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October/November 2025

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1. Dhoonmoon L (2025), Improving skin integrity and reducing MASD: early intervention with **MEDI DERMA-*PRO*** Ointment. JCN 39(3), pp.38-44.

AD609P-JCN190925V1

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Journal of Community Nursing
incorporating *Journal of District Nursing*
October/November 2025

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

ISSN 0263 4465

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http://www.jcn.co.uk

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

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

Institutional and overseas subscription rates:
United Kingdom: £175.00
Overseas: £295.00

UK subscription rate:
Six issues per year: £30

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

Risks and realities of violence in the community

As violence against nursing staff becomes more commonplace and the abuse suffered continues to increase, our 'Community matters' piece looks at whether violence specifically against community nurses is increasing. It discusses potential reasons for the rise in violence and abuse and the vulnerability of nurses working alone. Measures and processes that have been and are still taken to protect staff are explored, alongside their effectiveness. Remember to always report any instances of abuse, no matter how small and no matter how busy you are. Perhaps the most important section is the one headed 'Relying on number one' — please ensure that you read this and the advice offered. Take on board the recommended actions to support your safety at work and take all the precautions available to stay safe.

With self-care week fast approaching (17–23 November), I was interested to read the editorial from the Self-Care Forum (*pp. 14–15*). Their work — and the resources they have developed — offer practical ways to support and empower people to take an active role in their own health and wellbeing. Promoting self-care not only benefits individuals, but also reduces pressures on health services.

The responsibility of caring for the elderly population continues to grow in complexity, particularly as more patients stay in their own homes and health services focus on bringing care closer to home. A key aspect of this is identifying and managing dysphagia, which is vital to stay hydrated and nourished and reduce the risk of ill health, as Linda Nazarko explains in her article on dysphagia and renal function (*pp. 46–52*). Another important challenge is 'sundowning', a common issue for people with dementia. To provide holistic care that supports both patients and their families, clinicians must understand this condition and how best to manage it (*pp. 54–59*).

I was encouraged by Amanda Young's feature on beginning a nursing career in the community, rather than following the traditional path of starting in secondary care (*pp. 65–67*). I hope that more nurses will consider and explore this, as the scope of practice within the community, as this journal shows, is both wide-ranging and diverse.

I also hope you enjoy reading this issue and that you find it useful for your day-to-day practice. Remember, if there are any areas that you would like to see covered, please just get in touch.

Annette Bades, editor-in-chief, *JCN*

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Editorial board

As the UK professional lead in adult community nursing at the Royal College of Nursing and a Queen's Nurse, I am delighted to join the JCN editorial board. I am passionate about raising the profile of community care and influencing the future of this service. I feel privileged to be a part of the journal to help share knowledge and be involved in the development of discussions and conversations related to community nursing.
Cathryn Smith

I am a senior lecturer with a background in district nursing, continuing healthcare (CHC) funding, palliative care and diabetes.
I feel privileged to be able to influence the future district nursing workforce and love my job! I am passionate about innovation and encouraging district nurse students to reach their full potential. The JCN has been an integral part of my nursing career, with attendance at many JCN events and study days and the contemporary learning gained from reading each issue. The JCN published my first article and gave me the confidence to write more. A thirst for knowledge is fundamental in primary care, and this excellent free resource cannot be overstated. I am honoured to be part of the JCN editorial board.
Teresa Davies

I am a community nurse with a background in urgent community response. I am currently working as a senior lecturer and am passionate about raising the profile of community nursing (in all its forms) within pre-registration healthcare education. I am proud to be a Queen's Nurse and a non-medical prescriber and have a special interest in prevention of hospital admission, advanced physical assessment and multidisciplinary working. I am delighted to be joining the JCN editorial board and relish the opportunity to be a part of the ongoing conversation on developments in community nursing.
Abigail Brooks

I am passionate about advocating for nurses who make such a vital contribution in the community in so many varied roles. I am always keen to encourage nurses to develop their knowledge and skills as this leads to better care for patients. I am delighted and privileged to be joining the JCN editorial board at a time when the profession is developing at such a rapid pace, as this is an amazing opportunity to be part of those developments and share research and learning. I thrive when collaborating with others to promote best practice, influence policy and advocate for the nursing profession.
Catherine McArevey

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In each issue we investigate a topic affecting you and your practice. Here, we ask...

Is violence against community nurses on the rise?

It is an unfortunate fact of nursing life that much like below-inflation pay rises and other people's bodily functions, occasional incidents of abuse come with the job.

A recent report from the Royal College of Nursing (RCN) shed light on the issue with some shocking statistics showing that incidents of abuse and violence against staff in A&E departments had doubled since 2019, with nurses being punched, spat on and even threatened with guns and acid attacks ('Nurses too scared to even go into work — as violence against A+E staff almost doubles in five years' — www.rcn.org.uk).

But, while the level of abuse directed at staff detailed in the report is shocking, at least many A&E departments have access to emergency call buttons and security teams with plenty of colleagues on-hand, luxuries not always available to community nurses who often work alone, leaving them vulnerable.

Apart from some conveniently placed warnings about abuse not being tolerated in clinics and GP practices, it is often hard to see how trusts are making a tangible effort to protect community nurses. Also, the often-solitary nature of the job means that violence or abuse directed at community staff sometimes goes unreported.

So, how at risk are you as a community nurse, and what measures can you take to protect yourself?

As a district nurse, I've seen first hand how vulnerable we can be when working alone in patients' homes. The risk of violence against community nurses is a constant concern, and yet often viewed as an unusual incident. Unlike hospital settings, we lack security, alarms, or backup. However, most employers do have lone working policies, which offer general advice and guidelines. Community nurses are expected to manage risk on the spot with minimal support and generic training. Perhaps more bespoke training is required for community nurses, including self-defence techniques? Employers and line managers should also take notice and proportionate action when individual nurses raise their concerns about their safety in certain situations — sending two nurses into a potentially unsafe situation instead of one, which is often the suggested solution, is not adequate. In the meantime, we must prioritise our own safety: always update your work diary so that others know where you are, carry a charged personal alarm, enable the GPS on your phone, always plan your exit route on the way into a home, and trust your instincts. If a situation feels unsafe, leave and report it officially while making sure that your colleagues are fully aware of your concerns.

Gail Goddard
Senior lecturer, community nursing team, Buckinghamshire New University; Queen's Nurse

CRUNCHING THE NUMBERS

While we have all probably experienced some form of insult or bad behaviour in our daily work as nurses, how common is serious abuse or even violence?

According to a recent survey from Unison, up to 90% of nurses have experienced physical violence while at work, ranging from being thumped or kicked, having bedpans emptied over them or even stabbings ('Nurses and midwives subjected to violence at work on a daily basis' — www.unison.org.uk).

Nor is it just patients who are responsible. Of the 1,000 nurses,

Community nursing predominantly involves lone working, with a nurse or carer making an unaccompanied visit to a patient in their own home. Not many patients require a 'double up' of professionals. The range of referrals received is vast (with reduced hospital stay times) and includes all patients; some with a combination of physical ill health, mental ill health or learning disabilities.

Often community nurses are no longer assigned to provide continuous care for one patient; instead allocation tools share out the day's caseload. This approach fails to allow the nurse or carer to then build a rapport and understanding of individual needs with the patient/patient's relatives; instead, they are reliant on reading nursing and medical notes. The quality of notes can vary greatly. Important information which would be extremely helpful to the visiting professional may not be evident and could ultimately lead to issues arising. Potential for risk occurs when a nurse or carer does not know the full history and has been unable to build a trusting relationship with the patient.

Risk of violence from all patients is always a possibility, whether instigated through their mental or physical ill health. Pain can be a trigger, financial implications of ill health, lack of trust are all examples of potential risks escalating.

Some community visits could be due to safeguarding concerns being raised, in these situations the patient may not want your visit. As a member of the community nursing team, it is up to the patient to give consent for you to enter their home (unless you have identified a life-threating emergency). Difficult decisions have to be made and sometimes the patient does not want you there — but you know you are needed.

In my time as a community nurse, I have been scared. To ensure that I have done all I can to protect myself I made sure that colleagues had access to my diary and knew where I was and when. Many community teams now ensure you 'check in' and 'check out' of each home visit so your location is known. Some geographical areas, especially some rural areas, can have no access to phone signals of 4G/5G; making this an especially difficult activity to complete.

The one rule I have always adhered to is to ensure that when I park outside, I am facing the way I need to exit and this is not obstructed. During my visit I also make sure that I have a clear and unobstructed way to leave. Then, remember the basic fundamentals of nursing, that at all times you are being kind, caring and professional. Listen to your patient's concerns and respond appropriately. Recognise and respond to any signs of crisis. Ensure that both you and the patient remain safe. Never be afraid to seek help and support.

Melanie Lumbers
Freelance tissue viability nurse

midwives and students who responded to the Unison survey, 19% had been attacked by patients' relatives or other visitors. Perhaps most worryingly, almost 70% of those surveyed said that their workplace did not take the violence sufficiently seriously.

Unfortunately, it is not just nurses working in hospitals who are affected. Nurses in care homes and residential facilities also experience higher levels of violence and abuse compared with other staff, with a recent survey of 7,000 social care workers finding that violence, harassment and abuse were more common among nurses than other members of the social care workforce ('Research shows high levels of violence faced by social care nurses'— www.nursinginpractice.com).

Similarly, a debate at this year's Royal College of Nursing conference and reported in *Nursing in Practice* heard how employers have to take more robust action to protect community nurses from abuse and violence, with delegates discussing how working alone in patients' homes and in isolated communities often leaves community staff vulnerable to assault ('Powerful employer action needed to protect community nurses from abuse' — www.nursinginpractice.com).

Community nursing frequently requires practitioners to work alone in patients' homes — settings which can pose significant and often underestimated safety risks. Nurses may encounter volatile environments, incomplete clinical information, and the possibility of verbal or physical abuse from patients or others present in their homes. As healthcare delivery continues to shift into the community, the prevalence of lone working is rising, yet the safeguards in place have not kept pace.

Both the UK government and the Royal College of Nursing (RCN) acknowledge these risks. NHS Employers (2022) emphasise that trusts have a legal and ethical obligation to assess and mitigate risks for lone workers, including the provision of training, supervision, and safety equipment such as alarms or tracking devices. The RCN (2021) goes further, affirming that nurses have a right to a safe working environment and must not be expected to tolerate abuse or unsafe conditions. Their guidance rightly underscores the shared responsibility between staff and employers and empowers nurses to raise concerns and withdraw from unsafe situations.

However, acknowledging risk is not enough. While individual nurses can adopt protective strategies (such as the ones highlighted in this article), the onus must lie with employers to implement robust systems and invest in technologies that actively safeguard staff. Failure to do so not only jeopardises the wellbeing of nurses but also accelerates attrition from community roles, undermining continuity of care and compromising patient outcomes.

If community nursing is to remain a viable and respected pillar of healthcare, staff safety must be treated as a strategic and operational priority, not an afterthought.

Abigail Brooks
Senior lecturer in adult nursing, University of West London; Queen's Nurse

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WHAT IS DRIVING INCREASES IN VIOLENCE?

While many incidents of aggression against community nurses can involve patients with mental health issues or dementia, staff shortages that leave nurses attending patients on their own are also an aggravating factor.

Community nurses can also find themselves the victim of aggression from relatives or partners who are unhappy at their family members' care ('Workplace health and safety issues among community nurses' — bmj.com). This issue was particularly prevalent in the period immediately after the Covid-19 pandemic when significant delays in treatment caused frustration among patients ('NHS attacks: nurses being spat at, hit and punched at work' — www.bbc.co.uk).

There are also a raft of less commonly known reasons for violence against community nurses, such as people believing that nurses in uniform may have access to drugs, incidents of sexual assault and the increased vulnerability of nurses who are called out after dark ('Exclusive: nurses working alone are victims of hundreds of assaults, investigation shows' — rcni.com).

HOW CAN WE PROTECT STAFF?

In many hospitals the safety of staff is taken seriously, particularly in A&E where nurses are often protected by various measures including security guards, CCTV and body-worn cameras, as well as the reporting and logging of previously violent patients ('Urgent action needed to protect A&E staff from violence' — www.bbc.co.uk).

Over the years, various proposals for making community work safer for nurses have been mooted, including ensuring that they are not sent alone to visit known aggressive patients or isolated areas without back-up — often known as 'buddy schemes'. Back in 2007, there was even a plan to provide every lone NHS worker with a name badge that doubled as a personal

alarm, but typically funding issues meant that these did not pass into widespread use ('Community nurses offered no protection from abusive patients, survey finds' — rcni.com).

There has also been the usual management speak about protecting lone community workers by providing 'suitable and sufficient risk assessments', ensuring that potentially dangerous patients are 'treated in a safe and secure environment' and even 'identification of those responsible for the effective implementation of identified control measures' ('Improving the personal safety of lone workers' — www.nhsemployers.org).

Phew — bet you feel safer now, right?

Other measures have been touted over the years, including zero tolerance of violence from patients and better training for staff on how to manage abuse. However, one study found that many such schemes were 'aspirational' and not consistently implemented by managers in practice ('Workplace health and safety issues among community nurses — bmj.com).

RELYING ON NUMBER ONE

Overall, then, whether through a lack of resources, a perception that community work is less dangerous than acute care, or simple complacency, it appears that community nurses must take responsibility for their own safety. But what measures can you take to make sure you are safe at work?

If you find yourself in a situation that does not feel right, or if you feel threatened, consider the following ('Prioritising personal safety' — www.rcn.org.uk):

- Before you visit a patient's home, make sure that you have all the available information about their condition and have read their notes thoroughly to check for any red flags such as previous incidents of abuse
- If you have a communal online work diary, ensure that this is up to date with all your appointments so that colleagues know where you are at any given time
- If you have a personal alarm or tracking app on your smartphone, make sure it is charged and working
- If you feel in any danger upon entering a patient's home, have a ready-made reason to leave, for example that you have left some equipment in your car
- Remember that if a patient's demeanour is out of character or if they are displaying threatening behaviour, this may be due to a physical illness such as hypoglycaemia, acute stroke or a head injury. This may require urgent medical treatment and you should contact the emergency services without delay
- Remember that it is vital to document any near misses or incidents — including if you decided not to attend a patient because you felt threatened — this will help to protect yourself and your colleagues in the future.

Photograph: Studio Romantic/Shutterstock

For the modern community nurse, it is also crucial to embrace the benefits of digital technology. Using innovations such as smartphone tracking and personal alarms that connect remotely to your base can help to keep you safe, while integrating digital innovations into your routines also provides another layer of protection for the whole team ('Safeguarding and technology in health and social care' — nurselinecs.co.uk).

Lastly, it is important to remember that while you have a duty of care to your patients, you also have a responsibility to look after yourself. None of us want to refuse to treat anyone in need, but it is vital to recognise when a patient's home has the potential to become unsafe ('We have a duty of care to ourselves' — www.rcn.org.uk). After all, when it comes to community nursing, being 'safe' rather than 'sorry' is the best way to stay out of danger and ensure that you are fit to provide care to those patients who need it most. JCN

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Violence against all nurses is most certainly not a new phenomenon — it has been an issue for many years and in a variety of formats. However, it is on the increase despite strategies in place to reduce all forms of violence to nurses across all settings, including the community arena.

Community nurses can be particularly vulnerable to experiencing violence due to their working environment, i.e. working alone in individual's houses, not knowing who else apart from the patient may be inside the house when they enter, and the complex and changing needs of the individuals that they are caring for.

Community nurses are advised to follow lone working policies, act as directed for safety and utilise recording equipment and resources appropriately. However, such actions can be hampered by resource limitations, including training deficits, staffing issues and the scarcity of equipment such as personal alarms and monitoring devices. Therefore, robust resources should be in place to support nurses to reduce the risk of any form of violence being perpetrated upon them.

Community nurses need to be courageous advocates for their own safety, as they are for their patients' needs. They are well able to act with flexibility and decisively in an informed and educated way for their patients and so need to employ these skills equally to safeguard their own present and future safety.

Teresa Burdett
Independent nurse consultant

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Bridging the self-care divide: why understanding matters

Helen Donovan, chair, Self-Care Forum, organisers of Self-Care Week; independent nurse consultant and immunisation specialist nurse

As we approach National Self-Care Week (17–23 November 2025), new findings from the Living Self-Care Survey Study (www.selfcareforum.org/self-care-forum-research/) — conducted by the Self-Care Forum in partnership with Imperial College London's Self-Care Academic Research Unit (SCARU) — reveal a pressing need to rethink how we support self-care across the UK. Led by my colleague, Dr Peter Smith, president of the Self-Care Forum, the study is one of the largest of its kind and highlights a clear disconnect between public willingness to self-care and the professional systems meant to support it.

KEY FINDINGS: A NATION WILLING, BUT UNDER EQUIPPED

Nine in 10 people routinely manage common symptoms themselves. Yet more than half struggle to assess the benefits and risks of treatment options. Many, particularly those from underserved communities, face barriers rooted in low health literacy and limited access to professional guidance.

Healthcare professionals want to support self-care, but face constraints — including time, training, and resources. This creates a disconnect: while the public is ready to take more responsibility, professionals often perceive a lack of engagement. People self-care and are willing to do more, but they must have respect, support, confidence and clear information to act.

UNDERSTANDING THE DISCONNECT

This gap is not just theoretical — it has real consequences. The NHS 10-Year Health Plan calls for putting 'power in patients' hands', yet without consistent, relatable information and support, that power remains inaccessible for many. As professionals, we must meet people where they are, not where we assume they should be. That means recognising that most people's lives are not lived in the realm of evidence-based medicine, and adapting our communication accordingly.

NURSING ROLE: LEADING THE WAY IN SELF-CARE SUPPORT

Nurses are central to bridging this divide. From primary care to community outreach, we are often the most accessible point of contact for patients. Our role includes:

- Using health literacy techniques such as teach-back and visual aids to ensure understanding
- Embedding prevention and lifestyle support into routine consultations
- Leading local initiatives that promote mental wellbeing, physical activity, and chronic condition management.

The Self-Care Forum's Self-Care Aware fact sheets are invaluable tools in this work (www.selfcareforum.org/fact-sheets/). These free, evidence-based resources help nurses and other clinicians guide patients through common conditions like back pain, sore throats, and headaches. They offer practical advice, red flag warnings, and symptom timelines — all in accessible language. These fact sheets can be printed, shared digitally, or used as part of consultations to reinforce self-care messages.

THE BIGGER PICTURE: RISING DEMAND, SHRINKING CAPACITY

According to the King's Fund (2025), the NHS is under immense and growing pressure. Demand for health services has risen significantly in recent years — and continues to climb. Since 2018/19, GP appointments in England have surged by 20%, with over 370 million appointments booked in 2024 alone. Outpatient appointments (again this is data from England) have doubled since 2003/04, while A&E departments are experiencing 2.8 million more visits and 1.3 million more admissions than in 2010/11. These numbers are more than just statistics — they reflect a healthcare system under immense and increasing pressure.

The reasons behind this surge are complex and multifaceted. As life expectancy rises, more people are living longer, but not necessarily healthier lives. Many are managing multiple long-term conditions such as diabetes, cancer, frailty, and dementia. The prevalence of chronic illnesses is steadily increasing, with the Health Foundation projecting that 9.1 million people in England will be living with a major illness by 2040 — an increase of 2.5 million since 2019.

SELF-CARE AS A SYSTEMIC SOLUTION

Self-care is not just about individual choices — it is about creating systems

and environments that support those choices. That includes:

- Strengthening health education in schools to build lifelong literacy
- Promoting access to nutritious food, safe green spaces, and trusted health information
- Encouraging collaboration across sectors — from educators and employers to regulators and local authorities.

Nurses are uniquely positioned to lead this shift. As highlighted in *BMC Nursing* (Audulv et al, 2025), nurse-led self-care interventions improve outcomes, reduce symptom burden, and build patient confidence. A meta-analysis in the *European Journal of Cardiovascular Nursing* found that such interventions significantly improved self-care behaviours, self-efficacy, and mental wellbeing among patients with heart failure (Huang et al, 2022).

The Self-Care Forum continues to advocate for embedding these approaches into routine care, supported by practical tools like the Self-Care Aware fact sheets and campaign materials.

WHY SELF-CARE WEEK MATTERS

National Self-Care Week is a rallying point for everyone — individuals, schools, employers, local authorities, and healthcare professionals. It is a time to run workshops, share resources, and empower people to take small but meaningful steps toward better health. Whether it is knowing when to see a pharmacist, managing stress, or connecting with others for support, these actions matter.

The Self-Care Forum provides toolkits and guidance to help organisations get involved, making it easier to deliver consistent, impactful messaging across communities (toolkits and guidance can be downloaded at: www.selfcareforum.org/events/self-care-week-resources/).

FINAL THOUGHT: FROM AWARENESS TO ACTION

The Living Self-Care Survey Study is a call to action. We must close the gap between ambition and reality — between what people want and what they are supported to do. Nurses, with their trusted roles and community reach, are essential to making self-care a lived reality.

By respecting where people are starting from, using tools like the Self-Care Forum's fact sheets, and embedding self-care into everyday practice, we can build a culture of health rooted in empowerment, empathy, and equity. When self-care becomes a way of life, everyone benefits — individuals, communities, and the NHS itself. JCN

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Sleep, safety and sustainability

Muyi Adekoya, head of market development, chief nursing officer directorate — complex care on behalf of North Central London Integrated Care Board

Night-time care is one of the most complex challenges in adult social care. For decades, routine hourly checks have been the default approach to keeping residents safe. Yet this practice, although well-intentioned, often disturbs rest, reduces recovery, and increases risks such as falls and hospital admissions. In North Central London (NCL), we asked a simple but powerful question: could technology protect residents while also preserving their sleep?

In partnership with care providers and technology partner Ally Cares and Transformation Partners in Health and Care (TPHC), NCL Integrated Care Board (ICB) has deployed AI-enabled acoustic monitoring across care homes. What began as a falls prevention project has revealed something more profound: that by protecting sleep, we can transform resident wellbeing, support staff, and ease pressure on the wider NHS. This work was recognised nationally when NCL ICB, alongside its partners, won the *Health Service Journal* (HSJ) Digital Award for Connecting Health and Social Care through Digital earlier this year.

This initiative also supports the government's recently announced '10-Year Health Plan', which emphasises a shift from analogue to digital ways of working and from treatment-focused care to a greater emphasis on prevention, ultimately aiming to improve health outcomes.

INVESTING IN SLEEP AND FALLS PREVENTION

Following the pandemic, NCL ICB sought to strengthen digital support for vulnerable residents in care settings. Previous investments in remote monitoring had enabled better oversight of physical health, but one pressing issue remained: falls.

Falls were the leading cause of London Ambulance Service conveyances from care homes, often resulting in hospital stays that worsened frailty and reduced independence. As the author explained:

> *Pendant alarms and scheduled night-time checks were too reactive. By the time a pendant was pressed, the fall had already happened; by the time a carer entered a room, the resident was already disturbed from their sleep. We needed to move upstream, to prevent, not just respond.*

Through NHS England funding, NCL piloted acoustic AI technology in 10 homes. The initial focus was falls reduction. But as deployment progressed, an unexpected — and ultimately more powerful — impact emerged: uninterrupted sleep.

REDISCOVERING VALUE OF SLEEP

By replacing intrusive hourly checks with discreet monitoring, residents were no longer woken multiple times a night. The Ally system works by using a small wall-mounted acoustic sensor in each resident's room. This device detects patterns of sound and motion, such as coughing, restlessness, or signs of distress, without the need for cameras or physical intrusions. When an unusual event is detected, an alert is sent directly to the care team's handheld devices, allowing staff to review and determine if a response or physical check is needed.

In practice, this means that staff no longer need to carry out routine door-opening and light-switching checks simply to confirm a resident is safe. Instead, technology listens continuously in the background, ensuring privacy while providing real-time assurance. Residents remain undisturbed, while carers gain confidence that they will be alerted if help is genuinely needed. As Muyi Adekoya noted:

> *We went in thinking this was about falls. What we discovered was that the root cause of many night-time falls for residents was linked to poor sleep. With fewer interruptions, residents became calmer, more alert in the day, and less likely to fall. Sleep proved to be the hidden lever for improving care.*

The outcomes were striking:

- Up to 87% reduction in falls across participating homes
- 52% of residents reporting better sleep
- 36% reduction in unnecessary physical checks, freeing staff time
- Reduction in hospital admissions and ambulance call outs — one home went from 33 ambulance call outs to zero three months post rollout saving the NHS approximately £26,000.

For example, Compton Lodge in Camden saw night-time falls drop by 100%, staff saved six hours per night, and residents enjoyed a 42% improvement in sleep due to fewer unnecessary disturbing checks, leading to better eating, hydration, mobility and mood.

These results underline a simple truth: good sleep is not a luxury, it is a clinical necessity.

A CARE PROVIDER'S PERSPECTIVE

For Julie Burton, head of operations at Twinglobe Care, which implemented

the system at Azalea Court, the benefits were felt across both staff and residents:

The biggest impacts were staff wellbeing, which led directly to resident wellbeing. Staff were less tired, more fulfilled, and able to give care where it was needed most. Residents enjoyed longer periods of rest and were more receptive to care during the day.

She highlighted tangible operational outcomes:

- Improved staff retention and reduced sickness
- Occupancy stability — residents stayed longer, avoiding the 'revolving door' of hospital admissions
- 98.7% occupancy and 96% staff retention over five years — a sustainability model many providers aspire to.

Technology, she argued, is often misunderstood as a barrier:

We underestimate staff. They use technology every day from smartphones, smart meters, online banking. Far from resisting, our teams embraced AI monitoring as an 'unseen helper' that gave them confidence and freed their time to focus on meaningful care.

Julie's message to other providers is clear: 'Be open-minded, look beyond short-term finance, and recognise how technology can embed long-term stability in staffing and occupancy'.

LESSONS FROM IMPLEMENTATION

If outcomes are compelling, success was not automatic. As Louise Keane, a clinical lead involved in delivering the programme, emphasised:

Technology is not plug-and-play. It is a journey. You need leadership, trust, digital inclusion, and above all, relationships.

From her perspective, five groups needed to benefit: residents, relatives, staff, managers/owners, and the wider system. Each had different priorities, from reassurance for families, to digital skills for staff, to reputation and occupancy for providers. Meeting all these needs required careful design.

Louise outlined several critical success factors:

- Leadership and vision — homes that have strong leaders willing to be brave and trust the technology achieved far better results
- Staff inclusion and training — 'Leave no one behind' is essential. Even staff with limited digital skills were supported until confident
- Family engagement — clear communication reassures relatives that technology enhanced dignity and safety, not surveillance
- Clinical support and education — have support from a team of clinicians who can visit homes weekly to troubleshoot, train, and ensure data is translated into action
- Relationship building — success depends on trust between ICB, councils, providers and technology suppliers. 'Adult social care has often had things done to it', Louise reflected, 'this worked because it was done with providers, not to them'.

In addition, Louise noted that care homes reported a range of additional benefits including fewer infections and improved nutrition. Evidence has been demonstrated in these areas and several others and further data is being collected to strengthen the emerging findings. As she said:

We're not just seeing people live longer, they are living better. Good sleep reduces falls, lowers medication, improves continence, and enhances quality of life.

WHY THE HSJ DIGITAL AWARD MATTERS

National recognition through the HSJ Digital Award has been far more than symbolic. For the author and the NCL team, it validated a distinctive model:

- Pairing digital roll-out with clinical input
- Embedding robust support and a no-blame culture
- Measuring impact not only in data, but in lived experience of residents, staff and families.

TOWARDS A REPLICABLE MODEL

What does this mean for the future of community and residential nursing?

Several lessons stand out:

- Sleep as a clinical priority — it should be measured, protected, and actively supported in care settings, on par with nutrition, mobility, and medication
- Digital inclusion as workforce development — supporting care staff with new tools builds confidence not just for one system, but across the NHS
- Cross-sector partnership is essential — success required ICB leadership, local authority quality teams, clinical hubs, and providers all aligned
- Culture change matters as much as technology — a no-blame, collaborative approach encouraged innovation and sustained adoption.

The author concluded:

By using technology to guide when and how we respond, we can keep residents safer, improve their quality of life, and make our own work more effective and rewarding. This isn't about replacing care, it's about helping us deliver the right care at the right time. Most importantly, it gives us the opportunity to dedicate more time to the things that make the biggest difference to residents' wellbeing.

EMBEDDING SLEEP INTO THE FUTURE OF CARE

This programme has shown that AI-enabled monitoring can deliver safer nights, calmer days, and stronger systems. Enabling sleep reduces falls, which in turn avoids hospital admissions and protects NHS capacity — creating a virtuous circle where residents, families, staff, and providers all benefit.

In community nursing and across integrated care, sleep must no longer be an afterthought. It is the bedrock upon which resilience, recovery, and quality of life are built.

As Julie Burton summarised:

If you sleep well, you wake up with energy. You want breakfast, you want to talk, you want to participate in life. That is as true for an older person in a care home as it is for any of us. JCN

Colostomy UK's work within the stoma community

Ross Othen-Reeves, editor, writer and researcher, Colostomy UK

Colostomy UK is the country's oldest stoma charity. A great deal has changed over the years, although the one thing that has stayed largely constant is our mission — to support anyone living with any kind of stoma.

For those that may not be aware, a stoma is a surgically created opening on the surface of the abdomen that allows stool or urine to leave the body when the bowel or bladder are unable to function normally. Waste is collected in a 'stoma bag' which sits over the stoma, using an adhesive to attach it to the abdomen.

People have stomas for all sorts of reasons. From chronic conditions such as inflammatory bowel disease (IBD), through to various forms of cancers, as well as physical traumas which may be caused by an accident or childbirth (Colostomy UK, n.d.; NHS, n.d.).

Over 200,000 people in the UK are living with a stoma (also known as 'ostomates') (Osborne et al, 2022). They range from babies to older people, and everyone in-between. Ostomates experience a variety of challenges.

There is a lack understanding and awareness around what stomas are — not helped by the notion that 'poo is the last taboo'. Ostomates often find that public and venue toilets do not have the correct facilities to enable them to change their bags easily or hygienically. As a hidden disability, there is often a stigma associated with ostomates using accessible toilets too. Then there are also practical concerns to consider, such as leaks and sore skin, and the psychosocial impact on people's daily lives, including work, travel, and relationships, and the effect this can have on mental health (Ayaz-Alkaya, 2018).

'There is a lack understanding and awareness around what stomas are — not helped by the notion that "poo is the last taboo".'

Colostomy UK offers emotional and practical support to the stoma community through a range of services, provided by our small but mighty staff team and our fantastic cohort of 80+ volunteers, who each have lived-experience of life with a stoma.

Among other direct services, we provide a 24/7 stoma helpline, a private, monitored Facebook group with over 12,000 members, and a befriending service. Lots of people benefit from our health and wellbeing classes, called Active Ostomates, through which people can improve their fitness or find time to relax through things such as swimming, yoga and meditation. For hardier ostomates, we also have two incredible rugby league teams, including wheelchair rugby and our physical disability team. Through our quarterly magazine, *Tidings*, ostomates can hear the latest news in stoma care, practical tips from medical professionals and real-life stories from other members of the community.

We also work closely with stoma nurses and other relevant healthcare professionals through a number of initiatives. For example, we provide a variety of literature titles, free of charge to nursing departments.

We offer a workshop entitled 'caring for a person with a stoma' to healthcare professionals to help upskill on the unique needs of ostomates. Our bi-monthly newsletter enables clinicians to stay updated on the latest news from Colostomy UK and the wider stoma community. We can also regularly be seen at various events and study days for nurses, usually with Colostomy UK volunteers with us to deliver talks on any number of topics.

More information

To find our more about our work, you can visit the Colostomy UK website at: www.colostomyuk.org/

For more on our Grab a Cuppa Fundraiser, visit: www.colostomyuk.org/brew-up-something-special-grab-a-cuppa-for-colostomy-uk

And for our Stoma MythBusters campaign, please go to: www.colostomyuk.org/campaigns/stoma-mythbusters/

Our fundraising and campaigns teams arguably have the most varied and fun projects within the team, however. Every April we hold our major fundraising event, 'Step Up for Stomas', which sees scores of ostomates, friends and families, even clinical teams take up a physical challenge to help raise vital funds for the charity.

At the time of writing, the fundraising team was also just gearing up to the launch of our Grab a Cuppa coffee morning initiative that is running throughout the month of October, and into November. The aim of the event is to bring people together over a cup of tea or two, to ensure that they are able to access the emotional support, practical advice, or reassurance they often need. The event is also a great opportunity to raise funds for Colostomy UK, whether the events are taking place over a cuppa and a chat in the home, a bake sale at work, or an even bigger community get-together.

The campaigns team also has lots of exciting activities on the go. This includes supporting the government to ensure their stoma guidance remains updated and fair to all. Our stoma friendly toilets initiative pushes venues and public locations across the UK to become accessible to ostomates. Last year, some 51 new spaces went stoma-friendly, including stadiums, stations, and even castles!

National Stoma Awareness Day is also upon us, with the annual event being held on 4 October. To mark the occasion, we are running a major new campaign — Stoma MythBusters. As the name suggests, its aim is to challenge myths, break down stigma, and replace misinformation with real, lived experience.

So all in all, an exciting time for the charity. But then again, there never seems to be a dull moment!

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Digital wound care: how to make it work in practice

Debby Foley, head of partnerships, Minuteful for Wound, Healthy.io

THE SCENARIO WE'VE ALL SEEN

A service invests in a digital solution. The training is rolled out, log-ins are issued, and the dashboards look impressive. Six months later, the reality bites: project managers have come and gone, clinicians are struggling to juggle the programme with day-to-day pressures, and the executive team are waiting for 'the app to show impact'.

An app or solution cannot change services alone. It is not that the technology is failing, moreso that the approach is incomplete. Embedding digital tools in wound care is an important step but it is vital to start this digital journey with a partnership approach, as without wider organisational transformation, the impact can be limited. Digital suppliers cannot drive service change alone, but successful deployments have occurred with organisations that understand the partnership and journey they go on together.

The reward? A scaled and embedded transformation that supports a sustainable future for their service.

WHY DIGITAL LOOKS LIKE THE ANSWER

Healthcare systems today face an escalating wound care challenge, i.e:

- Rising caseloads and an ageing population
- Increasing wound complexity and multiple comorbidities
- Workforce shortages and extreme time pressures
- Inconsistent clinical documentation and reporting
- Lack of data on current caseload (Guest et al, 2020; 2021).

The platform, Minuteful for Wound (MfW; Healthy.io, healthy.io/services/wound/), can help to address these challenges by working with healthcare professionals to standardise assessments and align them to best practice, providing an environment for consistent wound imagery and measurements, flagging static and deteriorating wounds for early intervention and virtual multi-disciplinary team (MDT) review. These are all enablers, and it is how they are used that will drive change within organisations.

MfW's delivery team trains users, advises on the potential, and shares data and reporting insights. Yet, without process redesign, culture shifts, and clinical ownership, it is possible to miss out on the wider potential to improve services.

THE TECHNOLOGY

MfW is a CE-accredited digital wound management solution that transforms a smartphone into a clinical-grade assessment tool. By capturing wound measurements and imagery in real time, it enables clinicians across hospital, community, and outpatient settings to monitor progress, identify static or deteriorating wounds early, and supports timely, evidence-based interventions (Blake et al, 2023; Kivity et al, 2024).

The platform creates a shared environment for accurate documentation, virtual multidisciplinary reviews, and data-driven service insights, helping teams work more effectively across care boundaries. Assessment flows are aligned to best practice guidelines and integrated with electronic patient record providers. MfW supports services to improve outcomes while building sustainable models for the future.

WHAT A WIDER TRANSFORMATION PACKAGE LOOKS LIKE

For digital adoption to translate into better care, it needs to sit within a broader programme of service transformation. Working alongside partnership organisations, Healthy.io has devised a five-step checklist to set healthcare organisations up for success.

Change management

Share the rationale. From the start,

engage leadership, managers, and frontline staff. Explain the 'why', describe the goals and create a shared vision for how digital will help clinicians, patients, and the organisation as a whole. Bring project leadership along to training sessions, have them at meetings, activate communication teams and get the message out.

Identify the champions who can guide and drive change. Sell the vision, as even the most digitally averse team members can come on board and become advocates. As Saul Hill, professional head of podiatry, Sheffield Teaching Hospitals NHS Trust said:

> *Communicating the 'why' is the single most important step in achieving successful change, especially in healthcare. When teams understand the purpose and can see how digital tools will improve care for patients, streamline workflows, and make their own working lives easier, resistance is naturally replaced by engagement. Explaining the rationale clearly fosters a sense of ownership, builds trust, and transforms team members into advocates rather than critics; precisely the people who drive lasting, sustainable change.*

Clinical input and governance

Engage the specialists. Digital opens up the door for new ways of working; enabling virtual review to save specialist resource time, supported self-care for patients that can manage their own wounds and better integrated working across partner organisations. Bring the clinical resources and information governance specialists into the discussion, let them shape the workflows and create the new standard operation procedures and then share your findings with wider leadership.

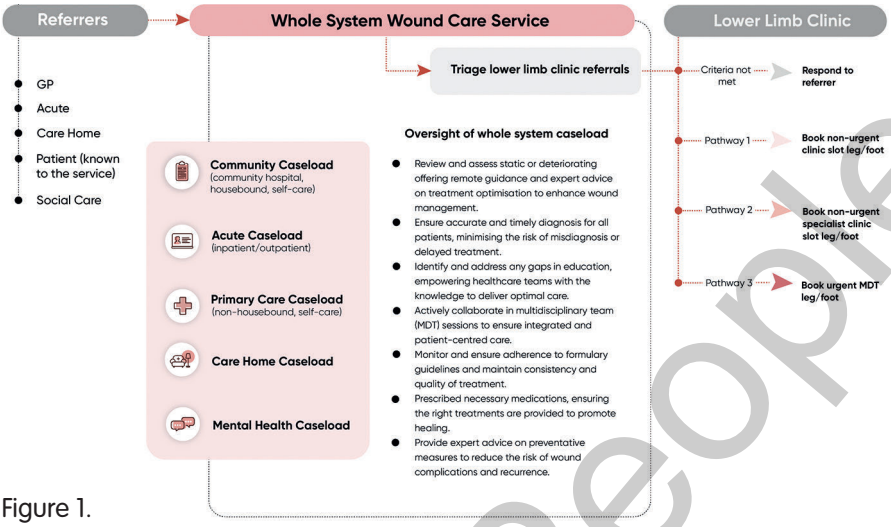

Figure 1.
Example overview process of a whole system wound care service with virtual oversight.

Process redesign

Map and improve. Map the current state and identify where duplication, delays, or gaps occur. Design the future state with digital in mind. *Figure 1* shows an example overview process of a whole system wound care service with virtual oversight.

Training and capability building

Do not rush to train. A common mistake is to try and get training booked immediately — yet, a poorly timed session can really impact momentum. Have everything ready first, set-up resources to help, e.g. use MfW's training hub to support teams with videos and walk-throughs.

Data-driven continuous improvement

Use data to drive. Consider data sets and ensure that what is being tracked is relevant to the organisation's goals. What will you measure and how? If you want to measure impact, you might need some baseline work, get the data you can but do not let it hold up starting the transformation. Ensure that the impact is evaluated. Look for research grants and speak to local academics, or seek funding opportunities to help if you do not have the expertise internally — there is support out there in the wider community.

Questions to ask before going digital

- Do we have clear goals and know our 'why'? Drive the change. What specific outcomes are we aiming for, e.g. faster healing times, better documentation, reduced visits?
- Is clinical and organisational leadership involved from the start? Everyone should help shape workflows and protocols.
- Have we mapped current workflows? Without knowing today's processes, we cannot redesign them for tomorrow.
- Are we prepared for change management? Technology adoption will require communication, champions, and ongoing support.
- How will we measure and sustain improvement? Metrics should be agreed up front, tracked regularly, and acted upon.

FINAL NOTE

If you are considering a digital wound care platform, take a broader view. See it not as an app, but as an enabler for transformation.

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WOUND CARE TODAY

2025 JCN study days and exhibition

At JCN we would like to thank our industry partners for their support to the 2025 JCN study days and exhibition. To share what has been happening at these UK-wide events, we invited our partners to give an overview of the topics they presented, which offer some valuable insights into their areas of care and highlight the education provided to our delegates.

INDWELLING URINARY CATHETERS: THE GOOD, THE BAD AND THE BLOCKING

With more than 90,000 catheter users in the UK, evidence suggests that catheter blockage is a common problem impacting on patient's health outcomes. Approximately 50% of people with long-term catheters will experience catheter blockages that have been caused by encrustation or biofilm formation (Gibney, 2016).

The frequent need to address blocked catheters places significant demands on NHS services and resources, in particular community-based nursing teams. Recurrent catheter blockage and infection can also be burdensome for patients and significantly impact on quality of life (Murphy, 2018; Paterson et al, 2019).

Unfortunately, infection and blockage may lead to life-threatening complications that result in hospital admission. Currently, there is limited data available on community onset catheter-associated urinary tract infection (CAUTI) rates.

Recurrent catheter blockage is frequently managed by community nurses who attempt to unblock catheters using catheter maintenance solutions. These solutions, prescribed on an individual patient basis, can cause mucosal trauma in the bladder (Holroyd, 2017). The trauma can be a result of the administration process, particularly when acidic solutions have been used.

Key points regarding catheter maintenance solutions:

- They should not be used to unblock catheters but to extend the lifespan of the catheter and reduce the need for frequent change
- They should not be used to prevent CAUTI
- They should not be used to unblock indwelling catheter in patients with a spinal injury who are at risk of autonomic dysreflexia.

Education and empowerment of community nurses is key to ensuring that people receive the most effective support and care for their individual needs. Community nurses are positioned to challenge the need for an indwelling catheter in specific patients and seek other options for bladder management. The HOUDINI protocol is a useful tool for supporting clinical decision-making (Adams et al, 2012).

Clinicians should not forget the fundamental aspects of catheter care that form a baseline for day-to-day catheter management. Ensuring individuals with indwelling long-term catheters (and their carers) receive the most appropriate support is key to preventing complications. This should include advice on:

- An effective hygiene regimen, particularly around the catheter site
- Adequate fluid and dietary intake to promote urine flow and prevent constipation
- Correct usage of medical devices and maintenance of the closed drainage system
- How to recognise the signs and symptoms of an infection and when to seek clinician intervention.

To manage frequent 'blockers' effectively, it is vital to identify the cause. Regular monitoring of urine pH has been an ongoing debate, but it can establish a pattern and assist in planning catheter change before blocking. Examination of the blocked catheter after removal is also important for evidence of biofilm formation or encrustation linking with higher pH levels (Stickler and Feneley, 2010). The key message after confirming that there is a clinical need for an indwelling catheter is to change the catheter before it blocks!

Implementing an open-ended catheter can be an effective way of managing recurrent blockage. These catheters, made from silicone, have a wider internal lumen and are associated with lower rates of biofilm adherence (Newman, 2022). Open-ended catheters can promote a better urine flow when used with fundamental catheter care.

Here, at Clinisupplies, we had the opportunity to share a service development undertaken in East London NHS Foundation Trust at the 2025 JCN study days. The project demonstrated that implementing open-ended catheters, assessing clinical need for indwelling catheterisation, providing staff training and addressing fundamental catheter care delivery could be effective in reducing the recurrence of catheter blockage. The full impact of this service development will be available for you to read as an article in a future issue.

From an education perspective, the JCN events and journal play a pivotal role in providing a platform for healthcare professionals to update their knowledge and skills in current evidence-based catheter management.

Moving forward, a robust data set is required to understand the impact of infection rates and catheter blockage in community-based patients. Such data could significantly impact on the development of initiatives to improve outcomes in people with challenging catheter complications.

Visit us at: www.clinisupplies.co.uk/

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Reviewing the importance of holistic assessment, discussing red flags with other contraindications/cautions to compression, together with reinforcing the importance of early intervention, served to guide clinicians to reflect on their current clinical practice, encouraging instigation of change and leadership as necessary.

We simplified compression choice for clinicians by covering each generic type, incorporating the needs of both the venous and lymphatic systems, why selection of the appropriate type of compression and fabric are essential for better healing outcomes, along with exploring possible reasons for non-concordance.

These key take-home messages were reinforced by the sharing of a unique compression matrix that explained the progression of CVI and stages of oedema. This tool assisted appropriate product selection by aligning patient needs with optimal and appropriate compression levels, leading to faster oedema reduction, improved wound healing, prevention of recurrence, greater patient comfort and better patient concordance.

We have been overwhelmed by the high volume of positive feedback this session has delivered and thank the JCN for this opportunity.

Visit us at: https://hadhealth.com/

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INTRODUCING WOUND BALANCE: PLACING THE PATIENT AT THE HEART OF WOUND HEALING

At this year's JCN roadshows, Hartmann has delivered impactful sessions on Wound Balance — a framework

that positions patients at the centre of wound care. The session highlighted the importance of early intervention, and a balanced approach to patient, wound and care to improve outcomes.

Hard-to-heal wounds represent a growing challenge in nursing. The NHS spends £8.3 billion annually on wound management (Guest, 2020), much of which is related to wounds that fail to progress. This subject was selected to encourage clinicians to reflect on their daily practice, identify red flags earlier, and adopt strategies to prevent wound complexity.

Central to the session was the concept of Wound Balance, an internationally developed framework that separates wound care into three key areas:

- Wound — assessing the wound and removing barriers to healing
- Patient — understanding patient needs, priorities, and lifestyle factors
- Care — reflecting on clinical practice to ensure effective, evidence-based interventions.

Nurses often encounter patients living with long-term wounds that affect physical health and can have profound social and psychological consequences. Patient stories shared during the session illustrated this impact. Brian, living with venous leg ulcers, described the loss of independence and confidence caused by odour, leakage and pain, while Carol's story recounted the immobility and despair she experienced.

For some individuals, reducing odour or wearing preferred footwear may be as meaningful as full wound closure. Understanding this perspective empowers nurses and emphasises the importance of involving the patient in their own care.

Key learning outcomes

The overarching message of the session was clear: placing the patient at the heart of wound healing through Wound Balance leads to better outcomes for both patients and clinicians. The sessions also provided a range of insights for nurses to apply in their daily practice.

Recognising risk and early intervention was a central theme. Chronicity develops faster than many realise, for example a venous leg ulcer may become chronic within two weeks. Identifying risk factors early, such as age, comorbidities, smoking, poor nutrition, or high stress levels, enables timely action. Missing simple steps such as measurement, photography, or appropriate documentation may have consequences for patient outcomes and professional accountability.

The concept of Wound Balance itself was also explored in depth. Complex wounds are often

'stuck' in the inflammatory stage, associated with impaired neovascularisation, reduced synthesis of collagen, increased proteolytic activity, and defective macrophage function. If the balance of matrix metalloproteinases (MMP) activity and inhibition is disturbed, the wound progresses to a state of increased extracellular matrix (ECM) degradation, alteration of cytokine profile, and degradation of growth factors, culminating in delayed or absent wound closure (Sabino and Keller, 2015). Using the Wound Balance framework alongside TIMERS (tissue, infection/inflammation, moisture, edge, regeneration, social factors) can help clinicians to identify what is preventing healing.

Clinicians are reminded that patients should be viewed as partners in care and that simple steps, such as encouraging hydration or small dietary adjustments, can support healing. Using patient questionnaires such as the quality of life tool to capture concerns such as pain, smell, or financial burden ensures that care is responsive and measurable (Blome et al, 2014).

Another key message was the need for professional reflection within the 'care balance' aspect of the framework. Evidence-based practice and upskilling are essential in a constantly evolving field. It was also suggested to delegates that there should be an openness to collaborate with wider multidisciplinary teams, such as diabetic specialists or mental health professionals where appropriate.

The session was closed with steps to prevent chronicity, including implementing the Wound Balance framework, and utilising a superabsorbent polymer (SAP) dressing to reduce inhibitors such as MMPs, elastase or microorganisms. Simple dressing choices can transform patient care by improving comfort, reducing odour, and restoring confidence in daily life. This was illustrated with case studies that showed how commencing RespoSorb® Silicone and RespoSorb® Silicone Border improved healing outcomes.

RespoSorb Silicone and RespoSorb Silicone Border are a brand of silicone superabsorbent polymer (SSAP) dressings used in wound care, offering a selection of 17 sizes (12 bordered and five non-bordered). The dressings work by absorbing exudate while also removing wound inhibitors such as MMPs and bacteria, which are often found in hard-to-heal wounds and inhibit wound healing (Mikosinski et al, 2022).

Conclusion

Wound Balance provides a practical way of structuring wound care, ensuring that clinicians, patients and wounds are considered in equal measure. For community nurses, this approach offers a clear pathway to improve healing trajectories and enhance patient experience.

Delegates were encouraged to:

- Identify red flags early and intervene without delay
- Use structured frameworks such as Wound Balance and TIMERS
- Align treatment goals with what matters most to patients
- Promote self-care and independence wherever possible
- Continuously reflect on practice, embracing evidence-based change and multidisciplinary support.

As the demand for community-based wound care continues to rise, the principles of Wound Balance equip nurses with the tools to deliver effective, compassionate care.

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Healing hard-to-heal wounds and improving quality of life

Luxmi Dhoonmoon

Some patients experience hard-to-heal wounds that fail to improve despite standard care. Copper-impregnated dressings can offer both antimicrobial activity and support for wound healing processes. This paper explores an evaluation undertaken by the author of the effect of copper dressings on wound healing, pain reduction, and quality of life in patients with hard-to-heal wounds who had previously been unresponsive to silver-based dressings. Four patients with chronic wounds (six to nine months' duration) were treated with silver dressings for six to nine weeks when hospitalised with no significant improvement. Their care plan was then changed to copper dressings for three to four weeks. Wound size and pain were assessed at baseline, week one and four. A cost analysis was also performed. All patients showed ≥50% wound size reduction within seven days, with full closure by week four. Mean pain scores dropped significantly from 4.75 to 0.25. Improved mobility and daily function were also reported. Treatment costs fell from £2,606 to £365 on average — an 86% reduction. The copper dressing used enhanced healing, lessened pain, improved mobility, shortened treatment time and reduced costs in these four hard-to-heal wounds which had been unresponsive to conventional care.

KEYWORDS:
■ Copper ■ Silver ■ Wound healing ■ Pain ■ Patient quality of life

Hard-to-heal wounds are wounds which have failed to respond to treatment despite addressing factors that affect healing, such as wound aetiology and comorbidities (Murphy et al, 2020). They often severely affect quality of life due to pain, limited mobility, and increased risk of wound infection (World Union of Wound Healing Societies [WUWHS], 2025). Their prevalence in developed countries is estimated at 1–2% (Nussbaum et al, 2018; Martinengo et al, 2019). Major wound types include:

- Venous leg ulcers (~3% in individuals >65 years)
- Diabetic foot ulcers (15–25% lifetime risk in diabetics)
- Pressure ulcers (5–10% of hospitalised patients)

(Sen et al, 2009; Armstrong et al, 2017; Nussbaum et al, 2018).

Such wounds impose a substantial burden on healthcare systems (Guest et al, 2015; Nussbaum et al, 2018). In the UK alone, 3.8 million wounds were treated by the NHS in 2017/2018 (Guest et al, 2020), an increase of 71% since 2012/2013 (Guest, 2020).

The key to preventing a wound from becoming hard-to-heal is conducting comprehensive holistic assessment, reaching an accurate diagnosis for the wound and addressing underlying factors that can reduce the capacity to heal, such as comorbidities, limited mobility, poor nutrition and infection, among others (Wounds UK, 2022). Infection is often a contributing factor in a hard-to-heal wound (Atkin et al, 2019) and is frequently managed with antimicrobial dressings, particularly silver-based products (May et al, 2022; Yousefian et al, 2023). However, these do not always lead to healing (Luo et al, 2022; May et al, 2022). A wound that shows less than a 40% reduction in size within four weeks is indicative of poor treatment response (Cardinal et al, 2008; Coerper et al, 2009; Snyder et al, 2010) and should prompt reassessment to determine whether a change in management is warranted (Atkin et al, 2019).

Correct use of antimicrobial dressings is essential, as prolonged or inappropriate application can be costly and is not consistent with evidence-based clinical recommendations (International Wound Infection Institute [IWII], 2022).

Copper, in a similar way to silver, possesses broad-spectrum antimicrobial properties (Salvo and Sandoval, 2022). The mechanism of action is multifactorial: copper ions released from dressings interact with microbial cell membranes, causing structural damage and leakage of essential cell contents. Additionally, copper generates reactive oxygen species (ROS), which further damage proteins, lipids, and nucleic acids within pathogens, ultimately leading to cell death (Salvo and Sandoval, 2022). Emerging evidence also suggests that copper may play a role in angiogenesis and extracellular matrix remodelling, potentially supporting wound healing beyond its antimicrobial effects (Salvo and Sandoval, 2022).

With the rise in antimicrobial resistance (AMR), it is interesting

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to note that, unlike traditional antibiotics, copper's broad-spectrum antimicrobial activity has not been associated with the development of AMR — hence its applicability for healthcare (Borkow and Gabbay, 2009; Bisht et al, 2022).

This article discusses four patients with hard-to-heal wounds unresponsive to silver dressings who achieved rapid healing after switching to copper dressings, highlighting their potential to accelerate healing, improve outcomes, and reduce costs.

CASE REPORTS

Four patients with hard-to-heal wounds of six to nine months' duration were admitted to the author's hospital (*Table 1*). Upon admission, they were treated with silver-impregnated and other superabsorbent dressings for six to nine weeks (this was to address concerns about potential biofilm and to provide prophylactic protection against infection), alongside standard wound care protocols, including appropriate support surfaces, regular repositioning and, for the patient with a venous leg ulcer (patient D), compression therapy following comprehensive holistic leg assessment. Despite these measures, the wounds significantly impaired daily function due to pain and restricted mobility, and failed to heal within the seven weeks (approximately) while on standard of care (SoC).

Subsequently, the wounds were managed with copper dressings (MedCu antimicrobial wound dressings, Creed Health) for three to four weeks (Melamed et al, 2021a; 2021b). Wound dimensions (length, width, depth) were measured using sterile disposable tape measures at baseline (when copper dressings started to be used), week one, and week four. Pain was assessed using the numeric pain rating scale (NPRS), ranging from 0 (no pain) to 10 (worst imaginable pain). Creed Health conducted a cost analysis for the author using current NHS prices to compare the cost and duration of previous dressings used with MedCu, as well as associated nursing time. Ethics approval was not required for this evaluation.

Results

Table 1 shows the patients' wound conditions at baseline. All wounds reduced in size in seven days once the copper dressings were introduced into their care plans (*Table 2*), from a mean 9.18±5.76 cm^3 at baseline to 0.84±0.61 cm^3 (mean ± SD). Full wound closure was achieved within four weeks in all four patients. Pain scores decreased significantly, from 4.75±0.96 at baseline to 0.25±0.5 at week four (*Table 2*). Two patients reported improved ability to sit and mobilise as wound healing progressed. Quality of life was assessed by identifying patients' engagement with therapists for increased rehabilitation on the wards. Better interaction with other patients, nurses and activities was also noted.

A cost analysis of the four patients, accounting for both dressing costs and nursing time, showed that SoC had a mean treatment cost of £2,606, whereas copper dressing management reduced this to £365 — an 86% cost reduction. Furthermore, the duration of the SoC, which was based primarily on silver containing dressings, took on average seven

Practice point

Copper dressings have been found to improve wound healing, especially in non-infected, hard-to-heal wounds which have previously been treated with silver dressings (Gorel et al, 2023).

Table 1: Wound conditions at baseline (before start of treatment with copper dressings; see overleaf)

Patient	Wound type	Wound dimensions (length x width x depth, cm)	T	I	M	E	S
A	Category 4 pressure ulcer to the sacrum	3x2x1	100% granulating, with no slough present in the wound bed	No malodour or clinical signs of infection	Low exudate	Slightly macerated	Fragile
B	Category 4 pressure ulcer to the spine	1.5x1x0.5	Thin layer of slough in the wound bed with granulation tissue; no bone visible	No clinical signs of infection; mild erythema and inflammation	Minimal thick amber exudate	Slow to advance	Red but blanching to touch
C	Category 3 pressure ulcer on the left ischial tuberosity	1x4	50% moist slough and 50% granulating tissue	No clinical signs of infection	Low exudate	Edges are flat and appear slightly macerated	Fragile
D	Venous leg ulcer	2x1.5x1	Superficial and granulating, with minimal moist, yellow slough	No clinical signs of infection	Moderate exudate	No undermining noted	No signs of cellulitis

*T = tissue; I = infection; M = moisture; E = wound edges; S = surrounding skin

Patient A

Patient A was admitted to hospital with a category 4 pressure ulcer to the sacrum, measuring 2.8cm (length) x 3cm (width) x 2cm (depth), with 2cm undermining between 5–8 o'clock. The plan was to cleanse the wound bed with normal saline and pat dry and lightly pack the wound cavity and undermining areas with a hydrofiber dressing and cover with a self-adherent soft silicone foam dressing to facilitate healing from the base of the wound bed. The wound was to be redressed every two days or sooner if soiled.

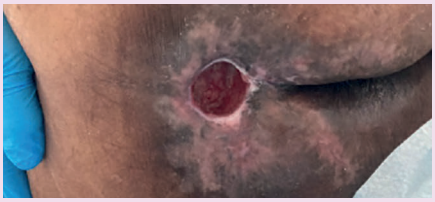

Figure 1.
Patient A on admission.

As wound was slow to progress (see wound dimensions in *Table 1*), it was decided to lightly pack the wound with an antimicrobial wound dressing with copper (MedCu) and cover with a foam dressing. The copper dressing was to be left in place and only the foam dressing changed if soiling occurred. After one week of this treatment regimen, patient A was discharged to the community to continue treatment with the MedCu dressing.

Patient B

At initial assessment, this patient's category 4 pressure ulcer to the spine measured 1.5cm (length) x 1cm (width) x 0.5cm (depth). A thin layer of slough was noted in the wound bed. There were no clinical signs of infection or malodour — mild erythema was observed due to inflammation. At dressing change, minimal thick amber exudate was present and the wound edges were slow to advance due to chronicity. Although the surrounding skin was red, it was not painful.

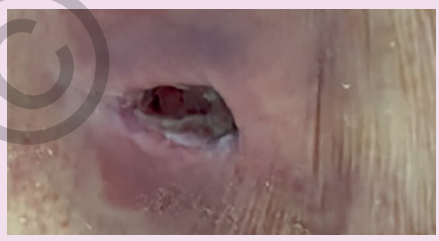

Figure 2.
Patient B on admission.

Figure 3.
Patient B after three weeks' treatment with MedCu.

Patient C

This patient had a category 3 pressure ulcer to the left ischial tuberosity measuring 1cm (length) x 4cm (width) on admission. Tissue types present were 50% moist slough and 50% granulation tissue. There were no clinical signs of infection and the wound was producing a low volume of exudate. The edges were flat and slightly macerated and the surrounding skin was fragile.

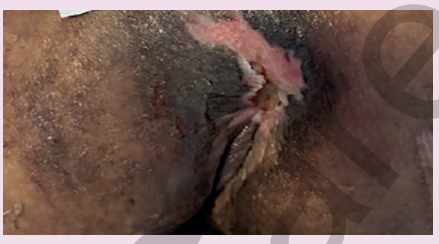

Figure 4.
Patient C prior to treatment with MedCu.

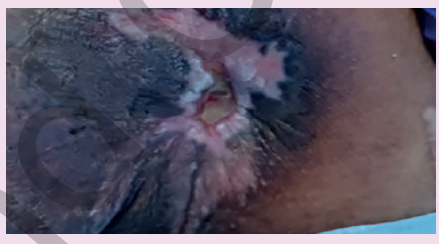

Figure 5.
Patient C after one week's treatment with MedCu.

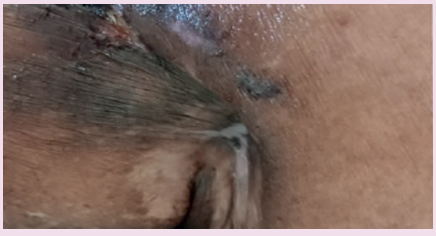

Figure 6.
Patient C after three weeks' treatment with MedCu.

Patient D

On admission, patient D had a venous leg ulcer to the right lower leg of six months' duration, which was being treated with a negative pressure wound therapy system. The moist, yellow slough was debrided at the bedside with a currette, which revealed full-thickness skin loss, granulation tissue and minimal slough remaining on the wound bed. No malodour or clinical signs of infection were noted and there was a low volume of exudate on the NPWT dressing. There was no undermining to the wound edges or bleeding. Healed pink scar tissue was noted at the wound edges, and the leg was not hot to touch or cellulitic.

Figure 7.
Patient D before treatment with MedCu. Wound measured 2cm (length) x 1.5cm (width).

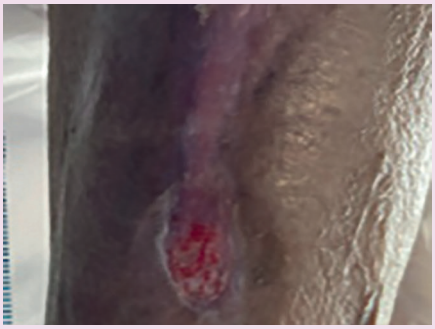

Figure 8.
Patient D after one week's treatment with MedCu. Wound now measured 1.6cm (length) x 1cm (width).

After three weeks' treatment with the copper antimicrobial dressing, the wound had 100% epithelial tissue present and the wound bed was moist with a moderate volume of exudate. The wound edges had healed and the surrounding skin was fragile.

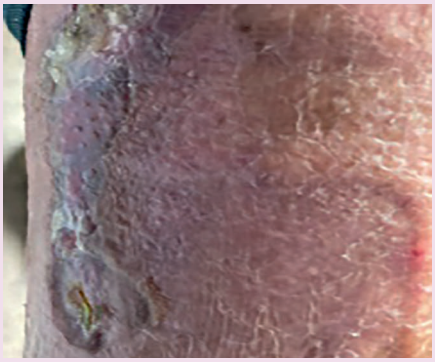

Figure 9.
Patient D after three weeks' treatment with MedCu.

The Habit of Silver VS The Healing of Copper[1]

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Table 2: Wound size and pain scores

Patient	Wound dimensions (cm^3)			Pain scores	
	D0	D7	D30	D0	D30
A	6.0	0.2	0	5	0
B	15.75	0.45	0	6	1
C	12	1.2	0	4	0
D	3	1.5	0	4	0
Mean ± SD	9.18±5.76	0.84±0.61	0	4.75±0.96	0.25±0.5

weeks without closing the wounds, while wound management with the copper dressings closed the wounds in 3.8 weeks, i.e. approximately half the time of the SoC period (*Table 3*).

DISCUSSION

Chronic wounds pose a significant challenge in clinical practice, often persisting despite standard care, including antimicrobial dressings such as silver-based products. Here, all four patients with longstanding (six to nine months' duration), non-healing wounds showed minimal to no improvement during a six–nine-week period of standard wound care, including silver-impregnated dressings. However, after switching to copper-based dressings, all patients demonstrated rapid improvement in wound healing, pain reduction, and functional mobility.

The mean wound volume reduction of over 90% within one week, followed by complete closure within four weeks, highlights the potential efficacy of copper dressings in reactivating stalled wound healing. This result is consistent with previous cases seen by the author and her team in the management of chronic wounds. The concurrent decrease in pain scores and reported improvement in mobility suggest that copper dressings may not only provide antimicrobial benefits, but also contribute to overall wound resolution and improved quality of life.

Importantly, the cost analysis indicated a substantial 86% reduction, with copper dressings achieving wound closure in approximately half the time required by silver-based management. This has significant implications for both resource allocation and healthcare system burden.

'The author's findings support the potential of copper dressings as a promising intervention for managing stagnated, hard-to-heal wounds... .'

These findings are consistent with previous literature on copper's role in antimicrobial defence, angiogenesis, and extracellular matrix remodelling (Borkow and Gabbay, 2005; Borkow et al, 2022), as well as other studies reporting improved healing of hard-to-heal wounds — mainly diabetic ulcers — when using copper dressings (Borkow and Melamed, 2021; Borkow and Melamed, 2025; Melamed et al, 2021a; Melamed et al, 2021b). While larger controlled studies are warranted, these results suggest that copper dressings may offer a valuable alternative in cases where conventional treatments fail.

CONCLUSION

The author's findings support the potential of copper dressings as a promising intervention for managing stagnated, hard-to-heal wounds, particularly in cases where traditional antimicrobial dressings are ineffective. JCN

Declaration of interest

The author does not have any conflict of interests, financial or otherwise.

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Table 3: Summary of treatment duration and cost comparison between SoC and copper dressings

Patient	Total duration of treatment (weeks)				Total cost of treatment			
	SoC (not healed)	Copper dressings (healed)	Weeks less	% less	SoC (not healed)	Copper dressings (healed)	Cost less	% less
A	6	3	3	50%	£1,870	£313	£1,557	83%
B	8	4	4	50%	£3,057	£417	£2,6398	86%
C	5	3	2	40%	£2,830	£417	£2,413	85%
D	9	3	6	67%	£2,666	£313	£2,353	88%
Average	7	3.3	3.8	54%	£2,606	£365	£2,241	86%

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Using compression in patients with heart failure

Ruth Christie, Teresa Davies

This case report explores the community management of a patient with a medical history of heart failure (HF) and oedema. Gold standard guidelines recommend targeting clinical congestion and oedema with increased loop diuretics alongside multilayer compression bandages for effective limb decongestion, reduction of swelling and limb shape restoration. Without early identification and intervention, oedema can worsen, leading to skin changes such as lymphorrhoea (wet or leaky legs), and having a detrimental physical, functional, and psycho-emotional impact on patients. Yet, HF and oedema continue to be mismanaged because healthcare workers have reservations about the use of compression therapy and concerns about overloading the circulatory system in patients with HF. This case report demonstrates appropriate treatment and management of oedema in patients with HF within a community district team setting, highlighting best guidance on diuretics, compression therapy, exercise, and skin care.

KEYWORDS:
■ Heart failure ■ Compression therapy ■ Oedema
■ Community practice

Many healthcare workers have reservations about the use of compression in patients with heart failure (HF), centred on a fear of overloading the heart and exacerbating symptoms (Legs Matter, 2023). A review by Urbanek et al (2020) concluded that compression can be used in patients with stable HF, but with caution in those with end-stage or decompensated HF.

Approximately 900,000 patients in the UK have HF, which is caused by structural or functional cardiac abnormalities and characterised by reduced cardiac output or elevated blood pressure, leading to inadequate tissue perfusion (Bromage et al, 2020).

The case report presented here discusses the management of a patient with HF and oedema in community practice. In accordance with the Nursing and Midwifery Council (NMC, 2018), confidentiality and ethical standards will be maintained and so pseudonyms are used.

CASE REPORT: KEN

Ken is an 87-year-old man with a medical history of HF. His current medication is bumetanide, a diuretic commonly used in HF (British National Formulary, 2024). He has a body mass index (BMI) of 28 kg/m^2, which puts him in the overweight category according to the British Association of Parenteral and Enteral Nutrition (BAPEN, 2024). Ken lives with his wife Dot; they currently live independently and self-manage all activities of daily living (Roper et al, 2000). He appears asymptomatic at rest. However, he has slight limitations with physical activity due to breathlessness. His HF classification based on symptom severity is class II according to the New York Heart Association (NYHA) (Yancy et al, 2013).

Ken's HF is considered stable and well-managed, although he has developed bilateral leg oedema. This can indicate decompensated HF, where a patient with stable HF experiences exacerbation of symptoms such as dyspnoea (shortness of breath), weight gain due to fluid retention and peripheral oedema (Bromage et al, 2020). Oedema is defined as swelling of tissue caused by the accumulation of interstitial fluid in a specific body part. Primarily it can develop due to genetic factors affecting fluid balance or lymphatic function, or secondarily as a result of tissue damage or obstruction of blood vessels and/or glands, which impairs normal lymphatic drainage (Brix et al, 2021). As a result, Ken has been admitted to the district nurse (DN) caseload to be reviewed three times a week.

On initial admission to the DN caseload, Ken was assessed holistically. This included a review of past medical and psychosocial history, as well as physical skin and limb assessment. Ken presented with moderate bilateral toe-to-knee oedema with mild limb distortion and areas of dry skin. Stanton (2025) suggests that assessment should include the six 'Ss'— story, self-care, site, skin, size and shape. Circumferential limb measurements are also recommended as a baseline measurement for volume (Nishimura et al, 2020). Although a non-invasive and cost-effective method for baseline oedema volume measurement, limb circumference measurement can vary between different professionals (Devoogdt et al, 2019).

Ascertaining the presence of peripheral arterial sufficiency through

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ankle-brachial pressure index (ABPI) measurement is pivotal, as peripheral insufficiency may contraindicate compression therapy, an important element of treating oedema (Cain et al, 2022). Patient tolerance can sometimes prevent successful measurement of ABPI readings, as cuff inflating on the legs can become too painful for patients to undergo the ABPI test (Scott et al, 2019). In Ken's case, an ABPI measurement was not achieved due to his discomfort.

The 'Chronic Oedema Wet Leg Pathway©' also advises that accuracy and value of ABPI results can be compromised by oedema and skin thickening (Lymphoedema Wales Clinical Network [LWCN], 2022). However, reviewing 'red flag' arterial symptoms such as decreased sensation, intermittent claudication, colourless limb, absent foot pulses and delayed capillary refill (Green, 2020) is sufficient to rule out compromised arterial status.

Overall, Ken's leg presentation and past medical history raised no concerns regarding peripheral arterial disease. Therefore, in this case, the detailed history and clinical examination were sufficient to rule out arterial insufficiency as a cause for his oedema, and care aimed to incorporate a safe level of compression therapy, medication adjustment and skin care.

In patients with HF and clinical congestion, timely adjustment of oral diuretics is crucial to prevent hospitalisation (Bromage et al, 2020) and is considered first-line therapy (National Institute for Health and Care Excellence [NICE], 2018; Magdy et al, 2022). During a DN visit, on recognising Ken's worsening symptoms of HF and oedema and limitations in regard to breathlessness and mobility, care requirements were discussed with the GP who requested a medication review from the HF multidisciplinary team (MDT) (NICE, 2018).

Diuretics

Bromage et al (2020) stated that increasing oral loop diuretic doses can effectively alleviate fluid build-up and reduce oedema through increasing diuresis. However, contrasting evidence suggests that diuretics cannot remove the waste fluid within oedema, as the fluid is a heavier molecule than water and increases the concentration of protein and macromolecules (Murdoch, 2020). Yet, this argument is solely for diuretic treatment of oedema and does not consider the efficacy of diuretics for management of HF-related oedema, as in Ken's case.

Loop diuretics are effective in the management of HF oedema, as they assist the kidneys when poor perfusion and an inadequate force of filter water and salts occur (Murdoch, 2020). NICE (2018) also supports the use of diuretics for HF fluid retention. Furosemide and bumetanide are viable loop diuretics with comparable diuretic activity (NICE, 2024). Although furosemide is a common first-line diuretic (Magdy et al, 2022), bumetanide's greater bioavailability results in higher absorption capabilities (Buggey et al, 2015). However, both options require monitoring of renal function, electrolyte imbalance and weight (Bromage et al, 2020).

It is also important to consider that increasing Ken's diuretics, although beneficial for his oedema, will additionally increase his urine output (Magdy et al, 2022). Although Ken manages with a downstairs commode and urine bottle, this new burden may create potential medication adherence issues (Viana et al, 2014; Meraz et al, 2022). However, with guidance from the DN, Ken was able to understand the rationale and benefits of diuretics.

Compression therapy

Compression therapy (CT), using garments, bandages or wrap systems, is the gold standard of care for treating oedema (Payne, 2024). Despite its benefits of decreasing venous pressure and improving lymphatic drainage (Todd et al, 2017), CT is not routinely offered to patients with HF (Atkin and Byrom, 2022). Indeed, contraindication factors arise from the idea that a sudden shift of blood from lower extremities towards the heart can worsen the cardiovascular condition and result in overload (Hirsch, 2018). However, CT applied to patients with HF stages I and II (NYHA), as in Ken's case, has little clinical impact (Shapiro, 2020) and should be considered safe (Atkin and Byrom, 2022). Moreover, CT can improve venous return to the heart and reduce inflammation and swelling by preventing blood and fluid congestion (Fletcher et al, 2021), subsequently decreasing oedema progression, preventing skin deterioration and risk of cellulitis, and thus improve symptoms and patient quality of life (Atkin and Byrom, 2022).

Multilayered compression bandages were initially applied to both Ken's lower limbs by the DN, in accordance with level 2 of the 'Chronic Oedema Wet Leg Pathway' (LWCN, 2022). Compression bandages are effective in limb decongestion, reduction of swelling and restoring limb shape (Fletcher et al, 2021). However, their cost, time-intensive application and frequency of clinical visits can pose challenges (Wigg and Lee, 2014). Additionally, as in Ken's case, patient acceptance of bandages can be compromised by hygiene concerns (Lee and Lawrence, 2019) and pain tolerance (Probst et al, 2023). Choice of CT should consider patient needs, preferences and dexterity (Ritchie and Turner-Dobbin, 2023). Ken was in multilayer bandaging for approximately one month for initial reduction of swelling. Once reduced, after a MDT discussion, it was decided to provide Ken with level 1 compression garments following onward referral to the lymphoedema team, as per guidelines (LWCN, 2022).

It is advised that once oedema and limb shape have improved, appropriate compression garments can be applied to reduce recurrent oedema episodes and improve patient independence (LWCN, 2022). Ken was able to manage the application and removal of his garments with Dot's assistance.

Skin care

Skin care is considered an important long-term cornerstone of oedema management to maintain skin integrity (Todd et al, 2017) and reduce susceptibility to skin problems such as cellulitis, skin thickening and

dryness (Raymond and Flanagan, 2017). Regular assessment of areas between the toes and skin folds is also important for highlighting signs of intertrigo, often triggered by skin-on-skin friction and moisture (Nobles et al, 2024). Intertrigo is prone to the development and risk of bacterial/fungal infections and spreading cellulitis (LWCN, 2022). Thus, effective skin care can positively impact patient wellbeing (Kottner and Surber, 2016). To remove dead skin cells and prevent the accumulation of emollients, Payne (2024) advises a daily skin care regimen consisting of three components; cleansing, drying and moisturising. However, thin and fragile skin can dry out with over-washing and cleansing, so a balance must be maintained (Voegeli, 2008). Moreover, in the initial stages, Ken's requirement of multilayered CT application complicated self-care and daily skin care. Daily CT changes are advised in the initial week of compression, which can then be reduced to two to three changes a week (Moffatt et al, 2016), dependent on patient tolerance and looseness of bandages (Moffatt et al, 2012).

The LWCN (2024) advises that multilayer CT, such as Ken's, can be changed two to three times a week, dependent on care requirements. Thus, in the initial stages, Ken was visited three times a week by the DN, providing an opportunity for a warm bowl cleanse, followed by emollient application before replacing the CT bandages. Ken had areas of dry skin with excess skin shedding, which was treated with an emollient — first choice of treatment for dry skin (Ersser et al, 2009).

Emollients occlude the skin's surface and increase water build up within the stratum corneum, resulting in softer, smoother skin and decreasing sensations such as itchiness and tightness. They are generally safe to apply with limited reported adverse effects (Ersser et al, 2009), although patient preference should be considered in selection and prescribing of emollients, as many patients can become reluctant to apply them because of their greasy consistency (Gallard, 2022). Additionally, patient dexterity should be taken into account, as assistance may be needed to reach the lower limbs (Payne, 2024). Once Ken was placed in hosiery, he was able to apply emollients independently.

Exercise

Exercise is another important aspect of oedema self-management, as increasing muscle pump action can encourage venous and lymphatic drainage and help maintain and improve range of movement (Wigg and Lee, 2014). Ken's BMI is 28 kg/m^2, meaning that he is overweight (BAPEN, 2024), and sedentary lifestyle choices will contribute to worsening of symptoms (Payne, 2024).

Exercise and weight loss can aid patients in self-management of oedema while improving mobility and swelling (Todd et al, 2017). However, exercise in the elderly can be difficult and occasionally unachievable, with issues such as decreased functional performance, muscle strength, flexibility and gait (Angulo et al, 2020). While Fu et al (2022) advise leg raise exercises to achieve muscle pump action, Smith et al (2024) discovered no improvement of oedema post-leg chair exercises and, in fact, recognised that self-care advice should consider patient capability, tolerability and preference. Subsequently, contrasting evidence encourages elevation and rest of the affected limb (Pugh et al, 2018), although overnight elevation is reported to reduce oedema by 90% (Mortimer and Levick, 2004). Healthy nutritional intake was also discussed with Ken, alongside advice around limb elevation in the daytime and overnight.

Psychosocial impact

Oedema can cause overwhelming life-long physical, functional, psycho-emotional, social and spiritual difficulties (Scerri et al, 2024). Ken was upset about the heaviness, discomfort and distortion in his lower limbs, and that he often had difficulty wearing slippers due to tightness, which would result in impaired mobility and functional independence. Although patients acknowledge the necessity and importance of bandages, the reduction in flexibility imposes various functional limitations and can be met with mixed emotions (Morgan et al, 2011).

Compression bandages often lead to feelings of embarrassment, anxiety, depression and are linked with poor body image (Greene and Meskell, 2016). Equally, many patients experience physical symptoms associated with oedema such as pain and discomfort (Gethin et al, 2011). Therefore, it is important that healthcare professionals develop an understanding of Ken as an individual and include an analysis of how oedema affects him personally (NICE, 2018).

Ken said that the CT negatively affected his ability to get up from his chair and made lifting his legs into bed difficult. Following discussion, he was provided with specialist footwear with Velcro, which was easier to put on over bulky dressings (Leigh and Barker, 2007). Ken was also given a hospital bed, which could be lowered to the floor. However, further reliance for care and assistance from Dot was observed by the DN. The impact of changes in lifestyle such as increased dependence on carers should be considered. Indeed, research states that oedema can negatively affect personal relationships, creating strained relationships between individuals (Greene and Meskell, 2016). Thus, it is important not only to identify Ken's needs, but also those of others affected, such as Dot.

Self-management

Oedema self-management is vital for maintenance and to prevent recurrence (Todd et al, 2017). The *NHS Long Term Plan* (NHS England, 2019) emphasises fostering patient empowerment, autonomy and self-management. Similarly, the NMC (2018) highlights the significance of acknowledging the contribution and value that patients can make by self-managing their own health needs. Thus, nurses should encourage and empower patients to share decision-making and self-manage their own conditions (NMC, 2018). Effective communication and therapeutic partnerships are key for improving

patient awareness and understanding of their condition and its management (Kwame and Petrucka, 2021).

Ken was provided with ongoing support and education, using leaflets and verbal guidance to support the rationale for and instruction on skin care, how to apply and remove compression hosiery, the importance of leg elevation and sleeping in bed. However, despite education and support, empowerment is a multifactorial concept relying on patient choice, capability and concordance in managing their condition effectively (Kwame and Petrucka, 2021). Omole et al (2024) highlight that patients should be willing to engage, however, it is also equally important to recognise if a patient may be incapable of self-care. In some cases, a multi-collaborative approach suits patient capabilities better — in Ken's case, he has the support of Dot, who assisted with his care needs.

CONCLUSION

This case has discussed the management of Ken's oedema in a community setting. Holistic assessment concluded that Ken exhibited no peripheral insufficiency and, while the pathophysiology of oedema varies, it was evident that Ken's was associated with his HF diagnosis. Thus, care aimed at medication adjustments, CT and skin care. The case initially analysed loop diuretics in the management of oedema and although noted not to be effective, contrasting arguments supported the benefits of diuretics as the cornerstone for HF-related oedema. Second, it discussed the gold standard and benefits of CT in oedema management, while considering the contraindications of Ken's HF diagnosis. It concluded that CT was safe and so Ken was initially placed into multilayer compression bandaging for about one month. Finally, it discussed the benefits of self-management in aspects such as skin care, exercise and leg elevation, while also considering the psychosocial implications of oedema.

Overall, a recommendation noted for future care would be to improve support for patients regarding self-management. In this case, the impact of oedema and Ken's further reliance on Dot was discussed. Signposting Ken and Dot to oedema support groups could be beneficial. Currently, Ken and Dot continue to self-manage Ken's condition effectively and are visited monthly by DNs to monitor his oedema. JCN

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Nutritional management of hypercholesterolaemia

Patrick Ward-Ongley

Hypercholesterolaemia, typically characterised by elevated levels of low-density lipoprotein cholesterol, remains a significant modifiable risk factor for cardiovascular disease. Before pharmacological intervention, UK guidelines emphasise the importance of making lifestyle changes — especially dietary modification — which can yield clinically meaningful reductions in cholesterol levels. This article equips community nurses with practical, evidence-based nutritional strategies to support patients in managing hypercholesterolaemia. Key areas include increasing dietary fibre intake and striving towards a Mediterranean-style diet. Controversies around saturated fat, seed oils, and dietary cholesterol are addressed through a nuanced, food-matrix lens. The article also explores the roles of phytosterols, cooking oils, coffee, and body weight in lipid management. With appropriate support, nurses can help patients implement simple, sustainable changes to lower cholesterol levels and reduce their risk of cardiovascular disease.

KEYWORDS:
■ Hypercholesterolaemia ■ Cardiovascular disease ■ Nutrition
■ Mediterranean diet ■ Dietary fibre

Hypercholesterolaemia is most commonly defined as elevated levels of low-density lipoprotein cholesterol (LDL-C) or non-high-density lipoprotein cholesterol (non-HDL-C) in the blood (Leucker and Ferraro, 2025). It is a major modifiable risk factor for cardiovascular disease (CVD), the leading cause of death globally (Ference et al, 2017). In the UK, around 40% of adults have hypercholesterolaemia, with increased prevalence among older individuals and those with comorbidities such as type 2 diabetes and obesity (Public Health England, 2020).

LDL-C plays a causal role in the formation of atherosclerotic plaques (Larsson et al, 2023), while high-density lipoprotein cholesterol (HDL-C) is protective, aiding reverse cholesterol transport and reducing inflammation (Rosenson et al, 2013). Guidelines vary: European recommendations stratify LDL-C targets by risk, with thresholds as low as <1.4mmol/litre for very high-risk individuals (Visseren et al, 2021), whereas the National Institute for Health and Care Excellence (NICE, (2025) guidance sets a general target of <2mmol/litre for secondary prevention.

Before prescribing statins, NICE (2023) advises that patients should first be supported to make lifestyle changes, including dietary improvements and increased physical activity. Dietary modification alone can produce meaningful reductions in LDL-C levels — comparable to those achieved from taking first-generation statins in some cases (Jenkins et al, 2003). Beyond effects on cholesterol levels, dietary changes also improve insulin sensitivity, inflammation, gut health, and weight regulation (Esposito et al, 2013). This creates a valuable role for community nurses in supporting sustainable, food-based strategies for CVD prevention.

DIETARY FATTY ACIDS AND THEIR IMPACT ON SERUM CHOLESTEROL

The type and source of dietary fat profoundly influences serum lipid profiles. Fatty acids fall into four main categories: saturated (SFA), monounsaturated (MUFA), polyunsaturated (PUFA), and trans fats. Their isolated impacts on cholesterol are summarised in *Table 1*.

Saturated fat: a nuanced perspective

Saturated fat notoriously increases LDL-C levels, as it can downregulate LDL receptors in the liver, reducing clearance of LDL particles from the circulation (Grundy et al, 2019). For decades, dietary guidelines have advised reducing intake of saturated fat to decrease LDL-C levels, based on the assumption that this would directly translate into reduced CVD risk (NICE, 2023). However, evidence suggests that this relationship is more complex.

In a detailed reassessment of the literature, Astrup et al (2020) argue that the health effects of saturated fat cannot be evaluated in isolation from the foods that contain it. While saturated fat generally raises LDL-C levels, it also increases HDL-C levels, and the overall impact on the LDL:HDL ratio and cardiovascular risk may depend on the specific food matrix — that is, the broader physical and chemical structure of a food, including how nutrients are packaged together and interact with one another. This perspective suggests that the health implications of saturated fat vary depending on the type of food in which it is consumed.

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Table 1: Different types of fatty acids, their dietary sources, and isolated effects on blood lipid levels (Astrup et al, 2020; Wang et al, 2023).

Fatty acid type	Fatty acid subtypes	Common dietary sources	Isolated effect on blood lipid levels
Saturated fatty acids	Lauric, myristic, palmitic and stearic acid	Butter, full fat dairy, red meat, coconut oil and palm oil (used in many ultraprocessed foods like biscuits)	↑ LDL-C (especially palmitic and myristic); ↑ HDL-C
Monounsaturated fatty acids	Oleic and palmitoleic acid	Olive oil, avocado, nuts, rapeseed oil	↓ LDL-C, ↑ HDL-C or neutral
Polyunsaturated fatty acids	Omega 6 (linoleic and arachidonic acid)	Sunflower oil, soybean oil, nuts, seeds	↓ LDL-C
	Omega 3 (alpha-linolenic, eicosapentaenoic and docosahexaenoic acid)	Oily fish (e.g. mackerel, salmon), flaxseeds, chia seeds, kiwi seeds, walnuts, algae	↓ triglycerides, slight ↓ LDL-C
Trans fats	Elaidic acid	Ultraprocessed foods containing partially hydrogenated oils as an ingredient (their use in the UK is now negligible). Take away food, especially deep fried chips	↑ LDL-C, ↓ HDL-C; strongly associated with cardiovascular disease
	Vaccenic acid	Ruminant food products: beef, butter, dairy	

HDL-C = high-density lipoprotein cholesterol; LDL-C = low-density lipoprotein cholesterol

For example, intake of fermented dairy products such as yoghurt and cheese is not associated with increased rates of cardiovascular events despite their saturated fat content, and in some cohorts, are even inversely associated (Astrup et al, 2020). The fermentation processes in cheese and yoghurt produce metabolites that may favourably modulate gut microbiota and lipid metabolism (Gao et al, 2025).

Whole milk, as well as yoghurt and cheese, contain a complex mixture of nutrients above and beyond saturated fat. Indeed, fat globules in the milk of mammals are surrounded by the milk fat globule membrane, which is rich in a variety of beneficial bioactive compounds like phospholipids and glycoproteins (Wilmot et al, 2025). These components may attenuate or even counterbalance the cholesterol-raising effects of saturated fats found within dairy (Astrup et al, 2020). Furthermore, the calcium found in dairy may form insoluble 'soaps' with fatty acids in the gut, reducing lipid absorption and increasing faecal fat excretion (Thorning et al, 2017).

Unprocessed red meat and dark chocolate, despite their high saturated fat content, have not been associated with increased CVD risk, similarly because of their complex food matrix (which includes proteins, micronutrients, phospholipids and other non-nutritive compounds) (Astrup et al, 2020). That said, butter, a food rich in SFAs but limited in micronutrients and beneficial non-nutritive compounds, appears to raise LDL-C levels more than an equivalent amount of SFAs from cheese (de Goede et al, 2015), and its intake is associated with higher mortality rates (Zhang et al, 2025). Indeed, the most recent systematic review and meta-analysis looking generally at SFA restriction for CVD concluded that 'a reduction in saturated fats cannot be recommended at present to prevent cardiovascular diseases and mortality' (Yamada et al, 2025).

Ultimately, it seems that the actual food source of SFA may be more important than the SFA intake itself; these findings support a shift towards a focus on individual foods and dietary patterns rather than nutrients in isolation (Astrup et al, 2020).

Seed oils and cardiovascular health

Seed oils, such as sunflower, safflower, soybean and corn oil, are rich in omega-6 PUFAs, particularly linoleic acid. Whether seed oils help or harm human health is currently one of the most intensely debated areas in clinical nutrition (Lee and Kurniawan, 2025). Processed foods which commonly incorporate seed oils include crisps, popcorn, crackers, baked goods like pastries, margarines, and fried foods. Some argue that the industrial processing of seed oils introduces lipid oxidation products and promotes inflammation, thereby increasing cardiovascular risk (DiNicolantonio and O'Keefe, 2018). Yet, the bulk of clinical and mechanistic evidence contradicts these claims.

Controlled feeding studies demonstrate that seed oils reduce levels of LDL-C and inflammatory markers, oxidative stress and insulin resistance (Fornari Laurindo et al, 2025). Seed oils are considered to offer cardiovascular and metabolic benefits, particularly when used to replace saturated fat from butter and palm oil (Lee and Kurniawan, 2025).

Typical 'Western' dietary patterns are sorely lacking in omega-3 PUFAs, but can be proportionally rich in omega-6 fats, leading to an imbalanced profile of PUFAs (DiNicolantonio and O'Keefe, 2021). A high ratio of circulating omega-6:omega-3 has been strongly associated with risk of all-cause, cancer and CVD mortality (Zhang et al, 2024). To obtain the benefits of omega-3s and to balance the omega-6:omega-3 ratio, it is recommended to consume one to two portions (a portion being ~140g cooked, or, volumetrically, the palm of a hand) of oily fish per week (Zhao et al, 2023). Thus, seed oils need not be demonised, but the benefits of a regular omega-3 intake alongside seed oils should be emphasised.

Phytosterols: efficacy and caution

Phytosterols, also known as plant stanols and sterols, are cholesterol-like compounds found in fortified spreads, yoghurts and yoghurt

drinks (e.g. Benecol). They are clinically proven to reduce LDL-C levels by 6–12% when taken at a dose of around 1.5–3g per day, after two to three weeks of continuous supplementation (Barkas et al, 2023). They work by reducing the absorption of cholesterol in the digestive system.

Such products can be expensive, and their potential benefit is not clear. At present, there are no randomised placebo-controlled trials to investigate the impact of phytosterol supplementation on rates of major cardiovascular events (Stellaard and Lütjohann, 2025). Furthermore, genetic studies have linked elevated plasma concentrations of circulating phytosterols with the presence of CVD, raising concerns about the safety of phytosterol supplementation (Barkas et al, 2023). These factors limit routine recommendation of their use.

Cooking oils and heat stability

Fats can become destabilised when exposed to heat, light and oxygen, producing lipid-oxidation byproducts which are associated with inflammation and vascular damage (Ng et al, 2014). SFAs have the greatest oxidative stability, although SFA-rich products typically used for cooking, such as butter, have negative effects on cholesterol management (Abrante-Pascual et al, 2024).

Coconut oil is composed of 90% SFAs, of which 70% are medium-chain SFA. This subtype of SFA is thought to be less atherogenic than the long-chain SFA found in regular butter, for example. Medium-chain SFA, however, have a lower smoke point than long-chain SFA, limiting coconut oil's utility as a cooking oil (Abrante-Pascual et al, 2024). On the other hand, while PUFAs typically have positive effects on cholesterol management, they have a relatively poor oxidative stability and are thus a suboptimal choice for cooking. MUFA-rich fat sources, like olive oil (especially extra virgin) and peanut oil, on the other hand, have both a high oxidative stability and positive effects on cholesterol management, making them preferable cooking oils (Abrante-Pascual et al, 2024).

The most effective approach, particularly when aiming for weight loss, is to use any type of fat sparingly during cooking (Abdollahi et al, 2024).

Dietary cholesterol ≠ serum cholesterol

Food itself can be a direct source of cholesterol, and there is debate as to whether those with hypercholesterolaemia should avoid cholesterol-rich foods, such as eggs, meat (especially offal), full fat dairy, butter and shellfish. Overall, the literature does not suggest that dietary cholesterol intake significantly impacts blood cholesterol levels (Schoeneck and Iggman, 2021). This is explained by the body's ability to alter the degree of cholesterol absorption and cholesterol synthesis based on dietary cholesterol intake (Fernandez and Murillo, 2022).

COFFEE AND LIPIDS

Coffee intake and hypercholesterolaemia presents another nuanced topic. While coffee is rich in bioactive compounds such as polyphenols which have antioxidant and anti-inflammatory properties, randomised controlled trials indicate that consumption of brewed, unfiltered coffee can cause a moderate to large increase in LDL-C levels (Schoeneck and Iggman, 2021). However, paper filters can be used with most coffee brewing methods to effectively filter out the diterpenes that are responsible for the hypercholesterolaemic effect of coffee (Orrje et al, 2025). Instant coffee is naturally very low in diterpenes and has a much smaller impact on LDL-C levels than brewed, unfiltered coffee (Svatun et al, 2022).

DIETARY FIBRE: A CORNERSTONE OF CARDIOVASCULAR HEALTH

Dietary fibre is a type of carbohydrate that is neither digested nor absorbed in the small intestine (Gill et al, 2021). Dietary fibre is naturally present in cereals (especially wholegrains), vegetables, fruit, legumes, nuts and seeds (Dhingra et al, 2012). Historically, dietary fibre was classified into two main categories: soluble and insoluble. However, this classification is now being phased out, as it is overly simplistic and can be misleading (Gill et al, 2021). Instead, dietary fibres are increasingly being classified based on their viscosity (ability to form a gel in the gut), fermentability (ability to be broken down by gut bacteria), and bulking capacity (ability to hold water and increase stool mass) (Opperman et al, 2025).

Dietary fibre with a high viscosity, particularly beta-glucans (of which oats are a good source), is particularly effective at reducing cholesterol levels because of its ability to limit cholesterol reabsorption in the distal ileum (Opperman et al, 2025). Fermentable dietary fibre, such as inulin, fructooligosaccharides, pectin and resistant starches, can be used by the large intestine to produce short-chain fatty acids (SCFAs), such as butyrate, acetate and propionate.

SCFAs lead to a host of physiological benefits, including the reduction of LDL-C levels by enhancing hepatic uptake of serum cholesterol (Münte and Hartmann, 2025). Whether a type of dietary fibre has a high or low bulking capacity seems to have minimal impact on cholesterol levels. However, high bulking capacity dietary fibre — such as lignin, cellulose, and hemicellulose, which are mainly found in wholegrains — play a crucial role in promoting bowel regularity, significantly improve insulin resistance and reduce the risk of developing type 2 diabetes mellitus (Kabisch et al, 2021).

Clinical trials have demonstrated that higher overall intakes of dietary fibre (25–29g per day) lower LDL-C levels as well as other CVD risk factors like bodyweight and systolic blood pressure (Reynolds et al, 2019). Consequentially, dietary fibre has been demonstrated to reduce the risk of CVD in a dose-response fashion (Reynolds et al, 2019). In the UK, the average intake of dietary fibre is only ~18g/day, thus most individuals will benefit from trying to increase the quantity of fibre in their diet (Norton et al, 2024).

MEDITERRANEAN DIET: A FOOD-BASED FRAMEWORK

The Mediterranean diet has shown

robust benefits in terms of both primary and secondary prevention of CVD (Estruch et al, 2018). The Mediterranean diet focuses on nutrient-dense, minimally processed foods like wholegrains, fruits and vegetables, legumes, nuts, (extra virgin) olive oil and fish (*Figure 1*).

The Mediterranean diet demonstrably lowers levels of LDL-C and triglycerides, and systemic inflammation, while simultaneously increasing HDL-C levels and improving HDL-C function (Frank et al, 2025). Its benefits extend beyond lipid modification, contributing to improvements in glycaemic control, endothelial function, and even cognitive health (Godos et al, 2025).

When compared to other cardioprotective diets (such as a low fat diet), the Mediterranean diet leads to greater reductions in LDL-C (mean difference -0.15mmol/litre) (Rees et al, 2019). In an eight-week randomised controlled trial, Meslier et al (2020) compared the effects of a Mediterranean diet versus no dietary intervention in 82 overweight and obese subjects. In the absence of any weight loss, the Mediterranean diet led to a mean decrease in LDL-C of 0.24mmol/litre (-8.3% from baseline). Other trials comparing the Mediterranean diet to a habitual diet have had similar results (Rees et al, 2019).

Such a modest reduction in LDL-C would only be expected to result in modest reductions in CVD risk, yet the Mediterranean diet is renowned for leading to substantial reductions in CVD risk, with the PREDIMED trial demonstrating a 30% relative risk reduction in a primary prevention context (Estruch et al, 2018). This discrepancy may be explained by the ability of the Mediterranean diet to specifically reduce the proportion of highly atherogenic small, dense LDL particles, replacing them with larger, less atherogenic LDL particles (Candás-Estébanez et al, 2024).

Practically, it is important to consider that asking a patient to follow a particular 'diet', such as the Mediterranean diet, can be intimidating, as the word diet often implies rigidity and restriction (Leske et al, 2012). In the author's experience, many patients find it more effective to focus on simple food swaps and gradually shifting their diet towards being less processed and more rich in whole foods — like wholegrains, fruits and vegetables — or to loosely track their dietary fibre intake and to aim for a diet high in fibre (e.g. 25–30g/day), both of which naturally nudge patients closer towards a Mediterranean diet.

Figure 1.
The Mediterranean diet food pyramid.

Patients who are interested in reducing their CVD risk via dietary changes should be offered information pertaining to the Mediterranean diet (e.g. Heart UK's Mediterranean diet webpage: www.heartuk.org.uk/healthy-diets/the-mediterranean-diet), with encouragement to try and apply some of the principles to their usual diet. Small changes to the patient's baseline diet are a useful starting point, for example by adding vegetables to their omelette, choosing fruit or nuts as a snack over crisps or biscuits, increasing the proportion of beans, lentils or chickpeas in meat-based dishes, and swapping white for wholemeal bread.

CENTRAL ADIPOSITY AND LIPID METABOLISM

While dietary composition remains central to lipid management, increasing evidence highlights the independent and substantial impact of excess body weight, particularly central adiposity, on circulating cholesterol levels (Limpijankit et al, 2022). The liver is the primary site of endogenous cholesterol synthesis and lipoprotein assembly. Over time, high calorie diets promote the deposition of intrahepatic fat, eventually leading to metabolic-associated fatty liver disease (Heeren and Scheja, 2021). Metabolic-associated fatty liver disease leads to excessive secretion of large very low-density lipoprotein particles from the liver, ultimately driving high concentrations of small, dense LDL-C in the blood (Heeren and Scheja, 2021).

Meta-analysis of randomised controlled trial data suggests that each kilogram of weight loss in people with obesity results in a mean 0.033mmol/litre reduction in LDL-C levels (Hasan et al, 2020). This equates to a mean 0.33mmol/litre or 0.66mmol/litre reduction in LDL-C in those who lose 10kg (~1.5stone) or 20kg (~3stone), respectively. Thus, significant weight loss can lead to dramatic improvements in LDL-C levels. Case studies with hyper-

responders to weight loss from dietary modification exist. For example, Van Rensburg (2018) reports on an overweight 33-year-old man with a baseline LDL-C level of 5.3mmol/ litre who, after six weeks of a low calorie diet and moderate exercise leading to 7.1kg weight loss, reduced his LDL-C level to 2.5mmol/litre without the use of any cholesterol lowering medicines. This reduction in LDL-C level was still approximately maintained at the six-month mark.

While there is limited research, it seems logical that a low calorie Mediterranean diet leading to weight loss would be particularly effective for reducing LDL-C levels. Preliminary research by De Lorenzo et al (2001) had 19 women with obesity eat a low calorie Mediterranean diet for two months, which led to a mean weight loss of 4.9kg and a relatively large mean reduction in LDL-C of 0.46mmol/litre.

CONCLUSIONS

Hypercholesterolaemia remains a prevalent, modifiable risk factor for CVD in the UK adult population. While pharmacological treatment is often warranted, especially in high-risk individuals, there is compelling evidence that food-based strategies, particularly those grounded in dietary patterns like the Mediterranean diet, can significantly reduce CVD risk. These benefits extend beyond reductions in LDL-C levels to include favourable changes in LDL particle size, increased HDL-C levels and HDL function, and improvements across a range of cardiometabolic markers.

The focus of dietary guidance is increasingly shifting away from isolated nutrients, such as saturated fat, towards overall food quality and dietary patterns. This reflects growing understanding that the health effects of nutrients depend on the food matrix in which they are consumed — as demonstrated by the cardioprotective nature of full-fat yoghurt and cheese. The Mediterranean diet stands out as the most evidence-based cardioprotective pattern, consistently associated with reduced CVD events and improved lipid profiles. In individuals with overweight or obesity, weight loss produces dose-dependent reductions in LDL-C levels and likely enhances the impact of dietary interventions.

Community nurses are uniquely positioned to bridge the gap between complex nutritional science and everyday practice. By offering clear, compassionate, tailored advice, they can support patients in making small, sustainable changes, such as increasing dietary fibre intake, that together make a meaningful difference to cardiovascular health over time. JCN

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Dysphagia, fluids and renal function

Linda Nazarko

As the UK population ages, the number of people with multiple long-term conditions and multimorbidity will increase. Hospital-based staff tend to specialise and will usually provide care for a single condition such as heart failure. This focus is not helpful for people with multimorbidity, as their conditions interact and medication prescribed to treat one condition may worsen another. People with multimorbidity require skilful holistic care to enable them to have the best possible quality of life. Nurses working in primary care are in a unique position to provide this care. This article examines how reduced fluid intake caused by dysphagia can affect renal function and offers advice on holistic management and treatment of both conditions.

KEYWORDS:
■ Dysphagia ■ Kidney disease ■ Fluids and diet ■ Comorbidities

Around 5.2 million people, one adult in eight, in the UK has dysphagia (Boaden et al, 2019). Dysphagia becomes more common in older age and is associated with neurological problems and frailty (Cohen et al, 2021; Knott, 2021). Dysphagia leads to difficulty eating and drinking (Royal College of Speech and Language Therapists [RCSLT], (2022).

In the UK, more than one person in 10, 7.2 million people, has chronic kidney disease (CKD) (Kidney Research UK, 2023).

CKD is defined as abnormalities in kidney function or structure (or both) present for more than three months with associated health implications. Kidney damage may cause fluid and electrolyte imbalance and leakage of protein and/or blood into the urine, resulting in proteinuria and haematuria (National Institute for Health and Care Excellence [NICE], 20255).

An estimated 3.9 million people are estimated to have CKD stages 1–2 and approximately 3.25 million people have stages 3–5 (Kidney Research UK, 2023). As kidney disease often has no symptoms until its later stages, both patients and healthcare staff may be unaware of its presence. There is no cure for CKD and treatment strategies aim to maintain the best possible kidney health (Kidney Research UK, 2023).

A National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2021) review aimed to identify ways to improve the care and treatment of all people with dysphagia. NCEPOD found that hospitals needed to improve the ways they identified people known to have dysphagia, screening processes, referral to speech and language therapists (SLTs) and communication with specialists within the hospital. The review found that people with dysphagia, their care givers and staff who would be providing care on discharge were not always given sufficient information (NCEPOD, 2021).

In the author's clinical experience, nurses working in primary care may be the person who first identifies dysphagia or CKD. The individual may need support and advice on how to manage both conditions.

WHAT IS DYSPHAGIA?

An individual requires intact motor and nervous systems to swallow normally. When there are problems, the person can develop dysphagia (RCSLT, 2022).

There are four phases in a normal swallow, as illustrated in *Table 1*.

There are two distinct types of dysphagia — oropharyngeal and oesophageal dysphagia.

Oropharyngeal dysphagia is described as difficulty initiating a swallow or passing food through the region of the mouth or throat (Menon, 2022). It refers to difficulty in transferring material down the oesophagus in the retrosternal region (Malagelada et al, 2015; Le et al, 2023). Oropharyngeal dysphagia is underdiagnosed and undertreated. It can affect up to 50% of older people and 50% of people with neurological conditions and is associated with aspiration, severe nutritional and respiratory complications and even death (Menon, 2022).

Oesophageal dysphagia is caused by diseases affecting the enteric nervous system and/or oesophageal muscular layers. Although it occurs less often than oropharyngeal dysphagia and has less severe symptoms, it is more commonly diagnosed (Clavé and Shaker, 2015).

Linda Nazarko, independent consultant nurse

CAUSES OF DYSPHAGIA

Dysphagia is more common in older people and affects 10–27% of those living at home (Almirall et al, 2013; Madhavan et al, 2016), although can occur in younger adults and children. The prevalence of conditions that affect swallowing rises with age (Patel et al, 2018; Cohen et al, 2021). Thus, increasing numbers of people are at risk of dysphagia due to population ageing. The number of people aged 90 years and over in the UK has increased by more than 250% in the last 30 years, and was 609,503 in mid-2020 (Office for National Statistics [ONS], 2021).

Causes can be categorised as obstructive, neurological and others. *Table 2* outlines causes of dysphagia (Knott, 2021).

Dysphagia may not always be diagnosed because the individual adapts to it and does not seek medical help. Although a person may develop complications of dysphagia such as weight loss or chest infections, healthcare staff may not consider that dysphagia is a contributing factor (Clavé and Shaker, 2015). It is important to be alert to the clinical features of dysphagia and to check if the person is experiencing swallowing difficulties when assessing and treating those at risk of dysphagia (Boaden et al, 2019; Smithard, 2015). Certain people are at greater risk of dysphagia than others (*Tables 2* and *3*).

IDENTIFYING PEOPLE WITH DYSPHAGIA

In the author's clinical opinion, the best way to identify dysphagia is to routinely ask people presenting at the surgery or in the community if they have any problems with swallowing. A survey of 791 people aged 60 and over attending 17 community pharmacies was carried out by pharmacists. Almost 60% reported difficulty swallowing medication, and admitted to opening tablets and crushing medications. When asked if they had told their GPs, 72% said that they had not been asked (Strachan and Greener, 2005). *Table 4* outlines the clinical features of dysphagia (Knott, 2021).

Table 1: Components of the normal swallow (author's own work)

Phase	Mechanism	Possible problems
Oral preparatory stage	Food is ground, chewed and mixed with saliva to form a bolus	Lack of teeth, difficulty biting and chewing. Lack of saliva to form a bolus
Oral	Food is moved back through the mouth with a front-to-back squeezing action, performed primarily by the tongue	Tremors of the tongue e.g. in Parkinson's disease and reduced tongue movement, e.g. due to stroke (Menon, 2022)
Pharyngeal	The food enters the upper throat area The soft palate elevates The epiglottis closes off the trachea, as the tongue moves backwards and the pharyngeal wall moves forward These actions help force the food downward to the oesophagus	Neurological disease, head and neck surgery, radiotherapy to mouth and throat
Oesophageal	Muscles propel food through the oesophagus. The oesophageal sphincter opens and closes efficiently. The bolus is moved to the stomach	Oesophageal stricture, malignancy, medical-induced oesophagitis and dysmotility and dysmotility secondary to disease (Le et al, 2023)

Table 2: Causes of dysphagia (author's own work)

Obstructive	Neurological	Other
Gastro-oesophageal reflux ± stricture	Cerebrovascular event or brain injury	Pharyngeal pouch
Eosinophilic oesophagitis	Parkinson's disease and other degenerative disorders	Globus hystericus
Infective oesophagitis	Diffuse oesophageal spasm	External compression (e.g. mediastinal tumour, or associated with cervical spondylosis)
Oesophageal cancer	Syringomyelia or bulbar palsy	Inflammation and infection, e.g. tonsillitis, laryngitis
Gastric cancer	Myasthenia gravis	
Pharyngeal cancer	Multiple sclerosis	
Post-cricoid web	Myopathy (dermatomyositis, myotonic dystrophy)	
	Chagas' disease	
Oesophageal rings	Achalasia	
	Motor neurone disease	

Table 3: Conditions and prevalence of dysphagia (author's own work)

Condition	Prevalence of dysphagia
Age-associated frailty	▸ 51–53% (Patel et al, 2018: Cohen et al, 2021)
Chronic obstructive pulmonary disease (COPD)	▸ 27% (Turley and Cohen, 2009; Lin and Shune, 2020)
Dementia	▸ 13–86% depending on type of dementia and severity (Espinosa-Val et al, 2020)
Multiple sclerosis	▸ 31–43% (Solaro et al, 2013; Aghaz et al, 2018)
Stroke	▸ 13–94% dependent on location and size of lesion (Langdon and Blacker, 2010; Arnold et al, 2016)
Parkinson's disease	▸ 11% and 87% depending on disease stage, duration and the assessing method (Schindler et al, 2021)

RED FLAGS

The term 'red flags' was introduced in the 1980s and is used to signal that the person requires urgent medical attention. In dysphagia there are three major red flags:

- Steadily worsening of dysphagia over a few weeks in an older person is suggestive of

Table 4: Clinical features of dysphagia

Coughing/choking during or after meals
Unintentional weight loss
Throat clearing
Wet, gurgling voice after eating
Fever
Chills
Changes in breathing
Food or liquids travelling back up through the throat or nose after swallowing
Feeling of food or liquids being 'stuck' in the throat or chest
Pain while swallowing
Heartburn
Dehydration
Excessive secretions
Leakage of food or saliva from mouth

malignancy and patients should be urgently referred under the two-week rule in England. Men over the age of 65 with new onset weight loss and worsening dysphagia have a 9% risk of cancer (Jones et al, 2007). Of note, most people (90%) referred under the two-week rule do not have cancer (Cancer Research UK, 2022)

- If the person is clinically unwell and has a suspected aspiration pneumonia, clinicians should treat or escalate the case using local protocols
- If the person has an unsafe or possible unsafe swallow, urgent medical referral is required (NHS, 2025).

ASSESSMENT IN COMMUNITY SETTINGS

If a person has a new or deteriorating swallow, nurses should follow local protocols. These may involve completing a dysphagia screen and possibly carrying out an initial assessment of swallowing.

In NHS community and acute trusts, most organisations have a locally agreed swallowing assessment that is completed by nursing staff on admission, or when a person's condition changes. This assessment determines whether a SLT assessment is required (Davis and Bradley, 2017).

Bedside swallowing tests have also been developed to screen for oropharyngeal dysphagia. A systematic review of these tests identified four tests with sensitivity of ≥70% and specificity of ≥60% (Kertscher et al, 2014). These were the Toronto bedside swallowing screening test (TOR-BSST©) (Martino et al, 2009), the volume-viscosity swallowing test (V-VST) (Clave et al, 2008), the 3-ounce water swallow test (Suiter and Leder, 2008) and the cough test (Wakasugi et al, 2008). A test often used in general practice is based on the 3-ounce swallow test (GP notebook, 2018).

TREATMENT OF UNDERLYING CAUSES OF DYSPHAGIA

Poor oral health can contribute to problems with dysphagia, as tooth loss, gum disease and infection affects the ability to bite and chew (Cichero, 2020). Nurses should check if oral health problems are contributing to dysphagia, treat any infection and advise the older person to seek dental treatment.

SPECIALIST REFERRAL AND INVESTIGATIONS

People identified as having dysphagia are normally referred to a SLT for further in-depth assessment. The SLT may recommend dietary and fluid modification and other treatments. These aim to improve nutrition and hydration and reduce the risks of aspiration pneumonia. Aspiration is the term used when foods or fluid passes through the vocal folds and enters the airway. It can be caused by impaired laryngeal closure or because of the overflow of food or liquids retained in the pharynx. The larger the volume of fluid or food aspirated, the greater the problem. Food and fluids can be aspirated into the trachea or more deeply. Deep aspiration is more dangerous than shallow aspiration. Acid material (such as orange juice) can set up an inflammatory reaction in the lungs and cause serious damage (Almirall et al, 2013). Aspiration that is not accompanied by a cough is known as 'silent aspiration'. This is much more dangerous than aspiration accompanied by a cough because food or fluids penetrate the airway and move deep into the lungs causing major respiratory problems (Almirall et al, 2013).

IMPORTANCE OF FLUIDS AND DIET

Dysphagia increases the risk of malnutrition and dehydration and can affect health and quality of life (Cichero and Altman, 2012). In many cases, it is not possible to treat dysphagia and the aims of care are to maintain nutrition and hydration, reduce the risk of aspiration pneumonia and ensure that the person is able to take medication (Nazarko, 2024). The key to maintaining nutrition and hydration in people with dysphagia is to promote safe swallowing and to ensure that the person has food and fluids which are of the appropriate texture and thickness. *Table 5* provides guidance on how to advise a person or caregivers on safe swallowing (Nazarko, 2024).

The UK adopted the international framework descriptors for levels of thickness in 2019 (International Dysphagia Diet Standardisation Initiative [IDDSI], 2019 — www.iddsi.org/standards/framework).

Table 5: Advice on safe swallowing (Nazarko, 2024)

Sit upright at 90 degrees when eating and drinking
Do not eat or drink when slouched or lying down
Take small bites of food
Take small sips of fluid
Chew food well before swallowing
Make sure that you have swallowed your food or drink before taking more
Do not wash down food with drinks
Do not talk when you have food in your mouth

Normal fluids, referred to as 'thin fluids' in the IDDSI framework, can flow quickly and because of the fast movement are more likely to increase the risk of aspiration than thicker fluids. Fluid that is thickened is stickier and is easier to control than normal fluids, thus reducing the risk of aspiration (Masuda et al, 2022). *Table 6* illustrates examples of fluid.

WHY OLDER PEOPLE ARE VULNERABLE TO DEHYDRATION

Fluid balance in the body is maintained by the thirst mechanism stimulating intake, and output is controlled via secretion of vasopressin (Ramsay, 1989). Ageing affects both mechanisms, increasing vulnerability to dehydration and kidney damage. Ageing impairs the thirst mechanism and older people are less likely to feel thirsty when becoming dehydrated (Begg, 2017; Kenney and Chiu, 2001).

Age-related changes to the renal system lead to increased vulnerability to dehydration and renal damage, as the kidneys are less able to concentrate urine (Andrade and Knight, 2017).

Pathological changes to the renal system lead to CKD. There has been a huge increase in the number of people with kidney disease in recent years (Kidney Research UK, 2023). This is thought to be due to growing obesity levels, hypertension, diabetes, heart and circulatory disease, and increased alcohol consumption (Kidney Research UK, 2023). *Figure 1* outlines how to maintain healthy kidney function.

FLUID REQUIREMENTS

NICE (2017) guidance recommends 25–30ml of fluid per kilo per day. NICE recommends that clinicians consider less fluid, i.e. 20–25ml/kg/day in frail older people and people with renal impairment or cardiac failure. If a person is obese, ideal body weight should be used to calculate fluid requirements (*Table 7*).

Dysphagia makes it difficult for people with CKD to drink sufficient fluids and CKD increases the risk of dysphagia (Kosaka, 2020).

PROBLEMS WITH THICKENED FLUIDS

Thickening agents, starch- or gum-based, can be used to thicken fluid. The rationale is that thick fluids have a higher viscosity and can compensate for a swallowing deficit by slowing down the flow of fluid from the mouth to the oropharynx, allowing time for glottis closure which could potentially reduce the risk of aspiration (O'Keeffe, 2018).

Many people who have dysphagia and require thickened fluids are dehydrated and there have been concerns that thickening fluid reduces bioavailability and prevents the body from using the fluid normally. Cichero (2013) examined this issue and found that bioavailability of fluid was not affected by the type of thickener or by the viscosity of the liquid. People who have thickened fluids are dehydrated because they drink less than people on normal fluids (Garcia and Chambers, 2010). There are a number of factors affecting fluid intake. Starch-based thickeners give fluids a starchy flavour and a grainy texture, which can affect the pleasure of drinking a fluid (Garcia and Chambers, 2010). Gum-based thickeners do not produce grainy textures and do not make people feel full up in the same way as starch-based thickeners. However, all types of thickener reduce the flavour of a drink (Cichero, 2013). The greater the level of thickener, the lower the level of fluid intake (Vivanti et al, 2009).

The Royal College of Speech and Language Therapy commented that it is becoming increasingly recognised that aspiration does not always lead to poor health outcomes and that frequently modifying the texture of food and drink can have a negative impact on a person's wellbeing. They now recommend that anyone being placed on a significantly modified diet should

Table 6: Fluids and the IDDSI framework

Consistency	Description	Example
Thin/normal	Still water	Water, tea, coffee without milk, diluted squash, spirits, wine
Slightly thick/naturally thick	Leaves a coating on an empty glass	Full cream milk, oral nutritional supplements
Mildly thick/syrup thick/stage 1	Can be drunk through a straw or from a cup Leaves thin coat on the back of a spoon	Smoothie, milkshake
Moderately thick/custard thick/stage 2	Cannot be drunk from a straw Can be drunk from a cup Leaves thick coat on back of a spoon	Custard

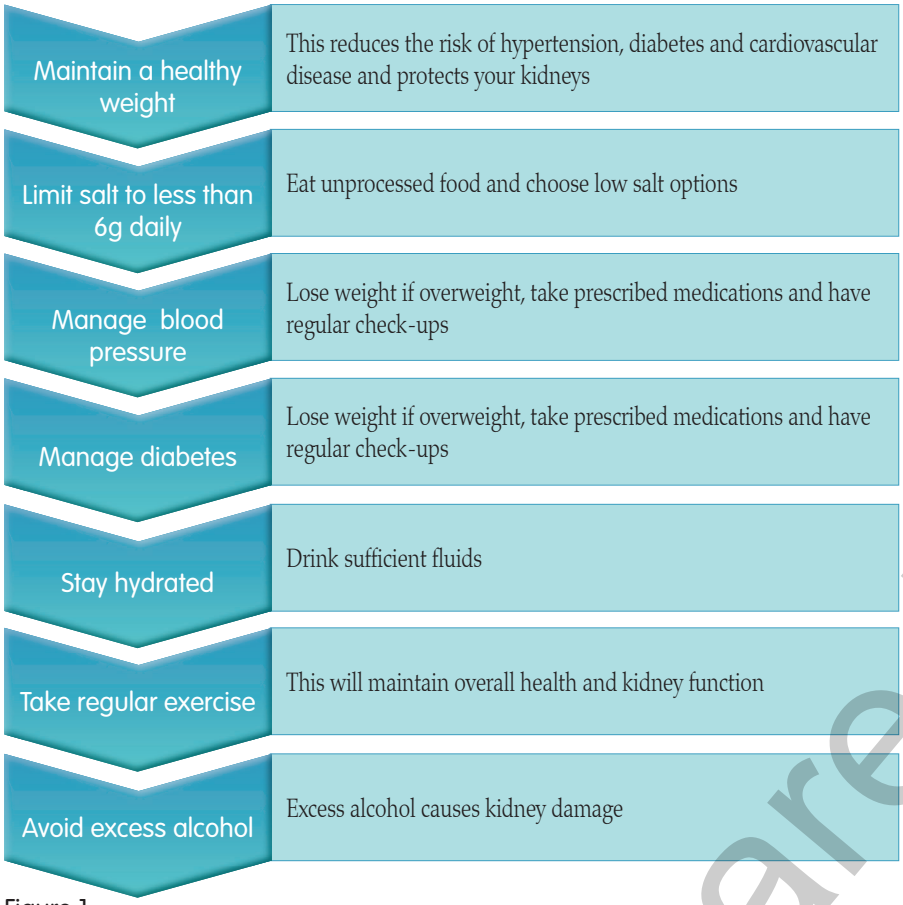

Figure 1.
Maintaining healthy kidneys (author's own work based on Baker et al, 2021).

be reviewed regularly (RCSLT, n.d.). Cicero (2013) recommends that clinicians prescribe the minimal level of thickness needed for swallowing safely and optimise management of individuals with dysphagia. O'Keefe (2018) points out that robust evidence that thickening agents reduce pneumonia in dysphagia is currently lacking.

CHOICE

In the author's clinical opinion, healthcare professionals can concentrate so much on evidence-based practice and doing the right thing that they forget that people have a choice about whether to accept or decline healthcare advice and interventions. O'Keefe (2018) reminds us that modified diets worsen the quality of life of those with dysphagia and non-compliance is common. He states that patients should be given adequate information about the potential risks and impact on quality of life, as well as the possible benefits, in order to make choices about modified food and fluids.

MEDICATION

People with dysphagia may struggle to swallow tablets and so all medication should be reviewed. This should consider if each drug is necessary, if any are contributing to dysphagia, whether other formulations which are easier to swallow are available, and if the medication can be safely crushed. The review should also check if any treatment given for one indication, such as dysphagia, can impact on renal health. Proton pump inhibitors (PPIs), e.g. omeprazole may be prescribed to people who suffer from reflux of gastric acid into the oesophagus, which can lead to or worsen dysphagia (Philpott et al, 2017). Long-term use of PPIs is also associated with declining renal function (Hatakeyama et al, 2021).

SKILFUL HOLISTIC CARE

As the population ages, people are living with multiple long-term conditions and they require skilful holistic care. In the author's clinical experience, there is a tendency

Reflection

Mrs Ramsey is 93 years old and has dysphagia. She has been prescribed a level four diet and thickened fluids. She is losing weight and seems dehydrated.

What would you do and why?

In what circumstances would you consider an emergency referral for a person with dysphagia?

Will you change your practice as a result of reading this article? If so, why?

in acute care for the person to be seen as a series of conditions rather than as a person with a number of interacting conditions. Nurses working in primary care are in a unique position to develop an overview of the person's health and to provide support to promote the best possible health. In people with dysphagia and CKD, this can include routine monitoring of renal function and nutritional status and supporting the person.

CONCLUSION

Dysphagia can have a major impact on a person's life. It can affect the ability to remain hydrated and nourished and increase the risk of infection and ill health. CKD can also have a major impact on the person's quality of life. By supporting individuals with both conditions and skilfully optimising health, nurses can make a real difference to their quality of life. JCN

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Table 7: Fluid requirements by ideal body weight (based on NICE, 2006, updated 2017)

Weight (kg)	Fluid requirement (ml)
35–44	1200
45–54	1500
55–64	1800
65–74	2100

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KEY POINTS

- Ageing increases the risks of dysphagia and CKD — conditions which can be undiagnosed and thus untreated.
- Dysphagia may be longstanding or detected when the person presents for treatment.
- It is important to ensure that hydration and nutrition are maintained and that the person is able to take medication.
- Using safe swallowing techniques and food and fluids of the appropriate texture reduces the risk of aspiration.
- When aspiration occurs, prompt recognition of problems saves lives and improves quality of life.

Resources

Dysphagia guide, e-learning resource — www.e-lfh.org.uk/programmes/dysphagiaguide/

Educational resources Rosemont Pharmaceuticals — www.rosemontpharma.com/health-professionals/education-resources

Helpful video guidance of how to test drink thickness using a 10ml slip tip hypodermic syringe: http://iddsi.org/framework/drink-testing-methods/. There are also useful ways of checking food textures on the site

The BAPEN tool is available online. It consists of three modules, with each module including case studies and care plans appropriate for the workplace and an online assessment, together with the ability to print off certificates of achievement. Key features include:

- Tailored case studies to meet staff needs and place of work
- Interactive and online
- Approximately 45 minutes on average to complete
- End of course assessment and certificate of completion.

BAPEN also provides a free downloadable booklet on the use of MUST: www.bapen.org.uk/screening-and-must/must/introducing-must

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Revalidation Alert

Having read this article, reflect on:

- Why dysphagia can affect renal function
- How you identify people with dysphagia
- The importance of fluids and diet
- Why patient choice should always be considered.

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

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Sundowning in dementia

Karen Harrison Dening, Amy Pepper

Sundowning, a change in the behaviour of a person with dementia that appears in the evening or during the night, is a well-recognised occurrence in dementia care. The behaviours observed can be agitation, aggression, anxiety or those associated with delirium. This article uses case studies to illustrate the ways in which sundowning may present, and explores possible rationales, approaches and interventions that might be useful in supporting the person, family carers and caregivers.

KEYWORDS:
■ Dementia ■ Nursing ■ Distress behaviours ■ Sundowning

The prevalence of dementia is increasing worldwide. In the UK, it is estimated that currently there are almost a million people living with the condition, expected to rise to nearly two million by 2050 (Wittenberg et al, 2019).

Dementia is an umbrella term describing a range of symptoms characterised by impaired cognitive and social functioning, and behavioural changes (Barber, 2020). There are many causes of dementia, with the most common being Alzheimer's disease, vascular dementia, dementia with Lewy bodies, mixed dementia and frontotemporal dementia (Prince et al, 2014). Dementia is most common in those over the age of 65 years, but it can also occur in younger people (diagnosed under the age of 65 years), termed young onset dementia (Knight and Pepper, 2024).

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'Sundowning may be the result of specific neuropathological abnormalities that interfere with normal circadian rhythm (the sleep/wake cycle) and behavioural regulation.'

Estimates suggest that up to 80% of people with dementia will experience distress behaviours at some point during the course of their disease (Ismail et al, 2015). Distress can present in many ways, including as agitation, aggression, apathy, or depression (Pepper and Harrison Dening, 2024). Any form of distress behaviours can pose significant challenges to both family carers' and health and care professionals' ability to provide care safely and effectively. One form of distress behaviour that a person with dementia may experience is often referred to as 'sundowning'.

SUNDOWNING

Sundowning, sometimes called sundowning syndrome, is a well-recognised phenomenon in dementia care. The term is often used to describe change in the behaviour of a person with dementia that appears in the evening or during the night. Some researchers believe that sundowning may be the result of specific neuropathological abnormalities that interfere with normal circadian rhythm (the sleep/wake cycle) and behavioural regulation (Gnanasekaran, 2016), although others believe the research to be inconclusive (Canevelli et al, 2016).

The change in behaviour seen in sundowning usually takes the form of agitation, aggression, anxiety, or those associated with delirium. Although sundowning is widely recognised, it is not well researched or found in any international classifications of diseases, so there is no diagnostic criteria or procedural standards for it. Despite this the term is widely used in clinical settings, with its understanding being based on clinical awareness, rather than a widely accepted definition (Reimus and Sieminski, 2025). However, as with the term 'wandering', sundowning is not a term that is accepted by people with the lived experience of dementia, as it implies a form of purposelessness and of stigmatisation.

Sundowning and stress

Stress is a natural human response that prompts us to address challenges and threats in our lives (World Health Organization, 2023). However, as dementia progresses, a person's stress threshold may change and their ability to manage their stress levels may become increasingly compromised (Pickering et al, 2022). Smith et al (2004) propose that a progressively lowered stress threshold in a person with dementia may provide some insights for both understanding and supporting sundowning.

In considering sundowning from this perspective we can see that it

manifests itself as various stressors layered one on top of the other, with changes to circadian rhythms happening alongside other factors such as pain, hunger, or fatigue. Such factors may lead to disruptions in a person's emotional regulation as they struggle to cope with these multiple stressors (Smith et al, 2004).

Sundowning and behaviour

Sundowning is often framed by a person's presenting behaviour, which leads to how it is viewed and then the response it invokes. This leads to the potential for diagnostic overshadowing that can often occur in dementia; where new or difficult symptoms are considered as a consequence of the dementia alone (Iliffe, 2013; Pepper and Harrison Dening, 2024). Indeed, Boronat et al (2019) proposed that sundowning refers to the occurrence or exacerbation of psychiatric symptoms in the evening hours in people with dementia. However, others have described the behaviours as psychiatric symptoms that appear in the evening in a general older population, regardless of whether they have dementia or not (Canevelli et al, 2016).

The authors would argue that reducing the definition to simply embrace psychiatric symptoms presents a narrow, medicalised focus and fails to acknowledge many influential factors, for example personal history, psychosocial, and environmental factors, that can often contribute to sundowning behaviours.

CASE STUDIES IN PRACTICE

This article presents two fictionalised case studies to explore approaches to support instances and contexts where sundowning often occurs. Drawn from the authors' clinical experiences, one portrays a situation in a person's own home (*Case study one*) and the second in a care home setting (*Case study two*). Each explores possible rationales, approaches and interventions that might be useful in supporting the person, family carers and caregivers.

Case studies can be educational and informative, and can offer a simulation of practice examples where carers and clinicians can identify themselves in or recall similar scenarios that they have witnessed or experienced (Seshan et al, 2021). Similarly, reviewing case studies can offer ideas for nurses on how to improve their critical skills, practice, and patient outcomes (Bi et al, 2019), as well as generating a deeper and multifaceted understanding of complexities encountered in a real-life clinical context (Seshan et al, 2021).

CASE STUDY ONE: MARJORIE

Marjorie, a 78-year-old woman, has been married to Tom for 48 years. Their two children live long distances from their parents. Marjorie was diagnosed with a mixed dementia (Alzheimer's disease and vascular dementia) eight years ago by the local memory assessment service. She has had an uneventful period thus far with her dementia, successfully continuing to live with Tom in their two-bedroom bungalow.

Over the years, Tom has adapted to the changes in Marjorie's cognitive decline and functional losses, providing prompts, support and direct care when needed. He has the support of an Admiral Nurse (specialists in dementia care) to provide information as and when he needs it.

One weekend, Marjorie started to uncharacteristically pace around their home in the late afternoon, becoming worse into the evening. She was calling for the children and kept trying the front door (they always keep this locked after a certain point in the day for security). Whatever Tom tried to do to settle Marjorie failed. In the end, Marjorie tired herself out and fell asleep in a chair in the sitting room. The same thing happened again over the next few evenings, with Tom's efforts becoming less effective over time.

'Sundowning often makes a person with dementia feel very strongly that they are in the "wrong place", that they "need to get home", even if they are already at home... .'

Sundowning typically happens in the late afternoon and evening, around dusk. It may be a brief episode or last for several hours. While symptoms often ease by the time the person with dementia goes to bed, in some people, they may continue into the night. What we see in *Case study one* is that the changes in Marjorie's behaviour are of sudden onset (over a couple of days) and seem to be quite uncharacteristic of her normal personality and behavioural pattern.

There are many possible causes for sundowning-type behaviours (*Table 1*) and sometimes a process of elimination or trial and error may be needed to find the underlying one(s). When we see a very sudden change in a person with dementia, we should always consider a delirium in the first instance, as sudden changes could be the result of an infection for example, which can be a medical emergency if not promptly identified and treated. Several tools are of particular use in the recognition and initial assessment of a possible delirium. The PINCH-ME (Dixon, 2025) is useful to consider some of the possible underlying causes (*Table 2*), and the 4AT is a brief assessment tool recommended by the National Institute for Health and Care Excellence (NICE, 2023).

Sundowning often makes a person with dementia feel very strongly that they are in the 'wrong place', that they 'need to get home', even if they are already at home and sometimes it may be the person's way of expressing discomfort and their need to get away from the thing that is distressing them (Stokes et al, 2023). It can be helpful to consider home as a feeling, rather than a physical place and think about ways to provide that feeling of safety and

Table 1: Sundowning, underlying causes and possible approaches to take (adapted from Dementia UK, 2023; Reimus and Sieminski, 2025)

Issue	Factors to consider	Possible approach to take
Sleep and circadian rhythm disorders	Poor sleep hygiene Daytime naps No fixed bedtimes Poor sleep environment Tiredness and over-tiredness Lack of exposure to natural daylight Difficulty in initiating sleep Insomnia	Promote good sleep hygiene and avoid undertaking 'normal' activity at an 'abnormal' time Promote access to outdoors during daylight hours, walking, etc. Evidence for the use of bright light therapy is currently inconclusive If unable to get outside, consider opening windows during the day and gentle exercise in line with current abilities Consider depression and referral to GP
Distress	Pacing Attempting to leave Agitation and aggression Other psychotic symptoms	Consider GP and/or mental health referral
Low mood	Insomnia Irritability Emotional lability	Consider depression and referral to GP Note: some antidepressants have a sedative effect which may increase the risk of falls
Level of alertness	Over-stimulation before bedtime A lack of activity or boredom (under-stimulation)	Distraction with meaningful occupation at times when distress tends to occur Sensory approaches to provide natural cues that it is bedtime (e.g. drawing curtains, dimming lighting, warm bath, use of lavender scent)
Underlying physical health need	Delirium Pain Hunger/thirst Side-effects of medications	Consider any possible underlying health problem giving rise to distressed behaviours and/or delirium, for example, a urinary tract infection, constipation, dehydration or side-effects of medications Consider the presence of pain
Carer factors	Family carer Lack of knowledge of sundowning Fatigue Care staff Fewer care staff being on shift in a care home to support the person Lack of knowledge of sundowning	Procognitive interventions; what is sundowning, sleep hygiene approaches, etc Consider additional support Optimise staffing levels at critical points in the day

security that comes with being at home when a person is expressing distress in this way.

Tom discussed his wife's behaviour with the Admiral Nurse (specialists in dementia care), which meant that she could support his understanding of sundowning. This can often help caregivers gain a greater awareness and insight of a particular behaviour in a person with dementia, fostering greater understanding and even tolerance which can assist in managing the behaviour. Reimus and Sieminski (2025) refer to this as procognitive therapy, which is an educational approach taken with family carers and caregivers. In Marjorie's case, this worked to some degree in that Tom had a better understanding of sundowning and felt less anxious about whether he was doing the 'right thing' or not, but Marjorie continued to show this distressed behaviour.

The nurse decided to rule out an underlying infection, given the acute onset of the sundowning. Marjorie had a urinary tract infection (UTI) that was probably causing a delirium-type effect that fluctuated across the day and was more impactful late afternoon and evening. Her UTI was treated with antibiotics but at the same time Tom was encouraged to reinforce good sleep hygiene by supporting his wife to get access to regular natural light in the day by outdoor walking, placing strategic nightlights to allow Marjorie to navigate her way to the toilet, and having consistent routines that marked the day naturally coming to an end, such as dimming lights, drawing the curtains and promoting activities that Marjorie would associate with the end of her day. A combination of all these elements significantly reduced her sundowning symptoms.

Table 2: The PINCH-ME mnemonic for identifying potential causes of delirium (adapted from Dixon, 2018)

Mnemonic	Possible things to consider
Pain	Look for non-verbal signs of pain; restless, crying out
Infection	Any signs of infection — urine, chest, wound?
Nutrition	Are they eating well, is there any weight loss?
Constipation	Is there appetite loss, abdominal pain, smelly breath?
Hydration	Is their urine dark or smelly, do they have dry lips and or skin, headache?
Medication	Are they experiencing any side-effects, have any new medications been started?
Environment	Have their surroundings changed recently; is it noisy/busy, or too hot?

There are several issues to consider in *Case study two*. Care staff often find such behaviours difficult to understand and manage in a multiple occupancy residence, such as a care home. Max is clearly distressed and unlikely to be deliberately behaving in this way. When distress is present, it can pose a significant challenge

CASE STUDY TWO: MAX

Max moved into the care home in his village three days ago. He had been living alone for the last two years following the death of his wife, Joyce. Max was diagnosed with Alzheimer's disease 11 years ago and Joyce had been caring for him during this time. They had no children or any close relatives.

As he deteriorated over time a care package had grown to support them both, finally he was receiving four calls a day from a home care worker to provide all personal care as Joyce had developed cancer and became physically unable to provide any hands-on care.

When Joyce died, Max was admitted to the care home permanently as it was considered unsafe for him to remain at home alone. From the first day in the care home Max started to pace the corridors and communal spaces from late afternoon into the evening, would sometimes go into other residents' rooms and often attempted to leave the premises. The care staff found it difficult to understand and manage Max's behaviour and, as they tried to contain him, Max would become increasingly distressed. Care home staff had contacted the local GP surgery to express concerns about Max's wandering and 'difficult' and deliberately disruptive behaviours in the evenings when they are always very busy.

to providing care in any context but probably more so in a communal setting such as a care home. In the evening there may be fewer staff, and they may be busy getting tired residents to bed and perhaps also tired themselves.

When changes in behaviour are framed as distress, there is an onus on health and care professionals to seek out the reason for that distress and develop strategies to support the person, rather than lay blame on them for their behaviour. In this approach, distress can then be defined as a change in behaviour related to, or as an attempt to communicate, an unmet need (Cohen-Mansfield et al, 2015). There are various strategies that can support communication in these instances (*Box 1*) (Pepper and Harrison Dening, 2024).

It may be that the care home staff have little knowledge and experience of working with residents who have dementia and so the staff would benefit from a precognitive intervention themselves to help them better understand behaviours associated with sundowning. In Max's case, it is important to educate the care staff that a need for a person with dementia to walk, at whatever part of the day, is not wandering. Wandering implies an aimlessness, whereas most people with dementia have a purpose to their walking; it may simply be that the onlooker fails to see or understand its purpose, or the person with dementia is unable to adequately express the purpose. Too often, wandering is perceived as a symptom of dementia. Such misinterpretation of the walking behaviour often relates to diagnostic overshadowing of dementia that can prevail, where any behaviours that people are unable to explain are put down to their dementia (Stokes et al, 2023).

It may be beneficial to consider Max's sundowning through a life narrative approach, looking at his current emotional context as well as environmental influences, which gives valuable insights to managing sundowning tendencies. This person-centred approach may entail documenting previous individual evening routines, identifying historical triggers such as shift work or childcare patterns, including culturally significant practices, and developing tailored evening protocols based on familiar music, foods, and activities (Möhler et al, 2023).

It might already be apparent to the reader what elements might be significant in understanding Max's behaviour, but some care staff may struggle to stand back or take time to consider the underlying issues, given the pressures of promoting safety for all residents, managing risk, busy work schedules, impending change of shift, being tired and perhaps not yet knowing Max as well as some other residents in their care.

People with dementia, as anyone, experience grief and loss when someone close to them dies, or for their loss of home and familiarity. In the moderate to later stages of dementia, a person may express their grief and loss differently as they have reduced ability to verbally communicate their grief and to comprehend the root cause of their feelings of loss (Pepper et al, 2025). As dementia progresses, people become more dependent on others for their day-to-day care, and experience progressive problems with communicating. These changes for Max, as well as his feelings of loss and grief associated with his wife's death and move from home, mean that he is less able to verbally express his feelings and may have led to his expression of distress.

Max's perceived wandering may be distress presenting itself as a form of searching, looking for his wife, and perhaps not understanding that she had died. We do not know if he has been told of his wife's death. There is still the prevailing view that people with dementia would not remember or find it too difficult to contemplate and deal with feelings of loss and grief. Similarly to Marjorie, Max may have an overwhelming sense of being in the 'wrong place' as well as a 'need to be home', perhaps not understanding where he is as it is not his familiar home environment.

Practice point

In people with dementia, distress can be considered as a change in behaviour related to, or as an attempt to communicate, an unmet need. This helps to understand how it can be addressed and supported rather than just 'managed'.

Box 1 Communicating with a person with dementia who is experiencing sundowning (adapted from Pepper and Harrison Dening, 2023)

- Use the person's name when talking to them and use it throughout your conversation, as appropriate, to keep their focus
- Face the person directly and make good eye contact; using these non-verbal cues lets them know that you are communicating and focused on them
- Speak slowly (although not so slowly that it appears patronising) and calmly, smile (where appropriate) as this conveys empathy and warmth
- Speak in short sentences, using language and words that are familiar to them and give simple instructions to avoid confusing the person
- Give the person with dementia more time — it may take longer for them to process what you are saying and think of a response
- Be aware of and maximise your non-verbal communication, for example, tone of voice, facial expressions, hand gestures and gentle touch (if they feel comfortable with this)
- Use active listening and be fully attentive to what the person is saying and/or trying to say. Also, pay attention to their non-verbal communication (e.g. facial expressions and posture)
- Focus on one question at a time
- Mirror what they say (repeating back to them) for affirmation and to let them feel that you are listening to them, for example,'… so you say you were a nurse before you retired…?'
- Consider using gestures that mime an action; for example, miming drinking a cup of tea
- Ask the person what is upsetting them. Listen carefully to their response and, if possible, see if you can resolve the reason for their distress
- Gently remind them what day and time it is
- Avoid contradicting or arguing with the person as this may increase their distress
- To ensure a person-centred approach to communication, try and find out as much as you can about their life story
- Try and hold the conversation somewhere that is quiet and calm, bearing in mind that they may prefer their own environment (e.g. home, care home room)
- Treat the person as an adult; do not speak in a raised voice as if they are deaf.

A bereavement is challenging for anyone to navigate, but the presence of dementia may further complicate a grieving process. Max may be unable to hold onto and retain the information that Joyce has died, and his communication difficulties will interfere with how he expresses his grief. It is therefore important that all those working with people with dementia and their families are aware that the ways in which grief is expressed or manifests itself may differ in people with dementia and have a toolkit or range of approaches to help support in these situations (Pepper et al, 2025). Best practice guidance on truth telling in dementia (Kirtley and Williamson, 2016) is to tell a person with dementia when someone close to them has died. If Max had been sensitively supported to understand that his wife had died, this may have helped him to grieve and reduce his distressed searching behaviours.

Pepper et al (2025) offer guidance on approaches that can be taken to support people with advanced dementia in their grief. One suggestion involves validating the expressed emotion by engaging with the emotion behind what is being said or asked. This can help to reassure the person, and may provide clues for what would support them in that moment. Consider the example dialogue between Max and a care home nurse (adapted from Pepper et al, 2025):

Max: (pacing the hallway and visibly upset) 'When is Marjorie coming back? I want to find her'
Care staff: 'You seem upset Max, are you missing Marjorie today?' (validating his emotions)
Max: (looking relieved) 'Oh yes' (feels validated in his distress)
Care staff: 'What would Marjorie say if she was here now?'
Max: 'She always knew what to say, we liked to walk together… I miss her so much'.

By demonstrating that the care home nurse has heard and understood Max's emotion they are able to offer reassurance to him and enable Max to feel that he is being understood and listened to, even when communication is compromised.

CONCLUSIONS

Sundowning is a frequent although not well-defined problem in people with dementia. Its underlying causes are often related to, and embrace a mix of various factors, such as the neurodegenerative process, a person's other comorbid or intercurrent conditions, historical or occupational behaviour patterns, and environment. Diagnosis should be based mainly on history and physical examination. Interventions should address the suspected triggering factor(s) and the most troublesome symptoms and effects of sundowning. The most effective and successful interventions are often multi-modal and personalised approaches, which may involve both pharmacological and non-pharmacological elements. JCN

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Revalidation Alert

Thinking about patients you have had where the person has dementia and has experienced distress:

- How did you acknowledge and manage this distress with the patient?
- In a similar situation, think about what advice and support you could give to the person's carers
- Could you use a procognitive (educational) approach with the carers to help them understand why sundowning is happening?

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

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KEY POINTS

- Sundowning refers to changes in the behaviour of a person with dementia that take place in the evening or during the night.
- Sundowning often makes a person with dementia feel that they 'need to get home', even if they are already at home.
- Procognitive (educational) interventions can be beneficial for both family and professional carers, to help them understand the behaviours linked to sundowning.
- Interventions should address the suspected triggering factor and the most troublesome symptoms.
- The most effective and successful interventions are often multi-modal and personalised approaches, which may involve both pharmacological and non-pharmacological elements.

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Psychological safety in community nursing: a reality or fallacy?

Edwin Chamanga

Psychological safety aims to reduce patient-related harm by creating high performing teams, which are open and transparent, functioning in the absence of retribution. Models for delivering nursing care, along with matrices designed to monitor their impact, can negatively affect the adoption of psychological safety in practice. Strategies have been designed at national level to ensure the adoption of psychological safety, while, at a local level, individual organisations can implement processes to improve psychological safety from floor to board.

KEYWORDS:
■ Community nursing ■ Psychological safety ■ Human factors
■ Just culture ■ Patient safety

The concept of psychological safety dates back to the 1950s; although Edmondson is credited for moving it forward in healthcare in the late 1990s (Capelli and Edor, 2024). It is regarded as a shared belief among team members that their team is safe for interpersonal risk-taking (NHS England, 2022). Alternatively, it is seen as a cultural environment where individuals feel comfortable being themselves and expressing their thoughts — a state of vulnerability without fear of negative consequences (Edmondson, 2003). The World Health Organization (WHO, 2019) acknowledged the importance of psychological safety as a vital component towards an open and blame-free safety culture, which is important for incident reporting or clinical transparency.

There are four stages or zones of psychological safety:

- Inclusion safety
- Learner safety
- Contribution safety
- Challenger safety

(Clark, 2020).

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'The World Health Organization (WHO, 2019) acknowledged the importance of psychological safety as a vital component towards an open and blame-free safety culture, which is important for incident reporting or clinical transparency.'

Collectively, they are essential for building strong, cohesive teams and enhancing patient outcomes. In their absence, individuals can feel fearful and inauthentic, i.e. they feel that they cannot express their true thoughts, feelings, or values in the work environment, often due to external pressures such as workplace culture, professional expectations, or fear of judgment (Clark, 2020).

Inclusion safety

This type of safety emphasises the creation of an inclusive environment where everyone feels valued and respected. It ensures that all team members, regardless of their background or role, can freely express their opinions and contribute to decision-making processes. Leaders and colleagues should actively listen to each other, validate perspectives, and create an environment where everyone feels heard. This can be achieved by celebrating cultural, experiential, and individual differences, i.e. recognising and appreciating the unique contributions of each team member (O'Donovan and McAuliffe, 2020a).

Learner safety

Learner safety encourages a growth mindset and continuous learning. This means individual nurses feel comfortable seeking feedback, asking questions, and admitting when they do not know something. It fosters professional development and improves patient care (Clark, 2020; France et al, 2020). Organisational leadership can cultivate this by encouraging ongoing education and professional development. This involves offering learning opportunities, workshops, and access to evidence-based resources, in combination with regular constructive feedback and learning from mistakes, while also emphasising growth rather than blame (France et al, 2020).

Contribution safety

Contribution safety enables individuals to share their ideas without fear of criticism or negative consequences. Therefore, nurses can actively participate in discussions, propose innovative solutions, and collaborate effectively with colleagues. Regular team huddles, brainstorming sessions, and suggestion boxes can facilitate this, complimented by acknowledging and appreciating contributions publicly (O'Donovan and McAuliffe, 2020b).

Challenger safety

This type encourages constructive dissent and critical thinking. It allows nurses to question existing

practices, advocate for evidence-based approaches, and challenge decisions when necessary, and all while maintaining a respectful and supportive environment. Leaders should actively advocate for evidence-based practices and encourage team members to challenge outdated approaches by encouraging debate with respect (Diabes et al, 2020).

PSYCHOLOGICAL SAFETY AS A CONCEPT BEING CHALLENGED

Psychological safety and these four stages/zones highlight the importance of a sense of belonging at a local team level compared to only at an organisational level. This is reflected in staff survey results, where nurses often report feeling more supported within their immediate teams, rather than by the employing organisation (de Vos et al, 2024; Vleminckx et al, 2024). Indeed, organisational relationships thrive across hierarchies when individuals feel seen, heard and valued (Hicks, 2018).

In nursing practice, it is argued that psychological safety cannot be fully realised due to the nature of many nursing roles. These roles are often considered to be repetitive and standardised, with an expectation of rule following, no risk-taking and that mistakes are harmful to patient safety (Capelli and Edor, 2024). As a result, such roles are seen as less creative, lacking opportunities for continuous learning. This is in contrast to organisational visions, missions and goals, which are purposely designed to serve the interest of the organisation. Great organisations achieve psychological safety by inspiring employees to identify with their roles, feel empowered and committed, compared to being instruments used for performing routine tasks. Thus, employees are motivated to provide service not only to the organisation but also the wider community (Powell, 2012).

The introduction of the Patient Safety Incident Response Framework (PSIRF) is influential in creating a culture that fosters psychological safety throughout organisational structures, as it focuses on treating risk and mistakes through:

- Compassionate engagement
- Learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight, i.e. an approach that strengthens learning response systems and improves patient safety rather than enforcing rigid compliance (NHS England, 2024a).

This is further bolstered by the adoption of the 'just culture', which suggests that employees are treated fairly, while putting emphasis on learning from patient safety events rather than being punitive (NHS England, 2018a). In some organisations, this has been adopted in human resources policies (NHS England, 2024b). Policies such as 'probation, disciplinary and allegations of abuse' have incorporated such change (NHS Employers, 2021), which can ultimately result in increased psychological safety. However, the ultimate question lies in the effectiveness of such approaches, i.e. the measurement of impact/how this will be measured in community nursing. For example, is it an audit of cases that resulted in disciplinary action? Or is a suitable matrix a review of cases which were referred to the regulatory body? Perhaps the absence of a baseline of what a non-just culture is poses a challenge in this domain.

NHS England (2022) advocates that for psychological safety to be fully embedded in healthcare settings, human factors should be taken into account. Human factors focus on enhancing clinical performance by understanding the environment in which care is delivered. This includes considering the team, tasks, equipment, workspace, organisational culture and human behaviour (National Quality Board, 2013). However, the origins of human factors come from the aviation industry, which may not be transferable to nursing practice. For example, a plane cannot fly without a pilot, but nursing teams are being supported by newly qualified or less experienced nursing staff, or are working with reduced staffing levels — placing both patient care and staff wellbeing at risk (Mitchell, 2022; Royal College of Nursing [RCN], 2022).

Another challenge to the human factor concept in nursing is the profession's reliance on job description, policy and procedures, and any deviations from these are culturally associated with disciplinary action (Langemeier, 2015). This is shrouded in a culture of blame and fear, where individuals are seen as the point of failure rather than the system (NHS England, 2022). This also reflects nursing as being a regulated profession, with increasing numbers of people leaving the register annually for various reasons including work-related pressure and negative workplace culture (Nursing and Midwifery Council [NMC], 2022; 2024).

Conversely, a psychologically safe environment is one that reports the highest number of mistakes (Edmundson, 1999), which highlights the need for a significant culture shift in how incidents and mistakes are reported, so that psychological safety can be embedded in practice by community nurses and their organisations. This need for a culture change should also be considered amid staffing shortages, where clinicians are under pressure to complete tasks, which increases the risk of making mistakes and fear of blame (National Quality Board, 2013).

PSYCHOLOGICAL SAFETY AT AN INDIVIDUAL LEVEL

As psychological safety is viewed through the optics of an organisational culture it is important to draw from the 'Discovery model' (Keller and Price, 2010), which is based on the premise that the mindset of the nurse influences their behaviour, and ultimately their behaviour influences practice and practice

influences outcomes. Therefore, with nurses regulated by a professional body which governs with professional standards, it is important to consider whether human factors, such as communication errors, workload and fatigue, are considered in the regulatory framework, or emphasis is only on accountability, which is informed by a set of rules or principles.

A report produced by the RCN (2024) indicated that suicide rates among nursing staff were on the increase. This report was not exclusively community nursing. The following three themes were noted as major causes for suicidal ideation:

- Working relationships
- Formal procedures
- Workload.

On the premise of adopting a psychologically safe work environment, these themes should be addressed. However, there is a lack of information around service provision and a general understanding of community nursing as most research is mainly focused on acute nursing care. Therefore, capacity modelling and service stratification in community nursing remains a challenge — resulting in demand that does not meet capacity (Chamanga, 2020; Day and Mitchell, 2020).

ORGANISATIONAL CHALLENGES WITH IMPLEMENTING PSYCHOLOGICAL SAFETY

The WHO (2019) acknowledged that the provision of care is becoming more challenging in a constantly changing and complex environment. It also notes that clinical safety measures which were implemented in the past had limited or varying success measures, influenced by service structures, cultures and/or behaviours. Thus, it is imperative that the implementation of psychological safety is viewed within the context of internal and external factors which may influence its success (Edmundson and Hugander, 2021; American Psychological Association, 2024).

The NHS is making efforts to move away from key performance indicators (KPIs), block contracts and payment by results (PbR), which are target driven and somewhat transactional and do not encourage transformational relationships, i.e. relationships which create lasting value on long-term engagement built on trust, collaboration, and mutual growth (Robertson and Ewbank, 2020; Robertson et al, 2021).

'Regular team reflection, training sessions, and open dialogue can reinforce the principles of psychological safety (Delizonna, 2017).'

Commissioning for Quality and Innovation (CQUINs) are designed by nature to be transformational, incentivising healthcare organisations to be innovative and achieve specific objectives (NHS England, 2018b). However, the transformational element is possibly questionable when organisations are faced with a punitive action if they do not meet certain targets, e.g. getting a threshold of 80% of staff vaccinated against flu — making it a money driven, rather than important staff wellbeing and patient safety exercise.

There are multiple domains used in practice for measuring quality, one of which is the Darzi pillars:

- Clinical effectiveness
- Patient safety
- Patient experience

(Department of Health [DH], 2008).

Arguably, care being delivered by each nurse is threaded through these pillars. However, in the author's opinion, the absence of their inclusion (i.e. the fact that the pillars do not take into account the wellbeing of the nurses delivering care) makes the expectations of the pillars' productivity focused, not recognising the best interests of the nursing workforce. This risks disqualifying nurses from being vulnerable and organisations from being inclusive — essential ingredients for the growth of psychological safety and driving innovation (Clark, 2020; Edmondson and Hugander, 2021).

RECOMMENDATIONS

Promoting psychological safety is an ongoing process. Implementing improvement processes, for example adopting recommendations such as the just culture policy, is insufficient to encourage and maintain a psychologically safe environment (Maben et al, 2023). Regular team reflection, training sessions, and open dialogue can reinforce the principles of psychological safety (Delizonna, 2017). As psychological safety relates to the culture or the behaviours of an organisation, in the author's opinion, it is prudent that it is included as part of an organisation's strategic objectives, potentially under organisational development. Healthcare organisations have been mandated to have roles such as freedom to speak up guardians and advocates (NHS Employers, 2023). There is an argument that these roles could be viewed as a failure to provide a psychologically safe environment, as employees need to seek alternative routes to raise concerns rather than being able to speak up for themselves and highlight issues in the workplace.

In hierarchical (top down, command and control), job description, policy and procedure driven teams such as nursing, psychological safety requires significant empowerment (Khoshmehr et al, 2020). Few achievements can be made until people consider themselves as the fountain of power and know how to manage it wisely and honestly (Hicks, 2018). Of course, some challenges are linked to people not feeling safe to speak up when there is injustice, especially from their managers or supervisors, which constitutes violation of their dignity. Yet, dignity is meant to provide a balance (Hicks, 2018). While individuals may differ in status, they are all equal in dignity, giving them the freedom to express their

authentic selves, with no judgement, prejudice or bias (Hicks, 2018). When individuals are treated with dignity, they feel safe to be wrong.

Some organisations have encouraged psychological safety in healthcare by harnessing quality improvement initiatives, thereby giving practitioners an opportunity to influence change (Halbesleben and Rathert, 2008; Grailey et al, 2021). This can be achieved by training and empowering nurses to run small projects, such as the plan, do, study, act (PDSA) cycle to explore how improvements can be made in practice. Indeed, failures met during the PDSA cycle are viewed as learning opportunities which help to identify areas for improvement (NHS England, 2019).

This approach encourages open discussion about what did not work and why, a key aspect of maintaining psychological safety in healthcare teams due to its focus on iterative tests of change (Reed and Card, 2018). By viewing failure as a chance to learn, teams can continue to innovate and improve without fear of negative repercussions for taking risks. This is already being seen in some areas of clinical practice such as incident management where there is a focus on compassion and after-action reviews (AARs), which offer a way of identifying best practice, gaps, and lessons from a healthcare event (WHO, 2024).

Based on the diversity of nursing roles and responsibilities, this paper cannot be generalised to all fields of community nursing. For example, specialist practitioners who often work in smaller teams may have a different perspective on psychological safety to generalists who work as part of a larger team. Therefore, a literature review or further research studies are needed to explore psychological safety in community nursing and what it means for different groups of nurses.

CONCLUSION

Psychological safety is an organisational culture created by diverse and empathetic approaches, which are emotionally aware of the biases and vulnerabilities of individuals or teams. Developing a psychologically safe organisation could result in higher performing teams, which are open to learning from patient safety incidents. JCN

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KEY POINTS

- The nursing environment is becoming dynamic, complex and challenging to navigate.
- Psychological safety in community nursing will help reduce patient-related harms by creating open and transparent teams.
- The four stages or zones of psychological safety are essential for building strong, cohesive teams and enhancing patient outcomes.
- Sense of belonging is essential in propagating impactful psychological safety in teams.

Revalidation Alert

Having read this article, reflect on:

- Why psychological safety matters in healthcare
- The four stages of psychological safety
- How you can promote it in your workplace
- The challenges organisations face when trying to implement psychological safety.

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

Going straight to community nursing

Here, Amanda Young, director of nursing programmes (innovation and policy), Queen's Institute of Community Nursing, looks at the opportunities that a career in community nursing can offer, from specialist practice qualifications to master's degrees. She also emphasises the importance of ensuring that student nurses can undertake community-based placements to support them in becoming the community nurses of the future.

The move to shorter hospital stays and an emphasis on avoiding hospital admissions has contributed to more complex care being provided in community settings, including community rehabilitation, intermediate care, people's homes, primary care and care homes (King's Fund, 2021).

This increase in demand for community care has lead to more opportunities for newly qualified nurses to go directly into primary, community and social care settings at the start of their career without having to work in a hospital, a secondary care setting (something that was an unwritten expectation in the past). However, many healthcare professionals still believe that newly qualified nurses should have experience in secondary care first.

'This increase in demand for community care has lead to more opportunities for newly qualified nurses to go directly into primary, community and social care settings at the start of their career without having to work in a hospital... .'

This is not the case at all and many graduates in the UK are now moving directly into these settings following positive community, primary care or adult social care placements during their nurse education (Queen's Institute of Community Nursing [QICN], 2022). They see the value of person-centred care, which is key in these settings, as when people are in their own environment they feel more in control and able to make their own decisions.

The 10 Year Health Plan for England restates that there is to be a shift from hospital to community care (Department of Health and Social Care, 2025). This will provide more opportunities for healthcare professionals to work directly with people in their own care setting, enabling them to be in charge. Community nurses are ideally placed to support the 10 Year Health Plan with their focus on the holistic and individual needs of people of all ages, enabling them to:

- Use enhanced communication skills
- Promote health
- Provide skilled wound care
- Deliver end-of-life care
- Support those with long-term conditions and complex health needs.

TRAINING OPTIONS POST-QUALIFICATION

Beginning a career in the community after you have joined the register as a nurse can lead to a number of future career options, such as working towards masters-level education with a year-long seconded specialist practice qualification (SPQ). Currently, SPQs are offered in a number of different primary and community areas, including:

- District nursing
- Inclusion health nursing
- Children's community nursing

- Adult social care nursing
- Community mental health nursing
- Community learning disability nursing
- General practice nursing
- Health and justice nursing
- Palliative and end-of-life care nursing.

The QICN (2023) has published voluntary field-specific standards for these programmes mapped to advanced level practice, in synergy with advanced practice programmes also offered for nurses working in the community. These standards (QICN, 2023) build on the Nursing and Midwifery Council (2022a) post registration standards and have been adopted by a number of universities across the country.

In addition, there are opportunities to undertake the year-long seconded specialist community public health nursing master's degree in health visiting, school nursing, occupational health nursing or public health nursing (Nursing and Midwifery Council, 2022b). These roles link mainly to the prevention focus of the 10Year Health Plan (Department of Health and Social Care, 2025).

Funding for these programmes comes centrally and organisations have a competitive interview process for secondment, with varying conditions attached to the secondment across the country (NHS England, 2024). Secondments can be part- or full-time, depending on the programme and the organisation's ability to release staff. The government has recently confirmed that level 7 apprenticeships will continue for advanced clinical practice, specialist community public health nurse, and district nurses (specialist practice qualification). It is usual to have experience of working in a particular field before applying for the opportunity to be seconded there, although some areas do not require this.

BENEFITS OF WORKING IN THE COMMUNITY

Applicants need to understand how working in the community provides a wider perspective of people's needs and what is important to individuals. This enables people to have control over their own health, through building relationships and communicating in a way that builds confidence to enable people to make choices that work for them (NHS England, 2025).

'The opportunity to see how nurses and other healthcare professionals address the challenges of keeping people well and out of hospital, giving them the tools to have conversations to address health issues, is important to help prevent crisis admissions to hospital.'

Community nurses work in situations that enable them to have conversations and to make a difference by problem solving. Recognising and accepting different values and cultures is key to developing relationships. Cotici (2021) and Gray (2021) give excellent examples of this in their blogs. Providing placements for students to have these valuable community experiences is vital for the future community nursing workforce.

Exposure to good student nurse placements in the community can highlight the reality of the work that happens, the team building, feeling valued by colleagues and empowering people to have control of decisions (Lees et al, 2025; Uren, 2025). The opportunity to see how nurses and other healthcare professionals address the challenges of keeping people well and out of hospital, giving them the tools to have conversations to address health issues, is important to help prevent crisis admissions to hospital.

People prefer to be cared for at home or in a care home. Care homes are also offering placements to student nurses so that they can experience the complex care issues that people face as they are living longer. Mahoney (2025) explained how his experience of a care home placement challenged his preconceived ideas, reflecting on the importance of prevention and how rewarding giving quality end-of-life care can be.

Newly qualified nurses and experienced nurses are welcome in all areas of primary, community and social care nursing. They can make a difference to people receiving care and are given more opportunities to become autonomous practitioners. This can allow them to address the patient's priorities with new ideas and up-to-date evidential practice to help shape the future of community and primary care nursing and to help prevent illness and keep people in control of their own health and care.

MOVING FROM SECONDARY TO PRIMARY CARE

A nurse choosing to transition from a secondary care role into primary or community care may benefit from shadowing a community nurse to experience what the role looks like firsthand, dispelling the many preconceived ideas about what work looks like in the community. As I moved from a ward manager to a community staff nurse many years ago, I realised that while I had many transferable skills, I also had a great deal to learn.

The biggest difference was person-centred care, the patient being in control, and my being a guest in their home environment. It was important to be able to think independently and to problem solve differently, for example, there were no dressing trollies or other equipment and there were different values related to home management (cleanliness and tidiness). It was the best move I ever made — I quickly became a qualified district nurse and then a team leader.

Now working at the QICN my preconceived ideas about the work that community nurses perform have been continually challenged. I would recommend that every nurse spends time with a variety of services as the work done is unbelievable, very valuable and completely different to

what you might expect. This could include working with families in temporary accommodation, or who are refugees, working with those with no fixed permanent home, providing end-of-life care, supporting those in communities such as parish nursing, working with offenders, or those with addiction issues, safeguarding adults and children, commissioning services, supporting those with mental health or learning disabilities, assisting ambulance services and much more. The roles are varied and cover many areas of life and nurses working in unexpected places.

CONCLUSIONS

Primary, community and social care nursing are the key to reducing secondary care admissions. Nurses working in the community deserve to be valued and commended for the work that they do — alone, in teams, in charge, whatever their role. They do a fantastic job, often unseen by others but it is work that really makes a difference. JCN

Ackowledgement

Photographs provided courtesy of Kate Stanworth, Queen's Institute of Community Nursing.

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KEY POINTS

- The move to shorter hospital stays and an emphasis on avoiding hospital admissions has contributed to more complex care being provided in community settings.
- This increase in demand for community care has lead to more opportunities for newly qualified nurses to go directly into primary, community and social care settings at the start of their career without having to work in a hospital, a secondary care setting.
- The 10 Year Health Plan for England restates that there is to be a shift from hospital to community care.
- Newly qualified nurses and experienced nurses are welcome in all areas of primary, community and social care nursing.

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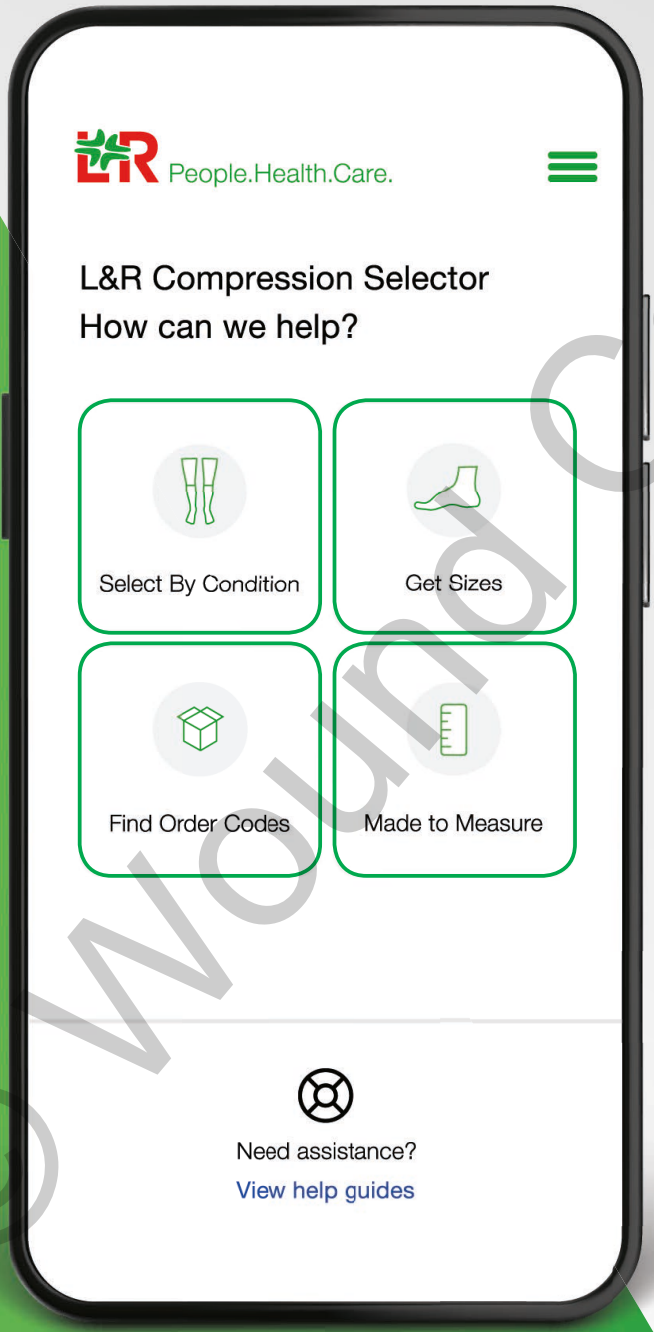

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