). This was a massive change that focused on care pathways across primary community and acute providers (Rosstad et al, 2013).

It provided national leadership, but with key local targets. The purpose was to avoid the 'one size

Table 1: Examples of vanguard sites introduced by 'The Five Year Forward View' (GOv.UK, 2014a; King's Fund, 2014)

Service	Purpose
Multicare providers (MCP)	▶ Independent GP will continue, but practices are now increasingly encouraged to build on strengths and become a focal point with a far wider range of ability to meet the needs of patients. This can be delivered through larger group practices, shifting consultations to out of hospital settings
Primary and acute care systems (PACS)	▶ A better range of integrated care by allowing GP and hospital services alongside mental health and community to work together
Urgent and emergency care networks	▶ Helping patients to get the right care at the right time, working to help patients use primary care more effectively — links to improving pharmacy, primary care, community mental health teams, ambulance services and community pharmacies. Developing linked hospitals with the emphasis on thinking about specialist centres, seven-day services with the right funding, strengthening clinical triage and measuring quality
Viable smaller hospitals	▶ According to the Dalton Review (Gov.UK, 2014a), sustainability is key and the benefits of having smaller hospitals cannot be overlooked if localised care is to be provided at the most competitive rates
Specialised care	▶ Defined the evidence for specialised care, e.g. stroke, or specialised cancer care. The blueprint was for the NHS in England to move towards a three-year review of the programmes concentrating on specialist centres modern maternity care
Modern maternity services	▶ The 'Five Year Forward View' looked at a proposition for a new model that looked at maternity units in relation to sustaining and developing services.
Enhanced care in care homes	▶ This looked at a range of services working in partnership, i.e. private organisations, NHS and local authorities to prioritise care for older people and develop new models providing quality services

fits all' approach. The vision was that there would be a reduction in health inequalities and a greater emphasis on out-of-hospital care. A variety of new systems were incorporated. These included seven new care models (Table 1) related to how money is spent and looked at 50 vanguard sites for the new care models programme (Gov.UK, 2014a; King's Fund, 2014).

2014: New Models of Care

Piloting of the new care models was undertaken based around the 'Five Year Forward View' (NHS England, 2016).

2014: Care Act

This covered integration priorities through promotion of integrated care (Gov.UK, 2014b).

2015: Sustainability and transformation plans (STPs)

STPs looked at new local blueprints for local bodies, aimed at collaboration and bringing together mental health and other NHS services (King's Fund, 2017).

2017: 'Next Steps on the Five Year Forward'

This document outlined the progress of the 'Five Year Forward View', including what still needed to be achieved in relation to integration and funding. Strengthening the workforce was pivotal (NHS England, 2017).

2019: 'NHS Long Term Plan'

This set out the vision for integrated care, including how the NHS would impact on outcomes from childhood

to end of life, from diagnosis to health prevention and support. The STPs were now working towards becoming an integrated care system (ICS), paving the way for future developments (NHS England, 2019).

2022: Health and Social Care Act

Setting out and using the ICSs, as indicated in the 'Long Term Plan', this Act sets the scene for care providers who came into force from 1 July 2022. It looks at improvements in health and social care through integration. For example, there are subtle introductions from funding to changes in delivery with the integrated care boards (incorporating health and wellbeing boards, place-based boards and primary care networks) and integrated care partnerships. The term clinical commissioning group (CCG) has now become obsolete and there are changes to incorporate health and social care (Gov.UK, 2022).

PARTNERSHIPS AND CARE

Integrated care has several different names that have been utilised in the literature through the timeline explored above, including integrated care, integrated health, coordinated care, seamless or transmural care.

Whichever name is used, the way organisations work together to ensure patient autonomy and choice is critical. The many strategies, such as single assessment, to collaborations, to ICSs, have had an impact on safe discharges and care experiences, with the purpose being to promote the concept of self- and joined up care, with digital methods becoming more commonplace (NHS England, 2014).

PROFESSIONAL WORKING THROUGH PERSONALISED CARE PLANNING

Nurses working in practice in different settings should consider patient health needs and circumstances. This is done through recognising wider (e.g. psychosocial, mental health) as well as medical or health needs, so that patients are reviewed holistically. To meet patient needs completely, it is essential

that care planning is effective and coordinated through communication, documentation and assessment (Anderson and Hewner, 2021).

It is important that assessment procedures are inclusive, considering family, carers and relatives — all of whom may or do play a part in the wellbeing of the patient.

The rise in the elderly population and finite nature of the NHS budget means that patients need to be provided with the right training (i.e. education to enable them to self-care) so that they can commit to their care. Any treatment, prevention and/or health promotion activities should be discussed and agreed between the patient, carers and healthcare professionals. This can free up clinician time to provide care for others and helps patients to apply their newly acquired knowledge and adhere to the treatment plan. The importance of effective communication should not be overlooked (Bauman, 2017).

Traditionally, there have been a range of different ways which nurses have used to assess, plan, implement and evaluate care (Toney-Butler and Thayer, 2023). The role of integrated and coordinated care looks beyond traditional nursing to a more joined up and linked approach between health and social care professionals — i.e. sharing values and beliefs so that care is coordinated. Different healthcare professionals may have differing agendas in regards to the viewpoint their profession takes. For example, a community nurse and podiatrist working together for a patient with diabetes with complex wounds, while both focusing on the patient come from different knowledge bases, and so the priorities of care will need to be shared. Thus, in the author's clinical opinion, overcoming barriers, such as who is to provide specific aspects of care, is important, particularly when supporting patients.

INTERAGENCY PLANNING

In essence, planning of care is as important as delivery, especially when using an interagency approach for

holistic care. Each professional needs to avoid promising what the other will do. This is to ensure that patients do not receive misinformation, resulting in the care team as a whole over promising and under delivering (see *Patient story*).

AVOIDING BREAKDOWN IN COMMUNICATION

It is vital not only to ensure that patients receive the correct knowledge, but that they also have a clear understanding of the role (and potential limitations) of the services provided by other health and social care services. When planning, the referrer needs to take into account logistics, limitations, and process requirements, e.g. the way in which the care is actually delivered, including the time needed (coordinated care can be time-consuming), as well as consideration for planning and/or forward referrals.

Furthermore, outcomes which are hoped to be achieved by a referral should be negotiated with the patient and teams to whom the referral is to be made. Defensiveness of teams involved, i.e. protection of 'their patch' or professional protectionism, can lead to difficulties that impact on the care being given. This seems to be changing, as the author has seen in clinical practice with ICSs and the way in which there is more commonality of language and better understanding of different roles, which builds interprofessional trust and understanding.

ROLE OF HOLISTIC CARE IN INTEGRATED CARE

The 'Code' (Nursing and Midwifery Council [NMC], 2018) demonstrates the importance of working with the patient, as there is an express need to listen to their preferences and work in partnership. This is central to making sure that people are empowered and involved in decisions. Within practice, the Code (NMC, 2018) effectively states that care requirements need to be communicated and evidence-based — patients should be at the forefront of any choices and integral to any decisions that are made.

During a district nursing visit, a patient was promised a new bathroom by a nurse in a community setting. The patient was given the impression that as their bathroom was upstairs, they would get a full new room and they were excited at the prospect. The nurse then referred the patient to the community social worker who they believed would arrange the new facilities. The social worker had to explain the limitations of their role, which would not lead to a full new bathroom but would, rather, lead to adjustments to the existing room that were far below the level of adjustment promised by the nurse.

Patient story

With regards to preserving safety, care should promote honesty, i.e. working with the patient to ensure that they are central to their care and choices made (NMC, 2018). This promotes trust between the healthcare professional and patient, with the aim of educating patients so that they can make informed choices. In primary care, nurses are key to supporting this process, often as autonomous practitioners helping to support the choices made (National Institute for Health and Care Excellence, n.d.).

In a wider capacity, collaboration means talking and working not only with the patient, but also their family and/or carers to promote self-care through knowledge, care, and negotiation. Nurses should work as advocates, providing leadership and protecting the wellbeing of patients, which involves prioritising and understanding their needs (Suhonen et al, 2018).

Holistic care recognises that the person is not just the illness. It incorporates mind, body, spirit, social/cultural, emotions, relationships, context and environment (Nursing Theory, n.d.). Such care is crucial as it enables the practitioner to understand the patient beyond their medical condition, so that they view the whole person, rather than looking at them as someone with an illness or injury. Indeed, community nurses, visiting patients in their own homes, are in an ideal position to realise that there are other priorities, as experienced first-hand by the author.

Being aware of a patient's priorities can be critical to providing

'A holistic approach that treats the whole patient, not just symptoms of their illness, is fundamental to the concepts of self-care and integrated care.'

patient-centred care. Community nursing is a special area in which nurses often visit patients on a number of occasions, which helps not only to make the patient's priorities known, but also establishes a way through the care the patient needs. Negotiation is key to patient care, especially person-centred care.

PERSON-CENTRED CARE

Health Education England (n.d.a) suggests that by empowering patients, the time of key staff can be freed up to make use of skills and competencies to assist with the person-centred approach, which is crucial to integrated care. For nurses working at a grass roots level, this can be liberating and ensures that there are the correct resources and/or group of staff supporting a particular patient.

Key principles of person-centred care include:

- ▶ Treating people with respect, dignity, and compassion
- ▶ Providing coordinated care, support, and treatment
- ▶ Offering care that is supported and caring
- ▶ Enabling people to encourage their strengths and abilities for an independent life

(Coulter and Oldham, 2016).

The Care Act 2014 looked at the person's journey and how this can be better understood, considering:

- ▶ Better care for adults
- ▶ Rights to independent advocacy
- ▶ Personal health budgets
- ▶ Better transition and responsibilities from children to adult social care.

These principles have underpinned policies since to safeguard patients.

CONCLUSION

This article has outlined the key policies that incorporate coordinated care. It is worth noting that integrated care has been recognised by the 'National service framework: older people' of 2001 to the 2022 Health and Social Care Act, and thus, is here to stay. Community nurses are at the forefront of delivering care that supports the patient, their values and family.

Care provision needs to involve all sectors working together from primary to secondary to tertiary care, as well as charities and third-sector organisations. A holistic approach that treats the whole patient, not just symptoms of their illness, is fundamental to the concepts of self-care and integrated care. Such an approach should be implemented at all stages of care, from assessment, to planning, to provision of care, and referral to other healthcare providers. If these stages are not implemented correctly, with seamless cooperation between all parties involved, there is a danger that the patient could become 'lost in the system'.

Ensuring that patients are educated and empowered to take

Practice point

Patient management incorporates the concept of self-care and, as a nurse, holistic management of patients is essential. This is particularly so when caring for patients in the community, as they need to be helped to develop skills/knowledge to care for themselves.

ownership of their care means that they can work in tandem with healthcare professionals and 'reap the benefits' of being engaged and understanding how to achieve optimal health outcomes. **JCN**

REFERENCES

- Anderson A, Hewner S (2021) Care coordination: a concept analysis. *Am J Nurs* 121(12): 30–8
- Baumann NA (2017) The importance of effective communication: some food for thought. *J Appl Lab Med* 1(14): 460–1
- Coulter A, Oldham J (2016) Person-centred care: What is it and how do we get there? *Future Hosp J* 3(2): 114–6
- Department of Health (2001) *National service framework: older people*. Available online: www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people
- Department of Health and Social Care (2006) *Our health, our care, our say: a new direction for community services*. Available online: www.gov.uk/government/publications/our-health-our-care-our-say-a-new-direction-for-community-services
- Department of Health and Social Care (2008) *High quality care for all: NHS next stage review final report*. Available online: www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report
- Department for Communities and Local Government (2013) *Neighbourhood Community Budget pilot programme*. Available online: www.gov.uk/government/publications/neighbourhood-community-budget-pilot-programme
- Department of Health and Social Care (2012) *Health and Social Care Act 2012: fact sheets*. Available online: www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets
- Department of Health (2012) *Liberating the NHS: No decision about me, without me*. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf
- Gov.UK (2013) *Integrated Care: Our Shared Commitment*. Available online: www.gov.uk/government/publications/integrated-care
- Gov.UK (2014a) *Dalton review: options for providers of NHS care*. Available online: www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
- Gov.UK (2014b) *Care Act*. Available online: www.legislation.gov.uk/ukpga/2014/23#:~:text=An%20Act%20to%20make%20provision,England%3B%20to%20establish%20and%20make
- Gov.UK (2022) *Health and Care Act 2022*. Available online: www.legislation.gov.uk/ukpga/2022/31/contents/enacted
- Health Education England (n.d. a) *Person-centred care*. Available online: www.hee.nhs.uk/our-work/person-centred-care
- Health Education England (n.d. b) *Community and district nursing*. Available online: www.hee.nhs.uk/our-work/community-district-nursing
- Henwood M (2010) *POPP: a look at the final report on Partnerships for Older People Projects*. Available online: www.communitycare.co.uk/2010/02/11/popp-a-look-at-the-final-report-on-partnerships-for-older-people-projects/
- HM Government (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care*. Available online: https://webarchive.nationalarchives.gov.uk/ukgwa/20130104175839/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118
- King's Fund (2014) *The NHS Five Year Forward View seven models of care*. Available online: www.kingsfund.org.uk/projects/five-year-forward-view
- King's Fund (2017) *Sustainability and transformation plans (STPs) explained*. Available online: www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained
- Mills JM (2017) A person-centred approach to holistic assessment. *Prim Dent J* 6(3): 18–23
- National Voices (2013) *A narrative for person-centred coordinated care*. Available online: www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care
- NHS England (2014) *NHS Five Year Forward View*. Available online: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
- NHS England (2016) *New Care Models: Vanguard — developing a blueprint for the future of NHS and care services*. Available online: www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
- NHS England (2017) *Next steps on the NHS Five Year Forward View*. Available online: <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>
- NHS England and NHS Improvement (2019) *NHS Long Term Plan*. Available online: www.longtermplan.nhs.uk/
- National Institute for Health and Care Excellence (n.d.) *Shared decision-making*. Available online: www.nice.org/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making
- Nursing Theory (n.d.) *Holistic Nursing*. Available online: <https://nursing-theory.org/theories-and-models/holistic-nursing.php>
- Nursing and Midwifery Council (2018) *Future nurse: Standards of proficiency for registered nurse*. Available online: www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf
- Office for National Statistics (2021) *National Population projections: 2020-based interim*. Available online: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2020basedinterim
- Rosstad T, Garasen H, Steinsbekk A, Sletvold O, Grimsmo A (2013) Development of a patient-centred care pathway across healthcare providers: a qualitative study. *BMC Health Service Res* 13: 121
- Suhonen R, Stolt M, Habermann M, Hjaltdottir I, Vryonides S, Tonnessen S, et al (2018) Ethical elements in priority setting in nursing care: A scoping review. *Int J Nurs Stud* 88: 25–42
- Toney-Butler TJ, Thayer JM (2023) *Nursing Process*. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan

The time is now to keep children with asthma safe

Here, Laura King, senior asthma practitioner, North-East London, explains why the time is now to pre-emptively act to avoid asthma attacks, which commonly peak in children and young people during mid-September.

This article is a call to action for those involved with children and young people (CYP) who have (or might have) asthma. The evidence has been clear for some time that there is an identified peak in asthma attacks in mid-September, the ‘week 38’ phenomenon (Transformation partners in healthcare, 2022). However, what is often not discussed is that there is a time when we can perhaps pre-emptively act to avoid attack — and that time is now.

Winter is often seen to be the time to consider respiratory health. However, for patients who wheeze, entering autumn with healthy lungs is key to resilience to winter viruses and triggers. ‘Pre-emptive medicine’ is one of the key focuses in recent national guidance (NHS England, 2021) and has been a pillar of best practice in both the National Institute for Health and Care Excellence (NICE, 2021) and British Thoracic Society/Scottish Colleague Guidelines Network (BTS/SIGN, 2019) guidance for some time. It is known that many asthma deaths are avoidable, and that there are many so-called modifiable factors that can contribute to mortality in asthma (Royal College of Physicians [RCP], 2015).

RISK PROFILES

When it comes to the annual review, we know what we should be asking — and that the time with patients is sorely limited. However, it is possible to identify CYP at increased risk of severe or life-threatening attack. While we are acutely aware of some (e.g. six or more salbutamol inhalers, any courses of oral steroids, hospital admissions or attendances), the single most predictive factor is a history of severe attacks (BTS/SIGN, 2019). However, the following should also be considered:

- ▶ Historical poor control
- ▶ Concurrent atopy (i.e. allergies, but especially food allergies)
- ▶ Psychological issues
- ▶ Parent or caregiver understanding
- ▶ Social deprivation (BTS/SIGN, 2019).

Salbutamol, while effective as a bronchodilator in occasional use (and, of course, the suggested treatment in the event of acute symptoms), can cause issues of its own when over-used, such as deregulation of the beta-2 receptors, also known as desensitisation (Barnes, 2007; Cazzola et al, 2013; Vähätalo et al, 2022). Thus, there is a clear action: treat the inflammation with something that will work, or risk the over-use of beta-2 agonists causing down-regulation of receptors. In plain English: if the patient keeps using salbutamol, it will eventually stop working.

WEEK 38 — ANNUAL PEAK

Week 38 is a phenomenon which is widely known in the asthma world (Transformation partners in healthcare, 2022). The week refers to the week of the year 38/52. It is a diary spread often circled in red or highlighted by those, like the author, in the trade, because historically this is when acute asthma exacerbations peak for the entire calendar year. This year, it sits in the week starting 18 September, 2023.

Week 38 is thought to be the outcome of the following — for some these effects occur in isolation, and for others it may be cumulative (Transformation partners in healthcare, 2022):

- ▶ CYP whose diagnosis is unclear, or whose triggers are generally in the autumn or winter may not be taking preventer medication at all
- ▶ CYP may become less adherent

Practice point

Inhaled steroids take time to work (usually at least four weeks), so the clock is ticking for those patients with niggling inflammation.

during the school holidays, due to being out of routine, on holiday, or simply forgetting in the midst of activities

- ▶ The cooler and often damp weather can trigger some CYP
- ▶ Spores surface at this time of year (Denning et al, 2006).

When considering the reasoning behind this, we can start to unpick how to act. Some of these factors come down to asthma basics — inflammation will either accumulate or return (depending on the individual), and without appropriate treatment this will worsen over time. For some, it is purely environmental and this needs to be considered annually in the context of that person’s treatment.

Often, in the author’s clinical experience, despite intentions of working pro-actively, clinicians actually end up reactively prescribing oral steroids, or prescribing preventers after the child has already had an attack.

Inhaled corticosteroids, by their very nature, will take around four to six weeks to reach full therapeutic efficacy and so this means that we are on a deadline to review or contact wheezy children and young people. To have time to commence, establish a routine and also whether it is effective, it would be timely to optimise treatment by August to ensure that the preventer therapy keeps that individual safe.

WHAT SHOULD WE BE FOLLOWING?

NICE (2021), BTS/SIGN (2019) and the Global Initiative for Asthma (GINA, 2022) all suggest a trial period when starting preventer therapy. In essence, the role of clinicians is to keep the patient in best health using the smallest dose inhaled steroid that is physiologically effective.

EXPLAINING TO CYP AND FAMILIES

The author often finds herself reviewing CYP in the summer, when they are (by all reports) well and do not feel like they need preventer therapy. A subset of these families will be concerned about corticosteroids, some around potential harm for their CYP, and some simply do not wish to give their child medicine.

For some families, they are just not recognising some of the subtler symptoms, such as a gradual increase in coughing, slight shortness of breath that gradually escalates or chest tightness that starts as very subtle and increases over time to feel normal. For some families with chaotic or stressful lives, this may simply not be noticed even by the young person (King, 2020). Thus, it is important to discuss. For example, a common consultation in the author's clinic may go like this:

Yes, they're totally fine. No symptoms at all.

Oh, fantastic, so not coughing at night — not wheezing — able to do everything their friends can? Able to run around/run for the bus/be active?

Yeah, they're fine, they can't do P.E. because of their chest so it's totally fine.

CONCERN AROUND STEROIDS

For some families this theme simply revolves around misunderstanding of inhaled steroids. Many parents or carers consider inhaled steroids dangerous and associate them with perceived side-effects more commonly seen with high-dose oral steroids, such as:



- ▶ Behaviour changes
- ▶ Weight gain from increased appetite
- ▶ So-called 'moon face'.
(Chan and DeBruyne, 2000).

Many caregivers also worry about dependence on steroids, the idea that their child may become addicted and that there are long-term side effects.

ANXIETY AROUND GIVING MEDICATION

Over the years, the author has found this to be a real worry in some of her patient populations. Often a simple conversation around the risks of not treating airway inflammation is enough to help minimise anxiety with the hope that further anxiety does not arise around potential attack. Understanding how and why medicines work can be the single most important factor, ensuring parents and CYP are making informed decisions when it comes to medication.

POOR ADHERENCE TO THERAPY

There could be many reasons for this, from pure dislike of the device or regimen, to legitimate side-effects. If patients' (or families') reasoning behind poor adherence is not understood, healthcare professionals are unlikely to be able to help. It helps to establish an open forum, allowing them to be honest. Perhaps try phrasing adherence spiel thus, *Taking medicines every day is really tricky and we are all human. How often do you think you forget the [preventer medication]?*

Some families have either had symptoms long term and have become used to them, or they do not understand that asthma should not limit activities of daily living. It can be useful to have a list in mind of celebrities or sports people who have asthma to illustrate your point, such as the Olympic cycling team which has a high number of athletes with asthma, along with high-profile footballers who are also known to have asthma.

TIPS FOR ESTABLISHING ROUTINE

There are several tried and tested methods in the author's arsenal of 'top tips'. For school-age children who have tried all the usual aide-memoires, such as placing the inhaler by their bed or toothbrush, suggest putting the device in their school shoes. While this might sound dramatic, it means that they have a physical reminder and barrier attached to an activity they have to do to leave home. In the evening, they can place the device back in their shoes for the morning. Similarly, ask the family if there is something that they do without fail (as long as this is safe and does not damage the device) to act as a physical aid to adherence.

If routine is a real issue (this might be particularly pertinent for CYP who have a chaotic family or home, or perhaps those who have attention deficit hyperactivity disorder [ADHD]), medication regimens can be tailored to their strengths — if they are better at remembering medication for the morning or evening dose, is there a way to change their regimen to once daily? If they are

forgetful when they are symptom-free, is maintenance and reliever therapy (MART) likely to ensure that they self-titrate when symptoms arise?

TIPS TO AID MEMORY

The answer? Education. It might be that this is the first time someone has had the time to explain what asthma is, the fact that it is inflammation and therefore needs to be treated with the correct type of medication to combat the fundamental issue. Often, CYP and their families understand asthma to be a series of events, they expect to have attacks with various frequencies, and to have limited activity.

Once all the above is established, i.e. failure in terms of asthma control, it is possible to start delving into what is causing a child or young person to exacerbate or continue experiencing interval symptoms.

In the author's clinical opinion, someone with good asthma control should feel the same and be able to do the same as someone who does not have asthma, apart from taking medication once or twice per day. Asthma should not limit activities, cause frequent cough or wheeze, or make them absent from school, nursery or work.

CONCLUSION

To combat the annual, notorious week 38 phenomenon, clinicians should start trying to pre-empt the factors causing it. These largely stem from:

- ▶ Poor diagnosis rates generally

leading to delayed prescribing of preventer therapy

- ▶ Poor adherence to preventer therapy
- ▶ The surge in winter triggers, such as weather changes and spores
- ▶ Poor understanding of asthma control and symptoms.

Acting now, with enough time to embed the therapy and establish good adherence, might start chipping away at these pockets of risk and help reduce pressure on the whole healthcare system. **JCN**

REFERENCES AND FURTHER READING

Asthma + Lung UK (2023) *How to avoid back-to-school asthma*. Available online: www.asthma.org.uk/conditions/asthma/child/back-to-school

Barnes P (2007) Scientific rationale for using a single inhaler for asthma control. *Eur Respir J* 29: 587–95

British Thoracic Society/Scottish Intercollegiate Guidelines Network (2019) *SIGN 158: British guideline on the management of asthma*. Available online: www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/

Callery P, Milnes L, Verduyn C, Couriel J (2003) Qualitative study of young people's and parents' beliefs about childhood asthma. *Br J General Practice* 53: 185–90

Cazzola M, Page CP, Rogliani P, Matera MG (2013) B2-agonist therapy in lung disease. *J Respir Crit Care Med* 187: 690–6

Chan P, DeBruyne J (2000) Parental concern towards the use of inhaled therapy in children with chronic asthma. *Pediatr Int* 42: 547–51

Denning D, O'Driscoll B, Hogaboam C, Bowyer B, Niven R (2008) The link between fungi and severe asthma: a summary of the evidence. *Eur Respir J* 27: 615–26

Dhruve H (2020) Preventing back to school asthma attacks. *Practice Nursing* 31(1). Available online: www.practicenursing.com/content/clinical/preventing-back-to-school-asthma-attacks

Global Initiative for Asthma (2022) *2022 GINA Report, Global Strategy for Asthma Management and Prevention*. Available online: <https://ginasthma.org/gina-reports/>

King L (2020) Getting the most from children and young people's asthma reviews. *J General Practice Nurs* 6(2): 54–8

Further learning

#Askaboutasthma — this year week of 11th September, with the theme of 'widening our view'.

This year the themed sessions are being run a week before the spike to ensure that clinicians can learn and implement when they face the surge of acute patients. There are themed days, including primary care, pharmacy and nursing, incorporating both live and recorded resources to ensure all can join in.

For more information visit:

www.transformationpartnersinhealthandcare.nhs.uk/our-work/children-young-people/asthma/ask-about-asthma-2023/

NHS England (2021) *National Bundle of Care for Children and Young People with Asthma*. Available online: www.england.nhs.uk/publication/national-bundle-of-care-for-children-and-young-people-with-asthma/

NHS England (2023a) *About the National Bundle of Care for Children and Young People with Asthma programme*. Available online: www.e-lfh.org.uk/programmes/children-and-young-peoples-asthma/

NHS England (2023b) #AskAboutAsthma 2023 campaign. Available online: www.transformationpartnersinhealthandcare.nhs.uk/our-work/children-young-people/asthma/ask-about-asthma-2023/

National Institute for Health and Care Excellence (2017) *Asthma: diagnosis, monitoring and chronic asthma management*. NICE guideline [NG80]. Last updated 2021. Available online: www.nice.org.uk/guidance/ng80

Royal College of Physicians (2015) *Why asthma still kills: National Review of Asthma Deaths (NRAD)*. Available online: www.rcplondon.ac.uk/projects/outputs/whyasthma-still-kills

Transformation partners in healthcare (2022) #AskAboutAsthma 2022. Available online: www.transformationpartnersinhealthandcare.nhs.uk/our-work/children-young-people/asthma/ask-about-asthma-2022/

Vähätalo I, Lehtimäki L, Tuomisto LE, et al (2022) Long-term use of short-acting B2-agonists in patients with adult-onset asthma. *J Clin Allergy Immunol Pract* 10(8): 2074–83

Resources

Tier training is available for free:

Tier 2 — E learning for health or tier 3 — BeatAsthma (both are free)

NEL lunch and learn sessions:

The author's network of nurse specialists (and friends) run monthly lunch and learn sessions virtually. The topic changes each month, and is usually seasonal.

Sign up at: www.eventbrite.co.uk/e/paediatric-asthma-lunch-learn-topics-tickets-623641637927

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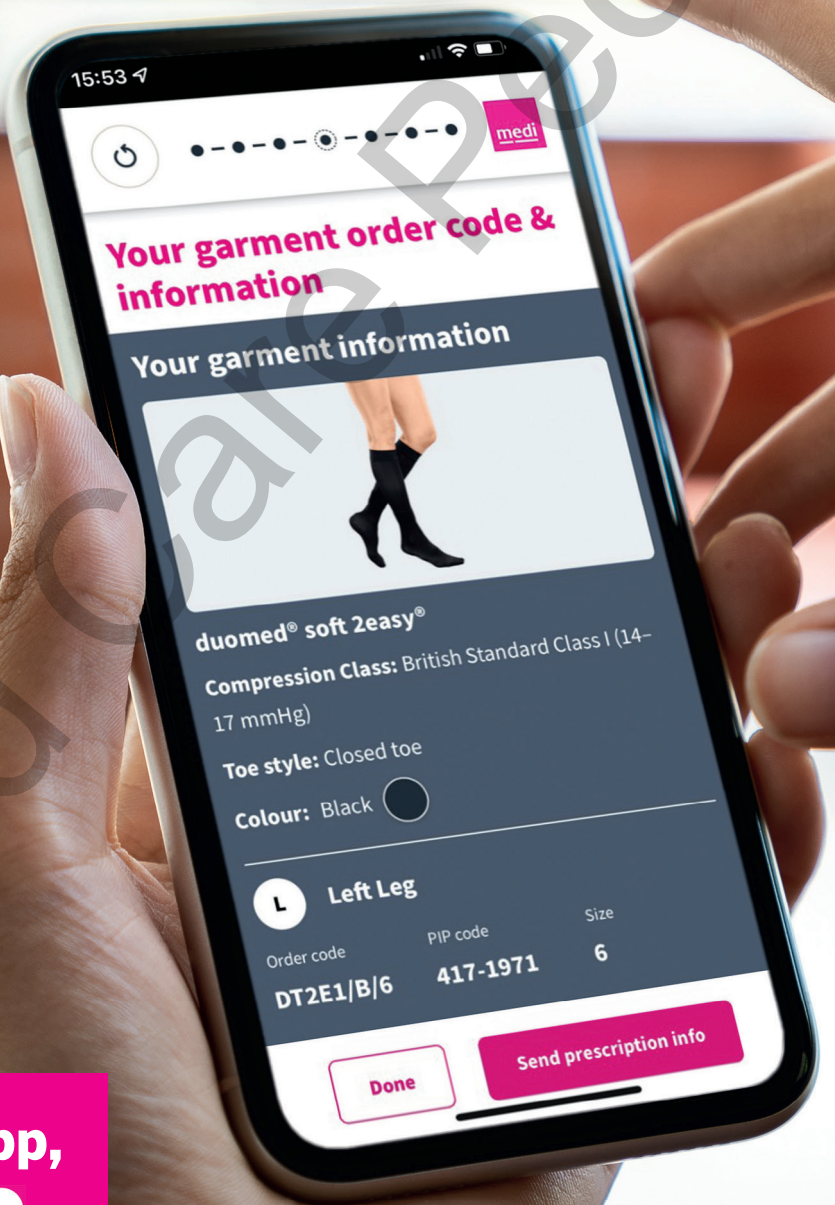
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