A TEXTBOOK OF COMMUNITY NURSING

THIRD EDITION



EDITED BY SUE CHILTON
AND HEATHER BAIN

ROUTLEDGE

A Textbook of Community Nursing

This third edition is a comprehensive and evidence-based introduction to this essential area of practice. Fully updated to take into account the wide range of nursing roles in the community, it provides an integrated approach to care, with a focus on physical and mental wellbeing.

It covers a wide range of topics, including research and community nursing, public health, professional approaches to care, risk management, safeguarding, therapeutic relationships, care across the lifespan, community nursing assessment, mental health, carers and families, spirituality, collaborative working, acute care in community settings, long-term conditions, end-of-life care, organisation and management of care, leading person-centred care and digital healthcare.

Incorporating current theory, policy and guidelines for practice, and underpinned by a strong evidence base, each chapter features learning objectives and activities. Case studies and examples from practice serve to illustrate the practical application of theory throughout.

This is an essential text for all pre-registration nursing students, students on post-registration specialist community nursing courses and qualified nurses entering community practice for the first time.

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Taylor & Francis
Taylor & Francis Group
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A Textbook of Community Nursing

Third edition

Edited by
SUE CHILTON and HEATHER BAIN

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

Designed cover image: Getty images

First published 2025
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

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First edition published by Routledge 2012
Second edition published by Routledge 2018

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Names: Chilton, Sue, editor. | Bain, Heather, editor.
Title: A textbook of community nursing / edited by Sue Chilton and Heather Bain.
Description: Third edition. | London : Routledge, 2025. |
Includes bibliographical references and index.
Identifiers: LCCN 2024030793 (print) | LCCN 2024030794 (ebook) |
ISBN 9781032389356 (hardback) | ISBN 9781032381176 (paperback) |
ISBN 9781003347545 (ebook)
Subjects: LCSH: Community health nursing.
Classification: LCC RT98 .T498 2025 (print) | LCC RT98 (ebook) |
DDC 610.73/43--dc23/eng/20240708
LC record available at https://lccn.loc.gov/2024030793
LC ebook record available at https://lccn.loc.gov/2024030794

ISBN: 978-1-032-38935-6 (hbk)
ISBN: 978-1-032-38117-6 (pbk)
ISBN: 978-1-003-34754-5 (ebk)

DOI: 10.4324/9781003347545

Typeset in Minion
by SPi Technologies India Pvt Ltd (Straive)

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FOREWORD

There has been a clear policy imperative for many years, in all four countries of the UK, that more healthcare should be delivered in people's homes and communities. Central to enabling that care is the role of the nursing team, including those nurses with advanced skills and the ability to lead and manage a range of practitioners to deliver care to individuals, families and carers, with increasingly complex needs.

The new edition of this comprehensive book provides an exploration of the evolving role of the registered nurse throughout the life course, recognising that, as the complexity of needs and the potential of technology develops, the registered nurse is seen to respond in the delivery of excellent, evidence-based care.

The themes of each chapter provide an insight into the current and changing policy context of health and care in the community and the political, economic, scientific and technical developments that have influenced and supported the expansion of the registered nurse's role.

Community is an exciting and rewarding environment in which a registered nurse can deliver expert care, with the potential to exercise creativity and autonomy in highly independent roles while also providing the leadership of their nursing teams and delivering increasingly complex care to acutely ill people in their own home environment. This book includes excellent examples of the expert nursing knowledge and skills required to provide these essential services in every village, town and city in the UK.

With such a responsibility and expertise, there is a need to prescribe the requisite underpinning education and training for these roles in the community. Building on the pre-registration qualification and the significant experience gained as a registered nurse, there is a clear understanding of the need for an advanced practice qualification in the senior roles, which includes an understanding of the impact of the social determinants of health, leadership of the team, management of the service, maximising the application of technology, independent prescribing, advanced clinical assessment and the management of risk in community settings.

Embracing people as partners in their healthcare is critical to excellent healthcare. For those with long-term conditions, this means recognising that the individual is an expert in their own care and taking a positive approach, wherever possible, to co-creating personalised care plans. A holistic, enabling approach to the delivery of nursing care can be a powerful intervention in all aspects of care, including prevention and the promotion of health and wellbeing – and addressing spiritual care needs.

Understanding population health and how to productively link with, engage and magnify all community assets in building wellness are as essential, as part of

the rich tapestry of community nursing services, as the provision of palliative and end-of-life care, or the self-supported management of long-term conditions.

Collaborative working with all services has always been central to registered nurses working in the community. A more integrated approach to health and social care in the community has been seen in recent years in every country of the UK, supporting a cohesive and coordinated approach to the provision of healthcare, social care and third-sector services. It is early days for this work and much of it is predicated on the relationships developed by the professionals on the ground, all providing elements of care for the same individual, their family and their carers.

An excellent example of the need for truly integrated care by registered nurses is the increasing number of citizens with long-term conditions who receive care from multiple organisations. Their care is most often coordinated by the registered nurse, whose skills extend beyond personalised care and clinical interventions to the organisation of all health and care needs – akin to being a conductor in an orchestra. The safety-critical and organisational skills of a nurse in the community should never be underestimated.

We also recognise and embrace the essential and often overlooked role of the carer. Registered nurses in the community support adult and young carers in their critical role as care partners. Carers in the home frequently provide the majority of care for individuals, and registered nurses recognise the importance of including them as part of the care planning team wherever possible while championing their frequently invisible role at a policy level.

With more people now cared for at home at the end of their lives than in previous decades, there is a significant focus on the registered nurse's central role in enabling excellent end-of-life care. There is just one chance to get this care right for the individual and for their loved ones too, and we know that the registered nurse has the knowledge, skills and expertise to manage this care, coordinating with multiple other agencies in the community, to ensure a seamless service.

Embracing new technology to improve the care of people in the community is now an indispensable part of the registered nurse's role. Maximising the use of technology to enhance and not compromise or diminish care will be a balance to be addressed in future years, recognising that technology has enormous potential for supporting new ways of working and improving efficiencies but that nursing is also a profession where human connections and contact are a critical element of expert care.

The authors of this excellent collection of chapters provide a magnificent range of relevant nursing subjects, each one of them central to the registered nurse's role in supporting people throughout the life course in the communities they serve.

I consider it essential reading for student nurses who wish to extend their knowledge and explore the exciting careers available in the community and for those registered nurses who are embarking on a new career in the community or a new leadership role in one of the many community nursing services.

The book provides an excellent and comprehensive understanding of current nursing policy, practice, education and research for all nurses delivering care in the community – an environment where the majority of clinical care continues to be delivered by hundreds of thousands of committed, expert nurses.

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ACKNOWLEDGEMENTS

Kate, an 'original' Queen's Nurse – for being truly inspirational.

Vicki Farmilo, Academic Liaison Librarian Health and Social Care, Oxford Brookes University Library, for her invaluable support with literature searching.

Anne Taylor, Director of Nursing, Parish Nursing Ministries UK, for her contribution regarding the role of the Parish Nurse in the Community.

Muriel Reid and Julie Churchill for contributions to the leadership chapter.

Helen McVeigh for her contribution to the lifespan chapter.

National Institute for Health and Care Research (NIHR) for their investment in nursing research opportunities to build capacity and capability of nurses.

Sophie Hyndman, RDS Oxford

Dawn Smith, Learning Disability Nurse and Karin West for case examples.

Nicola Verstaelen, Senior Research Programme Manager ICB, for case example.

Dr Philippa Olive, NIHR70@70 nurse co-leader, for case example.

Ann Sullivan, Consultant Physician, and Sophie Strachan, CEO, Sophia Forum for case examples.

Natalie Ryan, Clinical Lead, The Complex Care at Home Team, based in Cardiff, Wales, for kindly sharing her story regarding the Complex Care at Home Team.

Emerita Professor Judith Carrier, School of Healthcare Sciences, Cardiff University, Wales, for sharing her expertise and practice nurse perspective in the care and management of people with long-term-conditions.

Dr Mandy Brimble, Senior Lecturer, Children and Young People's Nursing, School of Healthcare Sciences, Cardiff University, Wales, for providing knowledge and insight into the specialist area of caring for children and young people living with long-term-conditions and their families, and the challenges faced in the transition from child to adult care services.

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Introduction

Sue Chilton and Heather Bain

This book has been designed to support staff who may be new to working in a community setting and is an essential guide to practice. We envisage that it will be useful for pre-registration students on community placement, community staff nurses and nurses moving to take up a community post. Students in post-registration health and social care courses may also find the book of value. The aim of the book is to develop and support nurses to work safely and effectively in a range of community locations.

Community nurses work in a great diversity of roles and a variety of settings – including schools, the workplace, health clinics, prisons and the home (NMC, 2022a, 2022b). They empower individuals, families and communities to have control over their health and improve their wellbeing. They also work across the lifespan, and with a range of social groups that include those who are vulnerable, experience inequalities and are socially excluded. Not only do community nurses work autonomously in leading, managing and providing acute and long-term health, social care, anticipatory care and palliative care, but they also have a public health remit. They have a pivotal role in health protection, ill-health prevention and health improvement.

A range of topics relating to professional issues in community nursing is addressed within the book. The text reflects recent and current government health and social care policy reforms and the effect of these on the roles and responsibilities of community nurses. It is acknowledged that the devolution of political power to the four countries within the United Kingdom has influenced health policies. There is now a much greater degree of freedom in relation to the health policies they produce. All recognise the shifting balance of care from the acute sector to the community, with an increasing focus on the management of long-term conditions to reduce hospital admissions. There are, however, various political stances providing differing opinions on how to develop health services that take the demographics of each of the four countries into consideration (Anandaciva, 2023).

Community nursing is seen in the context of not only political but also social and environmental influences. The authors take an inclusive approach, working from a health and social care perspective to meet the needs of people,

DOI: 10.4324/9781003347545-1

families and communities. Interpersonal and practical skills, as well as the knowledge base required by community nurses, are critically analysed and linked to relevant theory. The use of activities, examples and case studies/scenarios relating to the range of community nursing disciplines are included throughout the book to stimulate the reader's creative thinking. The themes running through the text are community nursing across the lifespan, evidence-based practice, reflection, inclusivity and diversity and current government policy drivers across the four UK countries. Each chapter has been written by a contributor or contributors with in-depth knowledge and experience of the specific subject area, resulting in a range of writing styles.

Topics covered within this text inform key aspects of the community nurse's role. A brief summary of each chapter follows:

Chapter 1 – 'Nursing in the community' – Explores definitions of 'community' and acknowledges its complex nature. A range of factors influencing the delivery of community healthcare services and the expertise required of community nurses are discussed.

Chapter 2 – 'Using research to inform evidence-based care' – Considers research and evidence in the context of community nursing. The range and diversity of community roles in supporting delivery and leading research are examined alongside the importance of public involvement.

Chapter 3 – 'Public health and the promotion of wellbeing' – Analyses the role of public health and wellbeing and considers the influencing factors for individuals and families across the lifespan. Assessment of needs and strategies used to improve health and wellbeing are appraised.

Chapter 4 – 'Professional approaches to care' – Discusses the concept of 'professionalism', professional standards, regulatory requirements and policies underpinning community nursing. The importance of lifelong learning and professional development for community nurses are explored.

Chapter 5 – 'Risk identification, mitigation and management' – Explores potential risks encountered by community nurses and recommends ways to mitigate risks. Risk is considered from the personal perspective of the community nurses and from a service user perspective.

Chapter 6 – 'Safeguarding' – Introduces the concept of safeguarding across the lifespan in the context of community nursing practice. Frameworks and tools that contribute to decision-making are examined.

Chapter 7 – 'Therapeutic relationships across the lifespan' – Provides a critical understanding of therapeutic relationships in the context of community nursing. Multiple perspectives with people as partners are considered.

Chapter 8 – 'The lifespan approach' – Considers how an understanding of the lifespan can enhance the quality-of-care provision by exploring different theories of growth and development.

Chapter 9 – 'Community nursing assessment' – Explores assessment frameworks which contribute to the nursing process. The concept of need and

the importance of communication within the assessment process are discussed.

Chapter 10 – 'The role of the community nurse in mental health' – Explores the relationship between physical and mental health. The roles of the community nurse in mental health assessment and associated interventions are examined.

Chapter 11 – 'Informal carers: the unpaid workforce' – Defines the term *carer* across the lifespan and discusses emotional, physical, financial and practical needs and associated risks of being a carer.

Chapter 12 – 'Spirituality: its place in a holistic approach to care' – Discusses the concept of spirituality and spiritual care within nursing. The importance of developing self-awareness and using appropriate tools to assess and address a person's spiritual needs are highlighted.

Chapter 13 – 'Collaborative working' – The political drivers that influence collaborative working within community nursing are explored. Examines the success of collaborative working both at micro and meso levels.

Chapter 14 – 'Approaches to acute care' – Defines acute care in the community setting and identifies the knowledge, skills and assessment strategies required by community nurses to manage it.

Chapter 15 – 'Emerging issues in long-term conditions' – Explores the impact of long-term conditions on individuals, families and communities across the lifespan. Self-management, case management and behaviour change are discussed.

Chapter 16 – 'Providing quality end-of-life care' – Highlights the importance of a holistic and timely assessment in order to effectively manage end-of-life care needs. Related tools and frameworks are considered alongside the diversity of the population.

Chapter 17 – 'Organisation and management of care' – Critically analyses work organisation and care delivery in the community setting with particular reference to prioritisation, delegation and skill mix.

Chapter 18 – 'Leading person-centred practice' – Explores contemporary leadership models to support person-centred practice and cultures. Theories and frameworks to support person-centred practice are promoted.

Chapter 19 – 'Digital healthcare' – Explores the associated terminology of digital healthcare and appraises its potential use in community nursing practice.

Chapter 20 – 'Facing the future' – Evaluates diversity and complexity within community nursing across the UK. Advanced practice within community nursing is considered. Finally, sustainability and the impact of climate change are considered.

Within each chapter, further reading and resources are suggested. We hope you find this book informative and inspirational in developing your professional practice.

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CHAPTER 1

Nursing in the community

Sue Chilton

LEARNING OUTCOMES

- Compare and contrast definitions of '*community*', exploring the context in which the term is used within community nursing.
- Appraise the systems and processes in place across the UK designed to organise and deliver health and social care services in the community.
- Critically explore factors influencing the delivery of community health and social care services.
- Critically discuss the complex nature of the environment of community healthcare and the range of expertise required of community nurses.

INTRODUCTION

This chapter considers the complex environment within which community nurses practise and offers some definitions of *community* and ways in which the term is used. It explores the wide range of factors impacting the services community nurses provide for people, families and communities and discusses ways of tailoring care to respond to local needs. Key skills and qualities currently required by community nurses are identified and discussed.

CAPTURING THE 'ESSENCE' OF COMMUNITY NURSING

Although, from an academic perspective, the notion of 'community' has been discussed widely across a range of disciplines, including sociology and anthropology (Cohen, 1985), clarity regarding a definitive definition is elusive. Indeed, Bell and Newby (2021) refer to over 90 definitions of *community* and highlight the challenges that arise when forced to impose a minimum definition. Similarly, Chavis and Lee (2015) recognise the importance of historical research in the social sciences into what constitutes a human community and warn that insufficient understanding and definition has, unfortunately, led to the failure of many 'community' efforts. Clearly, the meaning of *community* requires more careful thought and reflection than it is often afforded.

DOI: 10.4324/9781003347545-2

ACTIVITY 1.1

Reflection

Compile a list of words and phrases that help to define or capture the meaning of *community* for you. Identify any recurring themes that emerge when considering different types of communities or different contexts within which the term is used.

Laverack (2016) offers four key characteristics of a 'community' which help to summarise many of the definitions found in the literature. These are as follows:

- Spatial dimension – referring to a place or location
- Interests, issues or identities that heterogeneous groups of people share
- Social interactions that are often powerful in nature and tie people into relationships or strong bonds with each other
- Shared needs and concerns that can be addressed by collective and collaborative actions

Although the meaning of *community* is complex, the word itself largely conveys a positive impression and a sense of togetherness, conjuring up feelings of harmony, solidarity and cooperation and is frequently used by politicians as a result (Lowe, 2021). Chavis and Lee (2015) highlight how, in the social sector, the word is frequently added to the descriptions of social innovations as a symbol of good intentions, such as 'community policing' and 'community-based philanthropy'.

The uncertainty regarding the true meaning of the word *community* also applies within community nursing. It is pivotal that the context within which care takes place, including physical and social aspects among many others, is considered alongside the geographical location of care. By attempting to include the wide array of elements involved, the true complexity of nursing within the community begins to emerge. Although some of the challenges, such as interacting with people, families and communities, are acknowledged in the literature (Quaile, 2016), the meaning of *community* within community nursing is often assumed and taken for granted.

It would appear, therefore, that definitions of community often include the dimensions of people, geography or space and shared elements, relationships or interests and incorporate some form of interaction. Many of these common themes are captured in the following definition of 'communities':

> groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities can be local, national or international with specific or broad interests.
>
> (*WHO, 2024*)

Chavis and Lee (2015) concur and stress the importance of recognising 'community' as a feeling and set of relationships among people who have an

individual and collective sense; they can influence their environments and each other. The authors believe that common needs lead to the formation of communities and that most people identify and participate in multiple communities, which are often nested within each other. Technology and transportation have created communities that were unimaginable years ago.

According to the World Health Organisation (WHO, 2024), 'community empowerment' is defined as the process of enabling communities to gain greater control over their lives and thrive (Meisnere et al., 2023). This concept has informed both theory and practice in health promotion for more than four decades (Melo & Alves, 2019) and 'addresses social, cultural, political and economic determinants that underpin health and seeks to build partnerships with other sectors in finding solutions' (WHO, 2024). Meisnere et al. (2023) explore the concept of 'community health', recognising that being a member of a community can create a sense of belonging and purpose and be a source of support for understanding and changing factors that influence health, such as the social and structural determinants of health or environmental factors.

An awareness of the networks that exist within a community helps in identifying opportunities or strategies to engage 'hidden' members of the population. *Social capital* is a term used to explain networks and shared norms that form an essential component of effective community development. It is proposed that poor health is linked to low social capital and social exclusion where poverty or discrimination exist (Wilkinson et al., 2023). Community development work is inclusive, empowering and collaborative in nature and is underpinned by the principles of equality and anti-discrimination, social justice, collective action, community empowerment and working and learning together. Based on his research, Lowe (2021) concludes that 'a community is a group of people who share an identity-forming narrative' and that the 'story' can be about a place, a religion or any other social practice. He asserts that community is an important concept for social change as it enables us to see that

> *social change requires a change in some of the most important stories we tell ourselves. Social change requires that we rewrite our communal narratives. Social change is change in community.*
>
> (*Lowe, 2021*)

With this in mind, Marshall and Easton (2018) discuss how the principles of asset-based approaches to community development are a powerful mechanism for change and can be applied in community nursing to improve the health and wellbeing of people with long-term conditions. Buck et al. (2021) describe an increasing recognition in health policy and practice of the role of communities in improving health and agree that this is an essential aspect of developing a population health approach and reducing health inequalities (Chapter 3).

COMMUNITY HEALTH AND SOCIAL CARE ACROSS THE UK: POLICY, SYSTEMS AND PROCESSES

The population aged 65 and over in the UK is projected to increase by almost a third in the next 20 years (Centre for Ageing Better [CAB], 2022). As life expectancy increases and the baby boomer generation reaches old age, more people are living with long-term conditions or comorbidities (Chapter 15) – often referred to as 'major illness' – which has significant implications for the NHS, Social Care and other public services (The Health Foundation [THF], 2023). The number of people living with major illness is projected to increase by 37% by 2040, which is nine times the rate of increase in the working-age population (20–69 years), which is projected to grow by 4%. As a result, pressure on the health and social care services across the UK will increase markedly as will expectations on 'informal carers' (THF, 2023). By 2050, the over-60s and under-18s will be the same in number, and this population change is remodelling societies. According to Harper (2023), every government department must take ageing seriously. In future, older adults will have higher levels of human capital – education, skills and abilities – and old age, as defined by retirement and dependency, will happen at far older ages than at present. Harper (2023) believes that these are all issues that policy can address given the political and economic will.

For people with a long-term condition (LTC), there is strong evidence that self-care leads to improved health and wellbeing outcomes (WHO, 2023). Yet 45% of people with an LTC are not confident self-managers and tend to make more use of both elective and urgent services. In addition, the demand for health empowerment is increasing, resulting from a recognition of the value of renewable assets that individuals and communities can offer (Sanderson & White, 2018). In efforts to prevent and prioritise both premature morbidity and mortality, a longer term strategy for both investment and outcomes is required. Supporting self-care approaches and informed choices will enable people to feel more in control of their lives and potentially result in less use of elective and urgent care services (Barker et al., 2017; Deeny et al., 2018).

There is no simple solution to reduce the growth in the number of people living with a major illness. However, there is a growing recognition across the four nations of the UK that a long-term plan is needed to reform, modernise and invest in the NHS alongside an expressed commitment to invest in the UK's health and wellbeing, which needs to include a clear strategy for developing social care alongside healthcare. Common LTCs are currently predominantly managed in primary care, reinforcing the need to invest in general practice and community-based services.

According to the Office for National Statistics (ONS, 2024a), the UK population is projected to rise to 73.7 million by mid-2036 and to 76.6 million by mid-2046 (Figure 1.1).

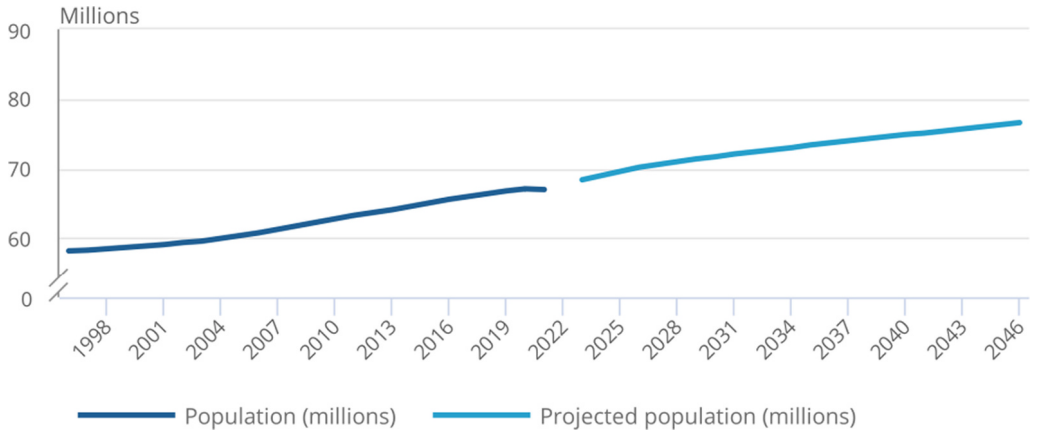


Figure 1.1 UK population estimates, mid-1996 to mid-2021 and projections to mid-2046. (ONS, 2024a).

In relation to the 15 years between mid-2021 and mid-2036, the total projected growth for the UK population is 6.6 million (9.9%). During this period, the projections for the UK as a whole suggest that 10.8 million people will be born, 10.3 million people will die, 13.7 million people will immigrate long term to the UK and 7.6 million people will emigrate long term from the UK. Of the projected 6.6 million increase in the total population, 0.5 million (8.2% of the total projected increase) is projected to result from a higher number of births than deaths, and 6.1 million (91.8% of the total projected increase) is projected to result from net international migration (ONS, 2024a). Clearly, such projections have implications for the work of a wide variety of community nurses who work across the lifespan (Chapter 8).

ENGLAND

By 2040, over 9.1 million people – around 1 in 5 of the adult population in England – are projected to be living with major illness, which is an increase of 2.5 million in 2040 compared with 2019 (The Health Foundation, 2023). According to the Centre for Ageing Better (CAB, 2022) and the 2021 Census (ONS, 2024b), there are 10.4 million people aged 65 and over in England, a 52% increase since the 1981 census.

In recognition of these projections, Prof Chris Whitty, the Chief Medical Officer, has described an 'Ageing Crisis' in his annual report (Whitty, 2023), highlighting poor health in later years, particularly in rural and coastal areas with poor healthcare provision and the fact that, in deprived regions, age-related issues emerge ten years earlier (The Health Foundation, 2018). In response, he offers six recommendations related to systematic planning by the state: taking responsibility for environmental factors, secondary prevention and treatment of risk factors, an onus on the medical profession to maintain generalist skills, to manage multimorbidity effectively, systematic collection

and sharing of data on older people's health, and research that is genuinely inclusive of older people and their health needs.

In 2019, NHSE published the *Long Term Plan* (NHSE, 2019) and pledged to improve care for individuals over the next ten years by making sure everyone gets the best start in life, delivering world-class care for major health problems and supporting people to age well. The plan commits to ambitious targets which are to be achieved by doing things differently, preventing illness and tackling health inequalities, supporting the workforce, making better use of data and digital technology (Chapter 19) and getting the most out of taxpayers' investment in the NHS. Key aspects of the plan include a shift to integrated care and place-based systems with increasing focus on population health and communities, emphasising the importance of asset-based models, social relationships, volunteering and social movements for health (King's Fund, 2024a).

The Health and Care Act (UK Parliament, 2022) built on both the NHS Long Term Plan (NHSE, 2019) and the DHSC's legislative proposals in the white paper entitled *Integration and Innovation: Working Together to Improve Health and Social Care for All* (DHSC, 2021a).

There are 42 Integrated Care Systems (ICSs) in England across seven regions and the integration of health and care systems aims to improve health outcomes, population health and reduce health inequalities. By working in partnership (ICPs), the ICS brings together health, social care and public health, as well as other bodies as appropriate, such as Local Authorities, to address the wider health and care needs of the ICS collaboratively (Figure 1.2). Within each ICS, the associated Integrated Care Board (ICB) is responsible for developments to meet the health needs of their population, creating a capital plan for NHS providers within their geography and securing the provision of health services to meet the needs of the system's population. In September 2021, *Build Back Better: Our Plan for Health and Social Care* (DHSC, 2021a, 2021b, 2021c) was published by the Prime Minister announcing additional funding to support the government's intentions for healthcare and adult social care.

People at the Heart of Care: Adult Social Care Reform (DHSC, 2021c) sets out a ten-year vision for adult social care and describes how previously announced funding will be used to reform adult social care, including developing the workforce, supporting digital transformation and improving integration with housing. The ten-year vision builds on the principles of personalised care to drive user-led social care and give people choice, control and independence (HFMA, 2024). In addition, a 'renewed' NHS prevention programme will focus on maximising the role of the NHS in influencing behaviour change, guided by the top five risk factors identified by the global burden of disease study: smoking, poor diet, high blood pressure, obesity and alcohol and drug use (NHSE, 2024).

In England, the current government has pledged to increase staff in the NHS with the NHS Long Term Workforce Plan (NHSE, 2023). It sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period and working in new ways

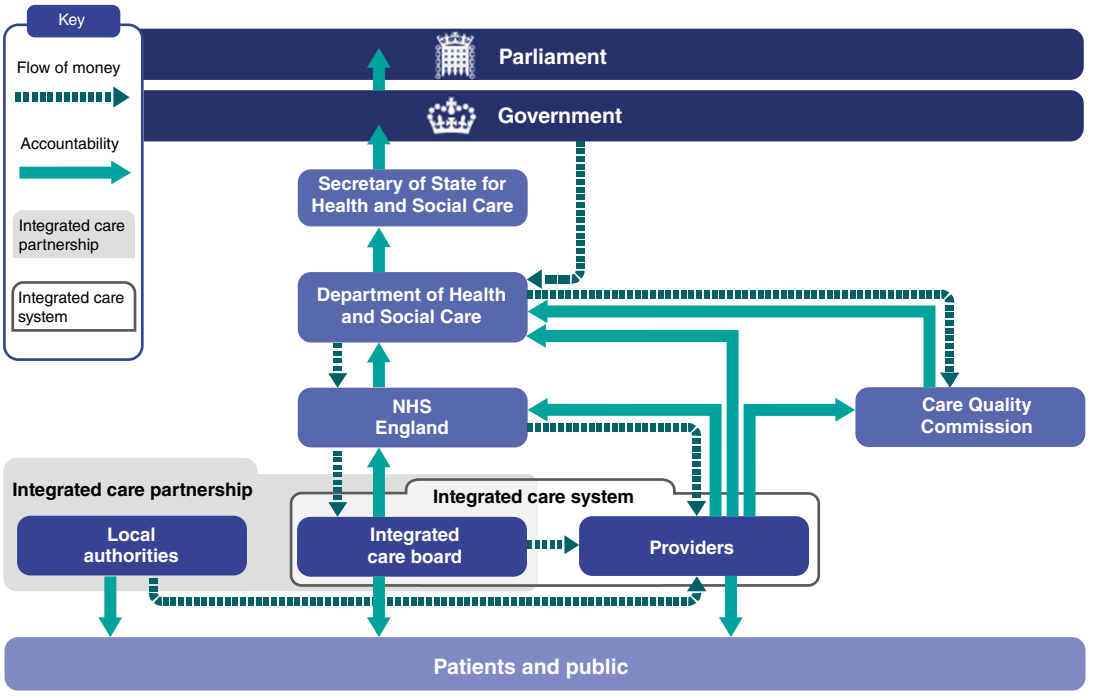


Figure 1.2 The Structure of the Health System in England.
(HFMA, 2024).

to improve staff experience and patient care. Commissioned and accepted by the government, it provides a costed plan for how the NHS will develop to meet existing and future demand and challenges and support population health and wellbeing. More than £2.4 billion has been committed to fund additional education and training places over the next 5 years on top of existing funding commitments. To enable moving more care out of hospital and invest in primary, community and mental healthcare, the plan will deliver a material impact on the size and proportion of NHS staff working in community settings. Key areas of activity focus on 'training, retaining and reforming' the workforce.

WALES

A Healthier Wales (Welsh Government, 2018) sets out a long-term future vision of a 'whole system approach to health and social care' in Wales, which is focused on health and wellbeing and on preventing illness. It focuses on preventing illness, supporting people to manage their own health and wellbeing and enabling people to live independently for as long as they can, supported by new technologies and integrated health and social care services which are delivered closer to home. 'New models of seamless local health and social care' at the local and national levels build on a foundation of local innovation including through Clusters of primary and community care providers. Regional Partnership Boards bring together Local Authorities, Health Boards and Third-Sector providers and

occupy a strong oversight and coordinating role. Regional partnership working is at the heart of developing high value models of integrated health and social care, which will be promoted for wider adoption across Wales. The Health and Social Services Group (HSSG) is the Welsh government department responsible for the NHS and social care in Wales. NHS Wales delivers services through seven Local Health Boards (LHBs) and three NHS Trusts and two special health authorities, which include Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW). The Health Boards are responsible for planning and providing NHS services, improving physical and mental health outcomes, promoting wellbeing, reducing health inequalities across their population and commissioning services. NHS Trusts manage Public Health and ambulance services as well as cancer and blood services. Other agencies include the Healthcare Inspectorate Wales (HIW) and the Care Inspectorate Wales (CIW). Public Service Boards are partnerships across public service agencies working together to improve local services, and the Citizen Voice Body (CVB) came into being in April 2023 and replaced the previous seven community health councils (Figure 1.3).

Although this is not a new vision, it is now supported by clear aims to establish new models of care in every part of Wales and provide services that are

Structure of the NHS in Wales

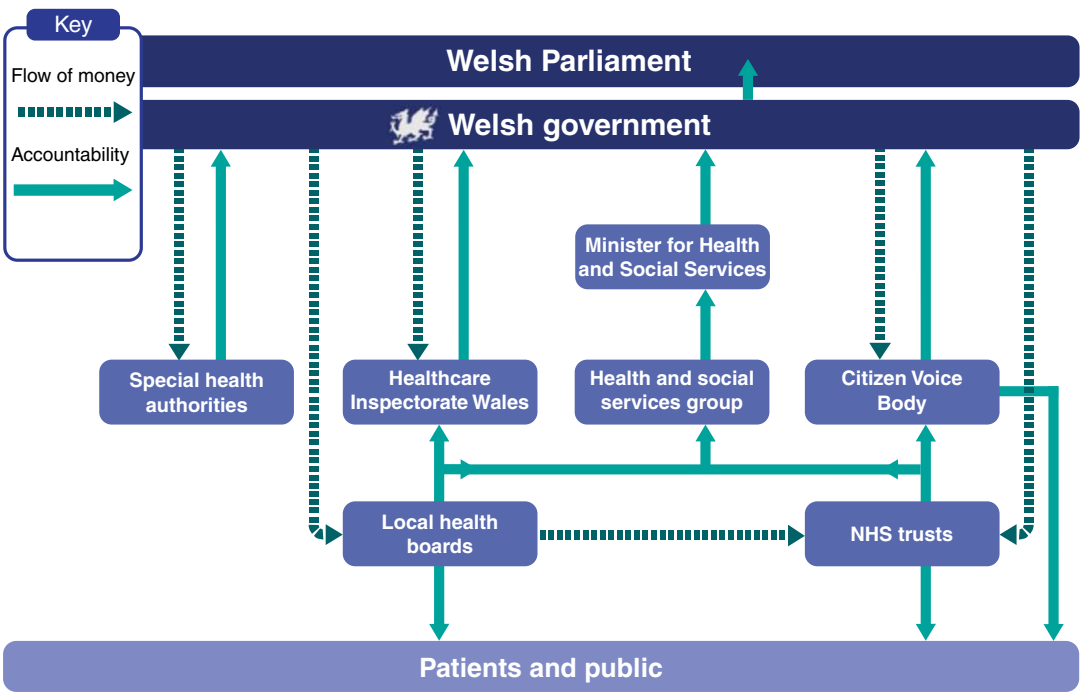


Figure 1.3 The Structure of the Health System in Wales.
(HFMA, 2024).

designed and delivered around the needs and preferences of individuals, with greater emphasis on sustaining a healthy population and preventing ill health. It proposes to ensure that the right level of care is provided at the right time, from the right source and in the right setting.

The Primary Care Model for Wales (PCMW) is a model for primary and community care developed as a whole-system approach to sustainable and accessible local health and wellbeing care. Focusing on place-based care, care closer to home and multi-professional working, it describes how care will be delivered locally, now and in the future, as part of a whole-system approach to deliver *A Healthier Wales*. Clusters are at the heart of this model and, given the key principles that underpin *A Healthier Wales* can be described as

> [a] cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities.
>
> (*Welsh Government, 2023*)

The 60 clusters in Wales are multi-professional, with representation from health, social care and third-sector professionals, who are working together to identify the assets, needs and priorities of the communities that they serve. Designing and delivering services that are seamless, focused on prevention and meeting the needs of the local community.

The Strategic Programme for Primary Care is the all-Wales primary care response and contribution to *A Healthier Wales* (Forde & Morgan, 2019–2020). Key to the success of the programme is support, engagement and collaborative working across all independent contractors, clusters, health boards and wider stakeholders. The programme features six key work streams, all designed to develop and deliver an increased pace and scale of previous work and address new, emerging priorities. The six work streams are Prevention & Wellbeing, 24/7 Model, Data & Digital Technology, Workforce & Organisational Development, Communications & Engagement and Transformation & Vision for Clusters.

A Healthier Wales: Our Workforce Strategy for Health and Social Care (HEIW and Social Care Wales, 2022), sets out the ambition to have a motivated, engaged and valued health and social care workforce with the capacity, competence and confidence to meet the needs of the people of Wales. The ten-year strategy was launched in 2020 by HEIW and Social Care Wales with substantial input from all partners. It includes 32 actions across seven themes with a focus on wellbeing, inclusion and the Welsh language.

SCOTLAND

The *Health and Social Care Delivery Plan* (Scottish Government, 2016) focuses on prevention, early intervention and support of self-management to achieve the 'triple aim' of better care, better health and better value. By further

enhancing health and social care services, the plan aspires to enable the people of Scotland to live longer, healthier lives at home or in a homely setting by providing integrated, person-centred, high-quality care. The vision is to build capacity in primary and community care, support the development of new models of care and avoid hospital admission and promoting early discharge wherever possible.

Within Scotland, the Health and Social Care Group (HSCG) consists of a number of government directorates, which support the development and management of health and social care services by NHS Scotland. The chief executive of NHS Scotland, who also acts as the Director-General of the HSCG, has a responsibility for providing strategic direction to the NHS in Scotland. There are 14 territorial NHS boards across Scotland with overall responsibility for the health of their populations. They are responsible for planning and commissioning of services, and also for the delivery of frontline NHS services to their populations. This involves planning and commissioning community and hospital health services including services provided by GPs, dentists, community pharmacists and opticians. Having overall responsibility for population health requires that NHS boards will work closely with relevant agencies, for example Public Health Scotland, in discharging this duty. Special NHS national NHS boards provide services across the whole of Scotland and include Public Health Scotland, NHS Education for Scotland; NHS National Waiting Times Centre; NHS 24, which provides health advice and information; the Scottish Ambulance Service and the State Hospitals Board for Scotland, which has responsibility for secure settings for those with mental health disorders who are unable to be cared for in any other setting. In addition, there are two departmental public bodies, which are Healthcare Improvement Scotland and NHS National Services Scotland (NSS) – which supplies essential services including health protection, blood transfusion and information technology. The Care Inspectorate regulates and inspects care services in Scotland to ensure that they meet the necessary standards. Community planning partnerships (CPPs) help public agencies to work together with the community to design and deliver better services to make a real difference to people's lives. There are 32 CPPs across Scotland, one for each council area. Each CPP focuses on where partners' collective efforts and resources can add the most value to their local communities, with particular emphasis on reducing inequality. The CPPs work alongside the 31 Health and Social Care Integration Partnerships – Integration Authorities (IAs) – and the 14 Health Boards that cover Scotland (Figure 1.4). The IAs have responsibility to ensure health and social care services are planned, managed and delivered in an integrated way (HFMA, 2024).

The *Health and Social Care: National Workforce Strategy* (Scottish Government, 2022) describes the future vision for the health and social care workforce, which focuses on recovery, growth and transformation. The strategy sets out a national framework to create a sustainable, skilled workforce with attractive career choices where all are respected and valued for the role they play in delivering a resilient,

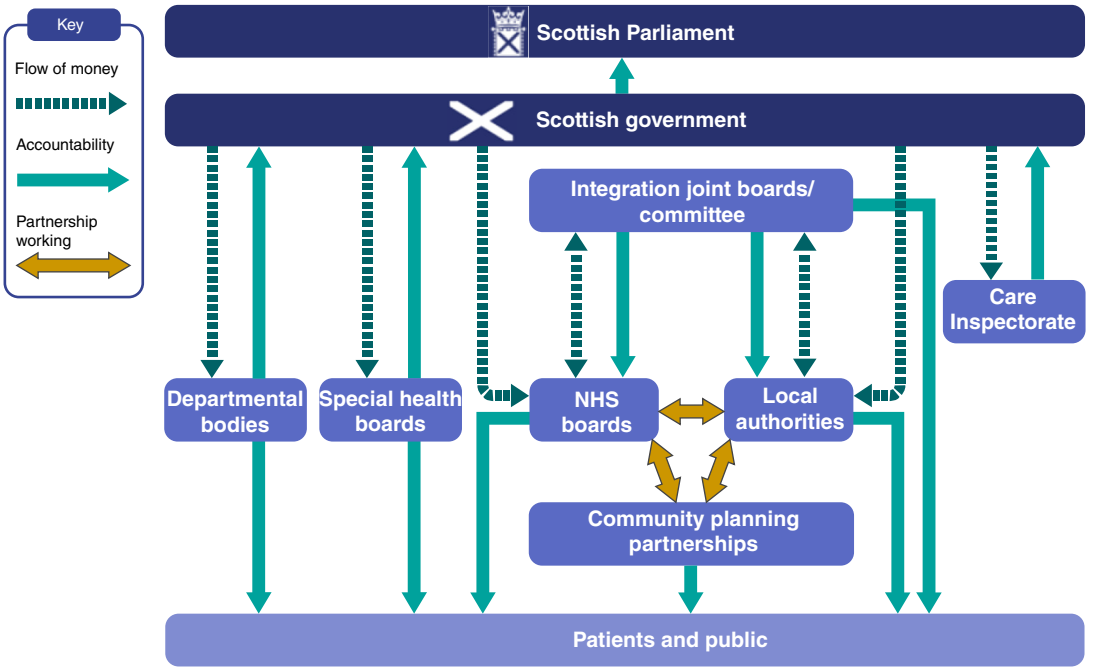


Figure 1.4 The Structure of the Health System in Scotland.
(HFMA, 2024).

efficient and high-quality healthcare service. The aim is to create a committed, well-supported workforce with the right skills and flexibility with a clear recognition of the need for a supportive and inclusive workplace culture to achieve this aim.

NORTHERN IRELAND

Health and Wellbeing 2026 – Delivering Together (Department of Health – NI, 2016) is a ten-year strategy for transforming health and social care in Northern Ireland. The ambition is for everyone to lead long, healthy and active lives with a focus on improving health, enhancing the quality and experience of care, supporting and empowering staff and ensuring sustainability of services. In 2021, the Health and Social Care Bill was introduced to address identified weaknesses in the system, particularly around complex and bureaucratic structures and provide greater clarity and transparency on accountability and decision-making. The bill became law in 2022 (Health and Social Care Act [Northern Ireland], 2022).

The Strategic Planning and Performance Group (SPPG) was established under the 2022 Act and replaced the Health and Social Care Board (HSCB). The SPPG has the responsibility for planning, improving and overseeing the delivery of effective, high-quality, safe health and social care services within available resources. Other healthcare agencies include the Public Health

Agency, the Regulation and Quality Improvement Authority, Patient and Client Council and Business Services Organisation. There are currently five local commissioning groups (LCGs), each of which is a subcommittee of the SPPG and is co-terminus with its respective Health and Social Care (HSC) Trust area. The five HSC trusts provide the full range of local hospital-based, mental health and community services. Regional and specialist services may also be provided by individual trusts. As integrated organisations, trusts also provide social care services including nursing home and domiciliary care, learning disability and children's community services (Figure 1.5).

The new ICS framework (DoH [Northern Ireland], 2024) aims to further enhance local and community partnership working, and LCGs are being replaced by area integrated partnership boards (AIPBs). Their key responsibilities cover the strategic planning for their areas, ensuring that local services meet local population needs and determining if there is a better way to deliver improved outcomes. It is expected that local-level structures will be based around existing GP federations and integrated care partnership areas and will align and integrate with local council structures (CPPs) and boundaries (HFMA, 2024).

The future model of primary care is based on multidisciplinary teams located around general practice. The teams will work collaboratively to keep

Structure of the HSC

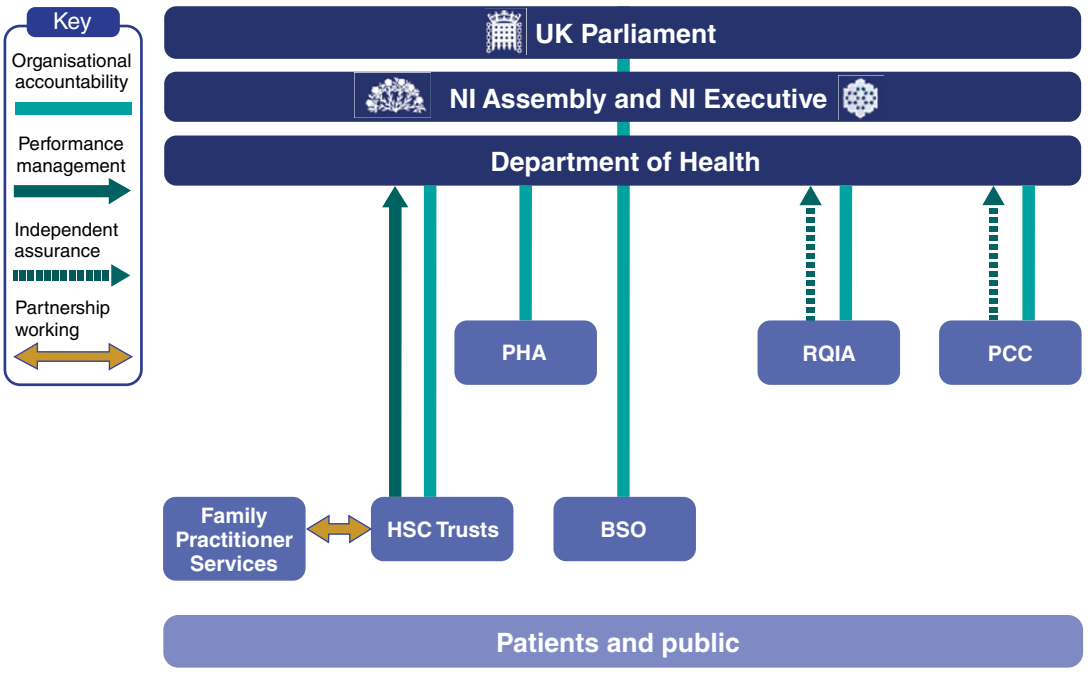


Figure 1.5 The Structure of the Health System in Northern Ireland. (HFMA, 2024).

people well by supporting self-management and independence and providing proactive management of high-risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high-quality support, treatment and care throughout life. A new model of person-centred care focused on prevention, early intervention, supporting independence and well-being is proposed. This will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care (DoH (Northern Ireland), 2023).

In 2018, the DoH (Northern Ireland) published the *Health and Social Care Workforce Strategy 2026: Delivering for Our People*, which sets out ambitious goals to further develop the workforce to meet the requirements of a transformed health and social care system. The strategy addresses the need to tackle significant challenges with supply, recruitment and retention of staff. The focus of the proposals is the vision of health and social care being a rewarding and fulfilling place to work for everyone with the best possible staffing levels and professional development opportunities to cultivate expertise.

This workforce strategy, which was updated in 2022, recognises the need for more investment in people and effective workforce engagement and planning. Skills development, career pathways, increased numbers of trainees, the development of new roles, investment in the wellbeing of the workforce and empowering and supporting the workforce to do what they do best were all identified as key elements.

ACTIVITY 1.2

Research and reflection

Access the health and social care policies relevant to your particular country and consider ways in which the national strategy is being implemented at a local level.

Legislation and health and social care policy form just one part of the proposed future vision across the four nations of the UK, and for successful implementation, much relies on having a competent, skilled and professional workforce (see Chapter 4), effective leadership and funding (HFMA, 2024).

Recent government proposals across the UK have not gone without comment as some of the more recent critiques reveal. Despite repeated government pledges to reduce health inequalities over recent decades, Marmot et al. (2020) reveal a reduction in life expectancy improvement, deteriorations in physical and mental health and widening health inequalities and state that the 'Social Gradient' is getting steeper. Marmot states that "this damage to the nation's health need have not happened. It is shocking… . Something has gone badly wrong" (Marmot et al., 2020:5) and reiterates his evidence-based recommendations. Buck et al. (2021) suggest that ICSs need to seriously consider the role

communities can play in improving and sustaining good health and should focus their attention on the place and neighbourhood level where the link to communities is strongest. In England, the recent merger of Health Education England, NHS Digital and NHS England into a single organisation provides an opportunity to tackle the current challenges of meeting the evolving needs of patients and the public resulting from an ageing and growing population. However, Hill (2023) recognises that there are also concerns that the merger could lead to increased centralisation and loss of authority for the digital organisation with the potential to impact patient privacy and confidentiality of data. In their research, *Making Care Closer to Home a Reality*, the King's Fund (2024b) found that the long-proposed vision of shifting the focus away from hospital care to primary and community services is far from being achieved. They recommend that there needs to be a 'wholesale shift' in focus towards primary and community health and care across the domains of leadership, culture and implementation, allowing every sector to deliver the care it has the expertise to provide.

FACTORS INFLUENCING THE DELIVERY OF COMMUNITY HEALTHCARE SERVICES

Community nurses face many opportunities as well as challenges within their evolving roles. The transition from working in an institutional setting to working in the community can be an enlightening experience. As a student on community placement or a newly employed staff nurse, it soon becomes apparent that there is a wide range of factors influencing the planning and delivery of community healthcare services. Such factors may include political, professional, economic, social, technological, legal and ethical as well as environmental influences, for example. Within the home/community context, the issues that impact an individual's health are often more apparent. People are encountered in their natural habitats rather than being isolated within the hospital setting. Assessment is more complex in the community, as the nurse must consider the interconnections between the various elements of a person's lifestyle to enable them to address the person's health and social care needs effectively. Chapter 9 explores the concept of assessment in more detail. In addition, community nurses often work independently, making complex clinical decisions without the immediate support of the wider multidisciplinary team or access to a range of equipment and resources as would be the case in a hospital or other institutional healthcare environment. It is recognised, for example, that community nurses are frequently challenged with managing very complex care situations which require advanced clinical skills, sophisticated decision-making and expert care planning (Quaile, 2016).

Defining health is complex as it involves multiple factors, which are considered in detail in Chapter 3. The concept of health has many dimensions such as physical, mental, emotional, social, spiritual and societal and all aspects of

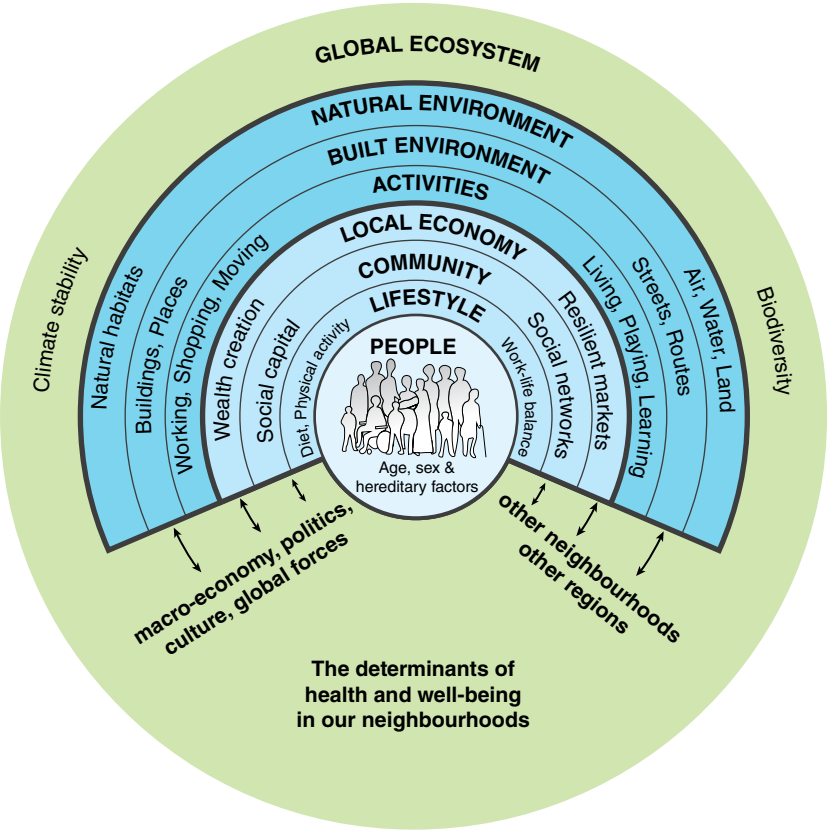


Figure 1.6 The Health Map: the determinants of health and wellbeing in our neighbourhoods.

(Barton & Grant, 2006).

health are interdependent in a holistic approach. As a result, it is prudent to view individuals within their wider context when considering issues relating to their health and wellbeing to ensure that these relevant social determinants are taken into account (Figure 1.6).

The Health Map (Grant, 2023) is a reminder of the need to always keep the wider context in mind in terms of our assessment of need and related responses. As many of the causes of ill health are contextual and wider, then so are some of the solutions. In fact, overall, the NHS has a relatively small part to play in the overall scheme of things. It is important to be imaginative in terms of the potential community and social resources available to help tackle health inequalities (Chapter 3). There are acknowledged inequalities in health status between different people within society and major determinants include social class, culture, occupation, income, gender and geographical location. Bambra (2016), a leading expert in public health, draws on case studies from across the world to examine the social, environmental, economic and political causes of health inequalities, how they have evolved over time and what they are like today.

Health inequalities were highlighted and 'put on the map' in the Black report of 1980 (DHSS, 1980) and relate to the difference between groups or populations defined socially and demographically that are unfair, avoidable and remedial rather than innate differences between groups (Watson et al., 2023). Several reports have been published since the 1980s, providing comprehensive reviews of the literature and research available on inequalities in health (DHSS, 1980; Acheson Report, 1998; Marmot, 2010, 2020). Although these documents have sought to inform the national public health agenda of the day, the reality is that unacceptable inequalities remain. Across the four nations of the UK, Public Health departments continue to identify targets to improve the health of their populations (NHSE, 2019; Public Health Wales, 2023; Public Health Scotland, 2022; DoH-NI, 2016).

Health inequalities are not random but related to the 'social gradient' in health: geographical locations with high levels of income deprivation typically have lower life expectancy. This relationship is referred to as the 'Marmot Curve' in the independent and influential report in England, *Fair Society, Healthy Lives* (*Marmot Review*, 2010). The main recommendations of this report were to give every child the best start in life; enable all children, young people and adults to maximise their capabilities and have control over their lives; create fair employment and good work for all; ensure a healthy standard of living for all; create and develop healthy and sustainable places and communities; and strengthen the role and impact of ill-health prevention. The *Marmot Review* (2010) stated that people living in more disadvantaged communities die 7 years earlier on average than people living in more prosperous communities. Those in the poorest neighbourhoods will also experience more of their lives with a disability – an average difference of 17 years. Disadvantaged children in Britain continue to experience poorer health outcomes than their wealthier counterparts, including increased levels of obesity and mental health conditions, and, according to child health experts, their future health and happiness are in jeopardy as a result (Royal College of Paediatrics and Child Health, 2017). The Children's Charities Coalition (2023) reports increased levels of unhappiness amongst children and the NSPCC reports that some 11-year-olds are very unhappy and have suicidal thoughts. Stress and its serious physiological impact on health are well documented in the literature (Wilkinson & Pickett, 2018). In addition, research studies of health and happiness have demonstrated that these concepts are influenced by the quality of social relationships (Wilkinson et al., 2023).

Regrettably, in his report, *Health Equity in England: The Marmot Review 10 Years On (*2020), Marmot reported a distinct lack of progress in all those areas identified in his previous recommendations and highlighted a lack of political will to do the right thing.

It is increasingly recognised, however, that nurses are at the forefront of health promotion and are well placed due to the therapeutic relationships they

form with patients, not to mention their listening skills and their emotional intelligence. As Sir Michael Marmot (Rosa et al., 2021) states:

> Nurses are in a position to devote their efforts and use the considerable trust they enjoy from society at large to work for a fairer society. Here are the steps needed to create health equity.

Marmot and colleagues offer six key recommendations to support nurses in creating health equity, which include education and training of nurses regarding the social determinants of health; measuring the problem by engaging in research and seeking evidence; seeing the patient in a broader perspective, reflecting population health needs; optimising employment conditions within the health sector; working in partnership; and the use of advocacy (Rosa et al., 2021).

Buck et al. (2021) support a more nuanced and integrated policy response and state that, although there is some evidence of integration of services, an approach to health inequalities delivered through population health systems, which clearly integrate NHS services with other public health services and public health initiatives, is required. Most importantly, they stress the central role communities must play in the future development of health policy and practice, which needs to reflect local knowledge, history and experience if it is to be realistic and effective (Buck et al., 2021). Population Health Management is a concept that is acquiring growing momentum in both health and social care policy and practice across the UK (Holmes, 2022). Chapter 3 explores key concepts relating to public health and health inequalities in greater detail.

Economic challenges clearly have consequences for health inequalities. In May 2019, the Institute for Fiscal Studies (supported by the Nuffield Foundation) embarked on a 5-year study (costing £2.5m), into inequalities in pay, health and opportunities, led by economist Sir Angus Deaton. World-leading experts from a variety of disciplines, including sociology; demography; epidemiology; political science; philosophy & economics, have been involved in the research.

The increased emphasis lately on the development of a primary care-led

ACTIVITY 1.3

Access the website for the Institute for Fiscal Studies Review – https://ifs.org.uk/inequality/ and explore the wide range of resources, which forms the core evidence base of the review, providing opportunities for engagement with government, researchers, the media and the public.

Identify at least one piece of evidence that will inform your future practice.

NHS has come about in response to demographic, technological, political and financial influences, among others. An increasing population of older people, shorter hospital stays, improvements in technology and patient preference have all contributed to the advocated movement of resources from hospital-based care to the primary care sector. The development of the required expertise,

which includes the knowledge, skills and attributes of all community nurses, to provide services away from hospital settings means that an increasing number of people with both acute (see Chapter 14) and long-term conditions (see Chapter 15) will eventually receive care at home or in a range of other locations within the community. It is envisaged that hospitals will mainly provide diagnostic and specialist services in the future (NHS England, 2019). If the aims of current policy directives are to be realised, plans to address the 'triple fragmentation' – between health and social care, primary and secondary care and physical and mental health services – as described by Stevens (2016) will need to be a priority (King's Fund, 2024a).

COMMUNITY NURSING: DEVELOPING THE REQUIRED EXPERTISE TO MEET THE NEEDS OF PEOPLE, FAMILIES AND COMMUNITIES

Government policies relating to the structures and systems that underpin the provision of health and social care across the UK (NHSE, 2019; Welsh Government, 2018; Scottish Government, 2016; Department of Health-NI, 2016) and shifting patient demographics have led to a recognition by community nurses that their roles and responsibilities are constantly evolving in response to the ever-changing healthcare needs of the populations they serve. In response, nurse leaders across the UK have published strategies for developing the community nursing workforce, which are detailed below. Leadership (see Chapter 18), practice development and partnership working (see Chapter 13) are identified as key elements within the roles of all community nurses.

ENGLAND

Community nurses form a pivotal part of the NHS workforce and the success of the NHS Long Term Plan (NHSE, 2019) depends on a wide variety of community nurses delivering care throughout England. Supported by NHSE, the national *Community Nursing Engagement Plan* 2021–2026 (Clennell, 2022) which focuses on three themes with seven action areas, supports programmes of work to ensure community nursing offers attractive fulfilling and flexible careers; enables community nurses to work collaboratively to improve patient outcomes and experience and ensures community nursing gets the full profile and recognition it deserves. The plan invites community nurses across England to contribute to the associated working groups and to join the Community Nursing Practitioners Network.

WALES

The *National Community Nursing Specification* (Strategic Programme for Primary Care, 2022) focuses on General Practice Nurses, Specialist Nurses and District Nurses and their teams. Recognising the value community nurses offer,

the specification outlines how nurses should be enabled to lead and support research and service improvements, have clear development and career pathways and be supported via access to regular clinical supervision to enable nurses to achieve the ambitions of the Primary Care Model. Proposals focus on standardisation, simplification and collaboration as key underpinning principles to improve the experience of people, families and communities in terms of their experience of health and social care.

SCOTLAND

The *Nursing 2030 Vision* (Scottish Government, 2017a) sets out the Chief Nursing Officer's long-term strategy to shape the future of the nursing workforce and identifies three main areas for action, which include personalising care, preparing nurses for future needs and roles and supporting nurses. *The Transforming Nursing, Midwifery and Health Profession (NMaHP) roles programme* (Scottish Government, 2017b) is also led by Scotland's Chief Nurse and aims to ensure nationally consistent, sustainable and progressive NMaHP roles and career pathways which will see an appropriately skilled workforce contributing to new models of care delivery. The programme also aims to support shifting the balance of care, by reducing unscheduled care and unnecessary admissions, enabling people to be at home and supporting the move further into prevention and anticipatory care. The programme will also clarify roles and levels of practice which will contribute to service reform and the move towards multidisciplinary teams. The initial focus was on reforming community nursing for adults due to the population demographic trends in ageing, ill health and co morbidity; clarifying the Advanced Nurse Practitioner contribution to support wider service transformation and reforming community nursing for children in line with evidence on ensuring the best start in life to support population health improvement.

NORTHERN IRELAND

The *Nursing and Midwifery Task Group (NMTG) report and recommendations* (DoH-NI, 2020) present a roadmap to provide direction in achieving world-class nursing and midwifery services in a reconfigured HSC system over the next 10–15 years. Within the context of developing a population/public health approach, recommendations were made to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes. The recommendations proposed reflect a new vision/ambition to maximise the contribution of nursing and midwifery. It is the ambition that nursing and midwifery deliver the right evidence-based care, with the right numbers at the right time in the right place by the right person with the right knowledge and, of course, most importantly, delivering the right experience and outcomes for people, families and communities.

In order to provide high-quality care to patients, community nurses need the necessary skills, knowledge and expertise, and it is the responsibility of individual practitioners and their employing authority to ensure that appropriate preparatory education and training are organised. Workforce planning assists employing authorities in predicting future demand in terms of recruitment and education of new staff and the continuing professional development of existing staff. In addition, employers develop and update policies and procedures in relation to the clinical responsibilities of community nurses, and these should relate to the latest benchmarking criteria and government/professional guidelines. The views of people, families and communities should influence the preparation of health and social care service providers and statutory guidance requires health and social care providers to effectively engage in partnership working (co-production) with people and communities to improve services and meet the public involvement legal duties (NHSE, 2022).

In the current climate, recruitment and retention of community nursing staff are proving to be a challenge and are reflected in the NHS Workforce Plans across the UK. Chamanga et al. (2020) conducted a literature review looking at those factors influencing the recruitment and retention of registered nurses in adult community nursing services and found that individual and organisational factors influence retention of community nurses and include work pressure, working conditions and a lack of appreciation by managers. In addition to the well-articulated need to improve working conditions and value the work of community nurses more, there is a growing recognition of the need to promote 'first destination' roles in the community for nurses on qualification. Initiatives include raising the profile of community nursing not only in the pre-registration curriculum and by developing more innovative community nursing placements (Chilton, 2024) but also by engaging student nurses in associated research activities, reflecting perhaps the ten key priority areas for community nursing research (James Lind Alliance, 2021; see Chapter 2 for more detail). In promoting careers in community nursing, NHSE is supporting the development of pre-registration blended-learning nursing degrees with a community/primary care focus (Ford, 2023).

The community environment is a fascinating yet complicated matrix of elements. There are myriad individuals, groups, agencies and organisations involved in the delivery of health and social care. Clearly, there are differences between communities in terms of the settings in which community healthcare services are offered. Provision will vary considerably between a very rural community as opposed to an urban one, for example.

An understanding of community care as a 'process' rather than a 'context' is proposed to enable us to value community nursing as advanced specialist practice in its own right rather than as institutional or hospital-based nursing in another setting. Appreciation of the true complexity of meeting the health and social care needs of people living in the community only really becomes

evident with experience. Research by Jackson et al. (2015), using the Cassandra Matrix activity tool, indicates that their methodology has significant potential to measure the complexity of nursing work in community settings. This ongoing, pioneering research may be able to help community nurses articulate the qualitative nature of more personalised, highly complex approaches to care in community settings rather than rely on measures that have traditionally only been able to capture more restricted task-based, quantitative activities.

ACTIVITY 1.4

Reflection

Drawing on personal or professional experience, list as many different community nursing roles as you can.

You may then wish to compare your list with those offered in the resources highlighted later.

Community nurses require expert knowledge, competence in holistic assessment, highly developed interpersonal (see Chapter 7) and clinical skills and a clear understanding of a whole systems approach. The topics addressed in the chapters of this book have been carefully selected to reflect the key knowledge, skills and attributes required of community nurses. Chapter 4 provides a comprehensive overview of specialist community nursing disciplines – SPQ (NMC, 2022a) and SCPHN (NMC, 2022b) – as well as a useful infographic capturing many of the diverse community nursing roles (QNI/NHSE, 2023).

Health and social care systems must continue to shift their focus away from hospital care to primary and community services if they are to be effective and sustainable. To this end, the King's Fund (2024b) in its report *Making Care Closer to Home a Reality* express the need for a clear vision with funding, staff and political energy directed at general practice, pharmacy, community services and social care, captured in the following quote:

> Like other countries, England needs to bend the curve on the predicted rise in demand for high-cost, reactive and hospital-based care. That means supporting people to take care of their health and wellbeing, intervening early and keeping people healthy at home for as long as possible, which can only be achieved by bolstering primary and community services.
>
> (*Baird, King's Fund, 2024b*)

FURTHER RESOURCES

GOV.UK – The best place to find government services and information – https://www.gov.uk/

NHSE Digital – *Data and Technology* – supports NHS staff at work, helps people get the best care and uses the nation's health data to drive research and transform services – https://digital.nhs.uk/

NHSE Digital – Quality Outcomes Framework (QOF) – Online database to find the results of your local GP practice and to report the latest annual QOF points in comparison with other GP practices locally, or across England – https://digital.nhs.uk/services/quality-and-outcomes-framework-qof-online-database

NISRA – Northern Ireland Statistics and Research Agency – https://data.nisra.gov.uk/

Office for National Statistics – The ONS has responsibilities for collecting, analysing and disseminating statistics about the UK's economy, society and population – https://www.ons.gov.uk/

Queen's Nursing Institute – The Queen's Nursing Institute is a charity based in London dedicated to improving the nursing care of people in the home and community and has a wealth of resources on its website – https://qni.org.uk/

Scottish Government – Health and Social Care Analysis – Collection of information from across the whole range of health and social care services for adults in Scotland – https://www.gov.scot/collections/social-care-analysis-statistics/

The UCL Institute of Health Equity – The UCL Institute of Health Equity was established in 2011 and is led by Prof Sir Michael Marmot. The mission of the Institute is nothing less than a fairer, healthier society.

Welsh Government – Stats Wales *Health and social care* – Contains a comprehensive set of information on health, health services and social services in Wales. They cover a wide range of topics including NHS primary and community activity, waiting times and NHS staff – https://statswales.gov.wales/catalogue/Health-and-Social-care

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CHAPTER 2

Using research to inform evidence-based care

Catherine Henshall and Lee Tomlinson

LEARNING OUTCOMES

- Critically analyse professional and policy drivers influencing community nursing research across the UK.
- Appraise the breadth of community nursing roles in supporting, delivering and leading research in different care settings.
- Critically examine different types of research evidence which might be used to justify nursing practice in a variety of community settings.
- Critically review the research process and its application within community nursing in terms of conducting, reporting and disseminating research.
- Critically analyse the importance of patient and public involvement throughout the research process.

INTRODUCTION

Research is widely recognised as being integral to the provision of a robust and rigorous evidence base which informs the delivery of optimal care. Community nurses are well placed to support, deliver and lead research activities within their care setting, as they provide holistic care to people living in their homes and local communities. This chapter explores how to identify opportunities for community nurses to engage in research whilst acknowledging the current context that they are working within, which can bring its own unique challenges and opportunities.

AN OVERVIEW OF THE POLITICAL, PROFESSIONAL AND POLICY DRIVERS INFLUENCING COMMUNITY NURSING RESEARCH

Research-active healthcare organisations generally have better safety and care outcomes, improved staff recruitment and retention, increased staff wellbeing and better career progression opportunities (Ozdemir et al., 2015; Royal College of Physicians, 2020). This is, in part, due to research-active clinicians' attitudes about the benefits of research for improving healthcare and improving

DOI: 10.4324/9781003347545-3

access to innovative treatments, as well as a commitment to ensuring that care is based on the best available evidence (Borschmann et al., 2014; Ozdemir et al., 2015; Lambert et al., 2015; Rahman et al., 2011).

Globally, nurses are the largest professional group of health workers (Goodacre, 2017) and are well placed to lead innovative and evidence-based care models (Martsolf et al., 2016). They possess a breadth of understanding across all aspects of health and social care coordination and understand the factors influencing peoples' social determinants of health; this was evidenced throughout the COVID-19 pandemic (Bass, 2020). Nurses can contribute to and shape the direction of future healthcare policy and practice by utilising their research knowledge to improve service delivery and care outcomes. However, for most nurses, opportunities to engage in research are often few and far between as they lack protected time for research and have minimal access to structured research career progression pathways, limiting their capability and capacity to progress (Henshall et al., 2020a). The current nursing workforce crisis means that opportunities to develop professionally beyond fundamental care delivery are often limited due to the highly pressurised environment nurses are working within.

Despite these challenges to engaging in research activities in recent years, there has been an increased focus and appreciation of nurses' valued contribution to healthcare research. Across the UK, healthcare policies have identified the need for transformational change to enable community nurses to lead changes to services and health outcomes. In England, the National Institute for Health and Care Research (NIHR), established in 2006 (NIHR, 2020), has been key to driving this change. Funded by the Department of Health and Social Care (DHSC), the NIHR's remit is to improve the health and wealth of the nation through research (Henshall, 2020b). The NIHR is committed to investing in improving research training pathway opportunities for all healthcare professionals (NIHR, 2020) and has placed increased strategic focus on enabling and upskilling the nursing workforce to enable them to play a key role in supporting, delivering and leading research. National NIHR initiatives, such as the Senior Nurse and Midwife Research Leader Programme (Henshall et al., 2020b), the Senior Research Leader Programme for Nurses and Midwives and the Nursing and Midwifery incubator, have all focused on developing research capacity and capability for nurses across England at a local, regional and national level. In parallel, NHS England published their Making Research Matter plan in 2021, followed by its implementation phase a year later. The plan sets out key areas of focus for NHS trusts to work towards to develop a more research-active nursing workforce. Community nursing is recognised for its enormous contribution through expert clinical skills and leadership, providing invaluable, highly complex care across the country. This is alongside an appreciation for some of the workforce challenges and how the professions are seen and valued (NHSE, 2023).

A commitment to nursing research is also apparent in the UK's devolved nations, with Wales having a specific Community Nursing Research Strategy (WAG, 2009), which details priorities such as seeing translational research embedded in services and evaluating the impact and value of community nursing. A more recent commitment has been detailed in the CNO strategy for Wales, which outlines plans to develop research career pathways and advocates for a culture of research and innovation in care delivery (Welsh Government, 2022). Northern Ireland's 'Career Pathway for District Nursing' document (Department of Health Northern Ireland, 2022) and Scotland's 'Transforming Nursing, Midwifery and Health Professionals' Roles: District Nursing' paper (Scottish Government, 2017) both detail how community nursing roles should have research embedded within them, as a central component of practice. In Northern Ireland, the District Nursing Framework policy document sets out a road map for commissioning, managing and partnering with other district nurses and district nursing services. The framework focuses on prevention and self-care that centres on maintaining population health. Co-production is at the heart of the framework, with service users playing a key role in developing care plans and co-designing services (Slainte & O Poustie, 2018). By examining and developing the evidence base it is possible to drive forward health outcomes and research-informed standards globally and make a positive difference in healthcare and service delivery (Baker et al., 2020). The guidance from the Royal College of Nursing (RCN) for advanced nurse practitioners clearly identifies research as one of the four central pillars of practice. This has contributed to a growing appreciation of the need for the integration of interdisciplinary, practice-based research, to optimise patient experiences and outcomes (Conway & Barratt, 2023). The RCN guidance states that nurses who are working at an advanced level should be incorporating research into everyday practice. This practice might include critical appraisal/evaluation, implementing research findings or disseminating conference presentations and publications. The acquisition of these research skills is cited as crucial to enhancing the safety, the delivery of high-quality care and responsive services (RCN, 2018).

Despite recognition by the UK government that coordinated working between hospital and community settings is imperative for optimising health and care outcomes (NHS England and NHS Improvement, 2021), most disease-specific research studies are written from the perspective of secondary care settings. Although national strategies and plans often focus on nurses and their engagement in research, a disproportionate focus on secondary care has led to challenges in community nurses' abilities to engage with the evidence base (Henshall et al., 2022). However, the recent NHS England-commissioned 'Self-assessment Organisational Readiness Tool' (SORT) provides a framework for organisations to assess their own research readiness on an ongoing basis (Ali & Cooke, 2023). The SORT tool has been designed to support continuous improvement in research and can be used in the community as well as

secondary care settings. The SORT is one mechanism that can help identify any improvements to research infrastructure that are required across organisations to promote the provision of optimal care for community-based people. Investing in the training and development of healthcare staff can lead to knowledge gaps being addressed, research problems being identified and the generation of new knowledge (Hare & Whitehouse, 2022).

With few research role models or research mentorship opportunities within community nursing (Bowers & Evans, 2022), the research component of the community nurse's role is often lacking (Brooke & Mallion, 2016). However, the identification of a research mentor and a research support network can be immensely valuable in terms of guiding and advising nurses on the best ways to navigate their research career pathways. A chosen mentor may be a community nurse or someone outside the researcher's sphere of practice; either way, the opportunity to share ideas in a constructive, confidential and supportive environment can be hugely beneficial. A mentor can give advice on getting research activities underway. Often it is sensible to start with small-scale projects or ideas and then to identify whether they are worth scaling up in the longer term. Sometimes it is possible to obtain small grant awards to support projects, with examples of funding sources including NIHR Applied Research Collaborations (ARC) and local charities that have an interest in the chosen topic area. Case Study 2.1 provides an example of a small project undertaken by a community nurse who identified a gap in service provision within the learning disabilities care sector.

CASE STUDY 2.1

Small project example

Dawn is a learning disability nurse; she completed a literature review to consider when adults with a learning disability are admitted into acute general hospitals.

The idea was developed during the COVID-19 pandemic, when many people with a learning disability were being admitted into hospitals, often without support from any family/carers. Dawn's clinical lead developed an acute liaison link between the learning disability health team and the hospitals in the area. The acute liaison link was used to help identify when adults with learning disabilities were admitted to hospital and provide onward support for safe discharge planning.

This was used to inform Dawn's research topic which explored the 'benefits of communication between learning disability health teams and acute hospital staff when someone with a learning disability is admitted'. Dawn examined the role of the learning disability liaison nurse and methods for identifying people with learning disabilities within acute hospital settings. This enabled a flag to be placed on electronic health records so that community teams were aware when someone with a learning disability was admitted.

In response to the national push for recognition of the value of community nursing research, an initiative was led by a group of NIHR Senior Nurse and Midwife Research Leaders. Working with the James Lind Alliance, they conducted a priority-setting partnership to identify the top ten priorities for community nursing (James Lind Alliance, 2021). These priorities signal an increased focus and impetus on research across the community nursing landscape.

ACTIVITY 2.1

Reflection

Table 2.1 lists the top ten priorities for community nursing as generated by the James Lind Alliance (JLA, 2021). In your own nursing roles consider which of these priorities is most relevant to your setting and how you might begin to explore these issues further. What might be some of the practical challenges and facilitators to designing research on your chosen topic? You will have an opportunity to develop a more structured research question relating to this topic later in the chapter.

Table 2.1 Community nursing priorities for research (JLA, 2021)

1.	How can community nurse teams better meet the complex needs of patients with multiple health conditions?
2.	How can community nurses promote shared care/self-care amongst patients, and support carers to provide some aspects of care (e.g. changing dressings)?
3.	How can community nurse teams best contribute to the management of acutely ill patients at home? What difference does this make to hospital admissions?
4.	What are the best ways for community nurses to involve unpaid carers/relatives/friends in decisions about their loved one's treatment and care?
5.	How can community nurse teams work effectively with social services and care services to improve the quality of patient care?
6.	How has community nursing changed in response to COVID-19? Are any of the changes (e.g. timed visits, new skills and working from home) worth keeping?
7.	Does seeing the same community nurse(s) over time make a difference to the quality of patient care?
8.	How can community nurses work effectively with other health professionals in hospitals and specialist community services to improve patient care?
9.	What are the stresses on community nurses and what impact does this have on their health and wellbeing? How can this be improved?
10.	How can nurses be encouraged to become community nurses and to stay in the profession?

COMMUNITY NURSING ROLES IN SUPPORTING, DELIVERING AND LEADING RESEARCH IN DIFFERENT CARE SETTINGS

The NIHR's Nursing and Midwifery vision is to enable nurses and midwives to support, deliver and lead research, developing a pipeline of research-active nurses and midwives (NIHR, 2023). In addition, NHS England's Chief Nursing Officer's Strategic Plan for Research (2021) devotes specific themes to releasing nurses' research potential and developing nurse research leaders. Together, national recognition of the breadth of research roles being developed is detailed, with a wealth of opportunities to support nurses to engage in research. Community nurses are well placed to take advantage of these opportunities to focus on people being cared for outside of the hospital environment.

Considering the evidence behind a clinical issue or intervention is a worthwhile place to start when thinking about the application of research. Conducting a literature review of any available evidence can identify issues that can influence or change nursing practice. NHS librarians can provide support and guidance with literature searches and literature reviewing can be a team effort, enhanced through the sharing of multiple perspectives. One example of where clinical teams collaborated with a local academic institution is at Keele University through the evidence-based practice group for general practice nursing (Finney, 2022) where critically appraised topics were used to ensure that practice was based on current evidence. Other organisations are building internal development programmes to offer early access to research opportunities. For example, the Research Champion programme at Kent Community Health NHS FT provides opportunities for staff to focus on a clinical question for their service, reviewing relevant literature and presenting their findings to the chief nurse to consider how care should change. Across this programme, staff convene as an annual cohort, attending academic sessions at the university and engaging in internal networking and mentoring sessions.

ACTIVITY 2.2

Reflection

In 2020, stakeholders at the national NHS England's Matron's virtual conference identified enthusiasm and appetite from senior leaders for access to a one-stop-shop-styled online toolkit offering concise, day-to-day practical guides about how to lead and embed research in practice. As a result, a Clinical Matrons' Research Interest Group (CMRIG) of over 200 matrons and senior leaders was convened to inform the core elements of a research toolkit. Its purpose is also to support the understanding of how research can be embedded into everyday health and care practice across all professions.

A commission by NHS England then provided funding to create the toolkit, titled Research Toolkit for Matrons and Health and Care Leaders. At the time of writing this chapter, this is undergoing publication review.

The commissioned team worked closely with members of the CMRIG to develop toolkit content under the following areas: understanding research and innovation, understanding evidence-based practice, enabling a research culture, supporting research delivery and embedding clinical academic careers.

The tool contains helpful case examples of how individuals have enabled research to become part of the culture and systems of care and will link directly to the NHSE Matron's handbook.

There is an online community of practice for all professional groups around how to embed research in services, where people can view webinars, share ideas and meet colleagues in similar roles to help shape their research practice – including how this can be fully realised within the community setting.

The toolkit can be used by any professional group in health and social care.

Please take time to explore the Matron's Handbook and keep in touch with news about the Research Toolkit for Matrons and Health and Care Leaders by visiting the Chief Nursing Officer for England's research NHSE webpage and FutureNHS site.

(*Ali & Cooke 2023*)

Nurses across the health system are often not aware of opportunities to recruit local people into national research studies. One role of the community nurse in this process is to identify people from the community who might be eligible to participate in the study and invite them to do so. Supporting recruitment and study delivery in the local community can add to the diversity of study data collected across different geographic locations with different populations. As nurses, part of our duty of care is to offer people opportunities to participate in research due to the many local benefits that research participation can bring, including access to different treatments, interventions and pathways. These studies are often part of the NIHR's national portfolio and are eligible for support from the NIHR's clinical research support function and Direct Delivery Teams that can help ensure that studies are delivered effectively and efficiently across community settings.

Increasingly, study activities cross organisational boundaries. For example, a study looking at rehabilitation after stroke may start by recruiting people from secondary care settings, but the intervention (rehabilitation) is likely to be delivered in home-based or other community settings. These complexities need to be considered carefully, particularly by those designing the research, to make the experience as smooth as possible for the participant. It is important that community nurses can contribute to all elements of study design, set-up and delivery to ensure the research is feasible to deliver and is acceptable to potential participants.

When considering community nursing roles in developing research studies, they are often assumed to be lone, purely academic roles. However, the reality is that the process is collaborative and often co-designed, bringing together people with different areas of expertise who can contribute to the project. Contributing as a community nurse is crucial to ensure that community nursing perspectives are evident in the research process. This will support studies to be optimally designed and encourage research teams to think more holistically about the best ways to generate high-quality research evidence that can be delivered pragmatically in community contexts.

For nurses who want to specialise in research leadership roles, many opportunities are available. They can require balancing working across healthcare and academic settings and institutions; this is made easier if the academic and healthcare partners have a shared vision and long-term sustainability planning is in place to develop clinical academic nursing roles, from early career researcher through to specialist nurse consultant and professorial roles.

IDENTIFYING TYPES OF RESEARCH TO BE CONDUCTED IN THE COMMUNITY SETTING

When deciding which research approach, methodology and methods are best suited to answering research questions within the community nursing setting it is useful to be aware of the wide range of approaches available and of the context for the topic. This will help to identify and select the best type of study design to do justice to the research question. Traditionally, within evidence-based medicine, a hierarchy of evidence has been used as a means of determining which evidence is best suited to informing clinical decision-making (Burns et al., 2011). This hierarchy of evidence places randomised controlled trials (RCTs) at the highest level and case series or expert opinions at the lowest level (Yetley et al., 2016) (Figure 2.1). This is because RCTs are designed to be unbiased, take place in a controlled environment and have less risk of systematic errors. Conversely, a case study or expert opinion may be biased by an individual's experience or opinions, with no control of bias (or confounders) present (Burns et al., 2011).

At face value, categorising types of research within this hierarchy of evidence makes sense, especially if the aim is to reduce bias and determine the efficacy of one intervention compared to another. This is because, by operating in a controlled environment, the risk of external variables contaminating the study findings is minimised. However, this does not consider the healthcare context and settings that most healthcare interventions take place within. Whilst an RCT may be able to demonstrate intervention efficacy, it cannot with any certainty demonstrate effectiveness. Efficacy trials (explanatory trials) determine whether an intervention produces the expected result under ideal circumstances. Effectiveness trials (pragmatic trials) measure the degree of beneficial effect under "real world" conditions, like a community setting (Lake et al., 2020.) As such, when designing an effectiveness trial, it is

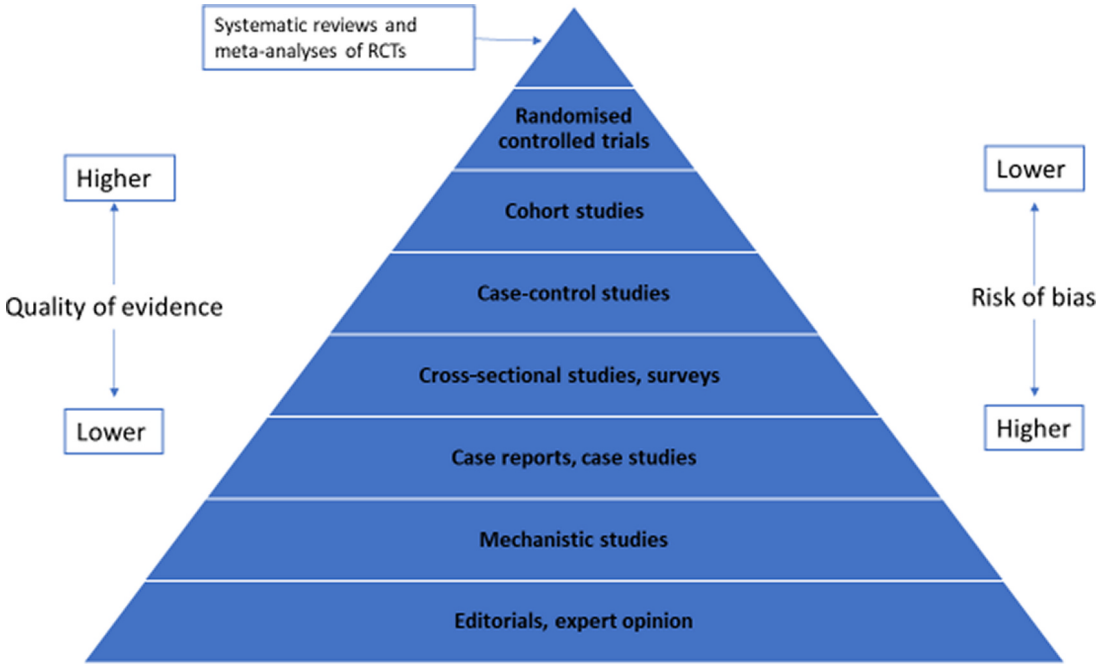


Figure 2.1 Hierarchy of evidence pyramid.

important to take into consideration the context and conditions of a particular setting, careful attention should be given to the measurement of adoption processes and the development of outcome measures that are relevant and meaningful (Lake et al., 2020).

Increasingly in healthcare research, realist approaches are being recognised as valuable in helping to account for the contexts and mechanisms that influence the outcomes that are being measured. Realist research attempts to answer, 'How, why, for whom, to what extent and in what circumstances?' and can be useful for making sense of interventions and programmes that are complex and have outcomes that are context-dependent (Pawson, 2013).

Regardless of the approach chosen to inform the research design, decisions about whether to undertake a quantitative, qualitative or mixed-methods study will be dependent on the questions being answered within the sphere of practice of the researcher (Table 2.2).

Within the community nursing setting, it is important to consider various factors that might contribute to the effectiveness of an intervention being successfully implemented. This might include characteristics, such as sex, age, ethnicity, severity of disease and others, as well as whether the person is being treated at home, in a hospital or in a community mental health centre (Lake et al., 2020). Other factors, such as accessibility to healthcare services, socioeconomic factors and ease of use, will all influence the degree to which an intervention is deemed feasible and acceptable to both community nurses and

Table 2.2 Quantitative, qualitative and mixed-methods methodologies

- Quantitative data: numbers-based, countable, or measurable. Quantitative data tell us how many, how much or how often in calculations.
- Qualitative data: helps us understand why, how, or what happened behind certain behaviours. It is interpretation-based and descriptive and relates to language.
- Mixed-methods research: represents research that involves collecting, analysing and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon.

(Bryman, 2016).

people in their care. Careful consideration of these factors will enable a study design that is best suited to answer the research question to be identified that is flexible, adaptable and context-specific in its approach.

When designing a study, it is important to consider the views of people, carers, colleagues and other stakeholders; this will help ensure that the study is designed to answer questions that matter to those either directly receiving or providing care. This 'co-produced research' ensures that by leveraging professional and end-user collaboration, people can be supported to contribute to the management of their own conditions (Elwyn et al., 2020). This is especially relevant when dealing with long-term conditions in the community, where supporting people to learn how best to reduce the burden of illness and treatment is crucial.

There are tools available to use to refine a topic of interest into a clear, answerable research question. The most commonly used tool is the patient, intervention, comparison, outcome (PICO) search tool (Eriksen, 2018); alternative tools include PICO, PICOS and SPIDER (Methley et al., 2014) (Table 2.3). There is no consensus on the best tool to use, and all are relatively similar (Eriksen, 2018). Some tools such as SPIDER are preferred for qualitative research questions.

Table 2.3 Tools to identify a research question

	PICO	PICOS	SPIDER
Diabetes and patient/service user	**P**opulation	**P**opulation	**S**ample
Healthcare services	**I**ntervention	**I**ntervention	**P**henomenon of **I**nterest
Named types of qualitative data collection and analysis	**C**omparison	**C**omparison	**D**esign
Experiences, perceptions	**O**utcome	**O**utcome	**E**valuation
Qualitative or qualitative method	Not applicable	**S**tudy type	**R**esearch type

PICO is frequently used for forming a clinical research question and can help ensure that the question is well defined, particularly when considering evidence synthesis. PICO can also be used to develop search strategies when undertaking literature reviews and can help ensure that the search terms are well chosen to support the research question (Eriksen, 2018). For the purposes of this chapter, we consider PICO in more depth (Table 2.4).

Table 2.4 PICO

	Quantitative	Qualitative
P	**Population** of interest. This may be a patient, carer, nurse or other member of the multidisciplinary team, for example. Keeping your study population central to the research question ensures that the evidence uncertainty in question remains relevant to, and focused on, your target population. (Leonardo, 2018). It is important to consider how your population boundaries are defined, whether by age, gender, health condition or location. Considering community settings, location is often key. For example, the population may refer to people receiving care in their own homes who are unable to access hospital care.	
I	**Intervention** This may refer to a treatment, care, therapy, rehabilitation or drug that is being tested, piloted or evaluated.	**Issue** This relates to the topic area that is being explored across the study population, e.g. health-seeking behaviours, smoking cessation, psychiatric support.
C	**Control/Comparison** The alternative to the intervention, this is likely usual care or may involve a placebo.	**Context** The context within which the population under study is viewed can impact the subsequent outcomes of the research. For example, the study population may be people who access smoking cessation classes within a group clinic setting on a weekly basis and this group setting may result in different outcomes than for people who try to stop smoking without this regular group support.
O	**Outcome** This relates to the key variable being measured to determine the effectiveness of the intervention group compared to the control group in the population under study.	**Outcome** This is still stated, but due to the exploratory nature of qualitative work, these may be less well defined and harder to measure at the study's outset.

ACTIVITY 2.3

Please review the following questions and decide whether they are better suited to a quantitative or qualitative approach. Can you identify the population, intervention/issue, comparison/context and outcome in the following examples?

- Does the provision of remote monitoring of people with diabetes in the community promote confidence and better glycaemic control?
- What aspects of care are undertaken by informal carers of frail older people with multi-morbidity; what support do they need from community nurses?
- What are the levels of work-related quality of life and organisational commitment of prison nurses working with high-security prisoners?

You might wish to discuss this activity with a colleague.

CONDUCTING, REPORTING AND DISSEMINATING RESEARCH

Undertaking research in community nursing settings can often feel daunting due to not knowing where and how to start the research process. However, often people working in community settings are really well placed to conduct research in this area as they are close to the issues on the ground and understand the care context and what matters to community staff, people and carers alike. Research ideas are often closely linked to the clinical or care context that nurses are working in and may often be focused on a nursing observation that requires further exploration. They might also be related to your own professional experiences, a challenge at work, a common care situation or health condition, complex care needs or workforce issues. Your topic area might also be related to clinical evidence uncertainties, social trends (e.g. COVID-19), and recent policy developments.

When considering and refining your research topic and research question, multiple sources of information can help you to make decisions about whether your choice of topic is the right one to pursue. These sources can include talking to other healthcare professional colleagues, people and carers about their experiences of the chosen topic; networking with other people interested in the topic area; reviewing the literature and identifying any published work (including systematic reviews) on the topic; reviewing strategy and policy documents; and talking to an academic advisor or mentor about your idea.

When thinking about your research idea and whether it is worth pursuing, to work through the following questions, it can be useful to consider the FINER tool (Table 2.5).

Table 2.5 FINER tool

FINER Components	Considerations
Feasible	Consider, is the project feasible? Are there an adequate number of participants? Do you have adequate technical capacity and resources to conduct the project? Is the project affordable and manageable in scope? Do you have time to see the project through?
Interesting	Is the project interesting to you? It is much easier to carry out a project if you find it interesting. Are you motivated to see it through? Do you see the potential benefits of conducting the project?
Novel	Has the project been carried out already? What will your project add to the current literature on the topic and/or the evidence base?
Ethical	Have you considered the ethical implications of conducting your project? Is there any potential to cause harm to people, carers or other participants? Have you considered issues around informed consent, data storage and transparency?
Relevant	Is the project relevant to scientific or professional knowledge, clinical or social policy and/or future research directions?

DISSEMINATING YOUR WORK

When thinking about disseminating the results of your study, there are multiple ways of sharing your work. These include, but are not limited to, publications in peer-reviewed journals, conference presentations, blogs, social media posts, poster presentations, public engagement events, workshops, webinars and podcasts. When considering which approach is the best one for sharing your project findings, it is helpful to consider who the audience that you intend to reach is as this will help inform your choice of dissemination strategy. For example, if you are interested in reaching academics and researchers who are interested in your chosen topic, then peer-reviewed publications and conference presentations are good choices. If you want to reach other community nurses you could also consider publishing a paper, but your target journal might be one that is read by large numbers of community nurses on a regular basis, or it might be a more informal blog. If you want to reach people and carers, you might consider a public engagement event or a webinar, and if you want to reach the public you might consider using social media, webinars or podcasts. It is important to note that all these dissemination strategies can be used in combination and interchangeably and that there is no one-size-fits-all

Table 2.6 Key considerations when writing for publication

Hints and Tips for Writing for Publication	Consider
Carefully consider who your target audience is. This will help inform the messaging of your paper and how you structure and frame it.	Who are you writing for? What is the purpose of your writing? Are you writing for nurses, academics, people and the public, managers, policymakers or all these groups?
What is your target journal? This will be informed by your target audience.	You might focus on a professional journal, such as a nursing or medical journal, or a methodological journal, a specialist wound care journal or an education journal.
Consider the balance between the impact factor of your chosen journal and its reach.	A journal's impact factor reflects the number of times in a given year papers published in the journal have been cited.
Again, this balance will be informed by who it is you are trying to reach and how.	The reach of a journal is an indication of how widely read that journal is by different audiences. Example: A community nursing journal may not have the highest impact factor but may have reach among community nurses.
Format and style your paper in line with your chosen journal's requirements.	Different journals have different sets of author guidelines which provide information on formatting and other manuscript requirements, including word count, font size and referencing style. This information can be found on the journal's web pages.
Protect time for your writing. This enables you to immerse yourself in writing and read relevant literature which you can include in your paper.	Try to block out a day or half a day at a time for writing. If you can't do that, try to find an hour or so at the start or end of the day and keep it free for writing. Identify the time of day (morning/afternoon/evening) that works best for you to write and allocate time according to your preferences. You can write papers chronologically or start with a specific section, e.g. the Methods section. Do what works best for you. You can just start writing, write a draft outline or list bullet points first – there is no right and wrong!
Be resilient – don't be afraid of rejection!	Almost all papers that are peer-reviewed are returned with suggestions for improvement, and sometimes they are rejected. Don't view this negatively but as an opportunity to further improve the quality of your paper as it has been reviewed by experts in the field. However, be prepared to defend your work if you don't agree with some of the reviewers' comments.
Collaborate on the writing process!	Most papers are written by more than one author, and paper writing should be a collaborative process. All co-authors are expected to contribute to the writing and/or critical review of the paper they are co-authoring, so set clear timelines for writing and feedback as a team and be responsible for sticking to these timelines.

ACTIVITY 2.4

Based on the tips within Table 2.6, prepare a brief publication plan, outlining key considerations for ensuring a high-quality output that is targeted at the right audience.

approach. It is for you to think about your audience, the intended reach of your work and the most effective dissemination strategy for raising the profile of your work both locally, nationally and more widely.

ENSURING PRINCIPLES OF EQUALITY, DIVERSITY AND INCLUSION ARE CENTRAL TO THE RESEARCH PROCESS

It is increasingly recognised in research that projects conducted should be informed by the people who are at the centre of the research and that those people are properly represented in the research that is undertaken. Care needs to be taken to ensure that research carried out considers the principles of equality, diversity and inclusion. The James Lind Alliance Priority Setting Partnership in Community Nursing (Henshall et al., 2022) provides an example of how people, carers and community nurses were represented through all stages of the research process (Table 2.7).

Table 2.7 Involving people, carers and community nurses

JLA PSP Process	Stakeholder Involvement
Formation of stakeholder group	Community nurses, people and carers accessed through community nursing networks, chief nurses, community nursing organisations, charities and patient and public involvement leads.
Survey development	Collaborative co-production approach with stakeholder group members employed. Designed to be inclusive by generating survey questions across a wide range of subject areas. Questions agreed and debated at stakeholder meetings.
Recruitment, data collection and survey accessibility	Survey promoted through a range of networks including national community nursing bodies, charities, social media, patient and public involvement networks and the NIHR. Paper and electronic versions of survey generated to increase accessibility.
Data analysis	Out-of-scope questions discussed with the stakeholder group to check that they should be excluded. Stakeholder group reviewed potential questions and reworded them until consensus is reached that they were representative and appropriate.
Final workshop	Stakeholder representatives fully involved in selecting, ordering and prioritising top ten priorities in community nursing.

Henshall et al., 2022.

ACTIVITY 2.5

Case Study – *Ensuring different research approaches to tackling health and social inequalities across different populations and communities.*

PrEP (pre-exposure prophylaxis) is a drug taken by HIV-negative people before and after sex that reduces the risk of getting HIV. The PrEP Impact Trial was established in 2017 to assess the need for PrEP in English Sexual Health Clinics. The use of PrEP is a safe and effective prevention option to all people at a substantial risk of HIV acquisition, irrespective of gender. In the Impact Trial, 80% of places were allocated to men who have sex with men (MSM), whilst 20% of places were reserved for women and other groups. This was reduced to 10% as the MSM places were running out. However, early recruitment data demonstrated a significant under-representation of women (<5%).

Intervention

To address the issue of low recruitment of women to the trial, the study team developed a questionnaire based on the national PrEP guidelines to assess potential factors associated with increased risk of contracting HIV, and this was given to women attending one sexual health clinic. The clinician recorded outcomes for PrEP discussion, PrEP eligibility and whether women were referred to the PrEP Impact Trial or opted for an alternative source. Over the course of 2 months, clinicians using the questionnaire identified 21 women (6.6%) who were PrEP eligible, of whom 15 (71.4%) had a conversation about PrEP documented, 8 (38.1%) accessed PrEP via the trial (6 cis, 2 trans; 6 White, 2 Asian), 1 (4.8%) self-sourced PrEP privately and 1 (4.8%) declined to participate in the trial.

During the preceding 26 months of the PrEP Impact Trial, 10 women had been recruited at the clinic.

Consider this approach in relation to a research idea you have relating to your own area of practice. Are there opportunities to consider alternative recruitment strategies to either be more inclusive or increase the number of participants approached?

ACTIVITY 2.6

Reflection

Consider some of the challenges that you might encounter when undertaking a research project in the community setting where you have identified an area for exploration or investigation. What might you do to overcome some of these challenges? How would you make sure that your participant population was included in the research project and that they had opportunities to engage with it? Who else might you need to engage with to promote research recruitment and ensure that the study remained focused on, and representative of, your participant population?

THE IMPORTANCE OF EMBEDDING PATIENT AND PUBLIC INVOLVEMENT THROUGHOUT THE RESEARCH PROCESS

Patient and public involvement (PPI) in research (or service user/lay involvement) refers to an active partnership between people, members of the public and researchers. This involvement is different to patients/people and the public participating in research projects; instead, PPI members contribute to projects in an advisory capacity (NIHR, 2015).

The central role that patients and the public play in contributing to all stages of the research process has been evident since the 1970s but over the last decade has gained increasing prominence and recognition as an important component in improving healthcare and service outcomes (Biddle et al., 2021; Brett et al., 2014; Ocloo et al., 2021). It is widely acknowledged by policymakers, researchers and research funding bodies that PPI representatives should be actively involved in the research process (Greenhalgh, 2019). This includes prioritising study topics, study management and design, data collection and analysis and disseminating findings (NIHR, 2015).

It is now an expectation in the UK that researchers provide details of the level and type of PPI within research funding applications and research outputs, such as academic journal publications. Without this evidence, research funding applications and outputs are likely to be rejected (NIHR, 2015). However, there is often a lack of access to funding to support PPI activities. The NIHR is a key proponent of PPI representation in research and provides PPI resources and support for researchers who are interested in designing people-centred research (NIHR, 2022). However, PPI involvement in research in out-of-hospital settings is often inconsistent, and it is important to recognise areas of good PPI practice to improve the quality of research conducted in community-based settings (Blackburn et al., 2018; Table 2.8).

Different and interchangeable ways of defining PPI exist, and it is important to consider how PPI members can be wholly embedded in the research process. This involves an active partnership between researchers, people, carers and members of the public to influence and shape research. This differs from patient and public engagement, where research knowledge is disseminated to stakeholders to whom the findings will impact, and to research participation, where an individual is recruited to take part in a study (NIHR, 2021).

Table 2.8 Key benefits of ensuring that people and the public are actively involved in research

Increased relevance to population	Forming alliances with people and the public is important in ensuring that new knowledge is co-constructed by scientists, as well as public citizens, thus increasing the accountability, relevance and transparency of research. This is important as a means of attracting funding for healthcare research, with PPI involvement in research seen as a key quality marker (Greenhalgh, 2019).

(*Continued*)

Table 2.8 (Continued)

Understanding personal impact	Involving people and the public with first-hand experience of living with a specific disease or condition can be invaluable when designing research (Greenhalgh, 2019). PPI members can share their experiences of living with a certain healthcare condition, what the challenges are and how it impacts their daily lives. This helps researchers develop a better understanding of the problems involved, which leads to a more informed and relevant research plan being developed.
Practical research design	PPI members can provide useful information regarding the practicalities of research and what is and isn't appropriate to undertake. This might relate to issues regarding recruitment and retention to research studies, adherence to study interventions and follow-up measures, and the acceptability and feasibility of study designs (Domecq et al., 2014).
Research papers are clear and easy to understand	PPI members can contribute expertise in reviewing research project documentation. This might include participant information sheets and consent forms, which need to be written using lay language and terminology to ensure that research participants fully understand the research process. PPI members are often asked to contribute to writing and reviewing lay summaries on research funding applications. These lay summaries are often central to determining whether a research project will be funded.
Address power imbalances	PPI representation can help address power imbalances and hierarchical structures within healthcare settings, challenging the resistance of some healthcare professionals to share control of the research process with patients and the public (Boaz et al., 2014). PPI allows public citizens to be given an authentic voice with which to input into research on their condition (Greenhalgh, 2019).
Increased transparency and inclusivity	PPI involvement helps address challenges relating to equality, diversity, and inclusion in research (Ocloo et al., 2021). In the UK, this is enshrined within legislation such as the Health and Social Care Act (Department of Health, 2005) and the NHS Constitution (Department of Health, 2012), which states that patients and the public should be properly involved in commissioning processes and decisions. The Equality Act 2010 prohibits discrimination in public services on the basis of nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation), helping to ensure a more transparent and inclusive research process. This means that the PPI work undertaken should be representative of the wider population, rather than being perceived as tokenistic or exclusive (Ocloo & Matthews, 2016).

PPI itself does not require ethical or research approvals; however, in order to construct a robust and credible research study most ethical bodies will look for evidence of PPI within the design process. This is to ensure that the research planned is ethical, relevant, acceptable, and feasible from a public perspective (NIHR, 2022).

Determining the most appropriate way to involve patients and the public in the prioritisation and development of a study will depend on the study itself and the population that is being recruited. To start, consider the six UK standards for achieving good public involvement in health and social care research.

The costs required for PPI activities can be included within a research grant application, or if required, separate funding awards specifically for PPI are available through charities or trusts. When writing a study as part of an educational qualification, it is unlikely that specific funds for PPI will be available. Instead, it may be preferable to work with already established public involvement groups to ask for their support and involvement in your research activity. This could be a support group, a community group or a public engagement group based within a community setting. Most people's motivations to take part in research are altruistic (Carrera et al., 2018), and people who take part in research often report better quality care (Raciti et al., 2022). Individuals will often be pleased to have the opportunity to influence future research, particularly when they can foresee longer term benefits (Wilson et al., 2015). It is important to remember to seek different perspectives, and often, family members or carers can provide rich thoughts and perspectives to shape a study.

Another consideration is thinking about the best way to meet with individuals or groups. This might be virtual or face-to-face. Virtual connections can help support an academic study when funding is not available and similarly support individuals without easy access to transport or with caring responsibilities at home (Wilson et al., 2015). However, virtual connections can have implications for relationship building and may pose challenges for people who do not have access to Wi-Fi, computers or remote working equipment. Ultimately, whether meetings take place face-to-face or remotely, it is important to build and maintain strong relationships; this can be facilitated through social engagement and establishing clearly agreed ways of working (Staniszewska et al., 2017, Wilson et al., 2015). Having an arena to reconnect with PPI members once relationships have been created is important and can be facilitated through social networking, blogs and tweets, for example (Wilson et al., 2015).

PPI relationships built throughout the study process have the potential to produce widespread benefits by generating appropriate changes to study design, improvements to recruitment materials and recruitment rates and dissemination strategies (Wilson et al., 2015). It is important when writing your study findings that the reporting of PPI activity is included for transparency and to aid the description of how public involvement has influenced the study process and kept it person-centred throughout.

ACTIVITY 2.7

Reflection

How do the six standards described in Table 2.9 fit with your study idea? Consider how you might include the perspectives of patients and the public at every stage of the research process.

Table 2.9 Standards for achieving public health and social care research

Standard	Details of Standard
Inclusive opportunities	• Offer public involvement opportunities that are accessible and that reach people and groups according to research needs • Research to be informed by a diversity of public experience and insight so that it leads to treatments and services which reflect these needs.
Work together	• Work together in a way that values all contributions and that builds and sustains mutually respectful and productive relationships. • Public involvement in research is better when people work together towards a common purpose and different perspectives are respected.
Support and learning	• Offer and promote support and learning that builds confidence and skills for public involvement in research. • Seek to remove practical and social barriers that stop members of the public and research professionals from making the most of public involvement in research.
Governance	• Involve the public in research management, regulation, leadership and decision-making. • Public involvement in research governance can help research be more transparent and gain public trust.
Communications	• Use plain language for well-timed and relevant communications, as part of involvement plans and activities. • Communicate with a wider audience about public involvement and research, using a broad range of approaches that are accessible and appealing.
Impact	• Seek improvement by identifying and sharing the difference that public involvement makes to research. • Understand the changes, benefits and learning gained from the insights and experiences of patients, carers and the public.

(NIHR, 2021).

CONCLUSION

This chapter has discussed how research is integral to optimising community nursing practice and supporting the development of community nursing careers. Key policy drivers from the four UK nations that pledge to support capability-building opportunities in clinical research have been identified. The breadth of different community nursing roles and working environments

that exist can not only add complexity to the research process but also offer a wealth of options to explore when developing a research question. Working with people and the public to influence study design at all stages of the research process ensures that the outcomes generated are relevant to the wider population. The importance of dissemination cannot be underestimated to ensure outcomes are widely shared and translated into practice, enhancing care delivery and the experiences of those receiving care. Engaging with a wide variety of research activities provides community nurses with opportunities to respond to clinical questions in practice, thus improving context-dependent knowledge for the benefit of people being cared for in the community.

FURTHER RESOURCES

National Institute for Health and Care Research – www.nihr.ac.uk

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CHAPTER

3

Public health and the promotion of wellbeing

Fiona Baguley and Debbie Wilson

LEARNING OUTCOMES

- Critically analyse national policy, policy drives, strategy and legislation in improving health and wellbeing.
- Critically appreciate public health and the influencing factors for health and wellbeing.
- Analyse health promotion and the role of the nurse in relation to individuals, families and populations.
- Explore the assessment of needs for individuals and communities.
- Appraise strategies and approaches used to improve health and wellbeing.

INTRODUCTION

This chapter introduces public health, identifies the relationship between health and wellbeing and discusses the approaches and skills required by nurses working in community settings to promote health. The intention is to reaffirm the importance of nurses positively influencing the health of the public and their ability to promote wellbeing at individual and/or community (population) levels. Throughout the chapter, activities are presented to support your learning and development; they are also intended to act as a catalyst to foster a deeper understanding of public health through reflection and informed discussion.

Health is a significant concept for both individuals and governments, in terms of living independently, being happy and contributing to society (Marmot et al., 2020; Green et al., 2015). To deliver a holistic approach to improving health and wellbeing, it is important to consider these components individually and how these may impact nursing practice for community nurses in all roles and settings. It is also important to consider whether individuals are responsible for their own health and wellbeing or whether health and disease are a consequence of socio-economic causes, resulting in governments being accountable for population health. To seek an answer to these questions, a consideration of how health is assessed and the factors that influence our health is required.

DOI: 10.4324/9781003347545-4

HEALTH INEQUALITIES STRATEGY AND POLICY

Health inequalities are complex and arise from an interaction of many factors; however, the gap may be avoided or limited with a concerted effort from the government, the community, and a collaborative approach (WHO, 2018). There are various models of health which demonstrate the interconnected relationship between all these elements, which include social, economic, political, environmental and behavioural. Reviews on health inequalities over the past decades, including, *The Marmot Review 10 Years O*n (Marmot et al., 2020), have made recommendations for strategy and policymakers to improve their nations' health. Tackling the determinants of health should be at the centre of any government strategy, including addressing poverty, the availability of good-quality housing, work conditions, education and learning opportunities and access to local social and cultural resources (Marmot et al., 2020).

ENGLAND

The publication *Health Equity in England: The Marmot Review 10 Years On* (2020) concludes that England's health is faltering. This review, marking 10 years on from the landmark study *Fair Society, Healthy Lives* (Marmot, 2010) reports the following:

- People can expect to spend more of their lives in poor health.
- Increases in life expectancy since the start of the 20th century have halted and have declined for women in the most deprived 10% of society.
- The health gap (health inequalities) has increased between the richest and poorest areas.
- Living in a deprived area in Northeast England is worse for your health than living in a deprived area in London.

(*Health Foundation, 2020*)

The recommendations from the report include giving every child the best start in life, enabling individuals to maximise their capabilities and have control over their lives, ensuring everyone has a healthy standard of living, creating fair employment and good work for all and creating and developing healthy and sustainable places and communities.

Introduced by the Labour government in 1999, Sure Start is an example of a significant policy aimed at improving child health and tackling health inequalities. Sure Start offers a joined-up service to support young children and their families initially set up in the 20% most deprived areas of England. Over the past 10 years, an erosion of funding by 60% to Sure Start programmes has impacted child health as reported in the Institute of Fiscal Studies Briefing (Catton et al.; 2021).

Table 3.1 demonstrates NHS England's CORE20PLUS5 approach to tackling health inequalities, focusing on the 20% most deprived areas in England as identified by the Index of Multiple Deprivation, identified at a local level and

Table 3.1 CORE20PLUS5 (NHS England, 2021)

CORE20 – The most deprived 20% of the national population	PLUS – Population groups identified at the local level; see the following examples	5 – Key clinical areas of health inequalities
Identified by the Index of Multiple Deprivation	• People experiencing homelessness • Drug and alcohol dependence • Vulnerable migrants • Gypsy, Roma and Traveller communities • Sex workers • People in contact with the justice system • Victims of modern slavery • Other socially excluded groups	• Maternity • Severe mental illness • Chronic respiratory disease • Early cancer diagnosis • Hypertension – case finding

five key clinical areas requiring accelerated improvement. This approach originally focused on adults but has been adapted to apply to children and young people.

SCOTLAND

Scotland has the lowest life expectancy of all four UK nations, and in recent years, its position relative to other Western European countries has also deteriorated. Inequalities in life expectancy between those living in the most and least deprived areas have widened, with the gap growing to 13.3 years for men and 9.8 years for women (Finch et al., 2023). The report published by the Health Foundation, *Leave No One Behind* (2023), found that inequalities are persistent and widespread and, worse still, continuing to grow, with the most deprived communities being left behind the rest of society. The report highlights concern with the prevalence of drug-related deaths, inequalities in the health and experiences of infants and children and health and socio-economic outcomes for young and middle-aged men.

Finch et al. (2023) suggest current strategies are built on and captured within Scotland's National Performance Framework (2023), which aims to create a more successful country, offering opportunities to all people living in Scotland, enhancing wellbeing, creating growth, reducing inequalities and providing equal importance to economic, environmental and social progress, through its 11 National Outcomes. Scotland's National Outcomes are aligned with the United Nations Sustainable Development Goals (2015).

Cross-sector working, enabling the pooling of resources, having shared aims and setting clear, focused and achievable short-term goals form part of a longer-term preventative approach to policy design to prevent the worsening of Scotland's health (Finch et al., 2023). This is consistent with the Save the Children's report (2023) *Better for Babies* that highlights the detrimental and potentially life-long negative impacts caused by health inequalities and poverty in Scotland and calls for a joined-up strategic approach between early years services, social security and fair working practices to reduce child poverty in households with babies younger than 1.

WALES

With widening health inequalities since the COVID-19 pandemic, Welsh Labour commissioned a review of health inequalities and the cost-of-living crisis, leading to the publication of *A Healthier Wales: Our Plan for Health and Social Care* (Welsh Government, 2021) and *Mind the Gap: What's Stopping Change* (Welsh NHS Confederation, 2022). The cost of health inequalities to the Welsh taxpayer is approximately £322 million per year (Public Health Wales, 2021). Both documents have a strong emphasis on public health, aiming to reduce health inequalities and improve health outcomes, setting a vision to spend more resources on health, wellbeing and prevention of disease.

NORTHERN IRELAND

The Northern Ireland Assembly (NIA) produced the strategic framework *Making Life Better 2013–2023* (DoH, 2014). This document aims to support individuals, families and communities to take control of their lives and lead healthier lives. The framework focuses on addressing differences and inequality to reduce the gap between the least and most deprived in Northern Ireland and reflects the findings of *The Marmot Review* (2010). Like other national strategies aimed at improving health, this framework directs efforts to local communities, devolving power from the national government.

Northern Ireland launched its Mental Health Strategy 2021–2031, with an emphasis on wellbeing, resilience and promoting good mental health. The strategy also focuses on addressing the determinants of health that may impact mental health (DOHNIA, 2021).

ACTIVITY 3.1

Consider your own national strategies, as well as relevant Nursing and Midwifery Council (NMC) Standards of Proficiency for Registered Nurses (2018). You may want to start with one key National Strategy, such as a Quality Improvement Strategy or Mental Health Strategy.

- Is it clear why nurses are required to understand the concepts of health and wellbeing across the lifespan in the NMC Standards (2018).

- How does that knowledge help meet the aims of the Strategy? What do the NMC Standards say about the professional role in supporting these concepts for the individual, groups, families and your colleagues?
- How do the NMC standards support you to influence the prevention of disease across the lifespan?

HEALTH, WELLBEING AND INFLUENCING FACTORS

HEALTH

According to Naidoo and Wills (2016), the word *health* is derived from whole, hale and healing, suggesting health concerns the whole person and their integrity, soundness or wellbeing. Health is difficult to define, and from a lay perspective, health may be the absence of a flare up in a long-term health condition, going to the gym regularly or eating a healthy diet. A professional may define health as the absence of disease (medical model) or more holistically as defined by the World Health Organisation (WHO, 1946, p. 1): 'Health is not merely the absence of disease, but a state of complete physical, mental and social wellbeing'. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition (WHO, 1946).

Whilst the reference to 'complete' may appear idealistic and unattainable, this definition acknowledges health as a multidimensional concept, recognising mental and social aspects should be acknowledged in addition to physical health (WHO, 2005; 1997; 1986).

As early as 1943, French physician Georges Canguilhem suggested health cannot be defined, but it is one's ability to adapt to their ever-changing environment. Canguilem (1991) noted health is not static and cannot be determined by a doctor but by an individual's ability to adapt to their needs. A more recent definition by Krahn et al. (2021) is of a similar view, in that health should be viewed as a continuum rather than a static state and should recognise one's ability to balance and adapt to life conditions and the environment.

The persistence of war, conflict and global inequality means not everyone benefits from the human right of health to the highest possible standard. Green et al. (2015) considers different dimensions to health; physical health, emotional health, social health, mental health, spiritual health and societal health. These dimensions demonstrate how difficult it is to define health and how health is measured. Scriven (2017) identifies five models to explore differing perspectives on health (Table 3.2).

WELLBEING

According to the Department of Health (2014), wellbeing influences health, and health influences wellbeing. Kim and Lindeman (2020) offer two different views of wellbeing. First is the hedonistic view, which suggests that life holds more

Table 3.2 Models of health (Scriven, 2017)

The medical model	• Defined and measured by the absence of disease • Uses sciences such as anatomy, pharmacology and biochemistry • Emphasis on treating disease rather than promoting health or tackling determinants of health • Negative approach • Top down, expert-led • Narrow understanding of health • Emphasis on individual responsibility
The holistic model	• WHO (1946) recognised health was more than merely physical, incorporating mental health and social wellbeing into their philosophy • Highlights the concept of positive health. • Difficult to measure and evaluate as subjective rather than objective
The biopsychosocial spiritual model	• Includes social, psychological, spiritual and emotional dimensions to overall health • Acknowledges health cannot be seen in isolation from our social and cultural environment
The wellness model	• Considers the extent to which individuals or groups can realise aspirations and change or cope with the environment • Emphasis on social and personal resources • Positive approach
The ecological model	• Offers a framework for how individuals and their environments impact one another's health • Multiple factors may determine health across the lifespan • Informs public health policy and health promotion strategies to consider socio-economic inequalities, laws and regulations

positive than negative pleasures. Conversely, the eudaimonism view argues a life worth living or pursuing is a good life. Ryff and Keyes (1995) notes that components associated with psychological wellbeing include self-acceptance, personal growth, relatedness, autonomy, relationships, environmental mastery and purpose in life. It is also important to reflect on the difference between wellbeing and happiness as these terms are used interchangeably. Theobald and Cooper (2012) suggest being well (wellbeing) is a state of contentment and can be sustained over time. Factors such as consuming a healthy diet and physical exercise may contribute to wellness. In contrast happiness is a transient state and closer to complete fulfilment (Theobald and Cooper, 2012).

Kee, Lee and Philips (2019) concluded that individuals who lead happy and fulfilling lives exhibit positive traits and notably are less likely to become ill, have higher immunity, live longer lives and have greater job satisfaction, leading to being more productive. These individuals are more likely to volunteer, be sociable, exhibit positive health behaviours and give to charity (Kee, Lee and Philips, 2019).

SOCIAL DETERMINANTS OF HEALTH

Health inequalities occur because of social inequality rather than an inequality in healthcare (Marmot et al., 2020). Whilst universal access to high-quality healthcare can contribute to good health and treat illness as it occurs, the causes of health inequalities are social, economic, cultural and political (The Health Foundation, 2022). The health of society is closely linked with social and economic progress; therefore, if society is prosperous, health tends to flourish. Population health is connected to the environment in which people are born, grow, live, work and age, known as the social determinants of health (The Health Foundation, 2022).

To promote health and reduce inequalities, it is important to understand how health is determined. Dahlgren and Whitehead's Model of Health Determinants (1991; Figure 3.1) is frequently used to depict and illustrate the determinants of health. This model focuses on broader influences of health rather than focusing on health services and health sector (Dahlgren and Whitehead, 2021). Age, gender, and other constitutional factors such as ethnic group, and hereditary elements are at the core of the diagram and cannot be changed. Individual lifestyle factors, for example eating a healthy diet and physical activity, may enhance our health and wellbeing. Conversely, if an individual smokes, engages in limited physical activity, consumes excessive alcohol, and eats a poor diet this may lead to poor health and non-communicable diseases (NCDs) such as cancers, cardiovascular disease and diabetes (WHO, 2023). The wider determinants of health, such as education, quality of housing, employment and the environment in which we live, have the greatest impact on

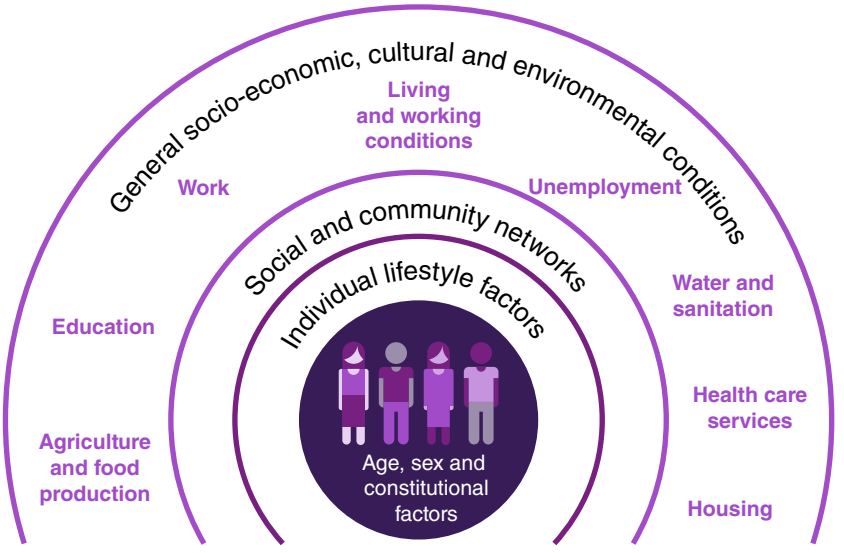


Figure 3.1 The main determinants of health.

(From Dahlgren, G, Whitehead, M., (1991). *Policies and Strategies to Promote Social Equity in Health*. Institute for Future Studies, Stockholm.)

our health (The Health Foundation, 2023). Similarly, unemployment, a lack of access to food, a lack of access to health services and poor working conditions may have a negative impact on people's physical and mental health and lead to NCDs, morbidity and early mortality.

ACTIVITY 3.2

Look at Figure 3.1 and think of the future health needs of populations and individuals due to poverty, inequality, climate changes or developments in the use of technology. Do you anticipate any changes to population health? If so, what will be the impact on your role as a nurse?

You may wish to consider Figure 3.1 from the perspective of a particular age group or population group. Are there specific influencing factors that should be included?

PUBLIC HEALTH

With migration from rural areas to towns during the Industrial Revolution, rapid urban growth occurred. Infectious diseases such as cholera, tuberculosis, typhoid and smallpox were significant, and life expectancy in industrial towns was around 19 years lower than in rural areas. The Public Health Act 1848 was introduced because of poor sanitary conditions and infectious disease epidemics, in response to the *Report of the Sanitary Conditions of the Labouring Population of Great Britain*, (UK Parliment, 1842). The report highlighted the relevance of social conditions and the health of the poor.

Contemporary public health focuses on preventing disease, prolonging life and promoting health (Public Health Scotland, 2022; Jones and Douglas, 2012; Acheson, 1998). These are termed 'upstream' approaches to health as opposed to 'downstream' approaches, which respond to treatment of disease, as depicted in Figure 3.2.

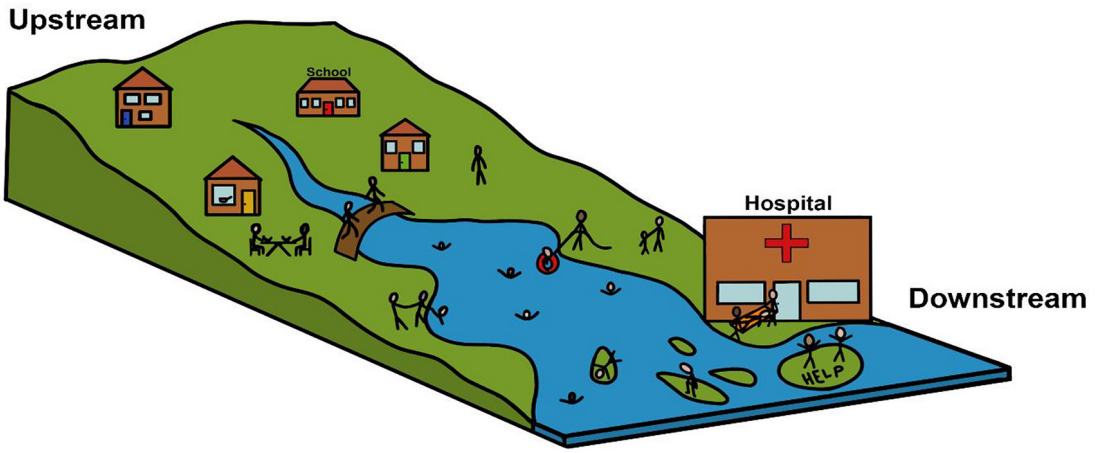


Figure 3.2 The upstream approach.

HEALTH PROMOTION AND THE ROLE OF THE NURSE

Nurses in the community deliver healthcare across the lifespan, which requires a diverse range of knowledge and skills (Foot et al., 2014). As nurses, every interaction should be used as an opportunity to support someone to improve their own health and wellbeing (NMC, 2022a; NMC, 2022b; NMC, 2018). The NMC, Future Nurse Standards of Proficiency for Registered Nurses (2018), platform 2, specifically identifies the importance of promoting health and preventing ill health; understanding the principles of health promotion, protection and improvement; and recognising factors that may lead to inequalities in health outcomes. It is important for nurses to acknowledge the impact of early years and childhood experiences on life choices and have knowledge of the determinants of health, illness and wellbeing in a global context.

The NMC Specialist Community Public Health Nurse (SCPHN) Standards (2022a), are structured around spheres of competency, with promoting health and understanding of public health interwoven through the six spheres. The skill of health promotion practice requires a deep understanding of communication and partnership working theories to achieve the agreed goal, which is to enable people to increase control over and to improve their health (empowerment and choice). Although health promotion is often defined in terms of working with populations and working with individuals, all interventions that aim to enable people to take control over their own health on an individual or a population basis are health-promoting interventions (Whitehead and Irvine, 2010).

The Standards of Proficiency for Community Nursing Specialist Practice Qualifications (SPQ) (2022b), consider the future of healthcare in the community and set standards for qualified nurses and midwives to undertake a specialist practice qualification. Platform 2 suggests nurses with an SPQ are pivotal in promoting health and wellbeing and protecting health, using their knowledge of the local community, in particular, to support individuals to enhance their wellbeing and mental and physical health (NMC, 2022b).

Health promotion is a concept and process that extends throughout an individual's lifespan, from the cradle to the grave. The ageing of modern societies remains one of the greatest challenges for health and social systems (WHO, 2022). Registered nurses with specialist qualifications will have knowledge about the factors that may lead to health inequalities and skills to assess individuals, families and communities to support them in making decisions to improve their health (NMC, 2022a, 2022b).

Current NHS resources are largely allocated to treat diseases once they already exist (downstream) rather than adopt an upstream approach to allocate resources to prevent individuals from becoming unwell in the first place (British Columbia Centre for Disease Control [BCCDC], 2020). With resources spent rescuing people from a river of ill health, this leaves no time to prevent so many people from falling into the river in the first place (BCCDC, 2020). An example

ACTIVITY 3.3

Using the following SWOT analysis tool, consider your own health, wellbeing and lifestyle. What are negative and positive influencing factors? Develop these thoughts and consider the factors that influence income, peer group, upbringing, culture, genetics and education. Consider your perceptions and expectations.

Strengths	**Weaknesses**
Opportunities	**Threats**

of the downstream approach focuses on treating individuals for lung cancer as opposed to upstream approaches, such as higher taxation on cigarettes, smoke-free areas and the regulation of tobacco companies (Jones and Douglas, 2012). A further example of an upstream approach can be found with the Scottish Government's introduction of the Minimum Unit Pricing (MUP) of alcohol in 2018. This is associated with a net reduction of 3% in alcohol sales in Scotland compared to England and Wales, which have not implemented an MUP (Public Health Scotland, 2022).

COMMUNITY DEVELOPMENT

Healthy, mature communities can become self-sustaining and self-developing and are essential to improve health inequity and health inequality. Community development aims to respond to the needs of a community, through engagement of the community. The aim is to work *with* communities rather than *in* communities (Green et al., 2015). Jackson (2021) suggests community development is a long-term approach to address imbalance in power based on social justice. This bottom-up approach involves collective intervention to activate communities to effect change, improve their health and build capacity and empowerment.

Community development aims to involve vulnerable and socially excluded people in decision-making processes (Green et al., 2015); in other words, it aims to promote and foster empowerment at both the individual and community levels (Table 3.3). Socio-ecological concepts identify that health is influenced by the communities within which we live and suggest that the relationships and connections that exist between individuals, families, groups and the environment are significant factors that influence health.

Table 3.3 Community development model (Jones and Douglas, 2012)

Community development model
Problems, targets and action defined by community.
Community target intervention, through capacity building and empowerment.
Community recognised as complex, evolving and subject to power imbalances and conflict.
Targets community structures, services and policies that impact the community's health.
Broad-based activities, targeting wider factors which impact health, but no direct health outcomes.

COLLABORATIVE WORKING

The health of individuals and populations across the lifespan is determined, not by health-sector activities alone but by social and economic factors, and hence by the policies and actions beyond the mandate of the health sector (NHS England, 2014). It is thus important for the health sector to work in collaboration with other sectors to raise awareness of the co-benefits of acting together for people-centred policies that promote health. A 'whole-of-government' approach to health works closely with other sectors such as finance, education, agriculture, environment, housing and transport to examine how their policies can help achieve their own objective while also improving health (Department of Health and Social Care, 2022; Health Improvement Scotland, 2022). An example of a collaborative approach is evident in the increased focus on the integration of health and social care services and the requirement of service user experiences to be evaluated and valued (Henderson et al., 2021). The integration of health and social care is a suggested solution to optimise the improvement of outcomes for populations (Henderson et al., 2021). It aims to provide consistency in the quality of services, end unnecessary time in hospital and promote individual and community independence by creating services that allow people to stay safely at home for longer. You will find more on Collaborative Working in Chapter 13.

USE OF TECHNOLOGY

Technological developments can be used to transform care systems and promote and improve overall health and wellbeing (Lorgelly and Adler, 2000). An increase in the use of technology has led to many recognised categories, such as tele-medicine, tele-healthcare and health informatics. eHealth is defined by the WHO (2021) as the use of information and communication technologies for health. Considering the changing demographics of society and considerable advances in technology, for many populations, some of the changes have led to a positive impact on population health and access to services, support and population empowerment. International and national strategies are evidenced

through an increased collaborative approach to improve healthcare. Digital health is recognised as one of the most rapidly growing areas in health today and is now considered integral to daily life (Lorgelly and Adler, 2000). You will find more in Chapter 19 on Digital healthcare.

SOCIAL PRESCRIBING

Social prescribing enables General Practitioners (GP), nurses and other primary care professionals to refer people to a range of local, non-clinical services. Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals in taking greater control of their own health (The King's Fund, 2017). Social prescribing can involve a variety of activities which are typically provided by voluntary and community-sector organisations. Examples include befriending, arts activities, group learning, gardening and a range of sports. The increased role of social prescribing in tackling issues such as loneliness is an area where priorities are being evaluated and further social prescribing programmes developed. Importantly, these initiatives should reach new or underrepresented groups such as schools, prisoners, and veterans (Department for Culture, Media and Sport, 2023). As with any change or development, there are considerations for the workforce involved in social prescribing, for example capacity, resources, support and the wider challenges of collaboration and service delivery in primary care.

ASSESSING POPULATION NEED

Public Health (Scotland) define need as 'the capacity to benefit from services', whether at the group, population or individual level (Public Health Scotland, 2021, p. 1), and Public Health England (2021, p. 1) defines the action of Health Needs Assessment as 'a systematic approach to understanding the needs of a population'; it can also be referred to as Population Health Management. While the concept of 'need' is generally considered to be subjective and socially constructed (Bradshaw, 1994), these definitions have an overall similarity in that they encourage professionals and all those involved in the identification and assessment of health needs to remain focused on those interventions that may benefit the target population and promote the active identification of people who could benefit from receiving those interventions, especially in the harder to reach or unrepresented groups in society. Systematic methods of identifying the health and healthcare needs of an individual or population and making recommendations for changes to meet these needs is carried out by agencies using a tool or model that provides practitioners with a framework for undertaking this complex and important needs assessment in a structured way (Public Health England, 2021). A needs assessment should be the starting point of any health promotion programme and is a key step to enable the

optimum in planning and resourcing service delivery. It should support service providers to understand the needs of the population and the type and distribution of health and care services that will bring the greatest benefit (Public Health England, 2021; Public Health Scotland, 2022; Laverack, 2016). In recent years, there has been an increased fusion, appreciation of and collaborative working between health and social care services, underpinned by the development of rigorous legislation (DoH, 2022). A health needs assessment could be done for a specific community or sub-group of the population, such as homeless people or people with learning differences, to understand what health and social care services are needed to meet their needs (Public Health England, 2021). Alternatively, a Joint Strategic Needs Assessment could be done by a partnership to support the development of a strategic plan. This would look at the needs of the full population served by the partnership and identify gaps or inequities in service provision.

Identifying individual and population health needs using assessment methods affords all nurses the opportunity to promote health and wellbeing in the communities within which they work, having the opportunity to inform at the local and national levels. Prior to undertaking a health needs assessment, it is important that professionals understand the underlying causes of health inequalities.

Bradshaw's Taxonomy of Social Need (1972) identified individual needs in four categories, and although these categories are not mutually exclusive, they illustrate how different perspectives on need are expressed. Each perspective conveys valuable information to the nurse and will add to the overall understanding of the perception of the individual (Table 3.4).

Table 3.4 Bradshaw's taxonomy of social need (1972)

Normative needs	Needs are defined by the expert. They are measurable against standards. If the individual or group does not fit the standard, then they are not recognised as being in need.
Felt needs	Needs are defined by what the individual wants, but they are often unexpressed. They are defined by social circumstances and personal perception.
Expressed needs	When a group or individual asks for their 'felt need' to be met, it then becomes an 'expressed need.'
Comparative need	When an identified need is used as a measure to define a need across a wider population or community. It highlights those with similar needs who are not yet receiving services.

Table 3.5 Approaches to the assessment of need

Approach	
Epidemiological	Epidemiological trends are studied, recorded and used as key drivers of change in public health and service provision. Trends are identified, policy influenced and services adjusted to meet future demands. The benefit of this approach is that its systematic and objective method quickly identifies specific problems; however, it can assume a standardised prevalence, a focus on medical rather than social needs (Haughey, 2008) and often a dependence on the existing data that may be incomplete.
Comparative	A comparative approach can be used cross-nationally and locally and compares levels of service provision between these localities. For example, the service provision in one town compared with another similar demography. Thus, it is often used to provide a timely and inexpensive assessment.
Corporate	A corporate approach considers making the needs assessment responsive to local concerns. This approach collects the knowledge and views of the stakeholders on the issues being addressed in the needs assessment. The stakeholders can be a collective of practitioners, in both primary and secondary care settings, health and social care service managers, commissioners of services, experts in the field and service users.

All approaches to health needs assessment will have their limitations and, as with any assessment process, may have several and sometimes conflicting, influencing factors, including the knowledge and skills of the individual exploring the need. Professionals should make appropriate use of assessment tools and ensure the inclusion of all relevant participants, such as marginalised or underrepresented groups.

Table 3.5 identifies several approaches to health needs assessment.

You may wish to read Chapter 9 on community nursing assessment.

ACTIVITY 3.4

Reflection

Are you familiar with the processes of identifying needs in your area of practice – whether for individuals, groups or populations?

Who do you regularly involve in your needs assessment, and who should be there ideally?

What are the barriers to collaborative working and the resources available to overcome these barriers?

What assessment tools are used, and how effective are they?

STRATEGIES AND APPROACHES TO PROMOTE HEALTH AND WELLBEING

ACTIVITY 3.5

Before you start, take some time to explore definitions of the following key terms:

Demography
Epidemiology
Empowerment
Social gradient
Equity/equality

HEALTH PROMOTION

The WHO (1974, p. 3) succinctly defined health promotion as 'the process of enabling people to increase control over and to improve their health'. This definition is still relevant today and relates to the concept of individual empowerment and the skilled nurse as an educator, informer and change facilitator. The definition underpins government policy, actively placing the individual at the centre of care and encouraging their involvement in the decision-making processes (DoH, 2012). There is is no single right approach, activity or way to carry out health promotion. The complexity of health and the interrelationship between the multiple influencing factors call for a variety of approaches and methods to be utilised to promote health. It is also important for practitioners to understand theories of behaviour change and why people seek help or not (Azimirad et al., 2023).

There are several models of health promotion, examples of which are in Table 3.6.

Public health clearly encompasses health promotion. It can be concluded that health promoters (e.g. nurses) should aim to enhance participation, equity and fairness to improve the health of individuals, families and communities. Nurses are involved in public health activity through their day-to-day contact with people, families and carers; delivering health promotion activity, planned or unplanned by providing information and education; and facilitating motivation and empowerment. Nursing professionals working in the community setting are in a strong position to promote health and wellbeing. Their knowledge of the local community and access to clients and their families in their own homes enables community nurses to develop a deep understanding of the factors that influence the health of individuals, families and communities. Their ability to influence the care received by individuals and influence local health policy development is high. The challenge is to identify and articulate the nursing profession's contribution to health promotion through effective leadership and using evidence-based, pro-active, contemporary practice (NMC, 2018; NMC, 2022a; NMC, 2022b).

Table 3.6 Health promotion models

Model	
Tannahill (1985)	Identifies prevention, health education and health protection in overlapping spheres to describe the services and activities that constitute health promotion practice.
Beattie (1991)	An analytical model that highlights the interplay of intervention (authoritative or negotiated which equates to professional or client led) and the focus of intervention (individual or society).
Tonnes and Tilford (2001)	Identifies educational, preventative, empowerment and radical approaches but views empowerment as central to health promotion.
Ewle and Simnett (2003)	This model describes five approaches to health promotion: medical, behaviour change, educational, client-centred and societal change. The values which underpin the approaches were represented in a corresponding gradient from professional-led to client-led activity. (See the Approaches sub-section.)

APPROACHES TO HEALTH PROMOTION

Table 3.7 Approaches to health promotion adapted from *Behaviour Change* Ewle and Simnett (2010)

Approach	
Medical approach	Based on a medical model of health and aims to reduce morbidity & premature mortality (freedom from medically defined disease & disability). It targets whole populations or high-risk groups and values preventative medical procedures. It is prominent in traditional health promotion and service delivery, but could be considered paternalistic (i.e., one person deciding what is best for another). It also focuses on the absence of disease rather than on promoting positive health and often ignores the social and environmental dimensions of health. The medical model embraces the following structure: 1. Primary prevention's goal is to protect healthy people from developing disease or injury in the first place through education (nutrition, regular exercise), legislation (seatbelts, Health and Safety at Work Act, 1974), examinations and screening tests to monitor risk factors for illness, immunisation and controlling potential hazards at home and work 2. Secondary prevention is the interventions after an illness or serious risk factors are diagnosed. The goal is to halt or slow the progress of disease (if possible) in its earliest stages; in the case of injury, goals include limiting long-term disability and preventing re-injury. 3. Tertiary prevention is interventions after an illness or serious risk factors are diagnosed. The goal is to minimise or reduce the impact of disease.

(*Continued*)

Table 3.7 (Continued)

Approach	
	It is worth mentioning screening at this point. As a practitioner working in the community, you may well be involved in a screening programme. Screening is a preventative activity that seeks to identify an unsuspected disease or pre-disease condition. It aims to find those most at risk for which an effective intervention is available (Crichton and Mulhall, 2015). Health screening is now a widely accepted service that is largely embraced by the public. Most people at some point in their life have undergone screening of one sort of another, for example breast screening, cervical screening, child development screening, elderly screening; blood tests, hearing test, etc. Although widely accepted, health screening, because it proactively seeks to detect disease before symptoms present, is often the subject of ethical debate and concern about whether the most vulnerable populations are reached (Crichton and Mulhall, 2015) Question: Are you familiar with the most recent Public Health Domain of the Quality and Outcomes Framework (HSCIS) for your nation?
Behaviour change	Encourages individuals to change their behaviour & adopt healthy lifestyles. It views health as belonging to an individual and assumes people can choose to change their lifestyle and improve their health. It often involves a change in attitude followed by a change in behaviour.
Educational approach	Provides individuals with knowledge & understanding to make well-informed choices about their health behaviour. The health promoter/health professional aims to impart information with minimal personal values, then the individual decides whether to act on the health education and any decisions reached.
Empowerment/client-centred	A 'bottom-up' approach that seeks to enable people to take control over their lives, identify their concerns and gain the skills & confidence to act on them. Agendas set by the client(s) – health professionals guide, support, facilitate & encourage, initiating the process and then withdrawing. Conditions for Empowerment: For people to be empowered they need to [r]ecognise and understand their powerlessness; feel strongly enough about their situation to want to change it; feel capable of changing the situation by having information, support and life skills (Naidoo and Wills, 2009).
Societal change approach	Sometimes termed radical health promotion, it recognises the importance of the socio-economic environment in determining health. It focuses on policy with the aim of changing physical, social & economic environments to have the effect of promoting health, that is, focusing on changing society, not the behaviour of individuals.

ASSETS APPROACH

Taking an asset-based approach involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits (Naidoo and Wills, 2016). The approach aims to empower individuals, enabling them to rely less on public services. However, there remains a limited evidence base linking actions to strengthen individual and community assets with improved health and wellbeing. An asset-based approach is, therefore, one which seeks positively to mobilise the assets, capacities or resources available to individuals and communities which could enable them to gain more control over their lives and circumstances (Rippon and Hopkins, 2015.)

A wide range of techniques are used to take an asset-based approach, including asset mapping, co-production and various community-led, community engagement and community development methods. Assets can be grouped as follows:

Individual assets – for example resilience, commitment to learning, self-esteem, sense of purpose.

Community assets – for example family and friendship networks, social capital, community cohesion, religious tolerance, intergenerational solidarity.

Organisational or institutional assets – for example environmental resources for promoting physical health, employment security and opportunities for volunteering, safe housing, political democracy and participation.

STRENGTHS-BASED APPROACH

A strengths-based approach refers to different elements that help or enable an individual to deal with challenges in their life, meet their needs and achieve their desired outcomes. These elements include personal resources, skills and abilities, knowledge and potential. This approach differs from an assets approach, which focuses on social networks and their resources, abilities and skills.

ACTIVITY 3.5

Case study

Case study	Activity
Sophie is a 27-year-old female living with her current partner, James, in a small rural town about 50 miles (80 km) from the city where they previously resided. They live in a social housing flat on the 2nd floor, and the lift is often broken. There are few amenities, and the area is considered 'unsafe' at night. Sophie began a hairdressing qualification but on moving house was unable to complete it. She now finds that she is expecting a baby in 4 or 5 months. James did not complete high school education and is distant from Sophie emotionally at this time. Since moving from the larger city last year, Sophie has not been able to find work. Her partner does some seasonal agricultural work and works part-time with a construction company. They share one vehicle that he uses for work. Sophie's 10-year-old daughter, Adele, lives with them. Since moving schools, Sophie reports her daughter has had 'trouble adjusting' and has become withdrawn and 'moody'. She has had difficulty making friends. She qualifies for the free/reduced-price meal programme at the school which she attends and arrives most mornings in time to eat breakfast.	What professional/personal networks are you a part of to advocate for this family? Is there a risk for (or previous experience of) adverse childhood events (ACEs)? How will you collect additional information regarding these risks? What are the risk factors that might impact the family's health and what are their strengths/assets? How might the social determinants of health factors impact on the family's health? If the family was in your geographic area, what resources/partnerships/programmes (social services) are available to address the needs of the family? How might social isolation potentially impact Sophie and Adele?

HEALTH PROMOTION IN THE WORKPLACE

Workplaces are often where people of employment age spend most of their working life and can be the cause of and impacted by acute and long-term health conditions. It can be seen from the determinants of health above that it is generally recognised that a working population is healthier, happier and more productive. The positive health implications of being in employment have led to a focus on health promotion strategies and guidance in relation to the workplace at a national level. When compared to strategies in other areas of public health, workplace strategies are in an unusual position because they serve the purpose of incorporating the wider public health agenda but put the onus on businesses/employers to take the lead to ensure that health is seen as a priority (Cvenkel, 2020).

ACTIVITY 3.6

Access and explore the Council for Work and Health – www.councilforworkandhealth.org.uk

There are also numerous resources and information specific to health and wellbeing in the workplace found on the UK Government Health and Safety Executive online site. Consider how these resources will be useful for you as a community nurse providing care and advice to people in employment to promote health and understand the possible services available.

Mental health is an integral part of health and wellbeing, as reflected in the definition of health in the Constitution of the WHO (2021). Mental health, like other aspects of health, can be affected by a range of socio-economic factors (described later) that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach. A well-thought-out wellbeing policy should encompass all areas of mental health, considering the relevant legislation including the Equality Act 2010, where various mental illnesses, such as depression, schizophrenia, eating disorders, bipolar affective disorders and obsessive-compulsive disorders, as well as personality disorders and some self-harming behaviours, are considered disabilities.

ACTIVITY 3.7

Reflect and consider the following:

- What support do we need in the UK to live healthier lives?
- Thinking about the future of health and social care services, where should our focus be?
- Consider the information you have been given in the chapter and think of the populations of people you provide or lead care for. What resources and knowledge need to be in place for each of these health promotion approaches to be successful? You can think of policy, legislation, attitude, values, skills, abilities and so on.

CONCLUSION

As services are redesigned to deliver care closer to home, it is widely acknowledged that the emphasis on health promotion and prevention of ill health belongs predominantly in community environments. With population changes and ever-emerging challenges, for example antibiotic resistance, it is incumbent on the current nursing workforce to develop an approach to community nursing that goes beyond the idea that nursing is no more than assessing, planning and implementing/evaluating the delivery of care associated with a set of clinical tasks. Effective community nursing must identify and engage in public health activity, inter-agency working, multi-agency working and research to promote health and wellbeing in society and for individuals.

Through the presentation of relevant underpinning theory/policy, this chapter has demonstrated that public health is everyone's business and that community nurses are in a key position to enable and empower individuals and communities across all levels, from some of the hard-to-reach groups in the population, such as the housebound, to those eagerly involved with promoting their own health and improving their own sense of wellbeing.

FURTHER RESOURCES

NHS England, All Our Health – https://www.e-lfh.org.uk/programmes/all-our-health/

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CHAPTER

4

Professional approaches to care

Bruce Harper-Ovstebo and Jane Mair

LEARNING OUTCOMES

- Analyse the professional standards, regulatory requirements, ethics and policies underpinning community nursing.
- Critically appraise decision-making approaches to manage complexity and risk in the community.
- Explore professionalism and accountability in integrated working environments and diverse cultures.
- Examine lifelong learning and professional development in a continuously changing community landscape.
- Reflect on the community nurse's influence in supporting learning and development in the community.

INTRODUCTION

The demographics of people and communities continue to be challenged by issues of an ageing population, increasing complex comorbidity, increasing demand for health services, widening and persistent health inequalities and issues regarding resourcing and increased costs (Whitley et al., 2022). These factors have led to governments across the UK to aim at shifting the balance of care to the community (NHS England, 2019a; Department of Health, 2018; Welsh Government, 2018; Department of Health, 2016), as highlighted in Chapter 1. These factors have also resulted in community care becoming more complex and diverse, which can pose challenges regarding professional approaches to the delivery of care by community nursing teams.

This chapter explores the concepts of professionalism, professional standards, regulatory requirements and policies underpinning community nursing. It also evaluates decision-making approaches relating to integrated working environments and diverse cultures. In addition, the chapter examines the need for cultural awareness, self-care and promotion of inclusivity within professional practice. Finally, this chapter appraises lifelong learning, professional development and supporting the facilitation of learning to maintain the professionalism of community nurses.

Throughout this chapter, a case study approach (Table 4.1) will prompt the reader to consider professional issues and illustrate the principles discussed in

DOI: 10.4324/9781003347545-5

the chapter. The Johnson family presents a complex situation that raises several professional challenges not uncommon within community nursing. There are several case-related activities throughout the chapter designed to help develop an understanding of the complexity of professional approaches to care.

CASE STUDY

The Johnson Family

The Johnson family lives in a small mining village in a two-bedroom, two-up-two-down ex-local authority house bought by the grandparents. Heather is currently the main carer for her husband, Bert, who has advanced Parkinson's disease. His physical condition has declined, but due to a lack of social carers, Heather is providing all care and is supported by the district nursing team for the administration of peg feeds and medication.

Their daughter, Bell, and her partner, Ali, had to move into the grandparents' home as she lost her privately rented house when her previous partner, Michael, was prosecuted and sentenced for child abuse of their child, Bailey. Michael is appealing the sentence on compassionate grounds, having been diagnosed with end-stage pancreatic carcinoma. Bailey remains on the child protection register as there have been concerns of neglect and abuse by Mum and partner Ali. As Bailey is just turning 5, a case review has been arranged as they transition from the care of the health visitor to the school nurse.

Ali is a registered nurse who currently works in the local private nursing home. The nursing home manager has become aware of the family's situation through conversation with the district nurse while tending to a palliative care patient within the nursing home. Ali is currently studying to become an independent prescriber using distance and online learning. It has been identified by the practice assessor that Ali has neurodiversity learning needs which require addressing.

PROFESSIONAL STANDARDS, REGULATORY REQUIREMENTS, ETHICS AND POLICIES UNDERPINNING COMMUNITY NURSING

There is no singularly agreed definition of who is a professional or indeed what professionalism is – both concepts have different perspectives and definitions resulting in misunderstanding and assumptions being made (Fitzgerald, 2020). Traditionally, a professional was associated with being part of an elite group of experts with claims to specialist knowledge and skills that licence their practice. Historically, a nurse did not require an undergraduate degree to practice; however, with Project 2000, it was acknowledged that nurses' professional status should be recognised as their knowledge had extended, focusing on wider community care. At this point, nursing became a degree-level profession (Davis et al., 2000). The nature of nursing work is vocational, practising with autonomy, and, like professional roles such as law and medicine, is valued within society (Fitzgerald, 2020). Professionals exercise their duty in the best interests of their clients, and thereby, their approach is intentionally altruistic. Nursing professionals may see themselves as the ideal advocates, being able to define the

person's needs, deliver patient-centred care, multitask, clearly communicate and determine any solutions based on their expertise (Rasmussen et al., 2018). Such attributes result in a high degree of professional autonomy and rely, particularly, on building trusting relationships with their clients.

In healthcare, registered practitioners are permitted access to the human body to undertake intimate or intrusive assessments, clinical examinations and treatments and have access to highly confidential and personal information about a person. Therefore, healthcare professionals have considerable power and high moral standards are expected of them to do what is best for the public; this is enshrined in law as a duty of care owed to the public and underpins the need for professionalism for those in recognised registered positions such as nursing (Dimond, 2015).

Nursing is a recognised profession; however, the exact definition of what this constitutes has been debated and defined by many researchers over the years. A definition by Willetts and Clarke (2014) recognises that nursing is a profession in its own right because of the body of knowledge, professional recognition, code of conduct and community recognition, which provides oversight and monitors the code of its members. While in more dated research, the following definition remains valid and well aligned with community nursing. Manojlovich and Ketefian (2002) define the nurse professional as an autonomous practitioner with specialist knowledge, community oversight and a code of conduct that they follow.

Community nursing is the umbrella term for the range of nurses working in the community. A community nurse can be defined as any nurse who is registered with the Nursing and Midwifery Council (NMC) and works in a community setting, including where people live, at home or close to home, in adult and child social care settings, educational settings, primary care, community clinics, outreach centres, custody and justice settings and other community settings or establishments (NHS England, 2019a). Additionally, there are many community nurses who go on to complete postgraduate study to gain a Specialist Practitioner Qualification (SPQ) in district nursing and other community nursing fields or Specialist Community Public Health Nurse (SCPHN) qualification in health visiting, school nursing or occupational health nursing.

Professional networks and associations provide oversight of the conduct of distinct groups of professionals. Professional and statutory regulatory bodies protect the public, police entry onto and removal of people from professional registers and examples include the NMC, the General Medical Council (GMC), and the Health and Care Professions Council (HCPC). The principles of revalidation, continuous professional development, fitness-to-practise procedures and good character by the NMC and HCPC provide additional mechanisms for a duty of care, protecting the public and the professions (HCPC, 2023; NMC, 2023a; NMC, 2023b).

In the case of the Johnson family (case study), they are owed a duty of care by a range of professionals: district nurse, health visitor, school nurse, prison nurse, social worker and GP. All professionals, and those who are members of a recognised profession, share distinct characteristics by being part of a profession (Table 4.1) and as a result of being a professional (Table 4.2).

Table 4.1 Characteristics of professions

- A distinct body of specialist knowledge and skills
- A lengthy and exclusive training leading to registration
- Altruism
- Code of practice
- Duty of care
- Ethical practice
- Autonomy
- Accountability
- Privileged access to and trusting relationship with clients
- Public trust and good standing
- Higher social status, pay, reward and career structure

Table 4.2 Six characteristics of being a professional

- Providing best practices for clients and society
- Acting with integrity in any environment
- Keeping current with theory and practice
- Critical reflection on one's own practice
- Contributing to the profession and other professionals
- Interacting with other professionals

Source: van Oeffelt et al. (2018).

ACTIVITY 4.1

Critical thinking

What are the differences between professionalism and acting in a professional manner?

Within the case study, can you identify any potential professional issues that may arise concerning Ali, her home situation and her professional practice?

There is a common set of principles that guides ethical practice in health and social care (Beauchamp and Childress, 2013). Decisions are based not just on clinical evidence but also on a set of moral principles. Health itself is enshrined within human rights values (World Health Organisation [WHO], 2015). To do what is right in some circumstances may involve different stakeholders who may have different views which will need to be considered when making decisions. Four ethical principles inform decision-making in healthcare practice (Beauchamp and Childress, 2013):

- Respect for autonomy
- Non-maleficence
- Beneficence
- Justice

Respect for autonomy: Individuals have the right to make their own decisions and provide informed consent to care. Professionals must respect the

decisions that individuals make and ensure their practice is consistent with this. There are exceptional circumstances in which individuals are unable to make decisions, and professionals must understand the circumstances and legislation that override this self-rule principle whereby an individual can be assessed as being unable to make a decision. In Scotland, this legislation relates to the Adults with Incapacity Act (Scotland) (2000). In England and Wales, this legislation is covered by the Mental Capacity Act (2000). Finally, in Northern Ireland, this legislation is included in the Mental Capacity Act (Northern Ireland) (2016).

Non-maleficence: Practitioners should cause no harm, whether intentional or unintentional. Any resulting harm due to a breach in the duty of care owed to that individual may be considered negligence, leaving the professional open to a charge of misconduct and subject to an action for compensation through the courts (Dimond, 2015).

Beneficence: Care offered should be beneficial to an individual, but this may not always be the case.

Justice: Care should be equitable in terms of need and access to resources. In the community, this may be a challenge as there will be unequal circumstances and resources affecting quality of care, for example, housing, access to family support or respite. To illustrate this, Gerrish's (1999) seminal research showed that there was unequal access to district nursing services for ethnic minority communities because of the way district nursing services were aligned to different GP practices.

To become a professional, there is a process of acculturation and socialisation whereby new professionals are exposed to the norms and values that pertain to a particular profession. All professions have their own values and concepts that guide and shape practice, and it is important to consider how these inform community nursing (Table 4.3; Banks, 2013). An important aspect of working in the community is the relationship between communities and its members, including people receiving care, families, carers and other professionals (NHS

Table 4.3 Common professional values

- Respect and dignity
- Caring
- Empathy
- Autonomy
- Holism
- Confidentiality
- Empowerment
- Partnership
- Equity
- Social justice
- Human rights
- Advocacy

England, 2023). While the common values that have been identified are similar across professionals, different professional groups will perceive these differently as discussed later (Tønnessen et al., 2020).

As previously identified, nursing has specific characteristics and professional values. These values are expressed in professional codes and frameworks of practice, for example, the NMC (2018) and the Royal Pharmaceutical Society (RPS, 2021), which set out clear values and frameworks guiding professional standards to which professionals are held to account. These professional codes are an important way of assuring the public that the profession is regulated and to have confidence and trust in the profession.

Policy directives shape the delivery of care in community nursing across the UK (as highlighted in Chapter 1) and continue to actively promote the movement of care from hospitals to home. The NMC provides a distinct role in setting educational standards to meet healthcare policy agendas across the UK. Higher education institutions are required to demonstrate that they meet these standards and are approved by the appropriate regulatory body to provide educational programmes. The NMC SPQ and SCPHN Standards of Proficiency (NMC, 2022a, 2022b) were updated in July 2022. Within these, there is an explicit focus on preparing future professionals for working within complex community environments and supporting families such as the Johnson family.

DECISION-MAKING APPROACHES TO MANAGE COMPLEXITY AND RISK IN THE COMMUNITY

Community nurses at all levels and grades, although part of a team, generally work alone and, as such, they should be able to analyse complex situations, think critically, and make decisions that are evidence-based (Shu et al., 2019). Community nurses in SCPHN and SPQ roles must possess the knowledge and skills required to exercise advanced levels of judgement for effective problem-solving and decision-making (NMC, 2022a, 2022b). The NMC Code (NMC, 2018) states that nurses must prioritise people, practice effectively, preserve safety and promote professionalism and trust. The NMC Code (NMC, 2018) places emphasis on shared decision-making with patients and empowering them in relation to their health and wellbeing. Whilst developing levels of autonomy, and perhaps moving into more advanced nursing roles in the community, the complexity of working within the Code (NMC, 2018) becomes increasingly apparent.

ACTIVITY 4.2

Discussion point

What informs your decision-making? You may discuss this with a member of the community nursing team. Consider different decision-making approaches utilised when supporting the Johnson family in the case study.

It is vital to recognise the role people, families and communities have in informing healthcare improvement and developing practice. The four nations of

the UK (Scottish Government, 2016a; Department of Health, 2016; National Assembly of Wales, 2019; NHS England, 2019a) recognise that services should be designed around how best to support individuals, families and their communities to promote and maintain health. To realise this ambition, it is key that those using services are actively involved in the planning, design and development of these services. The concept of 'co-production' is advocated as a way of drawing on the knowledge, ability and resources of not only those people accessing services but also the health and social care providers involved to develop solutions to issues pertaining to their community (Brandsen, Verschuere and Steen, 2018). For example, many health visitors have adopted the UNICEF baby-friendly initiative (UNICEF, 2017).

Co-production can further change the balance of power from professionals or services to individuals and communities so they have control over their health and wellbeing. Co-production can take different forms and is not always easy to implement due to culture and a lack of resources and understanding by professionals and communities (NICE, 2021). This change of approach in community nursing helps both the professional and the community ensure services are designed around the particular needs of communities and helps utilise resources effectively to overcome persistent health inequalities that exist (King, Eckham, and Moulton, 2021). Caution must be taken that these health inequalities do not continue to widen and persist. For example, Honeyman et al. (2020) report on how governments are aiming to improve the nature and access to digital technologies within the health system (see Chapter 19). However, there is evidence that where groups are already disadvantaged, the divide can become greater, which can involve those living in remote, rural and deprived areas; older people; and minority ethnic communities, as well as people with lower incomes, for example (Honeyman et al., 2020).

Effective communication is fundamental in decision-making in order to manage complex care and is essential to building relationships, promoting respect and dignity, achieving concordance and empowering and ensuring safety amongst staff and the public (Afriyie, 2020). The consequences of effective communication can be classified into healthcare system-related and patient–nurse-related outcomes (Skär and Söderberg, 2018). Effective communication can lead to positive and cost-saving results (Afriyie, 2020). Conversely, ineffective communication may lead to adverse outcomes. Effective communication in community nursing is multifactorial and multidimensional. It is a two-way exchange of information, and by using standardised communication tools, there is a strong emphasis on avoiding miscommunication. The consequences of poor communication can have damaging effects on the profession's reputation, highlighted in high-profile cases in which there have been communication failures. This was recently emphasised in the case of Martha Mills, who died of sepsis; despite the family raising concerns about her condition, this was ignored when, sadly, a second opinion would have saved her life (Dyer, 2023). As a result, 'Martha's Rule' can subsequently empower individuals and families

to formally request a review of their or their family member's case by a senior nurse or doctor if the person in question is deteriorating and they feel that their concerns are not being listened to (Dyer, 2023).

ACTIVITY 4.3

Action point

Refer to the Code of Conduct (NMC, 2018). How many of the standards refer to effective communication?

Risk management, in its simplest form, relates to the activities and policies that engage practitioners to encourage good practice and prevent things from going wrong (Price Waterhouse Commons [PwC], 2021). Every individual accessing health and social care should expect their services to be safe, effective, and patient-focused (Department of Health, 2019; Healthcare Improvement Scotland (HIS), 2021; NHS England, 2019b; NHS Wales Executive, 2023). Health and social services in the UK have a legal responsibility to ensure the necessary systems and processes are implemented to provide safe and effective healthcare. All community nurses have a responsibility to implement, evaluate and adhere to risk management whilst working in the community setting (NMC, 2023d). An example of this would be the management of risk around lone working (see Chapter 5).

PROFESSIONALISM AND ACCOUNTABILITY IN INTEGRATED WORKING ENVIRONMENTS AND DIVERSE CULTURES

The aim of holding community nurses accountable for their actions is to ensure that the public and patients are not harmed by their acts and omissions. To achieve this aim, Griffith (2019) outlines the functions of accountability in community nursing:

Protective function: The purpose of accountability is to protect the public from the omissions or acts of community nurses that might cause harm. You can be called to account for your competence and conduct if it is thought that you have fallen below the standard required of you.

Deterrent function: The penalties available to the NMC that hold nurses to account protect the public and patients by discouraging them from acting in a way that would be considered misconduct or unlawful. A community nurse must always act in a manner worthy of a registered nurse – whilst at work, in public and in their private lives.

Regulatory function: By making nurses accountable to a range of higher authorities the law regulates nurses' behaviour. Community nurses are rightly seen to be working autonomously and can decide what care and treatment a patient requires. This autonomy is not unrestrained, and the nurse must inform their decisions by reference to their regulatory framework and to the

evidence available. This makes it clear what standard of conduct and competence community nurses are required to comply with.

Educative function: Community nurses who are called to account and asked to justify their actions have their cases heard in public. This is to reassure the public that only the highest standards of practice will be tolerated. This public scrutiny of a community nurse's conduct allows other members of the profession to learn from the mistakes and misconduct of others (Griffith, 2019).

As can be seen in the case study, people and their families often live with complex situations in the community. Increasingly the role of interdisciplinary and multi-agency team working is an essential aspect of the community nursing role. Regarding the Johnson family, there would be a range of integrated interdisciplinary and multi-agency disciplines involved (Figure 4.1)

ACTIVITY 4.4

Critical thinking

Considering the case study, there are many interdisciplinary and multi-agency professionals involved. What challenges could this present regarding decision-making with the integrated team?

The importance of recognising diversity within the nursing profession is embedded within the NMC Code (NMC, 2018) and other health professional regulatory board requirements. It is identified that nurses and midwives must provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences and taking account of any need for adjustments.

Within the UK, everyone must also comply with the Equality Act (2010), and therefore, it is essential community nurses understand how this applies to

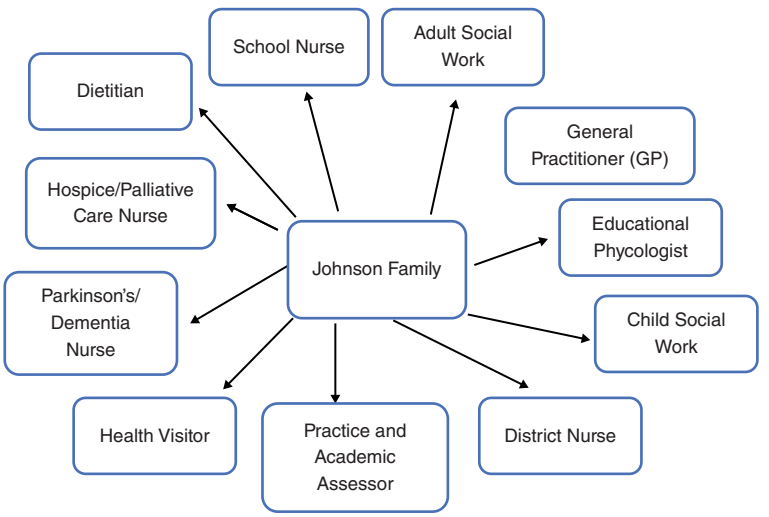


Figure 4.1 Integrated working environments supporting the Johnson family.

their practice. The act provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. It provides a discrimination law that protects individuals from unfair treatment and promotes a fair and more equal society. Effective and ethical practice in relation to diversity and equality, however, does not just occur by following legislation but requires considered reflexive and reflective practice (Stenhouse, 2021). The act is relevant to community nurses when delivering care and while working in teams.

There are clear inequalities within society (NHS Health Scotland, 2015; Welsh Government, 2016; NHS England, 2021; Department of Health, 2016). As community professionals, it is imperative to explore inequalities within your workplace and the wider community setting. There is widespread agreement by governments that the primary causes of health inequalities are the unequal distribution of power, income and wealth (NHS Health Scotland, 2015; Welsh Government, 2016; NHS England, 2021; Department of Health, 2016). This can result in the marginalisation of groups and individuals. The domains of health inequalities model (Figure 4.2) defines the factors that contribute to inequality (see Chapter 3).

INTERSECTIONALITY

The lens of intersectionality recognises that individuals have multiple aspects to their identity that can result in different means of privilege or inequity depending on context and social relations. Intersectionality is a way of exploring and understanding complexity in the world, in people and in human experiences

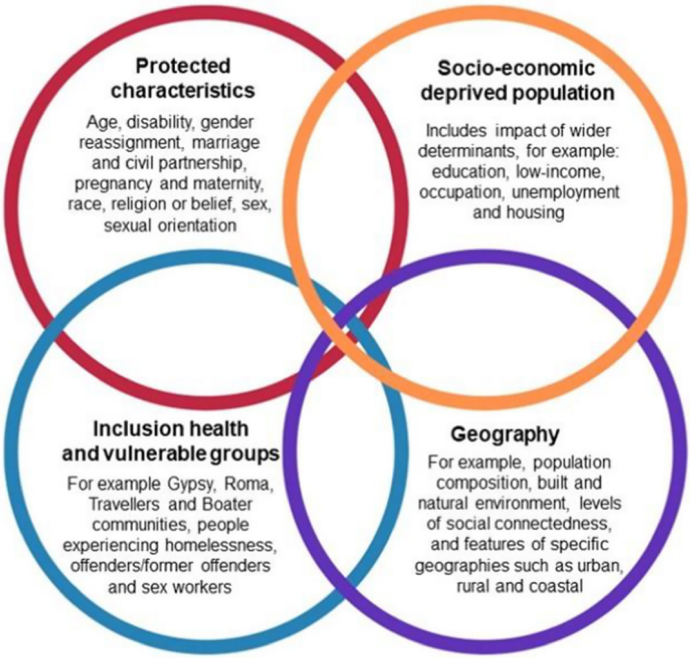


Figure 4.2 Domains of health inequalities.
Source: Government UK (2022).

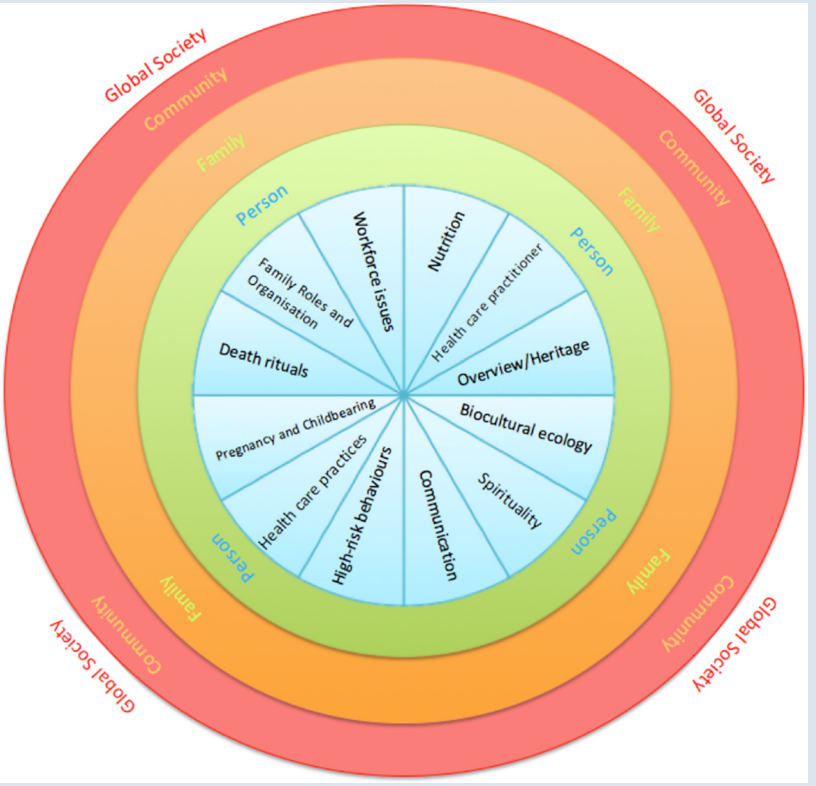
(Hill Collins and Bildge, 2016). Intersectionality views categories such as gender, class, ethnicity, ability and age, amongst others, as interrelated and shaping one another. For instance, Ali (see the case study), is a woman, white, a partner and bisexual. They are a nurse, university-educated and speak English; they also have some learning needs. Ali's intersectional factors have relevance to their relationships with others, for the structures and systems of power they live and work within and for their health and interactions with health services.

PURNELL'S MODEL FOR CULTURAL COMPETENCE (2021)

The Purnell model includes 12 cultural domains (constructs): overview or heritage, communication, family roles and organisation, workforce issues, bio-cultural ecology, high-risk behaviours, nutrition, pregnancy, death rituals, spirituality, healthcare practices and healthcare professionals. The model is a circle: the outer rim represents global society, the second rim represents community, the third rim represents family and the inner rim represents the individual (see Purnell, 2021). The domains provide the organising framework of the model. This model is particularly relevant for community nurses who work with people, families and communities to ensure they are culturally aware and competent.

ACTIVITY 4.5

Action point: Research Purnell's model of cultural competence



Look at the model, which is complex but highlights aspects within the 12 domains you may consider in practice.

Regarding Ali, what aspects of the model do you think are relevant, and how would they influence your approach to care?

LIFELONG LEARNING AND PROFESSIONAL DEVELOPMENT IN A CONTINUOUSLY CHANGING COMMUNITY LANDSCAPE

The WHO (2022) defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability, with or without the support of health professionals. This ideology refers not only to care delivery but also to health professionals as the health of nurses directly impacts the care of patients. Much has been written about nurses' burnout, stress and poor physical and mental health, including a lack of job satisfaction and moral negativity (Matarese et al., 2018; Melnyk et al., 2018). Despite these problems, teaching, normalising, and encouraging self-care have remained infrequent (Sist et al., 2022). A lack of self-care was exaggerated during the COVID-19 pandemic (Luo et al., 2020).

Self-care means activating measures and activities to stabilise and maintain health (Andrews et al., 2019). The responsibility for this process lies with both the individuals, who should apply the methods regularly, and institutions, which must offer opportunities for self-care that meet the needs of the staff (Blackburn et al., 2020). Self-care is a multidimensional construct and involves ways of behaving and thinking that can be learned (Wei et al., 2019). It can be defined as the ability to withstand significant change and disruption through effective coping and the capacity to undergo personal growth (Blackburn et al., 2020). Strategies are identified to promote coping and adaptability, such as facilitating social connections, promoting positivity and strengths, nurturing nurses' growth, encouraging nurses' self-care, fostering mindfulness practice and conveying altruism (Wei et al., 2019). However, if, in the first instance, work cultures were more supportive and caring, coping mechanisms such as these would not be required (Patrician et al., 2022).

As identified throughout this chapter, being a professional in the community is multifaceted, ever-changing and affected by political and global issues, meaning that change and disruption are an inevitable aspect of community nursing. Therefore, community nurses are required to be supported to develop self-care and care of others to ensure they are equipped with the supportive measures required to work in the community environment.

ACTIVITY 4.6

Reflection

Reflect on what support mechanisms could be available to support the wellbeing and self-care of professionals within the community setting? What measures are available in your area of practice?

Professional regulatory bodies, such as the NMC, HCPC and GMC, have the legal power to regulate their respective professions. In addition to the standards they set for education (NMC, 2023c), they also maintain a register of eligible professionals. Public confidence in professionals has been eroded in recent times by a series of damning reports into failings, abuse and neglect in healthcare and have led to damaging media attention and public enquires.

Consequently, health professionals are facing greater scrutiny to ensure they continue to remain competent. Traditionally, qualifying professionals were not required to undertake additional training or formally demonstrate they were keeping their competency up to date. This does not mean that practitioners did not do this, and many did voluntarily, but it was not an explicit requirement from professional bodies. Following on from recommendations from public enquiries and to ensure public trust in professionals, regulatory bodies have introduced revalidation and continued professional development requirements and fitness to practice and good character procedures to ensure public protection and trust, as well as ensure that practitioners remain competent in their area of practice (NMC, 2019; HCPC, 2023). One example of ensuring the professional development of those nurses working in the community is the legal requirement to revalidate their registration every 3 years to confirm they remain fit to practise and ensure public confidence in the profession (NMC, 2019; Table 4.4).

Table 4.4 Revalidation

Revalidation is a process to allow nurses and midwives to maintain registration with NMC. To do this, the nurse or midwife must demonstrate they have continued ability to practice safely and effectively. Revalidation Requirements • 450 practice hours, or 900 hours if renewing two registers • 35 hours continuing professional development (CPD; 20 hours must be participatory learning) • Five pieces of practice-related feedback • Five written reflective accounts • Reflective discussion • Health and character declaration • Professional indemnity arrangements • Confirmation

Source: NMC (2019).

ACTIVITY 4.7

Action point

Access the NMC website where you will be able to access the latest fitness to practice hearings that have been held (https://www.nmc.org.uk/concerns-nurses-midwives/hearings/hearings-sanctions/). Here you will be able to see examples of the range of concerns that have been raised about nurses' professionalism.

Reflect on how these may have an impact on the public perception of the nursing profession.

Table 4.5 Career opportunities in community nursing

- SCPHN
  - Health Visiting
  - School Nursing
  - Occupational Health Nursing
- Community Nursing SPQ
  - Community children's nursing
  - Community learning disabilities nursing
  - Community mental health nursing
  - District nursing
  - General practice nursing
  - Specialist community nursing

Source: NMC (2022a, 2022b).

In addition to revalidation and continued professional development requirements of regulatory bodies, professionals who enter community nursing posts are entering a varied and exciting career in which there is scope for lifelong learning.

Regardless of the community nurse's role, there is a variety of lifelong learning opportunities community nurses can engage with, ranging from less formal CPD activities to short, accredited courses, that help ensure professional knowledge whilst maintaining the requirements of professional bodies. Further development opportunities in community nursing extend to formal postgraduate qualifications, allowing community practitioners to specialise in specific areas and become specialist professionals in any of the areas in which community nurses work (Table 4.5). The updated NMC educational standards recognise a more diverse range of specialist community nursing professionals and specialist community nurses who work across the lifespan (Figure 4.3).

THE COMMUNITY NURSE'S INFLUENCE IN SUPPORTING LEARNING AND DEVELOPMENT IN THE COMMUNITY

As explored earlier, there are several settings within which community nurses work. Many of these settings will accommodate a range of students from undergraduate and postgraduate programmes and from a range of professions. It is important that undergraduate students are provided with a range of practice learning experiences in the community so they have the experience to meet the holistic needs of individuals in their future professional practice (NMC, 2023d). Supporting undergraduate students in community placements helps highlight the range of community nursing career options and roles which are not always well known to students. Additionally, these learning experiences prepare students with the foundation skills and knowledge for future community nursing careers (NMC, 2023d). There should be equal emphasis on community and hospital placements. In addition to undergraduate students, there are also postgraduate students who will be working within the community, either as community nurses completing postgraduate study or as community nurses on practice learning experiences as part of an SPQ or SCPHN programme.

Community Nurses Touching People's Lives across the Lifespan

Registered Nurses in the community have many different job titles. Many of them will join teams as community staff nurses with the opportunity to progress into numerous specialisms. Here are some of the community nurses that you or your family might meet at different times of life.

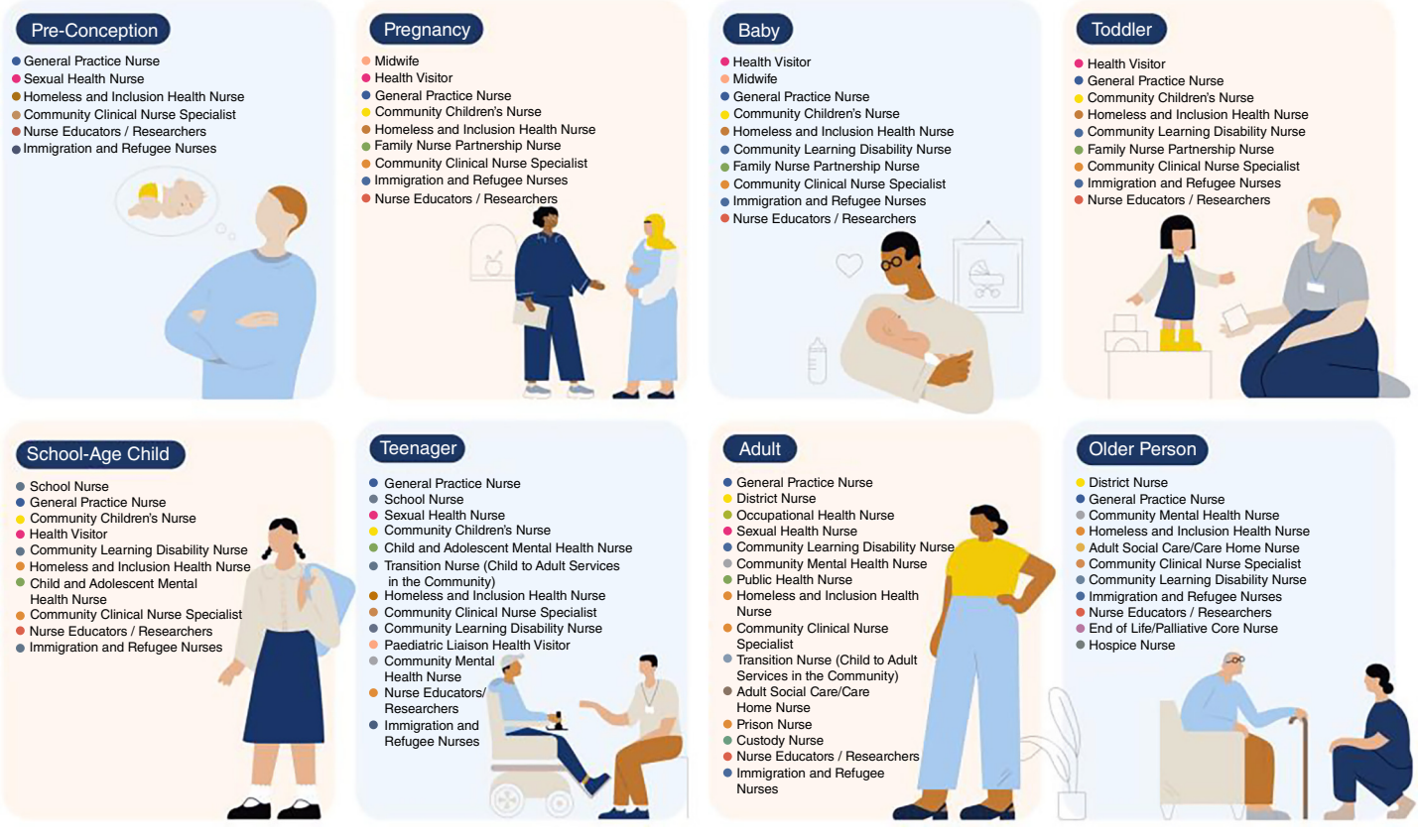


Figure 4.3 Community nurses – working across the lifespan.

Source: QNI (2023).

The NMC provides standards for practice learning for both under- and postgraduate students. These standards ensure that the practice learning placements remain varied and are audited to ensure that they support individual student learning needs and that reasonable adjustments are made for students with identified learning needs (NMC, 2023d). They also seek confirmation that professionals supporting students in practice have the knowledge and skills to support student learning and ensure that students achieve the competencies required during the practice learning experience (Scottish Government, 2016b).

Professionals have a responsibility to ensure that individual student learning needs are met and reasonable adjustments are put in place for students where required. As learners become more diverse, resulting in a wider range of needs, and with a focus on widening participation to reduce inequalities in education, it is important that community nurses are equipped with the skills and expertise to support inclusivity in terms of educational opportunities (QNI, 2022).

In addition to supporting student learning needs, it is important to be aware of student attrition and why students leave their programmes. The Reducing Pre-registration Attrition and Improving Retention (RePAIR) report highlights factors that, if unaddressed, could affect the supply of newly qualified nurses. These include student confidence level and the ability to be competent and are heavily influenced by the support and culture in the practice learning experience setting (Health Education England, 2018a and b). As the recruitment and retention of community nurses is a pressing issue (Chamanga et al., 2020), it is important we remain aware of the factors that influence the retention of student nurses. The RePAIR report also highlighted the overall percentage of students who do not complete their educational programmes on time which averages across the nursing fields at 33.4% (Health Education England, 2018). This report highlighted a need for community nurses who support students learning to be competent and consider their teaching and role-modelling skills as part of their revalidation and continued professional development. The findings of the RePAIR report also highlighted the need for cultural competence and the importance of supporting staff wellbeing has been discussed earlier and would apply to the support community nurses offer to under and postgraduate students while on practice learning experiences.

ACTIVITY 4.8

Action point

Access the latest education standards (NMC) to establish the role of the practice assessor and practice supervisor in supporting reasonable adjustments in practice for students such as Ali in the case study. Are you aware of the reasonable adjustment protocol in your area of practice?

RECRUITMENT AND RETENTION

Within community nursing, recruitment and retention of staff is of vital importance to maintain the quality of the service. Currently in the profession, there is

a reducing and ageing workforce, especially, those who hold SPQ or SCPHN qualifications, which has resulted in ongoing recruitment and retention issues (Chamanga et al., 2020; Swift and Punshon, 2019). There are new and emerging advanced practice roles, such as advanced nurse practitioner within general practice. While positive, this does mean that the more traditional community nursing roles have problems retaining staff, with professionals moving into other, often better paid, primary care roles (Morris, 2017). Issues with recruitment and retention are challenging for governments, which are aiming to move care closer to home and, despite measures to recruit and retain staff, these measures have to date been unsuccessful (Chamanga et al., 2020).

The impact of global issues, such as recovering from the COVID-19 pandemic, BREXIT and economic challenges, is causing shortages in human resources across many professions and community nursing has been particularly affected (Chamanga et al., 2020). While it remains a priority for the government and health boards to ensure the recruitment and retention issues remain a priority in community nursing, it is essential that the community nurse continues to support and facilitate positive practice learning experiences for students, as discussed earlier. Additionally, to help retain community nurses in the profession it is important that community nurses and their managers continue to ensure the wellbeing and self-care of community nurses and promote an inclusive and professional culture in the workplace (Rogers, 2021).

CONCLUSION

Within this chapter, the complex and wide range of topics that make up the professional role of the community nurse have been explored. Despite the history of professionalism within the nursing profession, there are circumstances, such as Ali's scenario in the case study, where the nurse's professionalism is called into question, hence the need for nurses to have a sound understanding of the issues addressed in this chapter. This also highlights the need for the regulator, the NMC, to uphold the profession and monitor the conduct of nurses. When nurses have been reported to have concerns about their conduct and professionalism, these proceedings are publicly recorded. This chapter has highlighted the importance of lifelong learning and professional development to maintain the community nurse's competence. Additionally, recruitment and retention of staff are issues in community nursing, and with the attraction and attrition of undergraduate student nurses, the importance of wellbeing and self-care remains fundamental to the profession. Understanding cultural competence and emotional intelligence in promoting equality, diversity and inclusivity are all important concepts relating to community nurses working within integrated environments and diverse cultures.

FURTHER READING

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FURTHER RESOURCES

Association of District Nursing Educators (ADNE) – *Useful resources of policy documents across the four countries of the UK* – https://www.adne.org.uk/

Care Inspectorate Wales – *Regulator of social care in Wales – regulator of health and social care in Northern Ireland* – https://www.careinspectorate.wales/

Care Quality Commission – *Regulator of health and social care in England* – https://www.cqc.org.uk/

Equality Act – https://www.gov.uk/guidance/equality-act-2010-guidance

Healthcare Improvement Scotland (HIS) – *Regulator of health and social care in Scotland* – https://www.healthcareimprovementscotland.org/

Healthcare Inspectorate Wales – *Regulator of healthcare in Wales* – https://www.hiw.org.uk/

Nursing and Midwifery Council – *Standards for Practice and Education* – https://www.nmc.org.uk/

Queen's Nurse Institute (QNI) – title https://qni.org.uk/

Queen's Nursing Institute Scotland (QNIS) – https://www.qnis.org.uk/

The Health and Care Professions Council (HCPC) – https://www.hcpc-uk.org/

The Regulation and Quality Improvement Authority (RQIA) – *Regulator of health and social care in Wales* – https://www.rqia.org.uk/

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CHAPTER

5

Risk identification, mitigation and management

Jayne Murphy and Lisa Clarke

LEARNING OUTCOMES

- Review the principles of risk management in accordance with professional and strategic standards of practice.
- Critically explore the risks to personal safety in community nursing roles.
- Examine the importance of preparation needed prior to visiting people in their place of residence.
- Evaluate ways to minimise risks to personal safety for community nurses in a range of community settings.
- Critically discuss the use of risk assessment and the implications of identified risks for staff and people using community services.

INTRODUCTION

Risk is inherent in community nursing, as it is in most areas of professional practice. There are risks evident from working with children through to working with people at the end of life, in people's homes, on the streets, in clinics, in residential care or in prisons. Community nursing encompasses varying roles offering a breadth of healthcare in varying environments and across the life course. With a priority of keeping people well, treating and managing acute illness and long-term conditions and supporting people to live independently (Charles, 2019), community nursing forms part of the wider network of services offered to people to receive care closer to home and reduce hospital admissions. Through risk identification, assessment and mitigation, safety can be addressed early to safeguard both staff and people using community health services. It is important for the community nurse to be adept at identifying risks and mitigating their potential or managing risks that cannot be eliminated. The risks can be defined as risks to the workforce, for example, staff's personal safety (Dean, 2021); risks from the workforce, for example, medication administration errors (Elliott et al., 2021); risks to people using the service, for example, breakdown in care (Age UK, 2023); and risks from people using the service or carers, for example, the potential of violence and aggression (Vento et al., 2020).

DOI: 10.4324/9781003347545-6

The World Health Organisation (WHO) works worldwide to promote health, keep the world safe and serve the vulnerable. The goal of the WHO is to ensure that a billion more people have universal health coverage, to protect a billion more people from health emergencies and to provide a further billion people with better health and well-being. In 2015, all the countries in the United Nations adopted the 2030 Agenda for Sustainable Development. It sets out 17 goals, which include 169 targets. The WHO's General Programme of Work defined the strategy for the four-year period 2019–2023, is based on the Sustainable Development Goals (SDGs) and is relevant to all countries. Goal 3 is to ensure healthy lives and promote well-being for all at all ages and includes financial risk protection in target *3.8 universal health coverage*. The WHO states that the safety of patients during the provision of health services that are safe and of high quality is a prerequisite for strengthening healthcare systems and making progress towards effective universal health coverage (UHC) under Sustainable Development Goal 3 (WHO, 2019).

This chapter will consider risk from two perspectives: the workforce perspective and the service user perspective. National policies that support the assessment and mitigation of risks will also be identified. The first section explores the safety of nurses working in community settings and includes preparation for home visiting, car safety and the principles of risk management. The second part of the chapter focuses on risk to others, primarily people using community nursing services, including carers, and the potential risks to them.

THE PRINCIPLES OF RISK MANAGEMENT AND PROFESSIONAL AND STRATEGIC STANDARDS OF PRACTICE

Within this section, reference will be made to the policy frameworks to support risk assessment across the four nations and professional regulation will also be considered.

The Nursing and Midwifery Council (NMC) Code of Professional Standards (2018) is structured around four themes: prioritise people, practise effectively, preserve safety and promote professionalism and trust. Risk is referred to in three of the four themes with respect to working co-operatively, record keeping, reporting concerns and avoiding and managing identified risks. This demonstrates the importance of recognising and managing risk from a professional perspective.

Risk management is both a professional and an organisational responsibility and is analogous with patient safety. The NMC and the independent regulators of health and social care across the four countries of the United Kingdom all stipulate responsibility in risk management from a workforce and an organisational perspective. The Health and Safety Executive (HSE) is Great Britain's national regulator for workplace health and safety, whilst the Health Service

Executive of Northern Ireland is the lead body responsible for the promotion and enforcement of health and safety at work standards in Northern Ireland. Both public bodies include risk management as part of their remit.

The Royal College of Nursing (RCN) identifies nursing as the largest safety-critical profession in healthcare (RCN, 2021a). It advocates that there is a requirement to ensure there is an adequate supply of the workforce and that it is imperative that staff are equipped with the necessary skills to be able to deliver safe and effective care.

The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England, ensuring the quality and safety of care in hospitals, GP surgeries, mental health hospitals and community services, dentists, ambulance services and homecare agencies. They provide guidance for providers on meeting the regulations within the Health and Social Care Act (2008), which includes Regulation 12: safe care and treatment (CQC, 2015). This regulation involves risk assessment and mitigation to prevent avoidable harm or risk of harm.

In Scotland, quality and safety are considered a top priority for social care, social work and early learning services in the Care Inspectorate three-year plan "Corporate Plan 2022–25." Healthcare Improvement Scotland supports staff to recognise risk assessments as an integral element of care delivery and provides tools to support the staff in addressing areas of risk.

The Regulation and Quality Improvement Authority (RQIA) is the independent body that regulates and inspects the quality and availability of Northern Ireland's Health and Social Care (HSC) services. The RQIA provides assurance about the quality of care, challenges poor practice, promotes improvement, safeguards the rights of the people supported and informs the public through the publication of reports. Their guidance recommends that there are systems in place to ensure that unnecessary risks to the health, welfare or safety of those supported are identified, managed and, where possible, eliminated (RQIA, 2022–2023).

In Wales, the Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales, and its purpose is to provide independent and objective assurance on the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements. They act so that health boards and their services know where they need to make improvements, and risk management forms a significant part of their scrutiny.

The NHS Patient Safety Strategy (NHS England, 2019b) describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. The foundations of the strategy are 'patient safety culture' and 'patient safety systems,' and the three strategic aims are 'insight,' 'involvement' and 'improvement.' The National Patient Safety Alerting Committee (NaPSAC) requires healthcare providers to introduce new systems for planning and coordinating the actions required by any National Patient

Safety Alert across their organisation, which is essential for effective delivery of systematic actions to protect staff from error and protect people using the service from the risk of death or disability. Failure to carry out the actions required under any National Patient Safety Alert may lead to healthcare regulators taking regulatory action. The NHS Patient Safety Strategy (NHS England, 2019b) sits alongside the NHS Long Term Plan (NHS England, 2019a), and the safety vision is to continuously improve people's safety through adopting safety measurement principles, learning from what does and does not go well and introducing a safety learning system and a framework to improve the response to incidents. The strategy recognises that focusing on patient safety could save 928 lives and £98.5 million per year. An update to the strategy was published in February 2021, primarily to address patient safety inequalities, with a new objective added to the safety system strand of the strategy (NHS England, 2021a). The improvement objectives of the updated strategy include delivering improvement programmes, such as managing deterioration, adoption and spread, maternity and neonatal safety, medication safety, mental health safety and addressing safety issues that affect older people, autistic people and people with a learning disability.

The Scottish Patient Safety Programme (SPSP), part of Healthcare Improvement Scotland, is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm. One of the workstreams is the SPSP for Primary Care, which aims to reduce the number of events which could cause avoidable harm from care delivered in any primary care setting.

ACTIVITY 5.1

Identify the strategic policy for health and safety in your particular area of the United Kingdom. Reflect on how this aligns with local policy guidelines and consider what your own responsibility is in relation to health and safety within your role.

PRINCIPLES OF RISK MANAGEMENT

Risk management is a step-by-step process for controlling health and safety risks caused by hazards in the workplace (HSE, 2023). The steps are to identify hazards, assess the risks, control the risks, record your findings and review the controls.

ACTIVITY 5.2

By reflecting, make a list of the risks that the workforce in your practice or community setting faces and that communities and carers face. List all the risks you can think of that the workforce poses and the risks that the communities and carers pose.

Identifying risks involves isolating individual risks to and within an organisation. The HSE (2023) explains this by exploring the environment to consider anything that might cause harm (any hazards), and this may include working practices, equipment and general maintenance of the environment. Where a potential hazard is identified, the associated risk should be assessed.

Risk assessment is establishing the impact that these risks pose on individuals and the organisation as a whole. A risk assessment is a qualitative or quantitative evaluation of the nature and magnitude of the risk (NHS Resolution, 2020). From an organisational perspective, a risk matrix is often used to establish the level of risk or how likely the risk is to occur and the impact the risk will have. The matrix is rated in a red, amber and green formula, and an action plan is generally devised in response to the level and severity of the risk. The risk score is calculated by multiplying the likelihood score with the severity of the impact score. An example of a risk matrix can be seen in Table 5.1:

Controlling the risk is also referred to as risk mitigation. It is important to take the necessary action to reduce the risk as far as possible and to minimise the potential harm from the identified risk. There is an organisational approach to risk mitigation, as well as an individual approach. An organisation, for instance, may develop a policy and introduce staff training whilst the individual is responsible for attending the training and implementing the policy within their practice.

When risks are identified, assessed and mitigated, reviewing the controls is the next step in the risk management process. This aspect utilises sources of information such as audits, patient records, patient complaints and satisfaction surveys to establish if the risk management process is effective. The residual risk is the risk that remains when the controls have been implemented, as it is not feasible to eliminate all the risks (Yawar Alam, 2016).

Table 5.1 Risk assessment matrix

		Impact				
		Insignificant 1	**Minor 2**	**Significant 3**	**Major 4**	**Severe 5**
Probability	**5 Almost Certain**	Medium 5	High 10	Very high 15	Extreme 20	Extreme 25
	4 Likely	Medium 4	Medium 8	High 12	Very high 16	Extreme 20
	3 Moderate	Low 3	Medium 6	Medium 9	High 12	Very high 15
	2 Unlikely	Very low 2	Low 4	Medium 6	Medium 8	High 10
	1 Rare	Very low 1	Very low 1	Low 3	Medium 4	Medium 4

Source: Safety Culture (2023).

THE RISKS TO PERSONAL SAFETY IN COMMUNITY NURSING ROLES

Considering the safety of health professionals, it is important to review the different settings in which people and their families receive care, which could include clinics, homes, residential care and the streets for those who are homeless. Risks are presented whether patients or service users have health conditions or public health issues. Risks can arise from individuals and the environment and therefore both need to be considered carefully and any risks assessed appropriately.

When considering the safety of community nurses, there are several levels that need to be assessed: from an employer, personal and environmental perspective to a legislative and professional stance. Risk assessment should start with the employer, and according to the Health and Safety at Work Act (1974), every employer has a duty to ensure the safety of its employees as far as is reasonably practicable. The 'duty of care' refers to organisational obligations to protect the "health, safety and well-being" of its employees by undertaking risk assessments, making sure the environment is safe and putting measures in place to prevent or minimise risk and protecting staff from discrimination (Advisory Conciliation and Arbitration Service [ACAS], 2023). It is important to ensure that risk assessments are carried out by a suitably qualified person, recorded and monitored frequently as part of an ongoing audit process. Health and social care are regulated and monitored by the HSE, which acts as the independent regulator of health and safety in the workplace alongside other organisations with regulatory powers such as CQC for England, Healthcare Improvement Scotland and the Care Inspectorate Wales.

Risk assessment is a tool designed to identify the consequences and likelihood of something causing potential harm or disruption and forms a vital element in health and safety management. Many community nurses will already be familiar with the concept of risk assessments, as this forms part of statutory training in accordance with the Health and Safety at Work Act (1974) and Management of Health and Safety at Work Regulations (1999). This training is required by law and is provided through healthcare employing organisations (RCN, 2022a).

Guidelines from the RCN (2021b) suggest undertaking 'Dynamic Risk Assessments,' promoted for staff working in isolation or undertaking home visits. Table 5.2 highlights key areas for consideration.

It is important that staff should have the means to raise the alarm if necessary. For example, the Suzy Lamplugh Trust (2007–2019) advocates the use of covert panic alarms, personal safety alarms or a buddy system. These safety measures should form part of an organisational safety plan.

Personal safety includes consideration of appropriate use of a vehicle for travel. Car safety considerations are indicated in Table 5.3. As well as car safety, it is important to consider the manner of driving and parking in risk management

Table 5.2 Key areas of consideration of safety for home visits

Assess the surroundings	Is there anything around which is cause for alarm? For example, a potential weapon or a dangerous animal. Think about how you will get out if things get difficult. Where are the escape routes?
Assess the client/s	Is their behaviour or the behaviour of someone with them cause for alarm? Are they acting in a strange manner?
Act	You are not expected to put your own personal safety at risk. If you feel unsafe withdraw from the situation to a place of safety and inform your manager. Where it is safe to do so, use de-escalation techniques. If you feel the situation is escalating, use strategies to remove yourself, such as "I just have to pop back to the car to get some notes" or "to the other room to get some equipment." Use your lone worker alarm systems as per employer's policy/procedure.

Source: RCN (2021b), prioritising safety.

Table 5.3 Car safety

Consideration	Rationale
Ensure the vehicle is well maintained	Not only is it inconvenient, but it may also be hazardous to break down in a remote place after dark. Well worth the expense of servicing and looking after the car.
Try not to run out of fuel	To avoid being left stranded in remote or potentially dangerous places.
Know your destination	Not all vehicles will have a Sat Nav, so know the area and keep a road map in the car.
Park with thought	Leave the car in safe places, close to the destination and in a well-lit area if possible.
Take out breakdown cover	This will offer reassurance that someone can assist you. Always state that you are alone and make it clear if you are a female.
Keep bags/valuables out of sight	People believe nurses carry medicines/ needles/syringes in their bags – prevent temptation and keep bags in the boot, out of sight.
Keep your car doors locked	Maintain your own safety when driving and always lock your car when you get out.
Weather variation	Driving in severe weather conditions adds additional risks for community nursing. It is advisable to undertake a winter check of your vehicle. The Automobile Association (AA) suggests an in-car survival kit, and it is well worth checking this year-round driving advice for all seasons. Also, consider the road conditions – it may be useful to keep a shovel, boots, spare warm clothing and blankets in the car. Having sunglasses available is also advised for low-level sun.

Source: Adapted from Murphy and Smith, cited in Chilton and Bain (2018, Chapter 4).

approaches. There is a significant risk of being involved in a 'road rage' incident. According to the Driving Instructors Association (2022), 70% of British drivers experience road rage, with Wales, England, Scotland and Northern Ireland having the highest to lowest percentages of road rage. Some of the causes of road rage are common manoeuvres for community nurses who drive as part of their daily routine due to the nature of their visits. For instance, slow driving and last-minute breaking are high on the list of initiating road rage responses from other drivers. When driving down a road, looking for house numbers or anticipating a turn, it can be easy to irritate other drivers, who may react in a negative way. It is important to mitigate the risks of being exposed to road rage by being conscious of one's driving style. If another driver reacts angrily, acknowledge their frustration, but do not confront that driver, as that might increase the risk to personal safety. Another driving issue is with parking, as there appears to be less tolerance in the past few years for vehicles being labelled as 'parked inconsiderately.' For example, there have been many reports in the media about angry homeowners leaving abusive notes on emergency vehicles when driveways have been blocked by ambulances (Daily Mail, 2019). It is therefore important to park considerately so as not to provoke negative responses from residents, which can increase risks to personal safety and car safety. Travelling to a patient visit carries risks, and once you arrive at the address, there are more risks to consider.

THE IMPORTANCE OF PREPARATION NEEDED PRIOR TO VISITING PEOPLE IN THEIR PLACE OF RESIDENCE

ACTIVITY 5.3

Consider all the risk assessment tools you use in practice. How do they support the delivery of safe and effective care? Is their value dependent on the skill of the person completing the assessment tool? Reflect on the skills required to make effective use of risk assessment tools and how this contributes to patient safety.

Considering organisational duties, by initially defining the roles and responsibilities of the employee, employers are able to raise awareness of local policies and procedures for all staff to follow. By providing statutory training, organisations can highlight communication pathways for the employee to use to raise any concerns, which is seen as best practice by ACAS. The employee also has a level of responsibility, nonetheless, and, by law, can refuse to undertake work that is deemed unsafe (Duncan, 2019).

Working within the community may pose many risks, which may include threats and abuse, but staff should also report needlestick injuries, falls or injury and work-related stress. NHS England demonstrates a commitment to reduce violence and abuse of NHS staff within its NHS People Plan (NHS England, 2020) and NHS People Promise (NHS England, 2021b). Awareness of safe staffing levels within the community has been highlighted for some

considerable time now. It is suggested that staffing levels should be based on service demand and the needs of service users (RCN, 2021a). Recently, the Queen's Nursing Institute (QNI, 2022) has developed workforce standards for district nurses that advocate teams should be staffed by 60% experienced registered nurses, 20% newly registered nurses and 20% nurse support workers, which include healthcare assistants and nurse associates, incorporating allowance for unplanned leave and absences. Whilst this highlights requirements within district nursing, there may also be workforce issues within other areas of community nursing that warrant escalation to ensure that the workload is proportionally distributed. Across the four countries of the United Kingdom, governments are aiming to enhance care delivery across health and social care through integrated care systems. Leaders are assigned to recognise the complexity of health and social care and become more creative in the delivery of population health and person-centred care across communities through effective partnership working (NHS Employers, 2022). Acknowledging workforce issues across England, NHS England has initiated the 'NHS Workforce Plan' (NHS England, 2023). This aims to address improving patient care by making the workforce more sustainable through retaining existing talent and using new technology to support services.

Teams working in the community often work in isolation, which may, for example, be a community nurse undertaking home visits alone or a staff member lone working within a community clinic. In such instances, being isolated from other colleagues highlights the importance of becoming familiar with the area. Profiling is an effective way of gathering information about the diversity of a community. Gathering local intelligence from employers and team colleagues will allow knowledge of the caseload. Appreciating the geography of the local area and care setting will heighten awareness of any safety issues to consider particularly for those members of staff who are working outside of normal office hours. Identification and quantification of characteristics of service users can highlight any particular traits to be aware of, for example, a history of violence, changes in cognitive function, behaviour when in pain or a tendency to intoxication or drug misuse. Although this information cannot make predictions of behaviour at the time of the visit with certainty, safety considerations can be put in place to reduce the risk.

ACTIVITY 5.4

You are asked to visit a patient on the fourth floor of a block of flats in an area renowned for high crime rates. What do you need to consider before the visit?

For many community nurses, caring for people in the community involves autonomous practice and independent working. Lone working is defined as "someone that works by themselves without direct or close supervision"

(QNI, 2017). This brings an element of risk, and the organisation should have local policies to support lone working. It is wise to become familiar with these policies and abide by the local contract.

Practical measures need to be considered that inform the legal stance on the type of car insurance that is required to use your car for work-related purposes. Mileage allowance rates are available for nursing staff on Agenda for Change contracts (RCN, 2022b). However, claims cannot be made for the commute between home and work. There has been a call to NHS employers to provide further financial support for those staff using their own vehicles for work purposes to support rising costs (Launder, 2022, RCN, 2022b).

MINIMISE RISKS TO PERSONAL SAFETY FOR COMMUNITY NURSES IN A RANGE OF COMMUNITY SETTINGS

ENVIRONMENT

Community nurses care for people in a variety of environments, and each of these environments carries their own individual risks. All environments require risk assessment, even people's own homes. Where it is relatively straightforward to complete a risk assessment and take mitigating action to address any identified risks in clinical settings, such as GP practices, nursing homes and clinical rooms, it is less straightforward in non-clinical settings, such as people's homes. Nonetheless, staff working in these settings need to be protected from any presenting risks, and comprehensive and dynamic risk assessment is important. Assessing the surroundings forms part of dynamic risk assessment, and, according to the RCN (2021b), contemplation for escape routes needs to be considered, as well as anything within the environment that may pose a risk, such as weapons and dangerous animals.

ACTIVITY 5.5

You are making a visit to a patient's home, and as you approach, you can hear a dog barking and growling behind the door. What do you need to do? Consider what safety measures need to be put in place.

HOARDING

Hoarding is now classified as a medical condition and is included in the World Health Organisation's *International Classification of Diseases, Edition 11* (ICD11) (WHO, 2022). Hoarding disorder is part of obsessive-compulsive disorders and is characterised by accumulation of possessions that result in living spaces becoming cluttered to the point that their use or safety is compromised. The individual amasses items and has difficulty discarding possessions due to a perceived need to save items and avoid the distress associated with discarding them. Amassment may be passive (e.g., accumulation of incoming flyers or mail) or active (e.g., excessive acquisition of free, purchased, or stolen items) (WHO, 2022). Animal hoarding, a distinct subset of hoarding disorder, has a

significant public health impact on the humans involved, as well as animal welfare. Individuals may exhibit self-neglect, apathy, social withdrawal and object hoarding, living within squalid, deteriorated, structurally unsafe and uninhabitable premises alongside neglected animals (Wilkinson et al., 2022).

Hoarding can pose a risk to community nurses' safety but also poses a potential risk to people's safety or to others who might reside in the home (for instance, children). Hoarding may therefore present a safeguarding issue. It poses a risk to the community nurse by restricting space in which to carry out nursing interventions and to promote effective infection control procedures. However, sensitivity is required when drawing attention to the risks hoarding behaviours present, and a patient-centred solution should be explored. Hoarding is considered a significant problem if the amount of clutter interferes with everyday living or if the clutter is causing significant distress or negatively affecting the quality of life of the person or their family. Hoarding disorders are challenging to address because many people who hoard frequently have little awareness of how it is affecting their lives or the lives of others or might be reluctant to seek help because they feel extremely ashamed, humiliated or guilty about it (www.nhs.uk, 2022). Hoarding is a problem that is unlikely to resolve itself; therefore, intervention is often required. Social workers or community nurses are typically the chosen coordinators of care, navigators of the system and advocates for patients with hoarding disorder, but input is required from multiple sources, including emergency services, social services and mental health services (Haighton, Caiazza and Neave, 2023). There is a company that offers support to people with hoarding disorder (https://hoardingdisordersuk.org/). There is no 'quick win' to solve issues and eliminate risks associated with hoarding disorder. However, effective referral to support services and effective risk assessment should help to minimise and reduce the risks as far as possible. The UK Care Act (2014) set out the legal framework for safeguarding adults, allocating considerable responsibilities to local authorities, and, with the UK Health and Care Act (2022), Integrated Health Boards are set to provide additional structure and support. GPs can enhance patient care by strategically utilising local protocols, key contacts and resources available to them and their teams, and when made aware, GPs can raise concerns and awareness of problems (Morein-Zamir and Ahluwalia, 2023). Further consideration for safeguarding can be found in Chapter 6 and discussion of support with mental health in Chapter 10.

RISK ASSESSMENT AND THE IMPLICATIONS OF IDENTIFIED RISKS FOR STAFF AND PEOPLE USING COMMUNITY SERVICES

PREVENTION

Prevention is a key factor in helping people to live well for longer, utilising the framework 'Make Every Contact Count' (MECC). MECC (NHS England, 2016) is key to delivering population health that uses a person-centred approach

to health (FutureNHS, 2022). Using six key principles, healthcare professionals can open up discussions with people using services about what is important to them and apply simple signposting to relevant services that can support improvement in health and well-being. In a world of improved technology, healthcare apps have become familiar, and MECC Link has been developed to aid professionals in signposting to local services. Health professionals can select the region where they work, which then opens another portal with a selection of services available. Using the process of 'Ask/Assist/Act' the health professional can then offer very brief advice.

The modern reforms of the NHS in recent years mean that there is a drive to manage more people out of hospital wherever possible (NHS England, 2019a). There is an increased awareness of the growing number of older people in society that has led to an increased demand for management of multimorbidity (National Institute for Health and Care Excellence [NICE], 2016). It is acknowledged that the wider determinants of health need to be addressed to help support the health and well-being of certain groups. Within the NHS reforms, the NHS Long Term Plan (NHS England, 2019a) aims to implement new models of care within a partnership approach to deliver improvements in health and well-being across populations. Comprehensive assessments are required to ascertain the care required by the individual, considering physical and psychosocial elements.

The Welsh NHS Confederation Health and Wellbeing Alliance (2022) published a briefing that supports addressing deprivation and health inequalities from a multi-disciplinary approach – the "Mind the Gap" report was developed by 50 organisations from health, social care and housing calling the Welsh government to develop a cross-government plan to tackle health inequalities in adults and children. According to the Office for Health Improvement & Disparities (OHID, 2022), vulnerability is defined as people in need of special care, support or protection, which may be due to age or risk of abuse or neglect. Those with frailty due to ill health, physical or mental disability, cognitive impairment, learning disability or long-term conditions are just some of the groups that could be classed as 'at risk'; however, not all people with a risk factor are classed as vulnerable. Scottish Government Health and Social Care policy highlights that more people are living with one or more complex health conditions and require more support. Their focus is to improve population health and offer strategic direction for health and social care staff but also promote local communities to develop their own approaches and solutions to health challenges (Scottish Government, 2023). In a bid to tackle long-term conditions, Ireland's HSE established national teams to lead and coordinate a comprehensive health service using priority programmes across the life course (HSE, 2023).

One marginalised group found to have reduced access to healthcare services and high morbidity and mortality rates is composed of those with no fixed abode. The Office of National Statistics (2021) reported 741 deaths with drug

poisoning, suicide and alcohol-specific causes accounting for over half of the deaths. A study led by Crisis Skylight Birmingham in partnership with Groundswell (2021) identified the homeless as being a particularly vulnerable group who face exclusion from mainstream healthcare. Findings from semi-structured interviews where 64 homeless people discussed the challenges they faced in accessing physical and mental health support highlighted significant difficulties. This group reported stigma and lack of awareness from healthcare staff. Barriers were experienced that were due to challenges in registering for GP and dental services. However, guidance from the British Medical Association (2018) identifies that anyone, regardless of nationality and residential status, may register with a GP with no contractual duty to seek evidence of identity or proof of address, suggesting a lack of awareness by many healthcare professionals. One way to improve this dichotomy is through education and resources, such as the Queen's Nursing Institute's "Homeless and Inclusion Health Programme," which is a useful platform to support the development of knowledge in how to provide high-quality, person-centred care across the age range for marginalised groups of individuals (QNI 2023).

In respect of risk assessment, there are many ways that risk is communicated to patients to support them to make lifestyle changes to reduce the risk of certain diseases, conditions and the consequences of these diseases. Smoking cessation is one example where the community nurse discusses the health risks with patients to encourage them to engage with smoking cessation activities. Medications are also often prescribed to reduce the risk of harmful events, such as statins for cardiovascular risk reduction. NICE (2023) recommends the use of a patient decision tool to explain the risks and benefits of taking statins (Figure 5.1):

ACTIVITY 5.6

Agnes is a 77-year-old lady with type 1 diabetes, and you are visiting her at home to administer insulin due to her poor eyesight. You note on this occasion that she is limping, and she advises you of a recent fall. What do you need to consider to assess the risk and prevent further falls?

FALLS

Falls cause the death of 684,000 people each year (WHO, 2021). Recognised as a global public health problem, falls can lead to reduced functional ability and have been found to be the leading cause of accident-related mortality in those aged 65 years and older, placing a significant burden on health systems. Although falls can occur across the life course, worldwide, 25%–56% of children seen in hospitals are due to a fall.

It has been found that multiple contributing factors, including muscle weakness, poor balance, visual impairment, certain medical conditions, certain medicines and environmental factors can result in an increase in falls in older

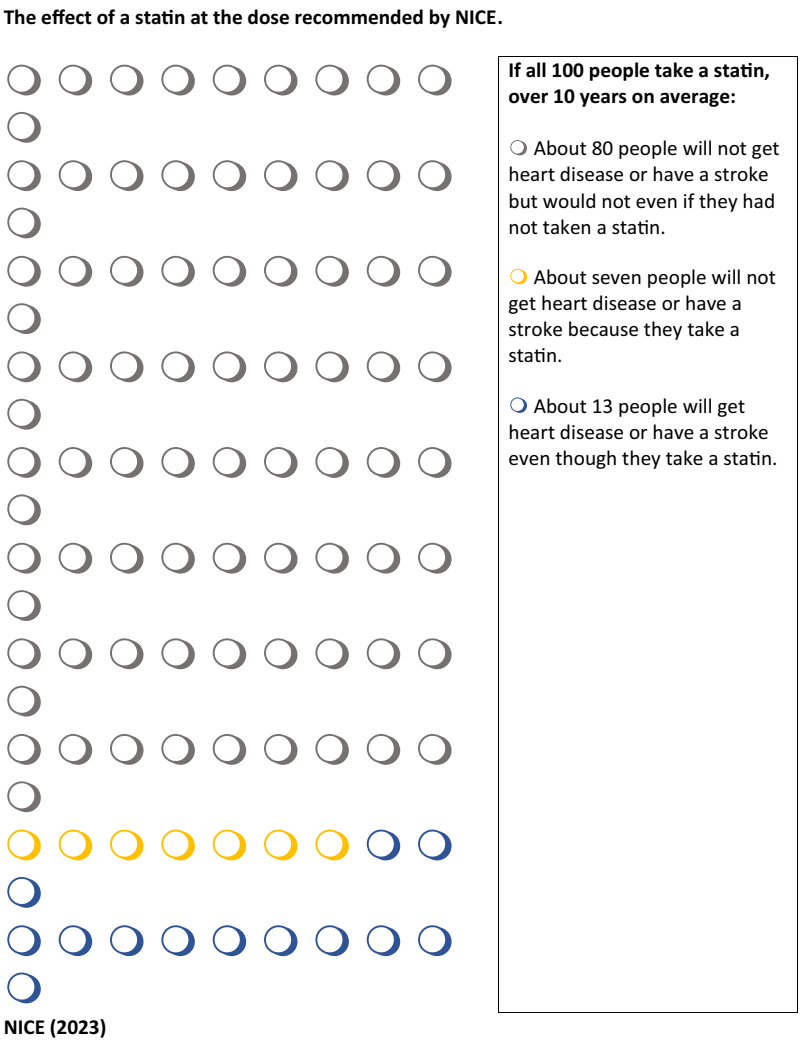


Figure 5.1 The effect of a statin at the dose recommended by NICE (2023).

people (NICE, 2017). WHO (2021) also highlights that 80% of fatal falls occur in low-middle-income countries. Health Professionals are encouraged to enquire about falls in their older service users and undertake a multifactorial fall risk assessment that allows interventions to prevent falls to be targeted to specific needs (NICE, 2017), which may require a collaborative approach across primary care multi-disciplinary teams. Some areas may have specialist fall services that will undertake the assessment and will have skills and experience in fall prevention. Following assessment, people can be offered interventions to support their needs, such as advice on correct footwear, medication use review, home safety assessments that consider trip hazards and checking for adequate lighting (Age UK, 2022). In a call to action, the WHO have developed a prevention strategy that draws on a systems-wide approach addressing biopsychosocial and environmental factors that can be considered from a healthcare

professional, policymaker, manager, researcher and advocate perspective to prevent and manage falls across the life course (WHO, 2021). Community nurses are in a unique position to identify, mitigate and manage falls.

Frailty is deemed a significant risk factor that can lead to falls, impaired mobility and hospitalisation, and although it is a distinctive health state associated with getting older, Smith and Wallington (2019) suggest that frailty should also be considered in younger populations with long-term conditions. Currently, it is thought that frailty can be prevented (British Medical Association, 2018).

ACTIVITY 5.7

Mrs S. is a 65-year-old woman who has a diagnosis of Alzheimer's disease and who lives alone. She is presenting to clinic with fever, dyspnoea, cough and myalgia and appears unsteady on her feet. She informs you that she does not have any help at home and is finding it more difficult to manage. How would you assess Mrs S for frailty?

The NHS Right Care Frailty toolkit (2019) supports the NHS Long Term Plan in caring for those who are frail. The framework suggests benchmarking and assessing current levels of care and highlights key actions to take to make improvements that will support those affected. Similarly, Healthcare Improvement Scotland has available resources to support frailty care planning and coordination. These toolkits promote and strengthen partnership working so that those people who are frail can be supported and staff have a shared awareness and understanding with opportunities to develop their knowledge through training.

IDENTIFYING PATIENTS AT RISK OF READMISSION AND ADMISSION

Avoidable hospital admissions and prevention of emergency readmissions remain a mainstay of policy discourse, and integration of services is geared towards this (Reed et al., 2021). Reasons for admission of patients who are deemed at risk of deteriorating health are multi-faceted and often complex. Focus now relies on identifying and minimising these risks and proactively managing patients to avoid incidences of inappropriate admissions (The Health Foundation 2021). Proactive management involves having appropriate services outside of hospital to manage patients and encourage self-management. The ability to predict which patients are at risk of having future unplanned admissions remains key and predictive models are a useful tool to facilitate this. There are various predictive risk models available to the NHS in the United Kingdom, and many models differ in the data on which risk is predicted, for instance, time period of admission and patient criteria for risk assessment. The importance of admission avoidance remains a significant theme in commissioning

services throughout the United Kingdom. There is some evidence that hospital care can be potentially harmful because of a lack of patient mobility and risk of hospital-acquired infection, malnutrition and dehydration. There is also concern about the suitability of the hospital for older people with complex healthcare problems who are often in need of some form of rehabilitation and for whom the process of recovery is likely to be multidimensional and recursive (Shepperd et al., 2022). Community nurses are ideally placed to identify patients at risk of avoidable hospital admission and there are a range of hospital avoidance pathways in use to identify patients and to initiate interventions to mitigate the risks of hospital admission. Further discussions around acute care can be found in Chapter 14.

ACTIVITY 5.8

What people do you consider to be at risk? Make a list and then reflect on what places them at risk. How can these risks be identified, mitigated and managed?

HOSPITAL ADMISSIONS DUE TO PATIENT SAFETY ISSUES

The Organisation for Economic Co-operation and Development (OECD) completes reports on the economics of patient safety and examines the cost of safety lapses in health care and the most effective and efficient way to minimise these across entire health systems. A report in 2018 found that globally, as many as four in ten patients are harmed in primary and outpatient health care and that up to 80% of this harm is preventable. The most detrimental errors are related to diagnosis, prescriptions and use of medicines (Slawomirski, Auraaen, and Klazinga, 2018).

Medication safety is considered further in respect to risk with potential 'Never Events' (NHS, 2021c). Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Medication administration is listed in *Never Events*, specifically (for community administration) administration of medication by the wrong route, overdose of insulin due to abbreviations or incorrect device and overdose of methotrexate for non-cancer treatment (NHS Improvement, 2021).

Patient safety issues such as falls, pressure damage, infections and problems related to nutrition and hydration affect older people more than any other population group (NHS England, 2019b). There are risk assessment tools in relation to each of these patient safety issues (for example falls risk tool, pressure risk score, sepsis risk score, malnutrition and hydration score). However, completion of these assessment tools in isolation does little to reduce the overall risk of hospitalisation. Reasons for admission are multifactorial and risk should consider how all these factors interplay to increase the overall risk. Risk

assessment should therefore link associated conditions to make sense of the likelihood of admission and the impact that the comorbidities have on the individual.

HUMAN FACTORS

The influence of biological, psychological and organisational factors on an individual at work can affect their health and safety, but it also affects their efficiency and productivity. Three interrelated aspects must be considered: the job, the individual and the organisation, defined as human factors (HFs) (HSE, 2022). Rosenorn-Lanng (2015) suggests that HFs have been found to be responsible for around 80% of errors in healthcare and recommends the SHEEP model to define human factors, which stands for Systems, Human interaction, Environment, Equipment and Personal. HFs have been applied by clinicians and others to highly variable degrees and frequently in limited, counterproductive ways (Catchpole et al., 2021). The Clinical Human Factors Group (https://chfg.org/) is a charity that works with healthcare professionals, managers and service users, partnering with experts in HFs from healthcare and other industries to campaign for change in the NHS and healthcare. From an organisational perspective, it is important to consider human factors and the potential role that HFs play in the risk management process. From an individual perspective, it is important to have insight into the influence that personal circumstances might have on existing risk and acting where these circumstances might have a negative impact and increase risk, particularly clinical risk that might harm a patient. It is imperative that work hazards are managed effectively; there should be processes in place to performance manage staff who pose a risk to patient safety through their actions or omissions. Organisations also need to ensure that they develop a positive workplace culture to prevent staff leaving the profession. The fair treatment of staff in a supportive environment encourages staff to be confident, open and honest. A recent article identified that ten years on from the Francis report, there appears to continue to be unhealthy workplaces that are having an impact on staff retention (O'Dowd, 2023).

ACTIVITY 5.9

Think of an incident in which you observed or in which were involved that involved HFs that compromised care (e.g., fatigue, cognitive bias, system failure). What, if any, workplace factors contributed to the event? How did this event affect you? What did you take away that you will use in the future?

RAISING CONCERNS ABOUT PATIENT SAFETY

It is the duty of all nurses to raise concerns if they believe that patients in their care are at risk. The NMC (2019) has produced useful guidance for nurses, midwives and nurse associates who have concerns. The booklet offers a step-by-step guide to raising and escalating concerns. It recommends following the

local 'raising concerns' policy and discussing the issues internally with the respective line manager. These issues may be about the safety and well-being of people in the nurse's care or the environment in which nurses work. To further support individuals to raise concerns, the NMC and General Medical Council (NMC/GMC, 2022) refreshed a joint statement on the professional 'duty of candour' for their registrants. This requires all health professionals to be open and honest with patients, colleagues, employers and other partner organisations. It suggests that working in a supportive and nurturing environment should support those individuals who wish to raise concerns. It is therefore evident that organisations must clearly enable nurses to raise concerns, which should then be investigated promptly and thoroughly (RCN, 2020). Guidance on escalating concerns from the RCN explains the process and support mechanisms that are in place for staff, people and carers. Healthcare staff members are encouraged to record all incidents that pose a risk to patient safety through their organisation's local risk management systems (LRMS). For organisations to review, audit, monitor and undertake analysis of any safety concerns, incident forms will be used as a reporting tool. These will detail the incident so that the clinical governance teams can undertake root cause analysis (NHS England, 2022a). However, the forms may vary locally and therefore it is suggested that nurses review their local policy.

All four countries of the United Kingdom have an initiative to encourage the workforce to speak up when they have a concern about patient safety. Freedom to Speak Up policies have been developed to help normalise speaking up for the benefit of patients and workers. Northern Ireland published Raising Concerns (2020), aimed primarily at public sector organisations and their employees to understand the value of an open and honest reporting culture. In Scotland, the Independent National Whistleblowing Officer published the National Whistleblowing Standards (2021) that underpin the approach that must be taken to handle any concerns raised by staff or those working in NHS services. NHS England (2022b) developed the Freedom to Speak Up Policy and expects all organisations providing NHS healthcare services in primary and secondary care in England to adopt the national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. The Welsh government published Speaking Up Safely (Healthcare Inspectorate Wales, 2023), which sets out the responsibilities of organisations in creating a culture in which speaking up is supported within a safe environment.

CONCLUSION

Most staff working in community settings enjoy a close partnership with people, families and communities. The health centre or surgery is at the heart of the local community, and relationships may build over a number of years. Visiting people in their homes is a privilege that greatly enhances the experience of community nursing. Taking practical precautions and taking time to think

about the assessment of risk and preparation are crucial elements of nursing in the community.

Risk management as a process involves identification, assessment and mitigation of risks that present to and from the workforce and to and from people using the service. Effective risk management acknowledges that risks cannot be eradicated, but potential harm (should the risks occur) can be minimised. There are innumerable risks that present in health and social care daily, and risk management takes these into consideration, predicts the likelihood of the risks occurring and the impact should they occur. The organisation should identify significant risks and implement protective interventions to reduce these risks from a strategic perspective. These interventions range from raising awareness, developing policies and procedures or assessment tools and providing staff training. Staff responsibility in risk management is to adhere to initiatives stipulated by the organisation and to make effective use of the assessment approaches to risk, whether that be application of professional knowledge or use of reliable assessment tools. An assessment tool is only useful if the person completing it is aware of its significance, can implement the findings and understands when to escalate any actions arising from it. Good risk management practice embeds patient safety and staff well-being in the culture of the organisation, and effective leadership can help this to happen to its fullest effect.

FURTHER RESOURCES

Care Quality Commission – www.cqc.org.uk
Healthcare Inspectorate Wales – https://www.hiw.org.uk/
Health Improvement Scotland – https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/
Health and Safety Executive – https://www.hse.gov.uk/index.htm
Health and Safety Executive for Northern Ireland – https://www.hseni.gov.uk/
World Health Organisation – https://www.who.int/europe/about-us/our-work
Organisation for Economic Co-operation and Development – https://www.oecd.org/unitedkingdom/
Suzy Lamplugh Trust – www.suzylamplugh.org
Hoarding Disorders UK – https://hoardingdisordersuk.org/
Clinical Human Factors Group – https://chfg.org/
Royal college of Nursing – https://www.rcn.org.uk/

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CHAPTER

6

Safeguarding

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LEARNING OUTCOMES

- Introduce safeguarding in the context of community nursing.
- Critically explore how legislation underpins safeguarding practice.
- Contextualise roles and responsibilities in safeguarding.
- Critically examine factors that contribute to decision-making.
- Critically analyse safeguarding theory and practice.

OVERVIEW: CONTEXT OF COMMUNITY NURSING

This chapter is an introduction to safeguarding in community nursing. It will introduce the concepts and principles but will also challenge the roles and parts played in safeguarding an individual or a group. The chapter will explore safeguarding in relation to the whole lifespan, ensuring the consideration of diversity and culture in addition to social capital (Häuberer, 2011) and how this can impact decision-making. Case studies and models will be used to critically explore the roles and responsibilities of community nurses in safeguarding and those of the multi-agency team.

Safeguarding is one of the key roles of community nurses. It involves applying a critical lens to what is seen and experienced whilst carrying out the core purpose of delivering unbiased, caring, compassionate person-centred care. It requires nurses to ask why and to question the picture presented. This can create conflict in the professional's mind and stimulate the examination of values, observations and motivations. This important role of safeguarding requires emotional and professional intelligence, in addition to robust processes and procedures to fulfil the role of a community nurse.

ACTIVITY 6.1

Reflection

Take a moment to reflect on your experience and learning around safeguarding children, young people and adults.

It's useful to see yourself as continuing your learning journey throughout your career.

DOI: 10.4324/9781003347545-7

LEGISLATION: SAFEGUARDING VERSUS PROTECTION

Firstly, it is important to explore the legislative framework and statute that underpins all safeguarding and provides the structure for decision-making; this includes the concept of consent and how this is pivotal to all decision-making.

Prior to the death of Victoria Climbié in February 2000 (Laming, 2003), the position of many agencies was to protect children who may have suffered harm rather than the prevention of harm (NSPCC, 2021). The learning and subsequent legislative change (Children Act, 2004; DfE, 2018) that followed the Laming Enquiry (Laming, 2003) brought about a distinct shift of focus and moved the emphasis from reactive protection to proactively safeguarding children and young people. Therefore, safeguarding could be described as the measures (both governmental and individual) that are in place to safeguard individuals. Whilst this significant change in perspective came due to the death of a child, the impact on safeguarding those in need from all age groups was profound. For the first time, the UK government started to explore legislation to safeguard adults.

CHILDREN AND YOUNG PEOPLE

The 1989 Children Act (Children Act, 1989) was reformed to recognise the findings from the Laming Inquiry (Laming, 2003) and amended to become the Children Act 2004 and 2008. This legislation provided the infrastructure that local authorities and other members of the multi-agency team were required by law to adhere to (Table 6.1).

The key message of the Children Act is that the child's welfare is paramount, signifying that the child's best interest takes precedence over others' requirements, be that the parents, an organisation or any other body. It is this principle that provides the backbone to decision-making and supports multi-agency working by placing the child's welfare at its centre. This is supported by Working Together to Safeguard Children (HM Government, 2023), the statutory guidance for multi-agency working to safeguard and promote the welfare of children. It remains the most significant working guidance in the field of safeguarding children and community nurses are well placed to have a working

Table 6.1 The Children Act

The Children Act (2004) categories of child abuse:
Physical Abuse **Sexual Abuse** **Emotional Abuse** **Neglect**
It is important to remember that whilst each category could stand alone, rarely a child or young person will experience abusive behaviour and not suffer emotionally too. Many categories will and do overlap, and the picture is often unclear and may appear ambiguous.

knowledge of the document to fulfil roles and responsibilities according to their country of employment.

Whilst Working Together to Safeguard Children (HM Government, 2023) remains the definitive working guidance, it is supported by other legislation that underpins the core principle that the child's welfare is paramount. Examples of this are the legislation that mandates the referral of those identified to have suffered or are likely to suffer female genital mutilation (Gov.uk, 2016) and the updated Criminal Justice Act (2023) that mandates the referral to children's social services of those children disclosing and those suspected of suffering from child sexual abuse (Gov.uk, 2024). In response to the Independent Inquiry into Child Sexual Abuse report (IICSA, 2022), it will be a legal requirement for those in regulated activity relating to children, such as teachers or healthcare professionals, to report child sexual abuse they are aware of. People failing to report will be barred from working with the young, and anyone protecting child sexual abusers could go to prison for seven years (Gov.uk, 2024).

For healthcare staff, the intercollegiate document (Royal College of Nursing [RCN], 2019) lays down roles and responsibilities and training requirements for all individuals working in health environments. As a community nurse, there is a requirement to adhere to these standards and organisations must provide support to achieve this.

ACTIVITY 6.2

Reflection

Reflecting on your current role and safeguarding training, who would you approach if you had a safeguarding concern?

ADULTS

Prior to the death of Victoria Climbié, there had been a growing awareness concerning the lack of legislation supporting adults in need of safeguarding. The publication of 'No Secrets' (Department of Health (DH), 2000) provided guidance for professionals but did not legislate support for adults. The Care Act (2014) in England replaced No Secrets (2000) and provided the statute to underpin the safeguarding of adults at risk of abuse or exploitation. This is supported by statutory guidance (DHSC, 2022) and the intercollegiate document for safeguarding adults (RCN, 2018), providing structure for roles, responsibilities and training for those working in healthcare.

Trends in adult safeguarding indicate that most adult-related safeguarding reports are consistently related to older adults (NHS Digital, 2020, 2023), with a substantial increase in cases in the over 85s. Since 2021, there has been a 9% annual increase in adult safeguarding concerns in England (NHS Digital, 2023). This is compared to 19% since 2019/20 in Scotland (Scottish Government, 2023). The data time frame since 2020 includes the period of the Covid-19 Pandemic, which may influence a spike in reporting (Scottish Government,

2023); however, data analysis (via local authority reporting) in the four countries of the United Kingdom is criticised as being incomplete and does not represent the full picture. The reporting of data for Wales merged with adult social service reporting in 2019, so comparisons in the prevalence of adult safeguarding reports are challenging to identify. Similarly, data for reporting adult abuse in Northern Ireland is not transparent.

CONSENT

Consent is a key component of all decision-making, and it is important for community nurses to understand the legislative framework and how it relates to safeguarding. Whilst adults (aged 18 years and over) are assumed to have the capacity (Gov, 2005), children (aged 0–17 years) are deemed by law not to be able to consent for themselves and must have an adult who has parental responsibility (Gov, 2011) to make appropriate decisions for them. Both assumptions have been challenged in law over the past years, which will be discussed further in the following section.

Whilst the legislative picture concerning consent is similar in each of the four nations of the United Kingdom, each country has its own specifics, and it is therefore important for community nurses to understand their local legislation and how this applies to practice (further detail of country-specific legislation can be found in Tables 6.2 and 6.3).

Table 6.2

England	Northern Ireland	Scotland	Wales
Legislation			
Children Act 1989 Legislative framework for England's child protection service. Lays out that the child's welfare is paramount. All those working with children have a duty to protect.	**The Children (Northern Ireland) Order 1995** Sets out parental responsibilities and rights. Duties and powers public authorities have to support children.	**Children (Scotland) Act 1995** Outlines the legislative framework for Scotland's child protection system. Outlines parental responsibilities and rights and local authority duties.	**Children Act 1989** Legislative framework for Wales child protection service. States that the child's welfare is paramount Lays out the duty of care to protect children.
Children Act 2004 Builds on 1989 Act. Duty on local authorities to have members who are accountable for delivery of services. Duty of all agencies to cooperate to safeguard and promote the well-being of children and young people.	**Safeguarding Board Act (Northern Ireland) 2011** Requires public authorities to cooperate in contributing to the well-being of children and young people.	**Children and Young People (Scotland) Act 2014** Amends the previous Act.	**Children Act 2004** Builds on 1989 Act. Duty on local authorities to have members who are accountable for delivery of services. Duty of all agencies to cooperate to safeguard and promote the well-being of children and young people.

(*Continued*)

Table 6.2 (Continued)

England	Northern Ireland	Scotland	Wales
Children and Social Work Act 2017 All child deaths to be reviewed. Social Work England is created as a regulatory body for social work profession. Relationship education and sex education provided in schools		**United Nations Convention on the Rights of the Child (incorporation) (Scotland) Bill 2021** Will incorporate the United Nations Convention on the Rights of the Child into Scottish law. This will mandate that public authorities will have to comply with children's rights.	**Social Services and Well-Being (Wales) Act 2014** Framework for social services which gives individuals a strong voice. Encourages a focus on prevention and early intervention. Established a national adoption service
			Well-Being of Future Generations (Wales) Act 2015 Requires the establishment of local safeguarding children boards
Policy and Procedure			
Working Together to Safeguard Children 2018 Sets out the requirements of the multi-agency team to safeguard children and young people.	**Children and Young People's Strategy 2020–2030** Sets out the strategic framework to improve the well-being of all children and young people in Northern Ireland	**Getting It Right for Every Child (GIRFEC) 2021** Principles to shape practice and policy that affect children and their families. Provides consistent guidance and aims to improve outcomes.	**Safeguarding Guidance (Welsh Government) 2021** Working together to safeguard people (2021) is the statutory guidance in relation to Part 7 of the Social Services and Well-being (Wales) Act 2014. This guidance covers the protection of children and adults.
What to do if you're worried a child is being abused: advice for practitioners 2015 Indicators of abuse and neglect and what actions to take if you have a concern.	**Regional Core Children Protection Policies and Procedures for Northern Ireland (Safeguard Board for Northern Ireland) 2018** Explains the actions that must be taken when there are concerns about the welfare of a child or young person.	**National Guidance for Child Protection in Scotland 2021** Non-statutory guidance that provides a child protection framework in which it sets out the roles and responsibilities of all multi-agency practitioners.	**Wales Safeguarding Procedures and Practice Guides 2019** Provides a common set of child and adult protection, procedures and guides

(*Continued*)

Table 6.2 (Continued)

England	Northern Ireland	Scotland	Wales
Mandatory reporting of female genital mutilation (FGM) 2016 Guidance on the responsibilities of the multi-agency team to report FGM. Came into force 31 October 2015			

Table 6.3

The Care Act (2014) classifies ten categories of abuse:
Physical Abuse Sexual Abuse Domestic Abuse or Violence Psychological or Emotional Abuse Financial or Material Abuse Modern Slavery Discriminatory Abuse Organisational or Institutional Abuse Neglect or Acts of Omission Self-Neglect
It is unlikely that an adult will suffer any form of abuse and not suffer emotionally; therefore, categories can overlap. It is also important to consider adult abuse in conjunction with capacity as defined by the Mental Capacity Act (2005)

CAPACITY, CONSENT AND SAFEGUARDING

Legislation throughout the United Kingdom gives protection to an adult's capacity to make their own decisions. As an example, in England, The Mental Capacity Act (2005) pertains to all adults over the age of 18 and young people aged 16 and 17 years of age. It provides the legislative framework that underpins an individual's right to decide how best to live their life. The Act assumes an adult has the capacity to consent unless proven otherwise.

One of the key principles of consent is that adults have the right to make their own decisions, even if they may be deemed 'unwise.' Because of this assumption, it also provides safeguards to ensure an adult's liberty cannot be compromised, unless necessary. These safeguards have been provided by an amendment to the Mental Capacity Act (2005) (SCIE, 2015) and provide a framework for those who may be vulnerable and need protection or advocacy. These are due to be superseded by the Liberty Protection Safeguards (Laing and Garratt, 2022) in an amendment to the Mental Capacity Act (2020).

It is therefore important for community nurses to consider this and the legal underpinning of consent, when considering safeguarding concerns about

people and their families. The capacity to consent is significant in all safeguarding decision-making and should be an integral part of every community nurse's toolkit.

Considering consent and using the legislation in England as an example, children and young people under 16 years of age are assumed by the law not to be able to consent unless proven otherwise. This presumption has been legally tested several times, with one of the most significant originating from Victoria Gillicks' challenge to the Department of Health on their guidance that professionals could provide contraceptive advice to those under 16 without parental knowledge (Wheeler, 2006). Fraser guidelines (NSPCC, 2022) were developed from this challenge and can aid community nurses in understanding a young person's ability to consent on sexual health matters.

Gillick competencies (NSPCC, 2022) can be used in a wider context to understand whether a child is able to make their own decisions and whether they can understand the implications of those decisions. When working with children or young people, it is important to have a good working knowledge of these two pieces of guidance and how they may impact decision-making.

Whilst practice and guidance support shared decision-making for children and young people under the age of 16, the law remains firm on sexual consent. The age of consent or legal age to have sex across the United Kingdom is 16; however, the Sexual Offences Act (Gov.uk, 2003) clearly legislates that children under 13 cannot consent to sexual intercourse or any sexual activity (Crown Prosecution Service, 2020). This is classed as statutory rape across the four countries of the United Kingdom and requires escalation to the safeguarding lead or local children's social services department.

TRANSITIONAL AND CONTEXTUAL SAFEGUARDING

In England, the age of childhood defined by the Children Act (1989) is up to and including the age of 17. The Care Act (2014) in England underpins safeguarding for people over the age of 18. It is argued that neither of these Acts were designed to meet the needs of young people between the ages of 15–25 (Holmes, 2021). The term 'youth' can be defined by the United Nations (2020) as people between 15 and 25. It is recognised that the Children Act accommodates abuse that is largely experienced in the home setting, aimed at younger children. This is a trend also experienced in adults with NHS Digital (2023) asserting that 47% of reports of abuse in England included the "most common location of risk" being in their own home. Young people (> 15) may not experience this trend and are more likely to experience abuse in extra-familial environments (Cocker et al., 2021).

The term 'transitional safeguarding' refers to the umbrella of safeguarding considerations that span the void between children's and adult safeguarding legislation and care structures (Preston-Shoot et al., 2022). Considered a set of principles that respects the unique needs of young people, transitional

safeguarding understands the vulnerabilities of 'youth' and respects both physical and psychosocial development (Hueglerand and Ruch, 2022). This adolescent transitional 'space' or 'in-betweenness' (Hueglerand and Ruch, 2022) considers a time of emerging into adulthood; examples could be school leavers, those not in education or employment, young people in the care system and/or known in the social care system. Young people can have increased risks of exploitation and find themselves part of the justice system. Transitional safeguarding necessitates professionals and agencies working together to address the gaps in provision affecting this vulnerable age range of 'youth.' This deeper level of understanding of need requires services to work together across boundaries for young people to continue to be protected by the law into adulthood.

The term 'contextual safeguarding' responds to the environmental and social elements that surround young people which can pose a risk to their safety, namely school, peer groups, relationships and public spaces (Firmin and Lloyd, 2020). 'Extra-familial' harm includes 'forms of child sexual exploitation, child criminal exploitation, teenage relationship abuse, gang-affiliation, peer-on-peer sexual and serious youth violence that are not instigated by a young person's parents or wider family' (Firmin and Lloyd, 2020, p. 4) and the risk extends to the online environment.

The experience of abuse will vary, as will the 'context' of the factors that increase the risk. Whilst the risk of youth and the breadth of literature, legislation and focus sits with children and young people, it could be argued that contextual safeguarding applies to adults. Adults can be vulnerable due to their context and experience online abuse, gang crime, 'cuckooing,' exploitation, trafficking, modern slavery and abuse. Cuckooing is a term used when drug dealers take over a person's home as part of a criminal gang (Spicer, 2021). The criminal activity of drug crime involves families of all ages; criminals prey on vulnerability and use fear and abuse to involve family members. This chapter will not explore the context of 'county lines,' but this is a topic worthy of greater consideration as a community nurse. Please access localised training across the United Kingdom, as the context and scale of this crime (county lines) will be part of local safeguarding training.

WHAT MOVES VULNERABILITY TO RISK

A vulnerability could be seen to apply to the individual themselves (Oakley et al., 2016). It is recognised that individuals may be vulnerable by nature of their circumstance; a baby is vulnerable, requires high levels of supervision and every care need must be met by another. Infants, children and young people are minors, and are particularly vulnerable as they require the care of others for this journey; the level of need understandably reduces as they approach adulthood. Whilst this view of implied vulnerability is a paternalistic view, it is reasonable to assume that children and young people are vulnerable by nature; having increasing levels of capacity, understanding and ability, this is not

straightforward as a measure (Bagattini, 2019) considerate of the variables and definition of adolescence.

Adults may be vulnerable for very different reasons at various stages of life or as a result of situations across their life course. As defined in 'No Secrets,' the definition of a 'vulnerable adult' is someone 'who is or may need community care services by reason of mental or other disability, age or illness, and who is or may be unable to take care of themselves, or unable to protect themselves from harm or exploitation' (Department of Health and Home Office, 2000). This definition could be considered to capture situational aspects of a vulnerability that may also be short term, being unable to protect oneself. An example is receiving a general anaesthetic where the individual who would normally be able to protect themselves becomes vulnerable and needs the protection of those around them.

Dunn et al. (2008) highlight that situational vulnerability on top of a known vulnerability increases the 'level' overall. Other terminology used as an alternative to vulnerable adult is 'at risk of harm' (The Adult Support and Protection (Scotland) Act, 2007). Whilst 'No Secrets' was repealed by the Care Act (2014) in 2015, the language that surrounds vulnerable adults has been criticised as not fully considering the diversity of adult vulnerabilities in any one of the varied definitions (Oakley et al., 2016). Whilst vulnerabilities alone do not necessarily equate a safeguarding risk, it is important to consider that the known vulnerabilities (and number of vulnerabilities) can increase the risk of harm (Dunn et al., 2008).

The definition of risk (as asserted by the *Oxford English Dictionary*) is the exposure to harm or an adverse unwelcome event that is likely to "endanger; to expose to the possibility of injury, death, or loss." The threshold of where vulnerability becomes at risk of harm has been deliberated with respect to adult safeguarding (Oakley et al., 2016) and remains complex when considering adolescent safeguarding due to social and individual influences as adolescence is a time where risk-taking behaviours are prevalent (Hueglerand and Ruch, 2022). Risk-taking behaviour may increase an individual's vulnerability, such as drug or alcohol use, peer groups (gang culture) and environmental risks (their location) which might place a person at risk of exploitation, grooming and violence. As noted, extra-familial risks are often linked to adolescents and adults (Cocker et al., 2021; Hueglerand and Ruch, 2022).

Safeguarding reviews and triennial reviews support the acquisition of what professionals may consider an underpinning evidence base to identify risk and support decision-making (Sidebotham, 2019). There are three commonly identified risk factors which are interlinked in the safeguarding of children, leading to a toxic environment and putting a child at risk of harm, known as the 'toxic trio' (Brandon, 2009). These are parental/carer substance misuse, domestic abuse and parental mental ill-health. Whilst it is valuable to identify the significance of these combined risks, particularly with reference to safeguarding children, Sidebotham (2019) challenges this language as overlooking other risks

which can accumulate risk and be consequential in building a picture-"parental adverse childhood experiences, a history of crime, especially violent crime, teenage pregnancy, social isolation, poor education and many other factors have all been shown to increase the risks of maltreatment" (Sidebotham, 2019).

The language of 'toxic trio' itself could be detrimental in relationship building with families, and Sidebotham (2019) cautions that professionals should be considerate about the language used with and about families. However, biennial and triennial reviews into the circumstances surrounding the death and significant harm of children supports that the three areas mentioned earlier can increase a cumulative risk of harm (Sidebotham, 2019), and community nurses should be aware of these influences.

It is pertinent to consider the myriad of protective factors surrounding individuals which reduce risk, in consideration of presented vulnerabilities. For example, a baby who has loving parents who responsively meet their needs and lives in a safe environment. If the mother were to suffer with postnatal depression, this is a maternal vulnerability, but it may not necessarily lead to a child who is at risk of harm. Alternatively, there may be instances where maternal mental health poses a risk. Not every vulnerable person is at risk, and equally, the absence of any vulnerability does not mean a child is safe from harm (Sidebotham, 2019; Hueglerand and Ruch, 2022).

Children, adolescents and adults can be surrounded by protective factors to reduce risk, despite vulnerabilities being present. Protective factors can be positive role models, loving parents, carers/families/schools and the provision of a safe place to live, study and work. It is acknowledged that during the COVID-19 pandemic, lockdown restrictions adversely impacted on vulnerable children (and it can be argued, adults) in the removal of safe places to be educated, with reduced healthcare services overseeing children with universal provision (midwifery, health visiting, school nursing and schools) (Safeguarding Board for Northern Ireland, 2021). Environmental and situational 'risk' can increase the likelihood of harm where vulnerabilities exist.

ROLES AND RESPONSIBILITIES IN SAFEGUARDING

Due to the universality of healthcare, all those working in healthcare have a substantial part to play in safeguarding, extending to the wider population (including those surrounding the people receiving care) (NMC, 2018). For many, community nurses will be the first contact with themselves and their families, in their own environment – for example, health visiting, school nursing and district nursing services are privileged to be able to see people in their own homes. This is different from the snapshot presented of people's lives in acute, clinical and healthcare settings and can at times present a significantly different picture. It is therefore key to understand professional accountability to individuals and the public in order to access help and advice should there be a concern (NMC, 2018).

It is important to recognise that whilst legislation underpins the work of health professionals, regional and local variations will occur in the form of policies and procedures in each health organisation and local authority. Localised guidelines will be regularly updated in line with any legislative changes, and it is therefore important to be aware of the local safeguarding lead and how to access support.

ACTIVITY 6.3

Reflection

Who is your local safeguarding lead, and how would you access guidance and support?

RECOGNITION

The ability to identify a safeguarding concern is a core competency of a community nurse, and this knowledge is likely to be developed through both education and experience. As an NMC registrant in the United Kingdom, developing the ability to manage risk to safeguard the population and colleagues is essential and involves an understanding of the law and quality assurance which will guide practice (NMC, 2018). Education alone can lead to a disconnect between theory and practice, whilst experience without education can leave the professional lacking the theoretical knowledge to underpin their observations and concerns, which in turn may lead to indecision and potentially leave an individual in an unsafe situation.

Since the legislative change in the early 2000s (RCN, 2018, 2019), it has been recognised that health professionals require a level of training commensurate with their role and experience in order to develop the important attribute of professional confidence (Bruce, 2013). Professional confidence is underpinned by reflective practice (Kolb, 2015; Morrison, 2005), which provides the scaffolding to thinking and decision-making, enabling the professional to acknowledge the environment in front of them whilst seeking guidance in order to understand the implications of this landscape.

Reflective practice and safeguarding supervision are key practices in developing knowledge and understanding alongside recognition of social capital (Häuberer, 2011) and professional and lived experiences, all of which may contribute to decision-making. Wallbank and Wonnacott (2015) outline the many interdependencies that can influence the ability of professionals to 'see' and act on concerns about a family or individual.

Reviews into the death of or serious injuries to a child through abuse or neglect (DfE, 2022) bring to the fore the impact on the practice of personal, professional, relationship and environmental considerations and how these can be mitigated through effective education and supervision. The Intercollegiate Documents (RCN, 2018, 2019) are the product of collaboration by all the major health regulatory and advisory bodies and published by the Royal College of

Nursing. This collaboration was born out of lessons learnt from the Laming Inquiry (Laming, 2003) and has continued to mandate the hours and level of training that each group of health workers requires in order to fulfil their safeguarding responsibilities. As with many mandates, there are varying opinions about the necessity and implementation of training and learning, but it cannot be denied that a lack of training and knowledge can and does lead to vulnerable people not being protected.

FACTORS THAT CONTRIBUTE TO DECISION-MAKING

DEVELOPING PROFESSIONAL CURIOSITY

The term 'professional curiosity' relates to those skills that are acquired to both understand and to communicate what is the reality for people, families and communities, and it encompasses the ability to probe into a reality beyond the presented situation (Manchester Safeguarding Partnership, 2022). The origins of this terminology can be attributed again to the public inquiry into the death of Victoria Climbié (Laming, 2003) with the use of the terms 'healthy scepticism' (p. 322) and 'respectful uncertainty' (p. 205) offering clarification. In 2010, Munro adopted the phrase 'curiosity' with respect to the 'questioning mindset' required by professionals to effectively safeguard individuals, families and communities. Whilst the terminology originates from child safeguarding enquiries, the concept in this section relates to all nurses, midwives and health and social care professionals across all age gradients.

It is acknowledged that professional curiosity is assumed to be part of the nurse and practitioner's key skill set, yet it is understood to be a skill that requires development and is often cited as a failing of professionals in Child Safeguarding Practice Reviews (CSPR) (or Serious Case Reviews (SCR) in England) (Muirden and Appleton, 2021) and adult safeguarding reviews (Preston-Shoot, 2017). Taking time to understand the skills required is important for both a novice and experienced practitioner.

COMMUNICATION SKILLS

Defining what it is to be professionally curious includes asking questions to elicit information without being intrusive or threatening (Williams and Chisholm, 2018). To reveal information with proficiency requires communication skills developed in life and enhanced in nursing practice and education and remains vital throughout a nursing career. Advanced communication skills are required to demonstrate curiosity and encompass open questions, enabling the ability to probe into responses sensibly (Williams and Chisholm, 2018). Sekerka et al. (2014, p. 270) considered the skill of "probing" as the exploration of "possibilities" and "seeking out additional information." Probing could be explained as following a conversation with further questioning in search of 'reality.'

A systematic review of evidence highlights that experienced practitioners develop the ability to analyse large volumes of information, identify trends and make sense of the truth (Muirden and Appleton, 2021). It is therefore established that developing skills of being curious takes time, mentorship, role modelling and feedback. Experience also comes from reflection, looking back at one's own practice, and using the evidence base presented. Whilst Laming (2003) considered professionals taking a sceptical approach 20 years ago, it is recognised that there is limited deliberation of the need to 'engage in professional curiosity' in literature and texts (Thacker et al., 2019, p. 253).

It is acknowledged that novice community nurses will continue to develop and be supported in the acquisition of advanced communication skills in order to become confident in being curious. Preceptorship, mentoring, continued professional development and reflection will be supported alongside safeguarding supervision in local organisations/trusts/NHS health boards. It is important, however, to recognise that CSPR, SCR and safeguarding adult reviews recognise the failings of nurses in exhibiting professional curiosity, despite being experienced nurses and practitioners. It is therefore important to deliberate the challenges faced by nurses in recognising the deterioration, escalation, risk or truth in a presented scenario.

BARRIERS TO PROFESSIONAL CURIOSITY

Barriers to professional curiosity exist beyond the development of inquisitive questioning and having a curious mind. These barriers could include disguised compliance, the rule of optimism and professional issues and a lack of confidence in managing the tension of dealing with uncertainty (Thacker et al., 2019). It is important to consider why these are recognised barriers in order to develop practice and skills.

- Disguised Compliance

  It is recognised, in the wake of SCR, that the failings of 'services' are often at the forefront of lessons learnt (Fox, 2022). Whilst recognising the vital role that agencies and services play in protecting children, young people and adults, it is also important to consider the concept of 'disguised compliance' and the 'paternal concept.' Within the landscape of ascertaining how catastrophic outcomes can occur, is the concept of deceit on behalf of those it is hoped should care for those most vulnerable, that being parents, primary carer, family and caregivers.

  Disguised compliance is the act of purposefully misleading professionals to believe a reality that is not true. This could be timed for the arrival of a home contact, complying with the conditions set out in a child protection plan or leading professionals to believe something that is not true, which would otherwise lead to a concern for the welfare of an individual. The challenge for practitioners is to 'think the unthinkable,' maintaining the individual at the centre of their care, in the search for their lived reality.

- The Rule of Optimism

  Whilst the perception of events is certainly subjective among professionals (Kashdan et al., 2013) in decision-making, it can also be argued that it is human nature to see the best in others and accept a presented reality. It is recognised that professionals will use their own barometer to support decision-making, which is based on a multitude of aspects which consider parenting, cultural practices and the wide variety of accepted practices.

  A historical understanding of the aspects of safeguarding decision-making can be seen in the work of Dingwall et al. (1983), who apply the term 'the rule' in encapsulating the moral characteristics applied when deciphering if 'cases' meet safeguarding 'thresholds.' Kettle and Jackson (2017, p. 1626) deliberate the leniency of applying "an optimistic lens to *their* interpretive decision-making" practices and argue that the phrase "the rule of optimism" has indeed been unhelpful despite trying to consider the 'elasticity' of parenting practices and contextualise decision-making. It has been argued therefore that this term has accommodated abuse by seeing the best in parents and caregivers who display some 'humanity' in their caregiving (Kettle and Jackson, 2017).

  Looking back, case reviews provide us with examples of how family practices have been accepted, from corporal punishment to ideologies of witchcraft and possession. It is important to remain culturally competent but know what the definitions of abuse are as a barometer, which is the threshold. The law across the United Kingdom's four countries can be seen as inconsistent in the decision-making surrounding smacking, for example, and practitioners will continue to be challenged until a levelling of law in the form of a total ban occurs across the United Kingdom.

  It is acknowledged that this chapter will not explore the concept of 'thresholds,' and again, this is a theme that is vital in supporting decision-making around escalation. Localised training can be accessed to develop a greater level of understanding in terms of thresholds, but the key message is that there is a tendency to see the best in others, and clarity should always be sought by remaining curious to explain ambiguities where possible. Whilst a 'strengths-based approach' to supporting families should be used in an organisation, this should not be at the cost to the individual at risk and rejection of significant concerns (Thacker et al., 2019). Community nurses should access the support of the Safeguarding lead and team and, most importantly, keep focused on the individual for whom there is concern.

- Professional Issues

  Thacker et al. (2019, p. 1628) divide this theme into subcategories of "normalisation, professional deference and confirmation bias," which are significant professional issues creating a barrier to professional curiosity. In developing professional confidence, these factors may resonate when turning to colleagues for guidance and support. Accepted norms of decision-making or accepted thresholds may be evident when questioning the reality

that is presented. The concept of 'normalising' behaviour, conditions or environments can be seen where practitioners may be desensitised to the reality of the lives of individuals, families and communities.

In dealing with the uncertainty and tension of an 'assessment' and discomfort with the reality and weight of professional responsibility, it is essential to seek support in the form of safeguarding supervision if required. Accessing the objective and confidential support of the safeguarding lead to share observations enables the development of a safe plan underpinned by local policy. Seeking support in this way can overcome 'professional deference,' which involves submitting to the wisdom, authority or respect of a colleague(s) and which can be experienced in a hierarchy of professionals. Professional deference often results from the fact that it takes courage to challenge the status quo.

ACTIVITY 6.4

Case studies

This chapter has encouraged you to consider safeguarding across the life course. Your community nursing role may feel distinct with boundaries to a defined population. It is important that you do not see yourself working in a silo and understand that safeguarding is everyone's responsibility, and we have a role to play in protecting everyone we encounter by working with other professionals and agencies.

In reading the following scenarios, try not to consider just one profession that this applies to. To consolidate your understanding of this chapter, consider the following case studies and ask these questions:

What are the risks in this scenario?
What would my role be as a community nurse in this scenario?
Who are the professionals that could be involved? Think broadly
Who could support the professionals in the case study?
What is the underpinning law(s) that apply in your country of work?
What do you need to do next to support your learning in relation to the scenarios?

1. Anya has a new baby. The family has lived in the United Kingdom for seven months, and maternity services were not aware of this family until the mother accessed A&E in labour at 39 weeks gestation. Anya is from Senegal, West Africa. The health visiting team has been informed by the midwifery team that Anya underwent FGM as a child aged 3. Anya has two daughters: the baby, who is 7 days old, and a 3-year-old daughter. The 3-year-old daughter has not been 'cut.' You are aware that there is a Grandmother living with the family. You have been informed that the mother has several health conditions, and the midwifery team has signposted the family to register with the GP service.

2. Jack is a 14-year-old male. He lives with his dad (34) and grandfather (69). Jack's dad is unemployed; he is currently on long-term sick as he has a very low mood and is receiving medication. Jack has a mother who is in a new relationship. Jack is not keen on his mother's boyfriend, so he stays with his dad now. He has a good relationship with his grandfather, but his health is deteriorating. Jack's mother shared concerns with the school nurse that she doesn't see Jack, and when she does, he has new trainers and clothes. She is not sure where he is getting the funds from. Jack has a new phone, and on the last occasion she saw Jack, he was distracted by his phone and asked her to take him home. When she dropped him off, someone opened the door that she didn't recognise, and the door quickly closed. Jack and his father are not replying to messages about who that person was.
3. Sandra is 56; she lives with her husband, Andy, who is 60. Andy is now a full-time carer for Sandra, who has secondary progressive multiple sclerosis. This is active, and her symptoms are worsening. Their home is small and crowded with furniture and items. A bedroom has been created in the living room for Sandra. The district nurse service is involved in Sandra's care as her needs have increased. Carers are now involved, as Andy is struggling to meet her personal hygiene needs effectively. The district nursing team is aware that they have grandchildren. Sandra indicates that one of their children (Kristie, 28) has recently moved back home with her 6-year-old daughter. It's the summer holiday, but you have not seen Kristie at all. Andy confides in the community nurse that Kristie left the child one day; it's now been five weeks, and Kristie has not returned but is in contact by phone. She intends to collect the child 'soon.' Andy does not feel able to cope; he is overwhelmed with his caring role but feels it's the safest place for the child right now. He tries to hide his fears from Sandra but is concerned Kristie is taking drugs again.
4. Gareth is 50, has a severe learning disability, and needs support with his daily activities. He attends a daycare centre. He lives at home with his parents, who help with his personal needs. Each day, he is collected by Heema, who is his driver. Gareth's mother is 82 with progressive dementia, and his father is 83 and cares for his mother, but his memory seems to be fading, he has not remembered about daycare in the last month. Heema has concerns about the well-being of Gareth as his personal hygiene is deteriorating. There is a night carer attending the home. Gareth said one day that he did not like the night carers, and they took his 'pocket money.' Gareth's father is aware that his wife's condition is becoming worse and has asked the GP for help. A referral to the district nurse team has been made.

CONCLUSION

In summary, it is valuable to recognise that knowledge is key; being aware of one's own boundaries and limitations is powerful and leads to seeking collective knowledge, sharing concerns and ultimately protecting individuals. It is important to recognise that it is not possible to have all the knowledge, and that is not an expectation, but knowing where to fill those gaps is vital. Whilst community nurses will often have specific expertise (health visiting, school nursing, community children's and district nursing), understanding the breadth of safeguarding obligations from children to adult services is an expectation.

Understanding limitations can enable the seeking of support, education and direction. Being aware of the unique roles undertaken in nursing is important, with the knowledge that nurses will work with and alongside many professionals to maintain the safeguarding of the population. Following processes and procedures locally in organisations will set the path to professional practice, whilst being aware of the underpinning legislative framework for the country of employment will ensure that professionals are acting with the individual's interests at the centre of care.

Finally, safeguarding is everyone's concern. In the protection of the public, community nurses must endeavour to seek support from colleagues in decision-making, develop a professional curiosity to see beyond the presented reality and be mindful of the barriers that can reduce the capacity to fulfil their safeguarding role.

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CHAPTER

7

Therapeutic relationships across the lifespan

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LEARNING OUTCOMES

- To develop a critical understanding of therapeutic relationships in the context of community nursing.
- To examine the principal theories and key concepts of developing therapeutic relationships.
- To appraise the scope of influential factors when nurturing and maintaining therapeutic relationships.
- To analyse and apply the principal theories of concluding therapeutic relationships in a community nursing context.

INTRODUCTION

> [At] the time at which most of us experience public services, our need for a kind, human and emotionally astute response is always greatest.
>
> –*Unwin (2018 p. 36)*

The aim of this chapter is to outline the benefits of building and supporting therapeutic relationships for both people receiving and delivering healthcare in the community within the context of contemporary community healthcare policy. Community nurses spend much of their time with people receiving care and their caregivers with positive therapeutic relationships forming a core part of care (Kwame and Petrucka, 2021). There is no one definition of the term *therapeutic relationship*; however, several authors agree that therapeutic relationships are essential in delivering effective short- or long-term healthcare (Allande-Cusso et al., 2022). Therapeutic relationships are the "backbone" of contemporary community nursing interventions, beginning with 'connecting work' which forms the 'glue' that builds 'constructive partnerships' leading to empowerment and self-care (Moreno-Poyato et al., 2021). The therapeutic relationship provides a foundation to build people's autonomy and decision-making (Molina-Mula and Gallo-Estrada, 2020). Therefore, distinct skills are needed by community nurses such as knowing ourselves and our feelings; fostering emotional intelligence such as caring, empathy and honesty; and

DOI: 10.4324/9781003347545-8

supporting an equal power balance to support self-care (McCormack and McCance, 2017; Collins, 2015). Also important, is consideration of each person's inseparable connection with their significant others, their culture, community and the environment in which they live (Riegel et al., 2021). The reader is guided to explore key relevant features that contribute to building, supporting and concluding meaningful autonomous therapeutic relationships in the community healthcare setting. In addition, the dynamic landscape of how government policy influences healthcare delivery and how change impacts the nurse/person/family relationship are similarly reviewed before offering a conclusion.

UNDERSTANDING THERAPEUTIC RELATIONSHIPS

Therapeutic relationships include giving time, empathy, respect, genuine engagement, and creating an open, friendly, caring connection to establish rapport and trust (Wright, 2021). Equally important is being well informed, reflective, reliable, open, honest and giving consistent clear messages. Wright's ATTACH mnemonic outlines this (Wright, 2021; Table 7.1).

Sharing power and control facilitates people's contribution to individual health and wellbeing choices in partnership and without judgement (Byrne et al., 2020). Agreeing on the care time frame or onward referral, meaningfully, optimises the co-production of a person-centred care plan ensuring that a person's needs are the priority (Rippon and Hopkins, 2015). These actions improve people's perceived satisfaction with the quality of their care and life

Table 7.1 Rationale for the ATTACH mnemonic

Authentic	Being authentic with service users is crucial, since we are our own instrument of care, and we use ourselves in our practice
Trustworthy	Being a reliable and well-informed professional incites service users to trust you, your judgement and your practice
Time-maker	Making time to be with service users makes them feel cared for and listened to and enables us to discuss the timeframe of care, including the ending of the therapeutic relationship
Approachable	Being approachable enables the nurse to demonstrate that they are accessible and visible and a good listener and provide an empathic response
Consistent communication	Communication is crucial and we also need to provide a consistent message, work as part of a team within recognised models of practice and meet the requirements of the Nursing and Midwifery Council
Honest	Honesty is a fundamental value of the nursing profession and enables us to have open and realistic conversations with service users

(Wright, 2021 p. 4).

Table 7.2 Peplau's theory

Peplau's theory
1) Both community nurse and person can interact 2) This interaction helps them to evolve and mature. 3) The two fundamental tools in nursing are communication and interpersonal skills. 4) Nurses must clearly understand themselves to promote the growth of those receiving healthcare and to prevent the limitation of people's choices to those that nurses value.

(Wright, 2021 p. 2).

Table 7.3 Peplau's phases

Peplau's Phases
Orientation phase – assessment of the individual's health and situation
Identification phase – person begins to feel they belong, and can deal with the health problem decreasing the feeling of helplessness and hopelessness (development of a care plan and who needs to be involved)
Exploitation phase – based on the needs and interests of people who feel like an integral part of the helping environment
Resolution phase – withdrawal/referral

(Wright, 2021 p. 2).

through reduced levels of anxiety and depression. In addition, this approach increases adherence to treatment and decreases healthcare costs (Kornhaber et al., 2016; Step et al., 2009). Peplau's (1952, 1962) seminal theory provides a useful structure in outlining the interaction and phases of a therapeutic relationship (Tables 7.2 and 7.3).

CONNECTING WITH SELF AND OTHERS

Having outlined the features of therapeutic relationships, connecting with self and others is considered. The core community nurse skills of self-awareness and reflective practice support connection through focusing, exploring and understanding themselves, their personal and professional values, ethical and moral obligations and commitments which supports the understanding of others (Younas and Maddigan, 2019). Every individual receiving and giving care is a unique human being with different sets of values, attitudes and beliefs as outlined in the chapter on spirituality (see Chapter 12). What is normal for one individual may not be normal for another. Not every person receiving healthcare may feel the need to build a close relationship with a community nurse preferring the distance of connecting through a phone call or online to talk about their health issue more easily (Mind, 2021; Lawrence, 2017).

Reflective practice and self-awareness contribute to connecting with people from diverse communities, cultures and backgrounds, supporting a

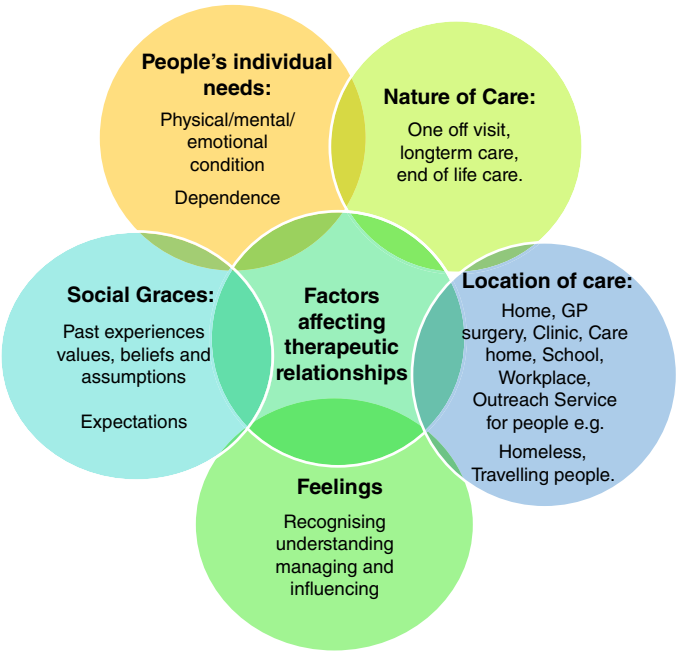


Figure 7.1 Factors affecting the therapeutic relationship. (Burnham, 1992; Roper-Hall, 2008).

non-judgemental and inclusive way for informed choices that align with people's values and moral ethics (Kwame and Petrucka, 2021; Younas and Maddigan, 2019; Rasheed, 2015). Other factors which enable connecting with self and others include verbal and non-verbal communication, the space and location of care, people's needs at the point of care, the nature of that care, and the level of dependence. People's expectations, past experiences, values, assumptions, identity, sexual identity and social differences termed Social Graces by Burnham (1992) and Roper-Hall (2008) are also important to consider (Figure 7.1).

RECOGNISING YOUR OWN PAST EXPERIENCES, BIAS AND CONTEXTS TO MANAGE PRACTICE

Community nurses need to know themselves as well as the person receiving healthcare to practice in a human and connected way (Peplau, 1952). Peplau (1952) offered guiding concepts of individual self-awareness and personal identity as important aspects that community nurses need to be aware of to be able to recognise how past experiences and biases may influence therapeutic relationships. A contemporary framework termed "The Social Graces" aids this (Roper-Hall, 2008; Burnham, 1992). A key aim of the Social Graces is to "name" power differentials supporting the identification of prejudice or privilege by outlining features that influence our personal and social identity enabling us to critically explore social differences. A mnemonic is provided with specific invisible and visible aspects of identity that contribute to everyone's perspectives, beliefs and behaviours (Figure 7.2).

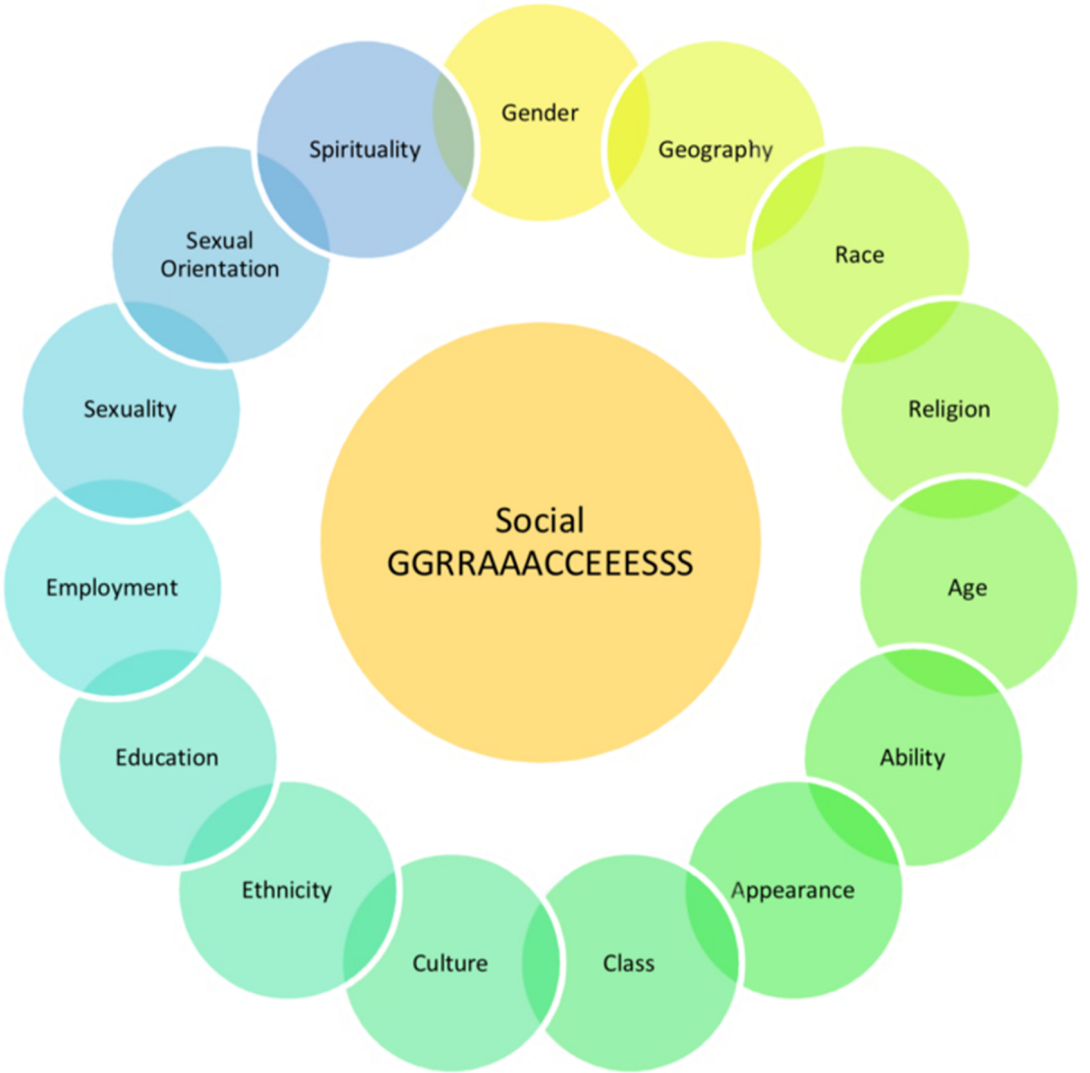


Figure 7.2 The social GGRRAAACCEEESSS. (BASW, 2022).

Early childhood relationships and experiences define how we engage, connect and build therapeutic relationships. During this time, neural pathways are constructed for understanding future relationships and building empathy with others (Graham-Ray, 2020; Singer and Klimecki, 2014). When babies and children experience warm attentive responses, they are primed to expect that this is normal. Conversely, cold, destructive, unpredictable and traumatic childhood experiences may make it more difficult for those affected to feel safe to build the trust needed for building therapeutic relationships (Hawthorne and Burley, 2020). Community nurses experience their needs and vulnerabilities which influence how they care for themselves, their colleagues and the people to whom they deliver healthcare. Being aware of these issues is therefore important as they can affect how people engage with primary care and how

community nurses engage with people. Self-awareness, therefore, is a key ongoing process that supports therapeutic relationships enabling community nurses to reflect objectively on themselves and the people they care for (Rasheed et al., 2018). It is a valuable tool in building and supporting therapeutic relationships with people enabling the delivery of respectful, reliable, safe community care experiences that may be remembered by people long after the therapeutic relationship has concluded (Foster, 2020).

ACTIVITY 7.1

Reflection

Reflect on how your life experiences might influence the way you connect with other people. How have you made connections with others?

It is important for community nurses to welcome feedback from various sources, for example from people they are supporting, peer feedback and formal supervision.

- How did you review the meaning of your connection(s)?
- Reflect on a time that you have sought and received feedback from others.
- Consider if feedback influenced your perceptions or your self-awareness.
- What actions did you take to improve the quality of your practice?

MAKING CONNECTIONS WITH PEOPLE, FAMILIES AND COMMUNITIES

Community nurses deliver healthcare across the lifespan, from pre-birth, childhood, adolescence, adulthood, older adulthood and end of life, with a growing gap between capacity and demand (West et al., 2020; Foot et al., 2014). They are primarily autonomous, lone workers, delivering complex and preventative care to people (including families and carers) in various locations (Chamanga et al., 2020; Maybin et al., 2016). As guests in people's homes (including care homes) and visitors in familiar, convenient settings such as the community, workplace, clinics, social settings, schools and prisons, community nurses navigate the delivery of healthcare in a variety of surroundings. People may feel more comfortable receiving healthcare in their own surroundings which can aid connections. However, this may not always be the case, for example people experiencing homelessness or "housed" in a hotel, gender-based violence, bullying in school or the workplace and people with a learning disability, may be afraid to seek healthcare. The diversity of healthcare delivery models can create barriers to connecting. These barriers can be overcome through genuine person-centred care as opposed to task and process-centred care, paramount to ensuring positive therapeutic relationships (Robertson, 2023; Kwame and Petrucka, 2021).

Community nurses may feel isolated and vulnerable due to their autonomous role, especially in relation to decision-making, if a courageous conversation is needed, for example safeguarding a child or vulnerable adult or the community nurse has recently transitioned from a hospital-based role to community practice (Queen's Nursing Institute [QNI], 2015). Healthcare delivery, in any of the settings outlined above, requires skill sets previously discussed to support the delivery of a holistic public health role to connect to people and communities. By identifying and breaking down potential barriers to connections, resilience and coping strategies will be built which will support safe practice (for self and those receiving healthcare), aiding decision-making and ultimately improving physical, mental health and social wellbeing to enhance the quality of life (Royal College of Nursing [RCN], 2015).

DEVELOPING THERAPEUTIC RELATIONSHIPS

THE DIMENSIONS OF AN INTERPERSONAL CONNECTION WITH OTHERS

The foundation of a therapeutic relationship between a community nurse and those whom they are supporting is an authentic interpersonal connection (Henderson et al., 2021; Henderson, 2022; Pratt, Moroney and Middleton, 2021; Arnold and Boggs, 2019). Authenticity can be promoted through a consistent and sensitive approach and behaviours that help others meet their needs (Grossman, 2022; Allande-Cusso et al., 2022). Adopting an open, honest, collaborative and respectful approach is characteristic of an authentic interpersonal connection that promotes trust between two individuals (Mcharo et al., 2023; Grossman, 2022). When forming interpersonal connections with others, the appeal of the other individual and elements of self-disclosure are key drivers (Karremans and Finkenauer, 2020). There are three key dimensions that influence the strength of a connection and its potential progression to a therapeutic relationship (Figure 7.3), which are further explored later.

First, the meaning that individuals place on the connection should be mutually understood. When expectations between people who access and provide support are fragmented it can lead to superficial and inauthentic connections (Henderson, 2022). For example, an individual who was receiving ongoing support for their long-term condition over many years might feel a friendly connection towards the community nurse, whereas the nurse might perceive the relationship as a purely working alliance. Second, similarity in the importance that each individual places on the connection is fundamental to providing an authentic interpersonal connection. If there are differences in understanding of the importance that the other has placed on the connection, it can lead to the connection being imbalanced and lead to difficulty in building a common bond (Boudioni et al., 2015; Hu, 2014; Petch et al., 2013). Finally, the direction of the power in the relationship is important. Community nurses might be viewed as being in an advantageous position over someone they are supporting,

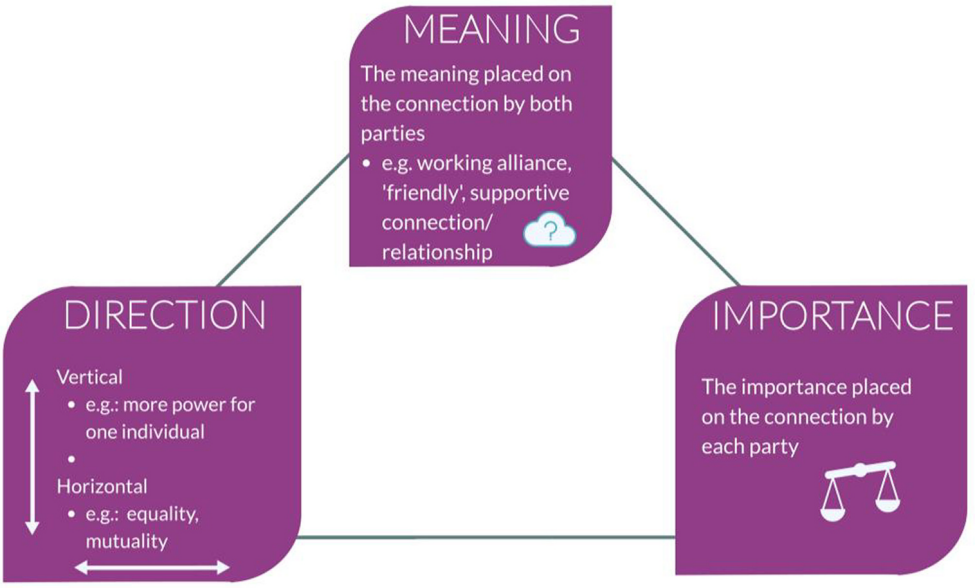


Figure 7.3 Dimensions of interpersonal connection.
(Adapted from Henderson, 2022 p. 5 and Karremans and Finkenauer, 2020).

attributed to their professional knowledge, abilities and skills, and putting them in a perceived position of power (Buchman et al., 2017; Carel and Kidd, 2014). Adopting a partnership approach to providing care and support can help promote trust and confidence.

A disjointed interpersonal connection between a community nurse and a person they are supporting can negatively impact the expectations of both individuals. It could hinder progression towards a therapeutic relationship and subsequently impact both parties' experiences of working together to access or provide community-based care. For an interpersonal connection to be nurtured and progressed into a supportive therapeutic relationship, it is imperative that both parties have a mutual and equal understanding of these dimensions (Henderson, 2022; Karremans and Finkenauer, 2020). Establishing parity of these dimensions does not necessarily need to happen through a formal process, but through an unwritten contract (Mitsi et al., 2018). Adopting an open communication style between individuals and discussing each other's expectations of the relationship, could help explore thoughts and feelings about the meaning, importance and direction of an interpersonal connection. Promoting a deeper level of connection to nurture a supportive relationship, could also lead to increased knowledge and understanding of the individualised health and wellbeing needs of people who access community nursing care (Pratt et al., 2021; Strandås and Bondas, 2018). Having these transparent conversations can help promote mutual understanding and manage the expectations of each individual. Conversely, a disparity in understanding could lead to the connection being unbalanced, affecting its progression towards a supportive therapeutic relationship.

KEY FEATURES OF THERAPEUTIC RELATIONSHIPS

It has earlier been highlighted that there is no singular definition for the term therapeutic relationship (Allande-Cusso et al., 2022). It is, however, widely recognised that several key features are foundational to therapeutic relationship development.

ACTIVITY 7.2

Discussion point

What is your understanding of a therapeutic relationship? Are there any features or characteristics that you would associate with therapeutic relationships?

If the previously discussed key dimensions are the necessary "ingredients" to help form an interpersonal connection, any good recipe must also have "methods" that tell you *how* to reach the end goal. Primarily, these connections require an investment of time and continuity of contact to progress to a supportive therapeutic relationship (Berscheid and Regan, 2016; Gillath et al., 2016). Relationships can have a profound effect on both the psychological and physical health and wellbeing of both community nursing staff and the people they support (Karremans and Finkenauer, 2020). Investing time and continuity in a connection allows the opportunity for key features to be nurtured and developed. Exploring the principles of trust, empathy, compassion, self-disclosure and continuity can support an understanding of the rationale for meaningful therapeutic relationship formation within community nursing practice.

Trust

Trust has been conceptualised as both a process and an outcome of interpersonal interaction (Gonzalez, 2017). Trust involves a willingness to be vulnerable to the actions of another person or people. It requires a belief that the other will act in accordance with a person's best intentions, wishes or will and is the basis upon which therapeutic nursing relationships are built (Rørtveit et al., 2015). Nursing within the community can present unique considerations in relation to trust. Consider, for instance, the initial confidence required to invite a nurse, who is often a stranger, into the intimacy of the home or personal setting at a frequently vulnerable time in a person's life. It is recognised that trust can be built through clear, consistent and transparent communication; respect for people's autonomy and decision-making; and demonstration of empathy and compassion (Wiechula et al., 2016). Conversely, barriers to developing a trusting therapeutic relationship include dishonesty, a perceived lack of time or interest to understand people, and exploitation of power dynamics, alongside a lack of professional knowledge (Ozaras and Abaan, 2018). It is established that trust between people and the professionals supporting them is a predictor of

people's satisfaction with their healthcare and can support people's confidence in their care delivery (Strandås and Bondas, 2018; Birkhäuer et al., 2017). In contrast, lack of trust can result in poorer outcomes with people being less willing to share important health- and wellbeing-related information or collaborate with professionals (Rasiah et al., 2020).

Within the UK, nurses are considered amongst the most trusted professionals (Ipsos, 2022). The development of trust is, however, an ongoing and dynamic process and trust is not all-encompassing (Pratt, Moroney and Middleton, 2021). For example, someone may initially trust a community nurse to have knowledge related to medication use or provide competent public health advice; however, only through repeated, respectful and negotiated interactions may be confident in sharing the complexities of their family circumstances. Thus, reflection on factors to support the development of trust is an important aspect of the community nurse's role. A focus on building mutual trust is also central to addressing health inequalities in supporting those who may have been marginalised by society or the healthcare system (Ellis et al., 2020; Alpers, 2018).

Empathy

Empathy is cited as central to therapeutic relationship development (Derksen et al., 2017). There is a body of research describing the benefit of empathic interactions on physiological and psychological wellbeing (Levett-Jones et al., 2019; Plotkin and Shochet, 2018, Hojat et al., 2011). Empathy has been characterised by the ability to understand another's experience in the world through sharing their feelings or perspectives, and further being able to offer an attuned response (Barker, Crowfoot and King, 2022). Empathy is often closely related to sympathy; however, it is the principle of connectedness and a "feeling with" rather than "feeling for or about" someone which is recognised as supporting empathic therapeutic interactions (Sinclair et al., 2017). When experiencing challenging circumstances people have reported that it is most helpful when practitioners empathise by taking time to understand, acknowledge and validate their situation rather than expressing pity (Sinclair et al., 2017).

Empathy is one of the core conditions of Roger's (1975a, 1975b) seminal person-centred therapeutic framework and thus is closely linked to the principles of congruence and unconditional positive regard. It is important when considering therapeutic relationship development that practitioners are genuine and authentic. Community practitioners may need to reflect upon how they can provide non-judgemental acceptance of the person they are supporting even if they may disagree with some choices or actions they make.

Some evidence suggests that healthcare professionals are most empathetic to those they perceive as most like themselves or who have shared a similar experience (Eklund, Andersson-Stråberg and Hansen, 2009). On the contrary, unconscious biases activated through a range of social and personal differences can result in practitioners expressing negative emotional responses to those

they are supporting (Riess, 2017). Experiencing a lack of empathy from practitioners is a reason people may choose to avoid healthcare interactions; empathy can strengthen a relationship and offer motivation in healthcare contexts (Moudatsou et al., 2020). Developing self-awareness and understanding of the influences that can affect empathy can support community practitioners' capacities to develop meaningful therapeutic relationships.

ACTIVITY 7.3

Reflection

Think about a time when you supported someone whose choices you disagreed with.

How did you demonstrate empathy in your interactions?

Compassion

Compassion is recognised as fundamental to the identity of the nursing profession supported by regulatory and policy expectations that nurses will provide care in a compassionate manner (Erbil and Pamuk, 2022; Nursing and Midwifery Council [NMC], 2018; McCaffrey and McConnell, 2015). A compassionate approach can help nurses connect with people, understand their needs and provide empathic and effective support and care (Durkin, Usher and Jackson, 2019). Despite the identification of compassion as a core nursing value the concept can remain unclear and has frequently been associated with a focus on the alleviation of suffering (International Council of Nurses [ICN], 2021; Younas and Maddigan, 2019). A wider definition encompasses being sensitive to a person's situation and having a genuine willingness to collaboratively seek solutions to identify their needs. This definition fits community healthcare due to the range of settings and diversity of people that community nurses work with. People who interact with community practitioners may not identify themselves as being vulnerable or experiencing suffering at the time of their interaction. However, the everyday community practices of attending, visiting, listening, advising, referring and supporting, often over an extended period, can all contribute to people's experience of receiving compassionate care (Hordern, 2020).

Compassion, as a hallmark of quality care, is highly valued by families, people receiving support, and practitioners providing services (Ghafourifard et al., 2022). There has been, however, recent public debate and concern that nursing staff can appear to lack compassion on occasion. Often, discussion around compassion can be focused on the behaviour of individuals (Tierney et al., 2017). There is evidence that organisational culture and structural challenges (such as staffing shortages) can impact practitioners' opportunities to have time to relate, empathise and connect with people on a therapeutic level. Facilitating self-compassion is cited as one means to reduce staff burnout and foster compassionate care (McVicar et al., 2021).

Continuity

Continuity plays a crucial role in establishing and maintaining relationships within community nursing. There are several dimensions to continuity that support the building of rapport and trust between people and practitioners:

- *Informational continuity* – The appropriate use of information on past events and personal circumstances to make current and future support appropriate for everyone.
- *Management continuity* – A consistent and coherent approach to the management and delivery of services that is responsive to an individual's changing needs.
- *Relational continuity* – An ongoing therapeutic relationship between people and one or more practitioners when requested.

(*Adapted from Haggerty et al., 2003*)

Therapeutic relationships are built on empathy, mutual respect and communication and continuity of care helps establish and maintain these relationships over time. Where possible people should receive support or care from a limited number of known individual practitioners (Rickenback and Freeman, 2019). Consistent interactions provide an opportunity for practitioners to develop a deeper understanding of people's needs, preferences and values, which can inform their approach to collaborative care planning and enhance people's health and wellbeing outcomes (World Health Organisation [WHO], 2018). Consistent contact can be particularly relevant when people are experiencing times of change or challenge such as during pregnancy or when receiving palliative care (Hudson et al., 2019; Perriman, Lee Davis and Ferguson, 2018). Continuity can also be helpful for developing trust to share relevant health information such as facilitating disclosure for people experiencing domestic violence (Heron and Eisma, 2021).

Providing continuity can often be difficult in the community due to staffing and retention issues, as well as service organisational approaches (Whittaker et al., 2021; Chamanga, Dyson and Loke, 2020). There is evidence, however, that continuity can have a positive impact not only on the individuals receiving care and support but also on the health service. Reduced hospital readmission of older people with long-term conditions as well as higher patient satisfaction are both associated with continuity of care (Facchinetti et al., 2020; WHO, 2018). The use of digital health innovations (as discussed in Chapter 19) can support the development and continuity of a therapeutic relationship when issues such as rurality or the COVID-19 pandemic made frequent face-to-face contact challenging. Practitioners, however, are required to carefully consider how they employ their therapeutic skills when engaging via digital means (Bantjes and Slabbert, 2022).

Self-disclosure in a professional and appropriate manner

Self-disclosure in the therapeutic relationship is the process of the practitioner sharing information about themselves with those they are supporting.

Self-disclosure can be a means of building rapport and trust with people through enabling a more genuine connection and by validating experiences; for example, a practitioner talking about their own experiences to offer an illustration of a point or demonstrate empathy. However, practitioners must be very mindful of their professional obligations and requirements to maintain appropriate boundaries with the people they are supporting (NMC, 2018). Effective self-disclosure in the therapeutic relationship involves carefully considering people's needs and circumstances. Practitioners must be attuned to people's reactions and ensure any self-disclosure is focused on enhancing support and wellbeing.

RELATIONSHIP BETWEEN INTERPERSONAL CONNECTIONS AND THERAPEUTIC RELATIONSHIPS

Figure 7.4 highlights the intrinsic relationship between interpersonal connections and supportive therapeutic relationships. It combines the key dimensions of an interpersonal connection (centre) and the subsequent key features for progressing and nurturing a therapeutic relationship (outer circle) (Henderson, 2022; Henderson et al., 2023).

For the next activity, please use the diagram below to guide your thoughts and reflect on therapeutic relationships in a community practice context. Consider the connections and relationships that you might form with people you support and their families and with colleagues; Figure 7.4 is equally relevant to both. These dimensions and key features can help you to make interpersonal connections and build mutually supportive relationships with others in wider health and social care sectors and organisations to support people in a community setting (Henderson et al., 2023; Henderson, 2022).

ACTIVITY 7.4

Reflection

Consider how the key dimensions for progressing and nurturing a therapeutic relationship could influence the relationships you have formed or will form with people you support and colleagues in the community. Critically reflect on the following scenarios.

Think of a time when you felt you had a strong therapeutic relationship with someone you were supporting and consider:

- The meaning, importance and direction of the therapeutic relationship. Were there similar expectations about these, between you and the person you were supporting?
- What key features in the diagram above could you identify in your therapeutic relationship?
- How did they impact the connection you shared and the support you were able to offer?

Now think of a time when you felt that a therapeutic relationship you had could have been stronger and consider:

- Did you and the person you were supporting have similar perceptions about the meaning, importance and direction of the therapeutic relationship, from both you and the person you were supporting? What impact did that have on the therapeutic relationship?
- What key features in the diagram above could you identify in your therapeutic relationship and were there any missing? If so, consider the impact those missing elements posed to the therapeutic relationship.
- Is there anything you might do differently in future to address missing dimensions or key features to help promote and nurture a therapeutic relationship?



Figure 7.4 Key dimensions and features of interpersonal connections and supportive relationships. (Henderson, 2022, p. 185).

Having reflected on the impact that the key features of therapeutic relationships can have when connecting with people we support, the absence of one or more of these key elements can have a profound effect. Cognitive dissonance, defined by Grunberg et al. (2022) as comfort in consistent behaviours and discomfort when your beliefs do not match expected behaviours, can lead to internal conflict and result in broken bonds of trust. This can be evident when someone that an individual relies on has abused their power to their own advantage. Some examples of cognitive dissonance are included in Activity 7.5. It can be difficult to regain trust in such instances. The case study in Activity 7.5 and accompanying activity offers an opportunity to explore this concept further and consider the impact that broken trust can have.

ACTIVITY 7.5

Case study	Activity: Exploring the impact
Barney Smith (pseudonym) is a gentleman who lives in his own home within his semi-rural community. With help from the Community Nursing Team, he manages multiple long-term conditions to maintain his health and wellbeing. He receives community nursing support twice a week to support him with a wound dressing, and twice-daily social care support with personal care. He reflected on his perceptions and experiences of cognitive dissonance: *"I don't know, I'm sure, she [a previous carer] might've taken ten, ten quid out of my wallet or something … but that frightened me a bit, because you can see, look, my wallet is lying there [points to wallet on the table] but, erm, I absolutely and completely trust Beverley [his current carer], erm, she is, I'm sure she wouldn't do anything like that but, mind you, the woman that did all this [the carer who was caught stealing] … I liked her … so you have the, the dissidence(dissonance), if you like, of somebody who you liked, but who's also been, er, thieving off people that she's supported …"* (Henderson, 2022, p. 151). Barney goes on to explain: *"I think Beverley works well because I can, I can count on her.… I know that she'll be there and that she won't, you know, she won't turn up sometimes and not others, that's really quite important to me" (Henderson, 2022, p. 152).*	Barney highlights trust as a key element of a therapeutic relationship and the positive or negative impact it can have on health and wellbeing. He emphasised the importance of the ongoing bond of trust he had with his current carer, Beverley. However, he also outlined how his negative experiences with a previous carer left him feeling frightened, with conflicted feelings of mistrust for someone with whom he had made a personal connection. When trust is lacking in a supportive relationship, it left one or both parties feeling vulnerable and troubled. Explore your thoughts and feelings about this case study: • How does it make you feel? • What is it you feel Beverley does that helps to promote a therapeutic relationship? Can you identify any of those features in Figure 7.4? • How will Barney's perceptions influence relationships you form when supporting someone in a community context?

As Barney highlights, recovery from experiences of cognitive dissonance is not impossible. He indicated that he has been able to move forward in a trusting relationship with his new carer, Beverley. Community nurses can be faced with the inconsistencies of cognitive dissonance because of the actions (or inactions) of other health and social care practitioners, which are out of their control. Exercising emotional intelligence and modified behaviours are key to reducing those inconsistencies. Self-awareness and regulation, along with social awareness and regulation, can help individuals (Grunberg et al., 2022).

INFLUENTIAL FACTORS WHEN NURTURING AND MAINTAINING THERAPEUTIC RELATIONSHIPS

THERAPEUTIC RELATIONSHIPS THROUGH NON-VERBAL AND OTHER MEDIUMS INCLUDING PLAY, THE SENSES AND THE ARTS, INCLUDING DIGITAL PLATFORMS

Developing and supporting therapeutic relationships in community healthcare may not always be straightforward depending on people's circumstances. It is important for community nurses to be inclusive when building therapeutic connections with those who communicate in different ways, for example age-dependent communication, people who experience neurodiversity, those who do not speak English as their first language and those with sensory impairment, learning disabilities or dementia. Community nurses need to be aware of how to promote and support a variety of communication to improve healthcare outcomes (Beauchamp et al., 2022). The starting point is through verbal and non-verbal communication, described as "the purposeful, interpersonal information transmitting process through words and behaviours based on both parties' knowledge, attitudes and skills which leads to patient understanding and participation" (Abdolrahimi et al., 2017). Communication comprises the following:

- 7% verbal (words that are spoken)
- 38% vocal (the tone and pitch in your voice)
- 55% non-verbal messages that people of different cultures, races, ages and capabilities that may be perceived differently

(*Gabor et al., 2015*)

A person receiving care in the community may find it challenging to express their healthcare needs when they have different reading, hearing, speaking, physical skills or everyday living needs. Nevertheless, they can communicate in other ways to express their needs and emotions through a variety of mediums including digital platforms, sign launguage (Makaton, British Sign Language), play, the senses and the arts (Iannelli et al., 2020; Schnaith et al., 2021). Examples include the use of interpreters, face-to-face or via Language Line and, play, art,

dance and music therapy to connect and support shared decision-making in community healthcare and reduce inequalities (Millard et al., 2021; Doyle, 2021). Non-verbal communication is a vital way of understanding and helping an individual understand what an individual is feeling whether it is conscious or unconscious. Strong therapeutic relationships improve satisfaction for those being supported and professional fulfilment, saving time and increasing compliance with prescribed medication (Greenhalgh and Heath, 2010).

BALANCING PROFESSIONALISM IN A THERAPEUTIC RELATIONSHIP

As described earlier, interpersonal connections and their progression to a therapeutic relationship are key elements of community nursing in any context. However, it is also important that these connections and relationships do not project an unprofessional association between community nurses and the people they support. Maintaining and balancing professional boundaries is central to therapeutic relationships with colleagues and people who receive support from community nurses.

There are standards to achieve in providing community nursing care in all contexts; however, in seminal work with caring professionals, Noddings (1996) highlights a distinct difference between professionalisation and professionalism. She indicates the former focusses on rule-bound interactions which could have a negative impact on the interpersonal connections between community nurses and people who access their services. An example of this is offered in a qualitative research study from Henderson (2022), where professionalism that some community staff projected was perceived by some people who used their services as unfriendly. Professionalisation can act as a barrier to building a supportive relationship. Balancing professionalism and friendly connections is imperative to building appropriate and meaningful quality relationships between individuals (Guanci, 2016). However, this should not be confused with forming a *friendship*, which goes beyond the boundaries of a professional role. Having a shared understanding of roles and boundaries whilst striving to achieve a friendly professional manner through empathetic communication can help to achieve this (Williams et al., 2019; Jeffrey and Downie, 2016).

PEOPLE AS PARTNERS

Current literature acknowledges a need for partnership working that can facilitate information and knowledge exchange as well as joint decision-making with people that community nurses support (Byrne et al., 2020). Co-production and co-design form the foundation of public policy, and implementation across community practice settings, promoting equality and inclusion for people that community nurses support (Osborne et al., 2016). Co-production relies on reciprocity between community nurses and the people they support and their families and working in equal partnership to explore shared understanding and

Table 7.4 Definitions of co-design and co-production

Definition	
Co-design	**Co-production**
People who use services are involved in designing services, based on their experiences and ideas. They have genuine influence but have not been involved in 'seeing it through'.	Co-production is an equal relationship between people who use services and the people responsible for services. They work together, from design to delivery, sharing strategic decision-making about policies as well as decisions about the best way to deliver services.

(The National Co-Production Advisory Group, 2021, p. 1).

solutions to support what is both provided and accessed (National Co-production Advisory Group, 2021). If an equal balance of power (discussed in Figure 7.3) is to be promoted, working in collaborative partnership with people that community nurses support and their families to co-design and co-produce community services is imperative (Ärleskog et al., 2021; Agid and Chin, 2019; Kaehne et al., 2018). The key definitions of each are outlined in Table 7.4.

Adopting an inclusive co-productive approach can help to promote active partnerships, on the basis that there should be 'no decision about me without me' (with reference to people who access community services and their families). Adopting a people as partners approach to designing and providing community-based care supports human-rights-based care. It promotes a focus on person-centred and relationship-based health and social care and health and wellbeing outcomes that are specific to the individual(s) (Henderson et al., 2023; Henderson, 2022).

ACTIVITY 7.6

Reflection

Have people you support been involved in making decisions about their care and co-producing the community services you have been involved in? Think of an example and reflect on the following:

- What were your experiences of being involved?
- Did it have an impact on partnership working?
- What went well and was there anything that could have gone better?
- What impact did this have upon you, the person you were supporting, their family and any other health and social care providers that may also have been involved?
- How might your partnership working practices develop in the future?

EXPLORING THE CONCEPT OF SELF-WELLBEING AND HOW THIS MIGHT INFLUENCE YOUR EXPERIENCES

Community nursing roles have become multifaceted and complex including leading and managing unpredictable situations, coordinating, partnership working with multi-agency professionals and supporting and tutoring students, colleagues, people receiving healthcare, carers and families (QNI, 2023b). Our first duty of care is treating people with kindness, respect and compassion (NMC, 2018). However, taking this duty of care in isolation, the needs of community nurses may be overlooked in favour of others' needs. Recent research found that nurses felt that they needed permission to be self-compassionate and self-care caring (Andrews et al., 2020). As healthcare delivery becomes increasingly regulated and scrutinised, community nurses experience elevated levels of psychological distress; however, employers have a legal duty to protect their employees from stress. When empathy is present in healthcare cultures, staff wellbeing, people's healthcare experiences and safe practice are enhanced, community nursing teams have high morale and are more effective, and job satisfaction improves (Lown, 2018). Community nurses supported by empathic healthcare cultures foster compassion, emotion regulation (self–other distinction) and self-care to nurture their wellbeing, resilience and effectiveness (Hofmeyer et al., 2020; Vachon, 2016). Therefore, it is vital for community nurses to consider the concept of their own health and wellbeing or self-care, balance the negative effects of working in stressful environments, avoid burnout and provide high-quality, effective and professional healthcare (Kim and Chang, 2022; Linton and Koonmen, 2020; West et al., 2020). An intervention that supports this is called "Schwartz Rounds®", which has been found to positively influence staff wellbeing and compassion for people and colleagues and has been adopted worldwide (Maben et al., 2018).

The COVID-19 pandemic has increased work-related stress, burnout and mental health problems with a risk of post-traumatic stress symptoms, moral distress and presenteeism (i.e. working while unwell; Kinman et al., 2020). Yet, despite this, a recent report by the King's Fund draws on a National Staff Survey showing that nurses and midwives are enthusiastic about their roles with a powerful sense of vocation (West et al., 2020). Over the last two decades, an assets approach to self-health promotion termed the salutogenic model has been applied to health promotion, including the workplace, and may be a useful guide for community nurses to care for themselves (Allan, 2014; Antonovsky, 1996). It supports self-wellbeing through the identification and use of individual personal and environmental resources that support health and wellbeing based on three components that make up what Antonovsky (1996) described as a sense of coherence (SOC). SOC consists of three types of life experiences relatable to community nursing: consistency (strengthening comprehensibility), underload–overload balance (strengthening manageability) and participation in socially valued decision-making (strengthening meaningfulness; Allan, 2014).

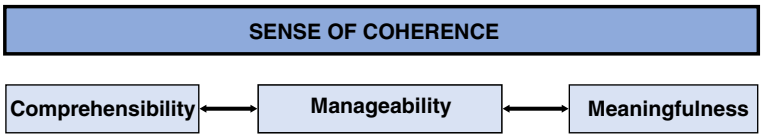


Figure 7.5 SOC.

The thinking behind this is that a healthy workplace minimises disease factors, is ordered and consistent and provides adequate resources to enable employees to effectively deal with stressors, and employees can recognise their sense of personal and organisational purpose (Roskams and Haynes, 2019). A strong SOC has been found to protect against anxiety, depression, burnout and hopelessness and is strongly and positively related to health resources such as optimism, hardiness, control and coping (Allan, 2014; Figure 7.5).

Caring for others with compassion is the reason we become nurses (Vachon, 2016). It is equally important that community nurses are proactive rather than reactive in caring for their own needs, through practising self-kindness and self-compassion to process their internal processes and emotions, cope with the work environment and help others with their health needs (Andrews et al., 2020; McKinless, 2020). Community nurses who take an assets approach and actions to build self-wellbeing and self-compassion build resilience, support their health and wellbeing and can effectively respond to challenges through self-efficacy, coping and mindfulness (Cusack, Smith, & Hegney, 2016; Table 7.5).

Table 7.5 Actions

Self-kindness versus self-judgement	Common humanity versus isolation	Mindfulness versus over-identification
Treat yourself with kindness, patience, empathy and forgiveness when you experience pain and failure, rather than being harshly critical or self-judgemental.	When we recognise our common humanity, we feel connected with others in our life experiences rather than feeling isolated and alienated by our suffering. Then things become more bearable.	Over-identification is about becoming consumed with our mistakes, ruminating, worrying and losing perspective.
Self-kindness is the antidote to fear. Kindness regulates fear through connection and warmth, similar to what we might experience with a dear friend.	We need to understand that our fallibility (making mistakes) is part of being human rather than proof of our inadequacy.	Mindfulness is feeling and seeing things as they are with non-judgemental acceptance.

(*Continued*)

Table 7.5 (Continued)

Self-kindness versus self-judgement	Common humanity versus isolation	Mindfulness versus over-identification
Self-criticism is a motivator for some people but is based on fear of failure and anxiety.	Self-compassion translates into forgiveness and helps us maintain perspective by recognising that everyone makes mistakes.	Mindfulness brings us to the present moment and helps us view our situation with perspective and without distortion. Our mind tends to focus on the mistake rather than the pain caused by it. This is the difference.
	When you feel upset, imagine what a good friend would say to comfort you.	Ignoring our pain/feelings will trigger more stress and worry and can lower immunity.
		When we notice our pain without exaggerating it, this is mindfulness.

(Adapted from Hofmeyer, Taylor, and Kennedy, 2020, p. 2).

Many healthcare employers, charitable organisations and nursing professional bodies provide resources and host websites with advice related to physical and mental health and wellbeing and practical advice and help, including issues related to money. Research shows that the ability of the individual to manage their emotions (emotional intelligence) increases resilience (Barratt, 2018). Other coping strategies to manage work-related stress, aid self-care, further increase resilience and improve wellbeing are regular clinical supervision, coaching, a supportive team leader, humour, using mindfulness, being able to switch off through exercise, hobbies and the arts (McKinless, 2020; Allan, 2014).

INFLUENTIAL FACTORS WITHIN COMMUNITY SETTINGS

Location for providing care and its influence on therapeutic relationships

Community nursing care can be delivered in a range of settings. Practitioners may be visiting homes or sheltered accommodations or offering services within a school or clinic environment. Some may be involved with homelessness outreach or prison services. Increasingly some aspects of care may also be offered via digital means. The environment in which interactions take place can have a substantial impact on therapeutic interactions (Kwame and Petrucka, 2021). Practitioners within the community often have the privilege of being invited into someone's private environment. This can provide them with unique insights into how they live and what they value and enable a more holistic

assessment. For instance, they may notice a lack of heating or electricity and be able to signpost to appropriate support services. Observing family dynamics may help in identifying informal carers requiring support or referral as part of family-centred care.

The intimacy and familiarity of the home setting may permit people to be more comfortable in engaging with practitioners and sharing important health and wellbeing information. Conversely, some people may be concerned that they may be judged on their living accommodations and be more comfortable in beginning a relationship within a more neutral setting. A lack of privacy and noisy surroundings are established as a barrier to communication with nurses (Amoah et al., 2019). A young person wishing to discuss anxiety may be hesitant to raise this in a busy school setting, however, may be comfortable to use a digital messaging service to make the initial contact with the nursing team. The location can also impact a nurse's confidence and competence especially if they are new within community practice. Understanding how to appropriately seek support is an important aspect to practitioner wellbeing and can subsequently contribute to informed therapeutic relationship development.

Uniforms and their influence on therapeutic relationships

It is worth considering how nursing uniforms may impact on therapeutic relationships and trust. Depending on their role, community nurses may or may not wear a uniform; however, most will be bound by organisational policy in relation to professional attire, primarily taking into account health and safety considerations. Uniforms and dress codes are a means of non-verbal communication to people receiving healthcare and can act as both an aid and a barrier. Both have negative and positive effects on communication depending on the age, experience and the needs of those receiving community care. For instance, bright, colourful uniforms may be more appealing to children. The style of the uniform may also help people to recognise specific community nursing roles. Uniforms have been identified as a sign of professionalism, trust and reassurance (Sanna et al., 2020). However, non-wearing of uniforms has been seen to reduce power imbalances, build rapport and is perceived as less stigmatising for some receiving healthcare (Chu et al., 2020).

Navigating challenges in therapeutic relationships: Having courageous conversations

Community nursing can involve having difficult and challenging conversations which practitioners may be apprehensive about. They may need to raise concerns regarding child neglect or have discussions about end-of-life decisions. Other examples might include discussing suicide or self-harm or issues around health promotion, such as alcohol use. People may put off these conversations because it is difficult to address issues that may arouse conflict or discomfort especially when we feel that getting the conversation 'wrong' may put ourselves, others or our relationships with others at risk.

Patterson et al. (2002) describe such conversations as "learning to communicate best when it matters most". It is important to remember that addressing difficulties and potential conflict is an important, functional and normal part of human relationships. When practitioners learn how to manage it well, these conversations can offer an opportunity to strengthen and repair relationships, learn and find new solutions to issues. A courageous conversation is a tool that you can use to resolve relational conflicts. You can guide your discussion with questions such as the following:

- What is the main issue?
- What are the consequences of the issue?
- What are the responsibilities of those involved?
- What are the hopes and plans for improving the future?

People appreciate honesty and clarity in discussion. Checking understanding can be helpful through using techniques such as teach-back, which is a means of asking people to explain in their own words what they have been told. When having challenging conversations, it is also important to consider the emotional impact on practitioners. The use of clinical supervision, a formal process of facilitated professional reflection and learning, can be a beneficial means of supporting practitioner wellbeing and decision-making to better contribute to positive outcomes for people receiving support.

CONCLUDING THERAPEUTIC RELATIONSHIPS

WITHDRAWAL AFTER THERAPEUTIC RELATIONSHIPS HAVE COME TO AN END

Having shared what may have been a meaningful healthcare experience, ending the therapeutic relationship at the end of an intervention, can bring a sense of loss of attachment (Sutton, 2021). The process can be made easier by having built and maintained a strong therapeutic relationship by utilising the skills previously outlined in this chapter which correlates with a positive and successful termination phase (Bhatia, 2017). For example, a responsive, collaborative and flexible healthcare intervention tailored to meet the individual's needs from the commencement of care with a mutual understanding of the duration, planned and agreed goals of care and treatment helps prepare for the termination phase (Norcross and Lambert, 2018; Tsai et al., 2017). At the point of concluding a therapeutic relationship, an opportunity arises to re-evaluate the achievement of intended goals and support provided (Mitsi et al., 2018). It also offers an opportunity to identify any goals that may not have been achieved, plan the next stages of recovery and any need for onward referral to help address need. For example, when community nursing support concludes for someone who is experiencing isolation/loneliness or learning to live with a long-term condition, onward referral to voluntary sector organisations or self-help groups may be appropriate to support the person (and their carers, families) move forward positively.

PROMOTING MENTAL HEALTH AND WELLBEING WHEN THERAPEUTIC RELATIONSHIPS END

There are many ways in which therapeutic relationships end and some may have a strong emotional and mental health and wellbeing impact on one or both individuals (Karremans and Finkenauer, 2020). A natural end might be expected, for instance, when a person reaches end-of-life and their death was anticipated. However, in other instances, the end of a therapeutic relationship might be unexpected. It can be challenging to accept when a therapeutic relationship ends for reasons out of the control of a community nurse or the person they are supporting (Price, 2017). An example of this might be when a prisoner is receiving long-term treatment from a prison nurse who is then transferred to another facility. This could have a psychological and emotional effect for both parties.

In both contexts, expected or unexpected, maintaining and promoting mental health and wellbeing for both individuals is important. The act of ending a relationship can itself evoke an element of emotional bonding between a community nurse and person they are supporting (Kaur, 2020). Use the prompts in Activity 7.7 to reflect on your experiences of therapeutic relationships.

ACTIVITY 7.7

Reflection

Remember back to a time when you felt a strong emotional bond with someone you were supporting or a health and social care practitioner who had supported you. When that relationship ended:

- How did you feel?
- How did you respond to your own feelings?
- What helped you to move on and gain closure, if at all?

CONCLUSION

This chapter has outlined the benefits of building and supporting person-centred therapeutic relationships for both people receiving healthcare in the community and the community nurses who deliver it within the context of contemporary community healthcare policy. The reader has been guided to develop an understanding of multiple complex perspectives of therapeutic relationships, underpinned by a holistic, ethical, assets-based and relational approach. The importance of self-reflection has been discussed along with the importance of seeking supervision and reflection to support critical analyses and consideration of how the theories and principles described in this chapter can be applied to the delivery of kind, considerate, careful, safe and evidence-based future care and practice in the community context. Finally, it has been

emphasised throughout this chapter that self-care is important as it is an intentional act that supports the emotional labour of community nurses to improve the care of people receiving healthcare and their families. Self-care is a

> [p]roactive, holistic, and personalised approach to the promotion of health and wellbeing through a variety of strategies, in both personal and professional settings, to enhance capacity for care of patients and their families.
>
> (*Hofmeyer, Taylor, and Kennedy, 2020 p. 2*)

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CHAPTER

8

The lifespan approach

Donna Edwards and Helen Layton

LEARNING OUTCOMES

- Critically analyse concepts and theories of human growth and development.
- Appraise the lifespan approach to health and healthcare through the exploration of a multi-generational family.
- Evaluate biomedical and psychosocial approaches to health and healthcare and their influences on people's unique concepts of and attitudes to health.
- Critically explore the stages of the lifespan – childhood, adolescence, adulthood, middle age and older age – to determine how the community nurse can enhance the quality of care for people, through a person-centred approach.

INTRODUCTION

This chapter will explore how an individual's experience of health and the provision of healthcare will change across the lifespan, specifically, during the commonly identified stages of childhood, adolescence, adulthood, middle age and older age. Theories of growth and human development and the biopsychosocial influences on health and healthcare will be critically evaluated, using a fictional multi-generational family to examine concepts within real-life scenarios.

The health of an individual across their lifespan is influenced by a complex interaction of physiological, psychological, social, economic, cultural and environmental factors (Boyd and Bee, 2019). A sound understanding of how these factors influence growth and development during different stages of an individual's life can enable the community nurse to adopt a person-centred approach in the assessment, planning, implementation and evaluation of healthcare interventions (Nursing and Midwifery Council [NMC], 2018b). The importance of developing a broad viewpoint and an awareness of all aspects on the lifespan continuum, from conception to death, should underpin effective healthcare provision, however, it is recognised that community nurses may have distinct roles often focused on specific stages of the lifespan (e.g. Health

DOI: 10.4324/9781003347545-9

Visitor 0–18 years). The NMC requires all nurses to play a key role in supporting and enabling people at all stages of life to maximise quality of life and improve health outcomes (NMC, 2018a).

HUMAN GROWTH AND DEVELOPMENT

Many concepts and theories of human growth and development have emerged since scientists began to examine the way individuals develop and change across the lifespan; gaining an understanding of these theories will enable the community nurse to better understand the individual and their experience and reaction to health and illness (Sudbery and Whittaker, 2019). In simple terms, growth can be defined as an increase in physical size and shape, whereas development is an increase in functional ability and maturity; however, from a biopsychosocial perspective, growth and development can be seen as multidimensional (Boyd and Bee, 2019). When born, the infant is subject to continuous physiological changes influenced by body composition and genetics, and there is profound development in the central nervous system that influences psychomotor development, memory and intellectual skills (Cameron and Schell, 2012). As the child grows, their personality evolves, they experience socialisation and develop relationships that are shaped and influenced by the physical and cultural environment that they live in (Nicholson, 2014; Calkins, 2015; Boyd and Bee, 2019). Aspects of growth and development can be related to all stages of the lifespan, although it is suggested that growth and development specifically apply to the period from conception to young adulthood, whereas the notion of ageing is more readily applicable from middle age onwards (Erber, 2013).

It is useful to consider some of the theories which underpin growth and development and a lifespan approach. These theories can be grouped into several different categories and can be classified according to the following broad headings: biomedical, psychodynamic, cognitive, behavioural, humanist and sociocultural (Table 8.1).

Although exploration of the various theories can provide key information on the different life stages, it is important to recognise that a lifespan approach can adopt an eclectic approach which successfully combines aspects of all these elements (Boyd and Bee, 2019).

THE LIFESPAN APPROACH TO HEALTHCARE

Throughout the lifespan, changes in physiology, psychology and behaviour that occur at recognised stages, can be influenced by how life is lived by individuals. Factors such as life experience, society, culture and the person's own health status will influence overall health and outcomes (Boyd and Bee, 2019). These changes, as well as the wider influences on a person's health and development,

Table 8.1 Influential theories of growth and development

Biomedical – Focuses on normal and abnormal biomedical functions of the body and changes in body mechanics over the lifespan (Cedar, 2022)
Psychodynamic – Based on the work of neurologist Freud and his work on the unconscious mind, the focus is on psychological drives within us that shape personality and behaviour (Mitchell and Zeigler, 2013)
Cognitive – Based on the work of developmental psychologist Piaget, cognitive development focuses on brain development, the development of skills, problem-solving and intelligence and making sense of the world (Mitchell and Zeigler, 2013)
Behavioural – Based on the work of the psychologist Skinner, behaviourism focuses on learnt human behaviour and how behaviours develop and grow through experience and interaction with the environment (Mitchell and Zeigler, 2013)
Humanist – Based on the psychologists Maslow and Rogers, humanism has an appreciation of the whole person, with intended consciousness, and having free will and choice (Schacter et al., 2019)
Sociocultural – From the work of psychologist Vygotsky, sociocultural theory describes how experience, culture and society influence behaviour and development of our higher level functions (Harris and Westermann, 2014)

are explored within this chapter through the use of a multi-generational family (Table 8.2), where a person's needs and healthcare requirements at various stages of the lifespan are considered and correlated to the biopsychosocial approach, from the youngest, Joshua, who is 2 years old, to Rose, who is 83.

Regardless of specialist area, it is important for the community nurse to recognise how a person's health can be influenced by their environment, society and the relationships they are in; having this holistic appreciation of the person's life will enable the community nurse to plan and deliver effective care tailored to their specific needs. It is recognised that the choices people make and how they live their lives will influence their health and health outcomes; most health outcomes are related to choices made by the person at each stage of the lifespan (Ogden, 2022). For example, a person who takes up smoking as a teenager may suffer the impact on their health in later years through respiratory disease or cancer (Christensen et al., 2022). Understanding why a person behaves in certain ways at different stages of their lifespan may help the community nurse consider the individual's unique concept of health and how, through person-centred care, they can enhance the individual's quality of care (Boyd and Bee, 2019).

When caring for people in the community, performing screening and/or genomic testing to identify common conditions such as diabetes or rheumatoid arthritis or rare inherited diseases such as cystic fibrosis is developing rapidly (Genomics Education Programme, 2022). Creating a genogram, a family tree of at least three generations, can be useful to undertake with an individual to recognise early signs of disease, make appropriate referrals for specialist advice and to plan treatment (Table 8.2).

Table 8.2 Multi-generational family

Multi-generational family		
Rose Reid (83) Black Jamaican, moved to the UK in 1961 at the age of 21, married to Jack for 58 years, but now lives alone, recent diagnosis of Alzheimer's disease and type 2 diabetes. Jack and Rose have 3 children: Carol, Faith and Andrew		
Jack Reid (was 85 when he died) White British Died 6 months ago of lung cancer, smoked since the age of 16		
Children Carol, Faith and Andrew		
Carol (57) divorced with rheumatoid arthritis, works full-time in an office. Does shopping for her mother Rose and visits her twice weekly. Is struggling with symptoms of rheumatoid arthritis pain, swollen joints, reduced mobility.		
Carol's children Jodie and Simon		
Jodie (27) single, unemployed, lives with her mother Carol with 2-year-old son Joshua; Jodie is 6 months pregnant with a new boyfriend who lives nearby.	Simon (25) single, works full-time, had been feeling unwell lately with stress and anxiety, has not had a serious relationship and prefers to spend time with friends.	
Faith (52) Divorced. Living through the menopause, in same-sex relationship with partner Marie. No children. Works shifts at supermarket. Lives 20 miles away from Rose.		
Andrew (54) married to wife Prisha (50) Andrew and Prisha live 5 miles from the city centre where Rose and Carol live; they are both employed and work for the NHS. Andrew is a pharmacist and works full-time, and Prisha is a part-time pharmacist; she received treatment for breast cancer 5 years ago. They are both overweight with body mass index (BMI) being defined as 'overweight'.		
Andrew and Prisha have 3 children Maya, Daniel, Pretty		
Maya (16) at secondary school, spends a lot of time with friends away from the home evening and weekends	Daniel (10) at primary school, enjoys playing rugby but overweight, diagnosed with asthma, daily inhaler	Pretty (8) has Down's syndrome, attends a special needs school

INTRODUCTION TO BIOPSYCHOSOCIAL APPROACHES TO HEALTHCARE

The biopsychosocial model emerged in the 1970s and attempted to integrate biomedical, psychological and social models of health to guide clinicians to treat patients not from a purely biomedical viewpoint but by considering psychological wellbeing and environmental factors (Ogden, 2022; Table 8.3).

Table 8.3 Examples of biopsychosocial approaches to health

Biological	Psychological	Social
Genetics, neurochemistry, physical health, disability, injury, immune response, age, gender, disease	Social skills, family relationships, self-esteem, mental health, beliefs and values, coping behaviour	Social support, lived environment, community engagement, family dynamics, work and employment

BIOMEDICAL APPROACHES TO HEALTHCARE

Historically, the biomedical approach has directed the organisation and provision of healthcare and remains the dominant model in Western culture (Cedar, 2022). The model recognises that health is the normal function of the body and illness is attributed to malfunction of the normal function, viewing the mind and body as separate from each other (Ogden, 2019, 2022; Cedar, 2022). The focus of the biomedical approach is to find the root cause of the illness in an attempt to improve the health of the person and ultimately delay death through interventions such as medication, surgery and vaccinations; it simply recognises the person as well, or ill, and that behaviour does not impact on their health due to illness developing from purely biological factors (Ogden, 2019, 2022; Cedar, 2022). While this approach may reach a diagnosis of the physical aspects of the illness, it does not adopt holistic understanding of the wider determinants of health such as psychological or social aspects which may be contributing to, or impacting on, a person's physical health and therefore is limited in its approach (Ogden, 2019, 2022; Cedar, 2022).

Nurse education is underpinned by a sound understanding of human anatomy and physiology, and it is essential that nurses can recognise normal physiology and changes to this to provide safe and effective care (NMC, 2018a). This knowledge should include understanding not only how the different organs and systems of the body work but also how they grow, develop and deteriorate across the lifespan. An understanding of growth norms is useful in child health monitoring and surveillance; tools such as human growth centile charts are used to record the growth of an individual from 0 to 18 years and allow monitoring and interpretation of the recorded results (Moy and Wright, 2014). Consider Pretty, who is small for her age; knowing there is an adolescent growth spurt which differs between the genders and that the male growth spurt, although greater in intensity, is usually on average two years behind that of females can determine whether this is normal variance or not (Boyd and Bee, 2019). The school nurse must also consider Pretty's diagnosis of Down's syndrome; short stature is a recognised characteristic, and people with Down's syndrome are at risk of developing medical conditions that may reduce growth such as congenital heart disease; early identification of poor growth or excessive weight gain is important for people with Down's syndrome (Dennis and Marder, 2015).

ACTIVITY 8.1

To further enhance your knowledge of growth centile charts, visit the Royal College of Paediatrics and Child Health webpage https://www.rcpch.ac.uk/resources/uk-who-growth-charts-2-18-years

and read the information on growth charts; there is a specific fact sheet on growth charts for children with Down's syndrome.

Read the article by Moy and Wright (2014) to further enhance your knowledge about using growth charts.

A sound understanding of physiological changes and the normal patterns across the lifespan may aid in the understanding, diagnosis and treatment of disease. While it may not be fully understood why ageing occurs, an understanding of the biological changes that happen as the body ages is important for person-centred care of the older person (Aldwin and Gilmer, 2013). How ageing affects the pharmacokinetics, pharmacodynamics of medicines and the body's response to bacterial or viral invasion is fundamental to delivering safe and effective healthcare (Farley et al., 2011). Similarly, it is important for the nurse to recognise that homeostasis; the ability of the body to maintain a relatively constant internal environment may be impaired in the very young, very old and in disease (Knight et al., 2020). For example, individuals affected by the influenza virus are more likely to be seriously ill and at increased risk of hospitalisation and mortality if they are at each end of the lifespan such as Rose or Joshua. Biologically, this correlates with human development and physiology; for example, lung function continues to increase and develop from birth until around age 20 years, stays stable on average for around 15 years and then begins to decline (Farley et al., 2011).

ACTIVITY 8.2

Reflection point

A few weeks previously, Rose had a fall resulting in a pre-tibial laceration to her lower leg which she has been dressing herself for several weeks. When the community nurse visits, Rose reveals the wound on her leg; following an assessment the community nurse suspects that it may be infected. On testing her capillary blood glucose, it is elevated at 8.9 mmol/L.

Using a biomedical approach, what could be influencing the slow wound healing for Rose?

What steps could you implement to support Rose with the management of her diabetes?

Daniel lacerated his leg whilst playing rugby at school; his mum, Prisha, has taken him to the general practice nurse for it to be dressed.

Due to Daniel's young age and playing outdoor sports, what advice might you give to Daniel and his mum about the wound?

Knowledge of the stages of wound healing and the normal progression of wound healing should underpin nursing care for Rose and Daniel. Daniel as a young healthy child will probably require little more than one or two simple dressing changes as it would be expected that his wound would heal within 4–7 days (Brown, 2015). Advice to Daniel and his mum, Prisha, would focus on keeping the wound clean and minimising infection while the wound heals. However, for Rose, cellular changes expected with the ageing process, including a diminished immune response, will result in prolonged healing time, and this may be further compromised by other physiological factors such as having diabetes (Dearsley, 2021). Advice and management may be more complex; establishing Rose's understanding of why the wound is not healing and how this is influenced by diabetes will be essential (Dearsley, 2021). Using a biomedical focus to guide practice can give the community nurse an indication of what to expect as the body ages although patterns of decline will not necessarily follow a predictable sequence and may vary from individual to individual (Farley et al., 2011). Crucial to care provision, it is important to recognise that biomedical factors need to be considered in the holistic care of a person.

PSYCHOSOCIAL APPROACHES TO HEALTHCARE

The psychological and social influences that affect and shape the individual's experience of development across the lifespan will alter as we grow, mature and experience life. Attitudes towards health, ill health and risk-taking behaviour will have an impact on overall health; beliefs and behaviours that we have in childhood and adolescence may change as we mature into adulthood and older age, and the individual's ability to cope with stress, illness and suffering will vary and transform depending on the level of exposure and social support received to manage these experiences (Ogden, 2019; Fortier et al., 2022). Health psychologists recognise that psychological factors such as beliefs and behaviours can affect the onset of illness; for example, young adults may take up smoking or vaping because they want to be part of a group, impress peers or look glamorous (Pribadi and Devy, 2020).

ACTIVITY 8.3

Reflection point

Daniel has started to vape sometimes at school as he feels pressure from his friends; he has asthma and has needed to use his inhalers more frequently recently.

Consider from a biological, psychological or social perspective how taking up vaping at a young age may affect his experience across the lifespan.

Psychological factors can also influence the way an individual makes sense of or manages their health and wellbeing. The concept of *locus of control* derived from social learning theory (Rotter, 1966) asserts that people who believe that

they have control over life events and can make personal changes have an internal locus of control, whereas those who believe that events are largely out of their control have an external locus of control. For individuals who have an internal locus of control, they believe that they have some control over what happens to them and can make choices that lead to positive health changes, whereas people with an external locus of control do not feel responsible for their health outcomes, relying on fate and luck rather than taking personal responsibility (Ogden, 2022). Drawing on cognitive theory, children are not able to distinguish between body and mind until about the age of 11, so it is not until adolescence that children begin to develop a sense of control over life decisions (Morrison and Bennett, 2016). Considering Pretty in this example, at the age of 8, she is not able to develop a sense of control as she is too young; furthermore, for people diagnosed with Down's syndrome, there is a delay in developmental milestones and cognitive development (Fearns et al., 2015).

As well as considering an individual's psychological development across the lifespan, peoples' social and economic status needs to be considered; to deliver holistic healthcare, the community nurse must recognise that an individual's ideas and behaviour towards their health cannot be divorced from their upbringing and the social contexts in which they participate (Beckett and Taylor, 2019). Attitudes to health and illness may also be shaped by generational features related to the era an individual was born into and the social norms and expectations they have been exposed to (Barry and Yuill, 2022). For example, attitudes to smoking in the last century have altered; the highest prevalence of smokers is among those aged 18 to 24, but this is reducing year on year, due to public health campaigns about the dangers of smoking, the introduction of e-cigarettes and the high taxation on tobacco products (Department of Health and Social Care, 2022; ONS, 2022).

It is well documented that health inequalities exist in relation to where people live, their gender, age, ethnicity, and their level of deprivation (Merrifield and Nightingale, 2021). Health outcomes are frequently linked to socio-economic status, the lower the socio-economic status the lower the health outcomes, which has been termed the social gradient of health (Marmot, 2010; Marmot et al., 2020). Whilst it is not possible to change the socio-economic environment of individuals, the approach that the community nurse adopts in delivering healthcare and health promotion activities would need to be considered. For example, the cultural beliefs and values held by parents will influence their decision whether to get their child vaccinated or not. Since becoming pregnant for the second time Jodie is not sure about vaccinating her new baby due to concerning side effects that she has read about on social media.

HEALTH: DEFINITIONS, BELIEFS AND ATTITUDES

The concept of health is important and it is essential to consider the individual's subjective interpretation of the meaning of health and illness. The way in which a person perceives and defines their health status is unique to them.

Health may be viewed negatively or positively as captured in the following quote:

- A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity (World Health Organisation [WHO], 1946)

ACTIVITY 8.4

Reflection point

What is your interpretation of health?

Consider how an individual's notion of health may change across the lifespan.

How might Carol define being healthy? How would this differ from Simon's definition?

The way in which a person defines health will impact their life choices and subsequent behaviour. Health perception will vary across the lifespan and genders, for example. Simon's definition may reflect strength and fitness, whereas Faith may focus on the ability to cope with life and the demands of work (Nettleton, 2021). As people age, the emphasis shifts from notions of mental and physical wellbeing and the ability to do things well in middle age to wisdom, contentment, happiness and resilient ageing in late adulthood (Boyd and Bee, 2019). It is important to note that health decline which may be associated with ageing does not necessarily equate to the person not feeling satisfied with the quality of their life (Boyd and Bee, 2019). Perceptions will be influenced by physiological, social and environmental factors. For example, a working individual or a parent of young children may consider that they have no time to be ill, and Faith's perception of health may well be influenced by her experience of living through the menopause.

As nurses, health promotion is fundamental across all roles; employing strategies to support an individual's adoption of healthy behaviours and lifestyle are central to improving the quality of life for everyone (Linsley and Roll, 2020). Statistics on mortality indicate that up to 50% of deaths from the 10 leading causes of death, such as heart disease, can be attributed to health-related behaviour (Ogden, 2022). The process of promoting health across the lifespan involves the community nurse supporting people to make informed decisions about their health, enabling individuals to take control of their own health whilst recognising the individual's unique lived experience of health, illness and disease. A proactive, preventative approach should enable the individual to make an informed choice. Current health policy supports patient empowerment and personal responsibility (NHS England, 2014; Department of Health [DH] Northern Ireland, 2014; Welsh Government, 2015; Scottish Government, 2016; NHS England, 2022). Health promotion is explored in greater detail in Chapter 3.

CHILDHOOD

Aspects of growth and development in childhood are rooted in the context of family life (Beckett and Taylor, 2019). Statistics highlight that within the UK, two-parent families remain the most common family structure (ONS, 2021). The fundamental structure of the family in the UK has evolved from the origins of the extended family group all living under one roof to more nuclear families living separately, divided by greater geographical mobility, and increasingly diverse family groupings, such as same-sex parents. The family construct can be considered to have a growth and development lifespan starting with developing a long-term relationship, then having children, child-rearing, separation and ageing family responsibilities (Boyd and Bee, 2019). A sound understanding of the concept of family enables the planning of individualised care for family members.

The basis of effectively meeting the needs of children is underpinned by an understanding of child development milestones (Sharma and Cockerill, 2014). Insight into emotional and behavioural development can enable the community nurse to respond effectively to children and family groups. At 2 years old, Joshua is developing social interaction and language skills and is mastering an element of self-control (he is toilet trained and dry through the day; Sharma and Cockerill, 2014). However, the arrival of a new sibling may provoke regression as he struggles to adjust to the change in his relationship with his mother (Calkins, 2015). A sensitive approach, alongside allowing Joshua to participate in caring for the new baby, may help with the process of adjustment. Support from the health visitor including statutory developmental checks and advice on access to local educational and day-care facilities can provide support and reassurance for Jodie and optimise Joshua's socio-emotional development and wellbeing (Public Health England, 2015; Public Health Scotland, 2016; NICE, 2016; Northern Ireland [NI] Government, 2021; Welsh Government, 2023).

It is important to recognise that children cannot be cared for in isolation from their family with its established health belief system. Attitudes underpinning health beliefs are hard to change so the community nurse needs to understand what contributes to family decision-making about health (Burch, 2022). Furthermore, the community nurse would need to have an understanding of both the Health Belief Model (Becker et al., 1988) and the Theory of Planned Behaviour Model (Ajzen, 1988) to help understand the complexity of behaviour change; recognising that change is underpinned by an understanding of the cost–benefit analysis and evaluation of its feasibility, alongside the views of the person's family and friends, in the decision to address their health behaviours (Ogden, 2022).

Daniel is less likely to comprehend the consequences of smoking as an understanding of chronic illness is dependent to some degree on the age of the child. A child aged 4–7 may perceive the causality of asthma as related to

ACTIVITY 8.5

Reflection point

Since the death of Jack, the whole family have felt bereaved as he was the patriarch of the family. Jack's smoking was always frowned on as it led to his death. Andrew suspects that his son is smoking as he has smelt it on his clothes, but Daniel denies this.

When Daniel has an asthma attack and has to go to the GP surgery for a review, Andrew blames his smoking, and they have an argument in front of the practice nurse.

Using the Health Belief Model (Becker et al., 1988) and a lifespan approach, consider how you could support the family in this scenario.

magic or naughtiness; by ages 7–11, they may have developed some understanding of allergies, while the older child will start to comprehend relationships (Alder, 2013). Daniel is likely to understand the cause of asthma but may not be able to relate this to cause-and-effect principles and coping mechanisms and is more likely to seek support and assistance from friends (Beckett and Taylor, 2019).

ADOLESCENCE

Adolescence is a time of significant changes marking the transition between childhood and adulthood. The characteristic physical changes of puberty are heightened by corresponding psychosocial development. In Western society factors such as earlier onset of the menarche and increasing time in formal education have widened the gap between physical maturity and adulthood (Alder, 2013). There is increased emphasis on social conflicts and personal dilemmas during this time as the individual endeavours to identify their role within society (Beckett and Taylor, 2019; Boyd and Bee, 2019). This challenges and changes relationships between parents and peers, and there is often increased conflict in families as the individual experiments with a variety of roles and styles. Disputes are frequently related to differences of opinion on rights and responsibilities (Boyd and Bee, 2019; Van Teijlingen and Humphris, 2019). Maya is frustrated by the attitude of her parents who consider her old enough to babysit for her younger siblings but not old enough for a sexual relationship, whereas from Andrew and Priya's perspective, Maya wants sexual freedom without the responsibility of the potential consequences (Van Teijlingen and Humphris, 2019). The challenge of achieving a sense of self and independence may impact healthcare, which may be particularly relevant for adolescents with a long-term condition. Peer pressure and the need for self-identity may mean that social logic replaces that of medical logic (Nettleton, 2021).

It is important to take an approach which establishes a level of trust with Maya as she may be worried about the nurse sharing information with

ACTIVITY 8.6

Reflection point

Maya is not getting on very well with her parents and is frequently argumentative and confrontational. She has started going out in the evenings, often coming home late. She is close to her cousin Jodie and confides in her that she is worried that she might be pregnant as she has been sexually active with her boyfriend. Jodie has gone with Maya to see the general practice nurse. The pregnancy test is negative.

From a biological, psychological or social perspective, consider the challenges that Maya may be facing in relation sexual health and young people.

her parents. Although Maya's pregnancy test was negative, she needs advice on sexual health in the future as adolescents are likely to have a greater sense of invulnerability in relation to risk-taking and are also influenced by peer group norms and pressures (Ogden, 2022; Beckett and Taylor, 2019). The community nurse needs to adopt a non-judgemental, approachable and friendly attitude in providing advice and support (Briggs, 2010). The emphasis should be on helping Maya enjoy her teenage years while minimising the risk of unwanted/unplanned pregnancy, sexually transmitted infections, cancer of the cervix and female infertility (NICE, 2017). Providing health advice for adolescents can be challenging and requires an approach in which establishing trust and offering sound advice and respecting them as individuals are key.

ADULTHOOD

When an adolescent turns 18 years old, they legally become an adult and are assumed to take more responsibility for their actions and decisions but they may equally rebel. There is a growing trend for young adults to remain economically dependent on their parents/guardians, choosing to live at home until they become financially independent (Beckett and Taylor, 2019). In early adulthood, between the ages of 25 and 30, the body reaches its peak for physical and cognitive performance; there is a focus on forming relationships and finding love, and typically, this is the period in which long-term relationships are established, with people getting married and having children (Beckett and Taylor, 2019). Emotional disturbance such as anxiety, depression and other mental health disorders are recognised as being high in young adults (Boyd and Bee, 2019), with the peak age of mental illness occurring in adolescence to early adulthood; common disorders seen at this stage of the lifespan are eating disorders, deliberate self-harm, substance misuse, suicide and depression (Jurewicz, 2015). Young adulthood is an important time for the nurse to raise awareness of health issues, highlight risk factors and establish person-focused preventative goals using health promotion strategies that are relevant to the young adult (GOV.UK, 2020; WHO, 2022).

ACTIVITY 8.7

Reflection point

Simon confides in his sister that he is worried about his health. He no longer enjoys going out with his friends and has increasingly lost interest in taking part in any activities outside of work. He confesses that he has not been sleeping and that this is impacting his ability to cope and make decisions at work. His poor performance has been noted at work and his employer has asked him to see the occupational health nurse. He tells his sister he cannot afford to be sick and cannot see what the nurse will be able to do to help. Simon has conflicting views regarding his sexuality, he has not had any serious relationships but thinks that he might be homosexual; he has not discussed his feelings with anyone.

What psychosocial factors may be influencing Simon's reluctance to access a healthcare professional?

Simon is probably aware that he has an emotional or mental health problem rather than a physical health problem. His reticence to see the nurse may be influenced by a variety of psychosocial factors. Gender-related expectations of manliness combined with Western cultural influence, which places an emphasis on self-reliance, may cause him to feel guilty about his lack of ability to cope and therefore fail to seek help (Barry and Yuill, 2022; Evans et al., 2023). Simon may also feel afraid of 'coming out' to his family and friends due to the stigma associated with homosexuality (Frost, 2013) which has generated feelings of low mood and a sense that he might be depressed. Receiving a diagnosis such as depression may have a significant impact Simon's personal, social and work relationships, and he may feel embarrassed to discuss this with his friends and family (Mental Health Foundation, 2021). It is important that the community nurse recognises that factors, such as stigma and attempts to fit in with social expectations of normality, may influence Simon's attitude about accessing healthcare treatment and advice and concordance with any prescribed treatment.

MIDDLE AGE

Middle age is the period between 40 and 60 years of age, when, typically, physical growth and development have been replaced by aspects of ageing. Erikson (1980) noted that middle age is defined as a time of conflict between contribution to the family or community (generativity) and concern for self (stagnation). The consequences of ageing may result in people experiencing worry regarding the future. Alder (2013) highlights the concept of 'the mid-life crisis' as a period of uncertainty and change that may be perceived as a last opportunity to achieve some of life's goals. Middle age may also be a time of re-evaluation and self-reflection and a time to focus on health behaviour and lifestyle choices. Commitments made in earlier life can sometimes be reviewed with people taking on new challenges and a reappraisal of one's identity (Beckett and Taylor, 2019).

Opportunities exist for the community nurse at this stage of the lifespan to effectively manage risky behaviours. Changing demographics, along with increases in the age of retirement, indicate that in the future, older people will account for an increased proportion of the working-age population (ONS, 2023). Occupational health and general practice nurses are in an ideal position to effectively target people during mid-life and seek opportunities to promote their health and wellbeing in the work environment; working with the individual or family the nurse can promote healthy lifestyle behaviours to improve healthy ageing (GOV.UK, 2020).

ACTIVITY 8.8

Reflection point

Andrew and Prisha have 'overweight' BMIs; Andrew has a BMI of 26, and Prisha has a BMI of 28. They both enjoy a glass of wine in the evenings, often eating late when they sit down in front of the TV. They feel that their busy lives do not allow them time to take regular exercise, apart from a walk in the countryside on a Sunday.

Consider how psychosocial factors are influencing Andrew's and Prisha's BMIs? Would there be any simple advice that you could give to adopt a healthier lifestyle?

It may be appropriate to identify how Andrew and Prisha view their health and their ability to control it. Health promotion and changing behaviour can be easier if individuals have a sense of control, where they feel they have some say in their future health: internal locus of control (Rotter, 1966). Since Prisha's breast cancer treatment 5 years ago, they have both felt overwhelmed and unable to take control of making healthy lifestyle changes; they feel that their health has been governed from the outside and have been finding it difficult to take responsibility for making changes to improve their wellbeing (Naidoo and Wills, 2016). Motivational interviewing is an approach to behaviour change that is a collaborative process, whereby the nurse can guide and empower the individual to make changes and can be particularly useful when confidence and the desire to change is low (Miller and Rollnick, 2013).

Andrew and Prisha are finding it difficult to make healthy food choices for themselves and the children; to access reliable and useful information, the community nurse could direct them to the NHS website 'Better Health: healthier families', that has reliable information to enable families to eat well and move more and is available across the four countries of the UK (NHS, 2021b). The NHS has also developed a 'Food Scanner' app that can be downloaded to a smartphone to help families make healthy food and exercise choices; this would be a great way to involve both Andrew, Prisha and the children to make healthy lifestyle and food choices (NHS, 2021b). Physical activity should be encouraged and is recommended for everyone, including children, older people and those

with physical and mental health disabilities (UK Active, 2022). Considering Rose, who is 83 years old; physical activity is still recommended every day to improve strength, balance and activity and reduce the risk of stroke and heart disease (NHS, 2021a). The community nurse could promote physical activity by encouraging Andrew and Prisha to involve the family and take on activities, such as walking, swimming or cycling, as well as school sports, or by referring to other services that might be available locally such as a health trainer, social prescriber or local walking groups (GOV.UK, 2022). The value of implementing a health-promoting social activity with additional social benefits can act as a useful motivator for ongoing behaviour change (Ogden, 2019).

An individual may be challenged by long-term illness at any age, although the likelihood will increase with age. Long-term illness can confront our sense of self and reminds us that normal functioning is often central to social relationships and activities (Nettleton, 2021). The impact of long-term illness on life is multifaceted; for Carol, who has rheumatoid arthritis, she may experience chronic pain and increasing disability that may lead to poor mobility and reduction in her physical abilities, which might lead to social isolation and depression. For Faith, who is going through the menopause, the cessation of menstruation and the reduction in the hormone oestrogen can lead to symptoms such as changes in mood, depression, anxiety, feelings of loss of self, night sweats, hot flushes, vaginal dryness, joint stiffness, aches and pains, amongst others (NHS Inform, 2023). Some women experience very few symptoms, but, for others, menopause can have an adverse effect on their quality of life (Norton and Tremayne, 2019).

ACTIVITY 8.9

Reflection point

Carol has the long-term condition of rheumatoid arthritis; recently, her symptoms of joint stiffness and pain have become worse, and she finds sitting for long periods at work very uncomfortable. She is frequently tired at work, with poor concentration, and expresses a low mood. Carol is referred to the occupational health nurse at work for an assessment.

From a biopsychosocial perspective, what could the occupational health nurse do for Carol?

Due to symptoms of the menopause, Faith is struggling at work, she is experiencing hot flushes and restless nights, during which she can wake several times a night with sweat-soaked sheets. As a result of poor sleep, Faith feels exhausted and is struggling to get up early for work when her early shift starts at 6 a.m.

From a biopsychosocial perspective, what advice could the occupational health nurse give Faith?

It is important to recognise that expected norms across the lifespan may be challenged and altered by long-term mental and physical illness. Recently, Carol's diagnosis of rheumatoid arthritis has resulted in her feeling easily fatigued with increasing joint pain and stiffness (NICE, 2020). Low mood and the stress of her daughter and granddaughter living with her have affected her capacity to cope; it is recognised that many people who have a long-term condition can experience poor mental health and depression (Boyd and Bee, 2019). The biomedical approach would emphasise the importance of maintaining Carol's mobility and effective pain management, which might include pharmacological and non-pharmacological treatments, such as analgesics and exercises, to manage symptoms (NICE, 2021). From a sociocultural perspective, inequalities in health, lack of social mobility, gender, age, race and other sociological factors will have exerted an influence on Carol's lifespan, and as a consequence, her opportunities and functional capability will have been affected (Thompson et al., 2021). For the community nurse, socio-economic considerations might include referring Carol to a social worker, housing officer or a local community support group.

The increase in symptoms of rheumatoid arthritis has resulted in Carol's realisation that she is less able to function in her duties at work and home, and she is afraid of losing her job. The disability employment gap is worse for women than men, particularly for those in the 50–59 age group (Chartered Governance Institute UK and Ireland, 2022). Following an assessment, the occupational health nurse might recommend to Carol's employer reasonable adjustments to enable Carol to remain in employment as long as possible; these could include modified seating, adjustable height desk, increased breaks, flexible working hours and working from home (Equality Act, 2010). When living with a long-term condition, there is no timetable of events as to how a condition may progress (Barry and Yuill, 2022), and the individual will need to be supported by the community nurse to respond and adapt to changes that occur across all stages of the lifespan.

OLDER AGE

Knowledge and understanding of the ageing process and what ageing means to people is essential for the community nurse to provide effective individualised care for people. Old age is often considered to begin at age 65, around retirement age, but increasing life expectancy has resulted in subgroups of young old, old, and the very old (over 85 years; Erber, 2013). Trends show there are fewer younger people and more older people in the UK, with increasing numbers of those living to be very old (GOV.UK, 2021). Globally, by 2050, the number of people over the age of 65 is projected to double, outnumbering people under the age of 25, and in the UK, 26% of the population will be aged 65 and over, which is estimated at 20.4 million people (GOV.UK, 2021).

Our understanding of ageing is influenced by the concept of ageism, stereotypes, social norms and expectations. In the UK, ageing and the physical changes, such as greying hair and loss of skin elasticity, particularly in relation to women, is generally viewed negatively (Clarke and Korotchenko, 2010), whereas in men, ageing can be viewed more positively with views of men becoming distinguished, mature and displaying competence (Alder, 2013). Popular stereotypes of ageing portray individuals as frail, demented and in poor health and are synonymous with decline, dependency and vulnerability (Barry and Yuill, 2022); some older people may hold stereotypical ideas of themselves, with others retaining a view of the inner self which is younger than their body as a means of negating ageist expectations and preserving a sense of dignity (Boyd and Bee, 2019).

As people age, they carry an increasing wealth of health experiences that are shaped by cultural and social norms. Positive ageing may be marked by an ability to look back on life with a sense of fulfilment and wholeness or the extent to which an individual is able to remain socially engaged (Beckett and Taylor, 2019). Erikson (1980) noted that individuals who could reflect on life with a sense of satisfaction achieved a sense of integrity rather than despair. Feeling old may relate to feelings of fear and helplessness, feeling different from peers and losing a sense of control over one's life and experiences, such as loss and bereavement (Age UK, 2019). Physical changes may restrict the capability for social involvement while factors such as changing roles and statuses in the community or decline in mental ability will impact the individual's experience of ageing. Living with diabetes, Rose has a sense of feeling old; she is starting to feel that she is a burden on her family who need to offer her increasing amounts of help due to living with diabetes, and she does not realise that she keeps forgetting things. Positive ageing is dependent on a complex interaction of biopsychosocial and economic factors; however, for individuals who have a long-term condition(s) and/or declining health, ageing may be associated with increasing vulnerability and frailty (NHS England, 2019; Centre for Ageing Better, 2022).

ACTIVITY 8.10

Reflection point

On her visits to Rose, the community nurse has noted that the house is rather untidy and that Rose looks unkempt and appears disinterested. Faith is also concerned about her mother; she tells the nurse that prior to Jack's death, her mother had enjoyed an active social life, but recently, she is withdrawn and sometimes aggressive and argumentative.

Critically consider how an understanding of ageing can influence the quality of care for Rose.

Social aspects of ageing may be characterised by patterns of adjustment that result in a process of disengagement in which the older person gradually withdraws from society. Social practices in retirement and cultural norms and values may mean that the older person becomes excluded from a variety of social settings and relationships; this may also be influenced by poverty and social class (Barry and Yuill, 2022). Rose appears to have lost the social contact and network of support she had with her husband, and without an active social network, she may be at increased risk of feeling socially isolated and lonely. Social isolation and loneliness can be associated with poorer health and increased mortality (Ratcliffe et al., 2021); therefore, the community nurse should recognise loneliness can affect people at any age across the lifespan, but in older people, it can put them at greater risk of cognitive decline and reduction in functional status (Cacioppo and Cacioppo, 2014).

ACTIVITY 8.11

Reflection point

As time progresses, Rose continues to struggle to manage at home. Following an assessment in the memory clinic, Faith informs you that Rose has early indications of Alzheimer's disease. Faith is worried about her mother's safety and how she will cope with caring for her with her increasing forgetfulness.

Consider how you might support Faith in coming to terms with her mother's diagnosis.

How might your understanding of a lifespan approach influence care for Rose?

Dementia is characterised by progressive functional and cognitive impairment (Jönsson, 2022). Rose is diagnosed with Alzheimer's disease, and her fluctuating memory means she is forgetting recent events and cannot consistently remember names and faces. She is having difficulty finding the right words to say, is experiencing mood changes and faces challenges in carrying out familiar tasks (NICE, 2022). The impact of a diagnosis of Alzheimer's disease might be frightening for Rose and devastating for Faith and Carol as Rose's daughters. Providing support, raising awareness and enabling the individual to live well with dementia, supported by competent healthcare professionals are all key elements of current policy (DH Northern Ireland, 2011; NICE, 2019; Scottish Government, 2023). Faith and Carol will need support and information on how to cope with and manage the cognitive and behavioural changes that their mother is experiencing. Identifying strategies to manage cognitive symptoms such as memory loss using prompts and reminders may be useful. A multiprofessional approach is essential including specialist nurses in dementia to plan personalised care and treatment to meet Rose's individualised needs using a biopsychosocial approach (NICE, 2018). The impact of additional caring

responsibilities may result in stress for the family; receiving support and advice from an Admiral nurse who supports families who are affected by relatives with dementia would be helpful (Lyons et al., 2022). The challenge for the community nurse and the healthcare team is to provide safe, family-centred care that will enable the individual to live well with dementia and remain independent for as long as possible.

CONCLUSION

This chapter has explored a lifespan approach to health and healthcare. Multidimensional views that take account of not only the biological and psychological but also, increasingly, the social, cultural and environmental aspects of health and illness are essential. Age, gender and individual perceptions of health will all influence individual needs, assessment and care provision. It is important to recognise that each person is part of a family system and that the healthcare needs of the individual may well impact the family. Proactive person-centred approaches and developing positive health should underpin holistic healthcare provision. Understanding how aspects of the lifespan relate to the physical, psychological, social, environmental and spiritual elements of an individual's life can positively influence care provision and the quality of life for people, their families and carers.

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CHAPTER 9

Community nursing assessment

Helena Kelly and Sheila Cameron

LEARNING OUTCOMES

- Critically define nursing assessment.
- Critically explore the importance of person- and family-centred assessment.
- Analyse the concept of need within nursing assessment.
- Critically reflect on the role of communication within the assessment process.
- Appraise the use of consultation models when undertaking a nursing assessment.
- Evaluate decision-making theory and how this supports nursing assessment.

INTRODUCTION

The aim of this chapter is to examine community nursing assessment by defining terminology and identifying what constitutes a person-centred assessment. The concept of need and its relationship to assessment are explored, along with existing assessment frameworks and consultation models that have been developed to meet the wide range of assessment perspectives that exist within a community setting. Decision-making and its essential alignment with community nursing assessment are then discussed, with opportunities to guide reflection on current practice. The chapter has been structured using the nursing process model which involves an evidenced-based five-step approach consisting of assessment, diagnosis, planning, implementation and evaluation (ADPIE), found to promote problem-solving and critical thinking during decision-making (Yura & Walsh, 1988; American Nurses Association, 2017).

EXPLORING THE MEANING OF ASSESSMENT

Assessment is a core skill for nurses, irrespective of their field of practice, as any subsequent care depends on the accuracy of the assessment and any mistakes in this process will inevitably affect the care that is planned. Indeed, the importance of the assessment process is reflected in the updated proficiency standards

DOI: 10.4324/9781003347545-10

that have been developed by the Nursing and Midwifery Council (NMC, 2018b) to support nurse education for the future nurse, the community nursing specialist practice qualification (NMC, 2022a) and the specialist community public health nurse (NMC, 2022b). In addition to this, developmental changes to UK health policy, which include improving the health of the population and providing healthcare locally, place the community nursing workforce at the forefront of community care (Scottish Government, 2017b; NHS [National Health Service] England, 2019). This emphasis on convenient access to care closer to and within the patient's home has continued to gain momentum, and the need for flexible and adaptable community nurses is at the forefront of many policy agendas (Scottish Government 2017a; Department of Health [DH], 2018; NHS England, 2019; Welsh Government, 2021a). More recent developments in relation to UK health policy have driven the integration of health and social care for adults which stresses the importance of seamless care (Scottish Government, 2015; Welsh Government, 2021b; DH, 2022; Northern Ireland DH, 2022). Indeed, health and social services are experiencing a rapid period of transition to respond to the needs of the ageing population and are engaged in strategic change within professional practice (UK Government, 2016; Scottish Government, 2022). This means community nurses remain in a unique position to reflect on existing assessment practices and review these for suitability and/or adaptation to meet the changing political and professional agenda. The NMC Code (2018a) reinforces the need for effective practice, suggesting that current community nursing assessment practice is worthy of exploration as it provides nurses with an opportunity to reflect on their current assessment skills and knowledge and identify ways to improve their practice. A starting point is examining what is meant by assessment.

DEFINING ASSESSMENT

Surprisingly, concise modern definitions of nursing assessment can be difficult to find in current literature. Seminal nursing theorists Roper et al. (1990) were quite specific in relation to assessment of the individual, highlighting that it included collecting information, identifying the problems and then determining the priorities. Although this first appears a superficial approach, far more detail is then provided and assessment is an ongoing activity gathering biographical and health data before considering an assessment of the individual's activities of living (Roper et al., 1990). In contrast, an early person-centred definition of assessment was provided by Worth (2001) that highlighted the ways in which the needs and requirements of the person drove the subsequent planned care and services. While this approach emphasises individual need, the need was usually determined by the professional, therefore diminishing the opportunity for a partnership approach. Recent definitions by Zhao et al. (2016), McCormack and McCance (2017) and Håkansson Eklund et al. (2019) recognise that individuals are core to person-centred care alongside autonomy

and decision-making underpinned by values for self-determination and mutual respect, promoting shared decision-making and partnership working. The NMC (2018a) promote that all nurses ensure every person is unique and that nurses endeavour to do everything to put the needs of the person first. The first step involves collecting data on the individual's unique physical, psychological, sociological and spiritual needs, allowing the assessor to see the whole person and not the illness or disease. These person-centred approaches to assessment ensure that care is planned in partnership with the person and their family (Ajibade, 2021).

ANALYSING CONCEPTUAL ASPECTS OF ASSESSMENT

Hogan-Quigley and Palm (2022) and Dains et al. (2020) state that individual health assessment is undertaken by conducting a health history and physical exam which is then followed by a diagnosis and treatment plan. Previously, Wright and Leahey (2013) suggested physical or spiritual suffering, illness, relationship issues or family crisis as indications for a family assessment. Although the types of health history described by Wilson and Giddens (2012) and Bickley and Szilagyi (2016) are suitable for the context of individuals presenting with a physical complaint or illness, this is clearly a different context from that of a family with health needs in the community setting that Wright and Leahey (2013) alluded to. Consideration of the indication for an individual health assessment highlights the complex and diverse nature of community nursing practice, as it is often the client group along with the community nursing service involved that dictate the form of assessment that will be undertaken. To reflect the increasingly complex nature of care that is required in the community and align to policy (Scottish Government, 2017b; NHS England, 2019; Strategic Programme for Primary Care, 2022), advanced practice roles have been developed. These encompass what is deemed advanced-level skills with the assumption that there is increased autonomy, education and skill. Reflecting this, new service developments and enhanced, increasingly autonomous community nursing roles such as primary care advanced nurse practitioners and advanced practice district nurses have been developed to meet the evolving needs of patients in the community.

PERSON- AND FAMILY-CENTRED ASSESSMENT

PERSON-CENTRED CARE

The idea of individuals being at the centre of their care was established in the Patients' Charter of 1991 and introduced the concept of the named nurse (King's Fund, 1998). Principles of person-centred care are detailed in Table 9.1 and these key areas represent an approach to practice, and indeed a nursing framework (McCormack & McCance, 2017). Before reading further, it may be useful to reflect on what is meant by person-centred care and the development of a definition of this.

Table 9.1 Principles of person-centred and family-centred care

Consideration of
• *The person's needs and beliefs*
• *The person as an individual*
• *The person's and the family's view in decision-making*
• *The person's and the family's fears and concerns*
• *The person's family, carers and friends*

ACTIVITY 9.1

Defining terms: Person-centred care

From your own perspective note the key components of person-centred care. Now link these ideas to community nursing assessment and write a short definition of 'person-centred nursing care'. Continue reading the chapter and then review your definition against those drawn from the literature in the following sections.

The term *person-centred* requires that all aspects of the person are considered, not just their situation or their diagnosis (Roberts & Machon, 2015; Sassen 2018), and this is a sound perspective for community nurses to start from, as it reflects a social model of health and places the individual in a community setting. Additionally, this approach links to the wider aspects of nursing assessment and the essential aspects of care, which include psychosocial and spiritual features and the impact these have on a person's health and wellbeing (Hogan-Quigley & Palm, 2022). To enable further consideration of the importance of spirituality within person-centred care, see Chapter 12. There is much more to be read about person-centred care in later chapters, but aligning to these principles will ensure a person-centred approach to assessment, which McCormack et al. (2021) refer to as an interaction and relationship between all those involved in care.

Involving a person in decision-making including the person's preferences, values and beliefs can help both the nurse and person understand what is important to them at each stage of healthcare (Tringale et al., 2022). The NMC (2018a) have also articulated that involvement within the code, using a key theme of 'prioritising people' to underpin the guidance and promote a partnership approach to assessment. The National Institute for Health and Care Excellence's (NICE, 2022) guidance currently emphasises the value of developing a partnership approach and shared decision-making in nursing assessment because shared decision-making guarantees that the person understands the risks, benefits and potential consequences of different options through discussion and information sharing. This places the person at the centre of their care. Therefore, it is misguided to suggest that, historically, nurses have not been involving people in their care when it may simply be due to a lack of an authentic description in the literature.

FAMILY-CENTRED CARE

A growing body of evidence supports the importance of family involvement in person-centred care and suggests that involving families in assessment and care planning promotes quality nursing care (Hagedoorn et al., 2021; Alcindor & Cadet, 2021). The NMC (2018b, 2022b) has reintroduced the concept of using genomics and genograms within nursing assessment, stemming from the seminal work of Bowen (1966), who was a psychiatrist and family therapist. A genogram is a type of family tree that is developed with the support of the practitioner and records the diseases and relationships within a family, usually spanning at least three generations (Rodgers et al., 1988; Cohen & Domakin, 2019). Genograms can be used as a valuable assessment tool and are developed in the form of a graphic presentation of a person's family structure, relationships, environment, health and social history (Mathiasen et al., 2023). The use of genograms within community nursing assessment can help develop an understanding of the sometimes complex dynamics within families and can contribute to disease prevention and identification and support of health promotion activities to achieve more targeted approaches to person-centred care planning. However, genogram completion may take time and elicit strong emotions (Magyar-Moe, 2009) and may not be perceived as relevant, useful or indeed essential to support person-centred care. The use of genograms within practice is demonstrated in a longitudinal mixed-methods study undertaken by Mota et al. (2022), who explored social support networks that were available for people diagnosed as frail. In the study by Mota et al. (2022), it was found that intergenerational relationships within the home can determine quality of life outcomes and that these are not universally positive.

Genograms are not without critique as there is no means to capture socioeconomic conditions within the home and not all situations, diseases and relationships have a symbol assigned to them (Kehoe, 2008). In addition to this, they capture a moment in time and cannot represent the minutiae of actual family interactions (Robbins et al., 1998). Furthermore, an important limitation to their use within an assessment is that there may not be a way to capture and archive the information that is gathered in a genogram in one location, such as a database, which means that this cannot then be retrieved for future care planning or further research (Piasecka et al., 2018). Nonetheless, genograms may be worthy of consideration within the community needs assessment, and it is useful to review how these may be undertaken.

ACTIVITY 9.2

Draw a family tree of all members of your family for 3–4 generations

Use the basic symbols to identify each person (see Figure 9.1) and the connecting symbols to show the relationship status, emotional relationships and trauma, illness or addiction (Figure 9.2)

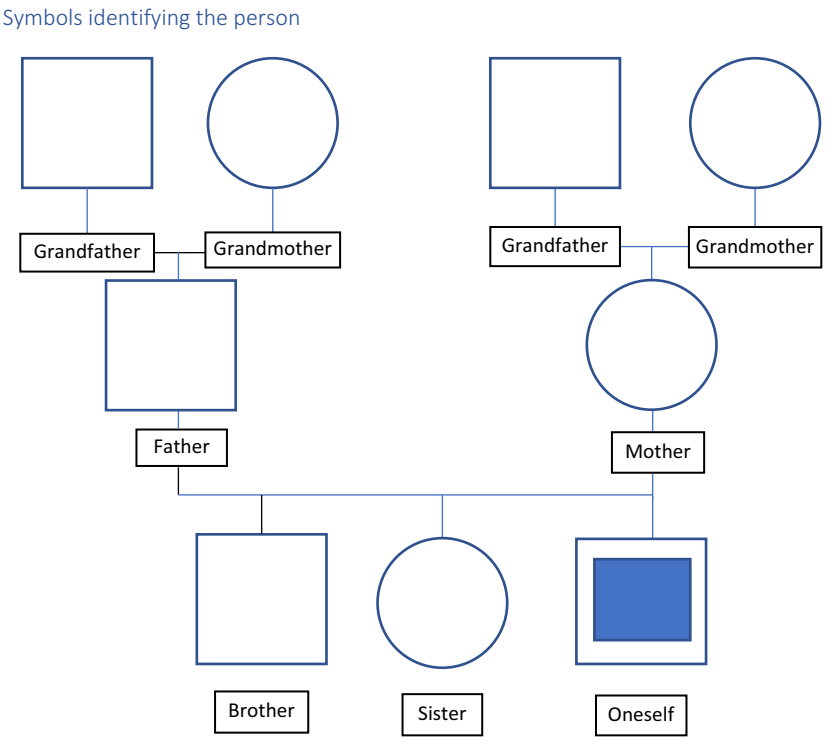


Figure 9.1 Symbols identifying the person. (Reference: https://genopro.com).

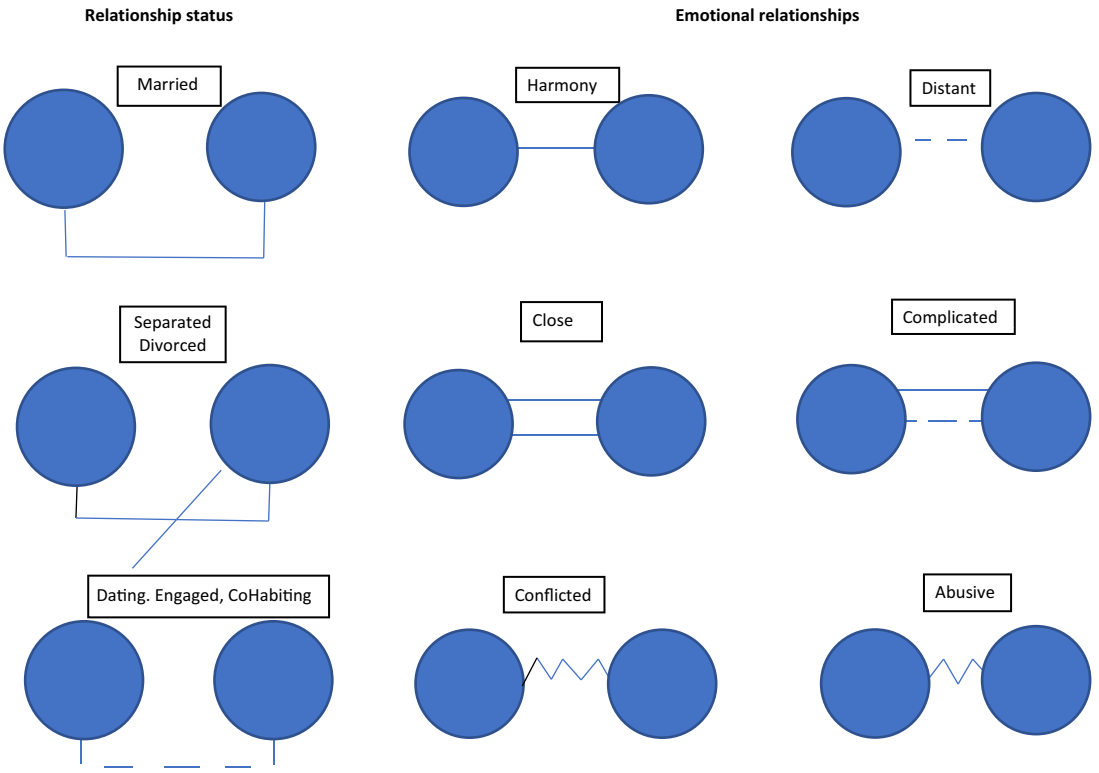


Figure 9.2 Symbols identifying relationships and physical effects.

EXPLORING THE CONCEPT OF NEED

A key aspect of health assessment links to the concept of need, and it would be difficult to undertake a person-centred assessment without consideration of need (Ajibade, 2021). Health needs can relate to various levels depending on the context, for example, helping individuals to identify their own health needs takes a different approach from identifying broad health needs within a local community (Coles & Porter, 2011). Maslow (1943, 1954) stated that there was a hierarchy of human need that is often represented as a diagram (Figure 9.3), with physiological need at the base and self-actualisation at the apex. This assumes that fundamental needs such as food and water require to be met before others can be achieved.

Later, seminal work by Bradshaw in 1972 identified a taxonomy of need from a sociological perspective that helps to explain individual need, and this is outlined in Table 9.2 providing a different perspective from Table 3.4 in Chapter 3.

Although Bradshaw's Taxonomy does provide a theoretical perspective of need that can be practically applied by community nurses, it is worth pointing out that there is no acknowledgement within the taxonomy of any associated resources, including the availability of services. This means that although needs in relation to individuals or families may be identified, an issue arises when the resources are limited and these needs cannot be met (Gov.uk, 2021). Therefore, although assessment has identified healthcare needs in partnership with an individual, for example, referral to an additional service, third-sector organisation

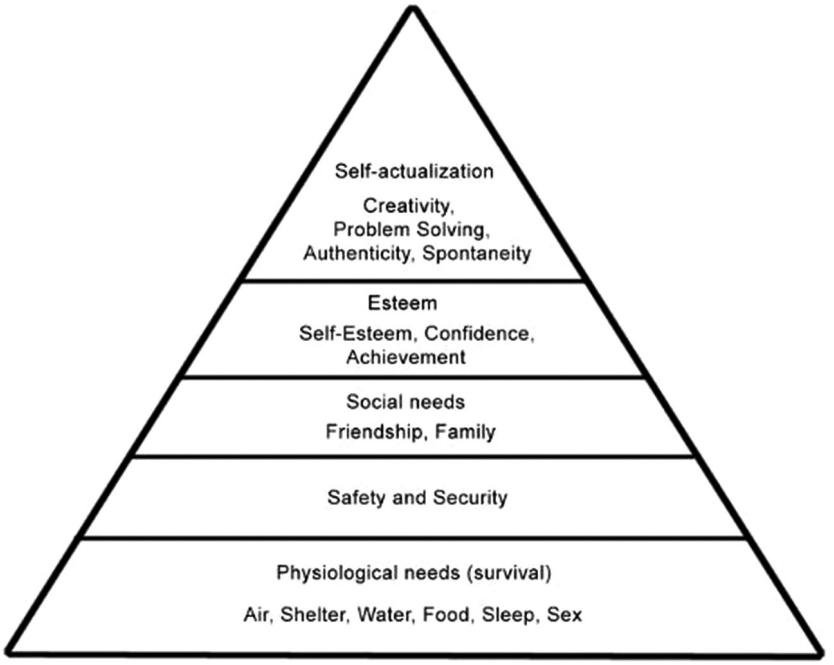


Figure 9.3 Maslow's hierarchy of needs.
(Adapted from Maslow, 1954.)

Table 9.2 Bradshaw's (1972) taxonomy of need

Normative need is explained as the need that the health/social care professional identifies. Although professionals are educated to recognise needs, it must be acknowledged that various professionals may identify different needs from each other. Furthermore, health needs can change over time.
Felt need is described as a need identified by the individual or carer. Although the individual or carer will be able to identify some of their own needs, they may not have a grasp of all that they require.
Expressed need is the articulation of a felt need by the individual or carer.
Comparative need is when in certain areas the individuals or carers are not receiving the same standard of care that is available elsewhere.

or a nursery placement, any treatment or service provision will need to be justified economically. Furthermore, if the need cannot be met because there is no transport to the service or the nursery has no spaces, then alternatives must be considered. Working within these constraints can be incredibly challenging for the community nursing team and can result in frustration and concern when trying to deliver evidence-based practice (Mathieson et al., 2019). Therefore, determining need along with being aware of local available resources is part of the assessment process, and analysing current conceptual aspects of assessment is the next logical step.

THE ROLE OF COMMUNICATION WITHIN ASSESSMENT

Nurses are required to have effective communication skills to develop therapeutic relationships, gather information and elicit clues within the assessment process and this is a complex phenomenon (Dithole et al., 2017; Ahrens & Elias, 2023). A vital aspect of communication within assessment is to gain insight into an individual's understanding of their own condition which is often referred to as their health literacy. Health literacy relates to an individual's understanding and ability to discuss and plan for their own health (World Health Organisation [WHO], 2015; NMC, 2018b) and consideration of the health literacy capability of the individual should be made prior to choosing the mode of assessment. The importance of this is emphasised in an integrative review of nine studies by Hogan et al. (2023), who found that nurses commonly overestimate the health literacy of individuals, and while this study pertains to people who are within an acute care setting, it can be assumed that a similar situation could be found within the community. Yang (2022), in a study using self-evaluation questionnaires, found that failure to assess a person's health literacy accurately can result in a one-sided and ineffective assessment. Communication skills, whether these are verbal or non-verbal, of both the person receiving and delivering healthcare information are key determinants in how information is transferred and received (Arnold, 2019). Therefore, the importance of awareness of health literacy in relation to social determinants of health should be considered a public

health priority (WHO, 2015; Scottish Government, 2017c). In summary, at the initial assessment community nurses should be aware that some people may not understand information about their health or may be unable to communicate. Creating an empowering environment using clear and adaptable communication is key to supporting people with their health literacy, particularly those without a voice or with a cognitive impairment (Byrne, 2022).

PREPARING TO UNDERTAKE AN ASSESSMENT

Toney-Butler and Unison-Pace (2022) state that assessments are rarely unexpected activities and are a crucial element of the nurse role; therefore, preparation is necessary to have the most thorough and meaningful interaction between the patient and the healthcare provider.

Whilst the assessment may be undertaken with the individual in person, it is increasingly likely that the assessment information will be captured electronically as developments in relation to mobile technology have promoted agile working across the United Kingdom (Innes et al., 2018). Face-to-face assessments remain the most common and the preferred approach for community healthcare practitioners. In a qualitative study, Hughes et al. (2022) reported that nurses found that face-to-face assessments provided visual clues that are often unnoticed in digital consultations, allowing a closer, more connected approach to gathering information. However, while a face-to-face assessment may be preferred, the data are captured digitally, and there are many assessment tools available to support this, which are discussed later in the chapter. There are many steps that can be considered in relation to preparing and then undertaking an assessment. The first of these relates to consideration of the use of a theoretical consultation model to underpin the approach to assessment.

CONSULTATION MODELS

Consultation is a process whereby a discussion takes place between two people; this may be in relation to a particular health problem or to get advice (Collins, 2023). The use of consultation models may have previously been more aligned with medical assessment and advanced nurse practice (Barratt, 2018). However, the context of health assessment has changed focus due to changes in preregistration nurse education and the future nurse proficiencies (NMC, 2018b) alongside nurses adopting new roles in practice, which has been discussed previously.

A theoretical consultation model to underpin the approach to assessment may be useful, and if these are not familiar, it is worth exploring these in more detail. Alongside others, there are seminal consultation models by Neighbour (1987), Kurtz and Silverman (1996) and Pendleton (2003) which are person-centred and may support nurses to undertake an assessment which has shared

understanding and expectation (McCormack et al., 2021). A critique of consultation models is that they are linear and systematic which may elicit a problem-solving approach on the part of the healthcare professional who is undertaking the assessment and consultation (Weaver et al., 2016), Nonetheless, consultation models such as Pendleton (2003) offer a structure based on exploring the expectations, concerns and ideas of the individual, and this is achieved by exploring the reason for the consultation, other issues, identified actions, shared understanding and decision-making, realistic use of time and resources and then maintenance of an ongoing therapeutic relationship. In addition, Bickley and Szilagyi (2016) explain comprehensive assessment in relation to a health history and complete physical examination, which includes family, personal and social history as part of seven components. Therefore, the focus of the consultation is usually around the presenting complaint and has a strong physical component. Even though this type of consultation clearly has a place in community nursing, for example, in long-term condition management and prescribing, the emphasis can appear medicalised with less focus on the person. However, this is tempered by the clarification of advanced-level nursing practice as those with enhanced knowledge and skills, further education at the master's level and the ability to make autonomous decisions based on the four pillars of advanced practice (Scottish Government, 2017; RCN, 2018; Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC), 2016). The emphasis is clearly on the significance of advanced health needs assessment for nurses working at this level. Using a consultation model like Pendleton (2003) can enable a person-centred assessment whilst also *clarifying the complaint* and *identifying any concerns* (Barratt & Thomas, 2019), and for those with a prescribing background, these terms in relation to risk assessment will no doubt be familiar. However, using the term *consultation* or *consultation models* may be unfamiliar, and adopting an assessment framework or proforma, which is discussed next, may be more familiar.

UNDERTAKING AN ASSESSMENT

As a reflective practitioner, it is useful to consider what happens in current practice and how assessments are undertaken, as this will inform a deeper understanding moving through the remainder of this chapter.

Following consultation, the ability to perform an enhanced physical examination and interpret diagnostic tests is beneficial for seamless care and a desirable skill for nurses, particularly those working in the community setting as autonomous and lone practitioners. This is reflected in changes to nurse education in response to the increasing complexity of care required in the community (NMC, 2018b). However, some advanced skills are connected to an advanced level of practice and can only be performed by nurses or practitioners who have completed additional education at the master's level (Royal College of Nursing, 2018).

ACTIVITY 9.3

Reflection point

Reflect on the way in which you currently assess an individual/client in practice including the assessment framework or model that guides you. Consider the age and context of the framework/model that you currently use and judge the following:

1. *It is fit for purpose?*
2. *You may wish to consider its strengths and limitations (is it simply a tick list, electronic or otherwise?) and its ease of completion along with any gaps you identify. Gaps in assessment frameworks often result in the practitioner having to key in additional information.*
3. *Does it have an evidence base?*
4. *Can you clearly identify the literature or research that underpins the tool?*

The NMC commissioned an independent report by Palmer, Julian and Vaughan (2023) to review the possibility of regulating advanced practice (AP), as AP is not currently regulated within the UK. Because of this, AP nurses and midwives are accountable for making sure they adhere to the legal frameworks in place. While this is reviewed, employers are responsible for making sure a candidate's credentials and prior experience in undertaking AP roles are appropriate. If the nurse or practitioner lacks the essential knowledge and skills at an AP level, conversation and liaison with colleagues and the wider Health and Social Care team may be required to escalate and commence additional treatment. Remember, it is important to always be aware of limitations within the boundaries and competencies of nurse registration and practice. A person-centred care plan will be developed in partnership with the individual, based on the assessment that has been undertaken, and this may focus on or involve the use of formal documentation or proformas which is discussed next.

ASSESSMENT FRAMEWORKS

If generic admission assessment frameworks, documentation or tools within the NHS are used, there is still a need to question the evidence base and identify the literature or research that underpins their use. It may be that there is ambiguity about what assessment frameworks or tools are available in practice, and this is an important discovery. Practitioners can find themselves using the documentation that their employing organisation provides them with and mistakenly believe this to be an assessment tool. Of course, in some cases, a validated assessment tool will be incorporated into the documentation, whether this is paper-based or electronic, and this should be clear for practitioners. Furthermore, the information gathered within the assessment requires to be reflected in what is documented and there is an assumption that nursing records mirror the assessment that has occurred (Toney-Butler & Unison-Pace, 2022). The challenge with assumptions of this kind is that although the nurse enters the findings from the assessment into nursing documentation, there is no guarantee

that the documentation is in fact an assessment tool. Therefore, a lack of awareness of the difference between an assessment tool and generic admission documentation is problematic if it is the documentation that drives the assessment because the focus may not be person-centred or, even worse, crucial information shared by the person may be missed (Toney-Butler & Unison-Pace, 2022). Furthermore, if the tool only allows the nurse to document tasks or tick boxes, then the ethos of assessment and responding to need, which are the key elements of community nursing practice, are lost. While some electronic assessment forms and tools use a tick box style, these can act as a prompt to enhance a person-centred approach that involves authentic partnership working. Hogan-Quigley and Palm (2022) suggest that as practitioners become more experienced there is less reliance on assessment tools as the process of assessment, analysis and decision-making merge.

ACTIVITY 9.4

Reflection point

Person-centred assessment tools must often be supplemented by additional specific assessment tools, for example, assessment of spiritual needs, nutrition, pain or postnatal depression. Now consider any additional specific areas of assessment (wound, memory, mental health, etc.) that you might want to undertake with people with whom you work in a community or in-patient setting. Are there specific assessment tools that you may choose? What evidence-based tools or frameworks are available in your area? What educational preparation and practice support do you apply in the clinical setting, and how do you support learners to engage with these within the local setting? Now identify any additional assessment tools that you are currently unfamiliar with and the ways in which you could access continued professional development (CPD) to develop your skills.

PLANNING, IMPLEMENTING AND EVALUATING CARE BASED ON YOUR ASSESSMENT

The importance of the cyclical nature of the nursing process must be reiterated as all individuals are required to be continuously supported and the person-centred care that they are given should be evaluated (Toney-Butler and Unison-Pace, 2022). Timeframes that are agreed on should be adhered to, and any changes or deviations from these are required to be documented. It is worthy of reminder that all documentation undertaken must align to regulatory standards such as the code (NMC, 2018a). Community nurses could lead the way in relation to demonstrating all aspects of true shared decision-making and documenting this process in practice (While, 2019). However, capturing the process of an assessment can be challenging, and there is often a lack of information that relates to the conversations and agreements made in the process of shared decision-making, which was also found in a scoping review by Marriot et al. (2023).

Regardless of the visibility of the process, this partnership or sharing of power between the individual and professional is a cornerstone of person-centred care, a term promoted in the literature by McCormack and McCance (2017) that has also been embraced by a range of organisations including The Health Foundation (2014). The Health Foundation (2014: 4) describes person-centredness as a situation in which there is 'recognition of the active roles that individuals can play as partners in their health and health care'. Notwithstanding, person-centred care can introduce complex challenges for community nurses as sharing evidenced-based information to enable authentic, shared decision-making can be time-consuming and is also dependent on the knowledge of the healthcare professional (Brand & Timmons, 2023). Resources are finite, and community nurses need to justify the time spent in patients' homes as the concern is that achieving genuine holistic person-centred care could be compromised. Concerningly, this notion of resource constraint is corroborated by a mixed-methods study by Taylor et al. (2021), who found that limited time hinders the ability to undertake appropriate holistic clinical assessment.

The National Institute for Health and Care Excellence (NICE, 2021) discuss the importance of shared decision-making, where the individual and the healthcare practitioner collaborate to develop an agreed-on plan of care and have produced a guideline to reflect this. Central to the tenet of shared decision-making is the ability of the healthcare practitioner to communicate in a clear manner, avoiding the use of jargon and explaining any terms that are not understood (Faiman & Tariman, 2019). Therefore, this links back to the consideration of health literacy and the importance of shared decision-making and a move away from historical terms such as adherence or compliance. Support for this person-centred approach is augmented in practice by the growing understanding of the term *concordance*, which involves a relationship of trust between the individual and the healthcare professional, sharing knowledge, understanding and beliefs to enhance health outcomes (Chapman, 2018).

Originally, the term *concordance* was used in relation to prescribing medications as

> many people want to be an active partner in decision making and this should be encouraged. People are more likely to be concordant if they feel they were able to negotiate on their own behalf. Therefore, asking, listening and helping them think the problem through and decide is more effective than simply telling them what to do.
>
> (*Barber & Robertson, 2020, p. 218*)

Whether prescribing decisions are required or not, assessment in practice does not stand independently, and decision-making is a close relation that needs to be used concurrently. Decision-making is part of the crucial cognitive process when assessment is being undertaken and ties together the evidence base that should underpin community nursing assessment practice.

APPLYING DECISION-MAKING TO ASSESSMENT

It is clear therefore that assessment cannot exist in a vacuum without decision-making processes with which to move the episode of care along. Sometimes it can be difficult to unpick what is meant when thinking about what guides decision-making, but what is clear is that for community nurses, nursing care must be evidence-based and not because of a whim or, worse, a comment like 'it is always done this way here'. As accountable practitioners, healthcare decisions that are made are rightly scrutinised and never more so than when a critical incident has taken place. Therefore, a robust rationale needs to be provided for the actions and decisions that are made (NMC, 2018b). Having a guide to support and understand decision-making processes, with an opportunity to reflect with afterwards, helps nurses to learn from experience.

ACTIVITY 9.5

Reflection point

Reflect on your current practice and determine what currently guides your decision-making. If you are unable to answer this, then please do not panic as help is at hand in the following section.

If you can identify a guide to your decision-making practice, now consider whether it has an evidence base.

Can you clearly identify the literature or research that underpins this guide?

If not, then this is something that you can investigate within your local area/NHS organisation.

CONTEXT OF DECISION-MAKING

As previously discussed in this chapter, within community nursing there is a wide variety of contexts of practice in relation to this group of individuals and the healthcare professionals involved. Examples of this may be young children and the potential input from health visitors, school nurses or community children's nurses, individuals with mental health conditions receiving support and input from community mental health nurses and, finally, unwell older adults receiving care from district nurses or practice nurses. These contexts are important as they determine the knowledge and skills required to deliver care and are highlighted specifically in relation to human behaviour, judgement and decision-making and (Croskerry, 2019; Wilcox, 2022).

Kahneman (2012) and Wilcox (2022) refer to two systems of decision-making. The first is *system one*, the intuitive route, which relies on a reflexive approach that requires little effort and does not depend on evidence to underpin the decision. This may be linked to recognising patterns and cues that have been seen before by the practitioner. Intuitive decision-making may incorporate heuristics, which are also known as mental shortcuts, and these may result in bias (Croskerry & Campbell, 2021). *System two* is described by both Kahneman (2012) and Wilcox (2022) as the analytical route, which relies on a rule-based approach and has a scientific evidence base. This analytical approach

may be a more reliable system of decision-making; however, there is an associated effort, cost and time that cannot be ignored (Croskerry, 2019). Using a more analytical approach within decision-making may be linked to not only novice or more junior healthcare practitioners but also those who are unsure of the presentation of signs and symptoms, who do not recognise the pattern or cues and consequently an analytical approach may be preferred in relation to patient safety. Therefore, decisions are made depending on the situation at hand and may involve system one or system two thinking. It is worth considering that when decisions are made in system one these may be prone to bias but are more efficient if they are correct (Kahneman, 2012). There is also a note of caution with system two thinking; if the practitioner's interpretation is faulty, for example, the assumption that a red painful wound is infected when it is inflamed. Overall, the balance in the use of intuition and analysis within decision-making may be linked to experience and confidence (Pelaccia et al., 2020).

Therefore, in practice, there needs to be an awareness of both intuitive and analytical thinking to ensure that the blend of these is used these judiciously (Croskerry, 2019). The following case study illustrates this from a community nursing practice perspective.

ACTIVITY 9.6

Case study and reflection

Mrs Grant is aged 84 years and is not known to you or the team. She has requested that you visit as she would like some help and advice in relation to a problem with constipation.

Intuitive approach – Fast and reflexive with minimal effort

Your experience with people in this age group links constipation to medication side effects and reduced fibre in the diet along with a lack of fluids and lesser mobility. This intuitive approach relies on the context to guide the decision, and in this case, it is the gender, age and assumed comorbidity of the individual.

Analytical approach – Slower and deliberate with considerable effort

Your experience with people in this age group links constipation to medication side effects and reduced fibre in the diet along with a lack of fluids and lesser mobility. However, you are aware that a change in bowel habit and any bleeding could indicate bowel disease or cancer. This knowledge combined with the use of the Bristol Stool Chart and a history of the complaint will identify a normal bowel pattern and stool consistency.

It is not Mrs Grant who has constipation as you first thought; she would like some help and advice about her husband as she is his main carer. Mr Grant has multiple sclerosis and poor mobility, and he has had several recent falls. As a result, he has stopped the osmotic laxative he had been taking for several months as his bowel movements are loose and he needs to rush to the toilet fairly frequently. He has been soiling underwear and

sheets, which has been upsetting for them both, and now his normal bowel pattern has ceased. Mr Grant now feels extremely uncomfortable and nauseous. This analytical approach extracts any irrelevant information (in this case the person with constipation is not Mrs Grant) does not focus on the specific context and uses guidelines to support clinical practice.

While Croskerry (2019) states that repeated specific experiences may convert analytical decisions into intuitive ones, a raised awareness of the context of situations, although helping us make sense of the situation, can also provide a distraction from the reality and lead us to assumptions that are not accurate. Earlier work by Croskerry (2009) in relation to pattern recognition explains a situation in which a person presenting with visual aspects of a complaint and their appearance can trigger a bias in the decision-making. Furthermore, any subsequent data gathered from the person can be used to confirm the initial diagnosis, even when it is not accurate. For example, a person presenting with a painful mouth, evidence of an ulcer and white plaques on their tongue who has just completed a course of antibiotics may result in a biased decision that this is oral thrush when the ulcer may be early oral cancer. Although Croskerry's work is aimed at medics and in particular those who work in emergency medicine, it can illustrate how a failed approach to decision-making can occur, a fundamental message that community nurses need to be aware of.

CONCLUSION

To deliver effective care to individuals in the community, assessment needs to be placed under scrutiny. Determining existing assessment strategies and underpinning theory that supports assessment in practice is a starting point. Person-centred assessment in community nursing practice involves a partnership approach where information is gathered in relation to the individual's physical, psychological, social, environmental, spiritual and cultural wellbeing using recognised evidence-based frameworks. Family and carers are included in the assessment where appropriate, and depending on the needs prioritised, the focus of the assessment can move along a spectrum from concentrating on a physical assessment utilising advanced clinical skills with one individual to focusing on genograms which explore wider family assessment. The flexible approach practised by community nurses is a real strength, undertaking robust evidence-based assessments that have clinical decision-making embedded in the process. These assessments demonstrate and evidence the accountability and essential underpinning knowledge and skills in relation to delivering person-centred care using shared decision-making. This ongoing approach will facilitate community nurses delivering the high-quality care that people expect and deserve. By revisiting theories of assessment, including assessment tools and decision-making frameworks, current and future community nurses will be able to provide a clear rationale for their practice and take responsibility for implementing any improvements within their own clinical area.

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CHAPTER

10

The role of the community nurse in mental health

Roy Litvin and Julie Bliss

LEARNING OUTCOMES

- Evaluate the relationship between physical and mental health.
- Critically examine mental health assessment and the role of the community nurse.
- Review mental health interventions available to community nurses.
- Appraise the need for collaborative working and referral to specialist mental health services.

INTRODUCTION

The NHS Long Term Plan (NHS England, 2019) reiterates the continued focus on moving care out of hospitals and into the community with an emphasis on prevention, early intervention and rehabilitation and reablement. The focus on community care is reflected across all four countries of the UK, with Wales focusing on an interpreted health and social care system that delivers care closer to home (NHS Wales, 2021). Community nurses are key to the success of the delivery of care closer to home with 40% of contacts with community services taking place with children, young people and people of working age compared to 60% with people aged 65 years and older (Scobie and Kumpunen, 2023). This requires community nurses to be able to manage increasing complexity and work in partnership with individuals, families and communities, as well as other professionals and organisations to meet care needs. This is at a time when one in four adults in the UK is living with two or more multiple long-term conditions (NIHR, 2021). People living with multiple long-term conditions identify that their mental health and emotional wellbeing are not considered by healthcare professionals when assessing their long-term conditions. They report that not addressing their mental and emotional wellbeing can result in a worsening of their physical health (NIHR, 2021).

Promoting health and preventing ill health is core to healthcare delivery. This is reflected across the NMC education standards, including the platforms of the Future Nurse Proficiencies (NMC, 2018a). The NMC (2022a) Standards of Proficiency for Community Nursing Specialist Practice Qualifications

DOI: 10.4324/9781003347545-11

(SPQs), developed with a range of key stakeholders, identify seven platforms which include promoting health and wellbeing and preventing ill health, alongside assessing people's abilities and needs and planning care. The NMC (2022b) Standards of Proficiency for Specialist Community Public Health Nursing include a focus on population health, working with people of all ages, to improve health outcomes. Taking into consideration the increase in the number of people living with multiple long-term conditions, with the importance of considering mental health and emotional wellbeing alongside physical health, this chapter examines the relationship between long-term conditions and mental health and examines the role of the community nurse within this context. Chapter 15 explores further emerging issues in long-term conditions.

The World Health Organisation (WHO) states that

> Mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.
>
> (*WHO, 2022a*)

Mental health lies along a continuum and is experienced differently from person to person and across cultures. According to Patel et al. (2018, p. 1553), "The mental health of each individual is the unique product of social and environmental influences, in particular during the early life course, interacting with genetic, neurodevelopmental and psychological processes affecting biological pathways in the brain". Within this context, everyone's mental health is a unique product of biological, psychological, social and environmental influences. These factors interact and interweave in complex ways to cause mental health difficulties. Consequently, people will experience mental health distress in very different ways, and likewise, interventions and treatments may be either biological (e.g. medication), psychological (e.g. talking therapies) or social (e.g. peer support or social prescribing) in nature, and often a combination of these. This way of conceptualising mental health, illness and care provision is often referred to as the biopsychosocial model, initially conceived by George Engel in 1977.

It is perhaps unsurprising that living with one or more long-term physical health conditions, which may impact independence and quality of life, can be linked to mental health difficulties. Taking into consideration some of the psychological influences that can contribute to promoting mental health and wellbeing, Keyes (2002) identified six feelings that foster psychological wellbeing (Table 10.1) which can be used by community nurses as a framework to inform the assessment of psychological wellbeing. They can also inform interventions when working in partnership with people living with co-morbidities who report that their emotional health and wellbeing are often neglected.

Table 10.1 Feelings that foster psychological wellbeing

• Self-acceptance
• Positive relations with others
• Autonomy (or ability to think for yourself)
• Environmental mastery (the sense that you can change your circumstances for the better)
• Life purpose (having goals and feeling helpful)
• Personal growth (being able to learn from the stresses and challenges of life)

Source: Keyes (2002).

THE RELATIONSHIP BETWEEN PHYSICAL AND MENTAL HEALTH

Taking into consideration that the prevalence of living with two or more physical long-term conditions is almost universal in older adults, an understanding of the link between physical and mental health is important for community nurses. Living with two or more long-term conditions is associated with several factors, which include mental health difficulties such as anxiety and depression (NICE, 2018; Table 10.2).

It is important to note that people living with a long-term condition are three times more at risk of depression than those who do not have a long-term condition (Read et al., 2017). Furthermore, while depression and anxiety are experienced by people living with a long-term condition, it is also important to acknowledge that for some long-term conditions, for example cardiovascular disease, there is also an increased risk of cognitive impairment and dementia (Edwards, 2017).

The mechanisms underlying the relationship between mental and physical health are complex and evidence suggests that a combination of biological, psychosocial, environmental and behavioural factors may all be involved (Prince et al., 2007, Patel et al., 2018). The community nurse, often providing care in the home setting, is well placed to assess these aspects in practice in a person-centred way and intervene accordingly. For example, according to Sachar et al. (2022), quality of life, dietary control, relationships with healthcare professionals and

Table 10.2 Living with two or more long- term conditions is associated with the following

• Reduced quality of life
• Reduced life expectancy
• High treatment burden
• Mental health difficulties, such as anxiety and depression
• Fragmentation and problems of coordination of care
• Functional difficulties
• Polypharmacy and increased adverse drug events

Source: NICE (2018).

carers, and overall prognosis can be improved by considering the psychological needs of people with diabetes. People living with diabetes who experience mental health difficulties are known to have poorer glycemic control which results in the development of diabetic complications (Sachar et al., 2022). Therefore, addressing the psychological and mental health difficulties of people living with diabetes can improve glycemic control and other physical health outcomes. Similarly, anxiety, depression and reduced social skills are some of the psychological issues experienced by people with a diagnosis of cancer (Macmillan Cancer Support, 2011) and addressing these may improve people's quality of life. It is also likely that anxiety and depression may affect the families of people living with long-term conditions and cancer (Guthrie et al., 2016). In all these instances, the community nurse is well placed to support the individual, their family and their support network.

Mental health problems are experienced in a range of long-term conditions (Table 10.3).

While many people with long-term conditions experience mental health problems, it is also important to recognise that people with mental health problems have an increased risk of physical health problems. On average people with serious mental illness (SMI) have 15 to 20 years shorter life expectancy than the general population. Reduced life expectancy is due to higher rates of physical health conditions such as cardiovascular disease. Moreover, some of the medications used to treat SMI can cause obesity and thus increase cardiovascular risk (Public Health England, 2019).

Table 10.3 Research evidence on the prevalence of co-morbid mental health problems

Cardiovascular disease (CVD)	• Depression is two to three times more common in a range of CVD including stroke, angina, congestive cardiac failure and following a heart attack • Prevalence estimates vary between 20% and 50% • Anxiety problems are also common in CVD
Diabetes	• Two to three times more likely to have depression than the general population • Also, an association with anxiety
Long-term obstructive pulmonary disease	• Mental health problems three times more likely than the general population • Anxiety disorders particularly common; for example, panic disorder is ten times more prevalent
Long-term musculoskeletal disorders	• Up to 33% of women and more than 20% of men with arthritis may have a co-morbid depression • More than one in five people over the age of 55 with long-term arthritis of the knee have been reported to have a co-morbid depression

Source: Naylor C, Parsonage M, McDaid D et al. (2012, p. 4) *Long-term Conditions and Mental Health the Cost of Co-morbidities*. London: King's Fund Centre for Mental Health.

ACTIVITY 10.1

Reflection

Take some time to reflect on two people living with a long-term condition whom you have worked in partnership with. In relation to each of the people you identify, answer the following three questions:

1. Could they have been depressed or anxious?
2. How did you consider the impact of their long-term condition on their psychological wellbeing and social functioning?
3. Did they raise the issue of their mental health with you?

MENTAL HEALTH ASSESSMENT AND THE ROLE OF THE COMMUNITY NURSE

Having explored the relationship between physical and mental health, it is important to examine mental health assessment tools and consider how they can be used by community nurses. The Standards of Proficiency for Community Nursing SPQs (NMC, 2022a) and the Standards for Specialist Community Public Health Nursing (NMC, 2022b) clearly set out the requirement that community nurses evaluate the impact of the wider determinates of health, for example poverty, housing, education, and income, on the current and future physical and mental health of people, recognising that health is a fundamental human right (WHO, 2021).

Primary care can play a key role in supporting people with mental health difficulties and is the main source of formal support for mental health with only 10% of individuals with a mental health issue being referred to specialist mental health services (Naylor et al., 2012). Primary care provision with support from specialist mental healthcare professionals, when appropriate, can support people's needs more effectively. However, there is often a lack of partnership working across service providers resulting in care that is often fragmented, which can have a negative impact on the effectiveness of care management (Banstola et al., 2023). Consequently, the detection and treatment of co-morbid mental health problems is often not done well. Within this context, partnership working across services is crucial for effective care management. Moreover, it is important for the community nurse to take a holistic approach and consider mental and physical health jointly when working with individuals as they are inextricably linked.

Coventry et al. (2011) undertook qualitative research to identify and explore the barriers to the management of depression in people with long-term conditions. They interviewed 19 healthcare professionals, mainly from a primary care background, and seven pairs of service users and carers. Their work identified that depression was a natural response to the long-term condition and needs to be considered as part of the assessment and management of the long-term conditions. Furthermore, there was a suggestion that using structured assessments, for example those driven by quality outcomes framework requirements, could result in a reductionist approach to case finding rather than a holistic person-centred assessment of individual needs. The healthcare

professionals interviewed suggested that people rarely used the term *depression* to describe their low mood. This was supported by some people who use services who reported that they did not always tell their general practitioner (GP) that they felt low in mood (Coventry et al., 2011). The lack of sharing with the GP regarding low mood may be related to evidence that stigma has a small to moderate impact on people seeking help for mental health problems, this appears to be more prevalent among military and health professionals as well as ethnic minorities, young people and men (Clement et al., 2015). Janlöv et al. (2018) undertook a qualitative study which explored the experience of Swedish community nurses working with adults who experienced mental ill health. The study identified that community nurses need to be competent in assessing and managing mental health difficulties, which in turn requires support from their employing organisation. Taking into consideration the impact of stigma regarding mental health, would suggest that community nurses need to raise the issue of mental health with people who use services by asking direct questions using familiar language rather than language or jargon often used by healthcare professionals. A further qualitative study undertaken in Sweden interviewed ($n = 25$) district nurses who felt that mental health promotion and the management of mental health difficulties were important. However, the study identified that in practice, the district nurses did not include mental health promotion within care plans and that collaboration with other services was key in achieving this (Grundberg et al., 2016).

For community nurses working in partnership with people with long-term conditions, consideration of the individual as a whole person, including their social and psychological circumstances, along with history taking, will strengthen the ability to appropriately diagnose depression. Recognition of depression and an understanding of its diagnostic system enables community nurses to address the situation, and, if necessary, refer on to the GP or mental health service. Diagnosis of depression requires consideration of three areas: severity, duration and course (NICE, 2022). In practice, some of the symptoms of a long-term condition and depression, such as fatigue, can be present in both illnesses (Box 10.1). Therefore, it is important to rule out any physiological cause before diagnosing depression.

For the purposes of this chapter, the National Institute for Health and Care Excellence (NICE, 2022) Depression in Adults: Treatment and Management NICE NG 2022 have been referred to as the evidence base is more recent and up to date. NICE also published its 2009 guideline on depression in adults with a long-term physical health problem: recognition and management which should be referred to. What is important to remember is that when working with people with long-term physical health problems and depression the nurse will need to "consider the role of both the long-term physical health problem and any prescribed medication in the development or maintenance of the depression" (NICE, 2009, p.20). Moreover, the nurse will need to "ascertain that the optimal treatment for the physical health problem is being provided and

Box 10.1 Depression definitions

The severity of depression exists along a continuum and includes the following:

- Symptoms which may vary in frequency and severity
- The duration of the depression
- The impact that depression has on personal and social functioning

Traditionally, depression severity has been grouped under four categories (subthreshold, mild, moderate, severe). However, in the recent NICE (2022) guidelines for depression in adults, treatment and management and new episodes of depression are defined as less severe or more severe.

Less severe depression encompasses subthreshold and mild depression, scoring less than 16 on the Patient Health Questionnaire (PHQ)-9 scale.

More severe depression encompasses moderate and severe depression and is defined as depression scoring 16 or more on the PHQ-9 scale.

Source: NICE (2022)

adhered to, seeking specialist advice if necessary" (NICE, 2009, p.20), as not receiving the right treatment for the physical health problem may cause, impact or exacerbate depression.

Community nurses can utilise two focused questions often referred to as the Whooley questions (Whooley et al., 1997), set out in the NICE (2022) guidelines when they suspect that the individual with whom they are working may have depression (Table 10.4).

One of the challenges of identifying and managing depression in people living with a long-term condition is the complexity of symptoms that could be related to the long-term physical health condition or depression. For example, sleep disturbances, weight gain or loss, fatigue and reduced appetite are symptoms that can indicate a physical health difficulty or depression. Therefore, and as mentioned earlier, before diagnosing depression it is vital for the community nurse to assess which symptoms may be caused by the physical health long-term condition and which may be caused by the depression. The signs and symptoms of depression can be found in Box 10.2.

Table 10.4 Whooley questions

1	During the last month, have you been bothered by feeling down, depressed or hopeless?
2	During the last month, have you been bothered by having little interest in doing things?

Source: Whooley et al. (1997), NICE (2022).

Box 10.2 Signs and symptoms of depression

In ICD-11, depression is defined as the presence of depressed mood or diminished interest in activities occurring most of the day, nearly every day, for at least 2 weeks, accompanied by other symptoms such as the following:

- Reduced ability to concentrate and sustain attention or marked indecisiveness
- Beliefs of low self-worth or excessive or inappropriate guilt
- Hopelessness about the future
- Recurrent thoughts of death or suicidal ideation or evidence of attempted suicide
- Significantly disrupted sleep or excessive sleep
- Significant changes in appetite or weight
- Psychomotor agitation or retardation
- Reduced energy or fatigue

In the *DSM*-5, depression is defined as the presence of five or more symptoms from a list of nine symptoms, during the same 2-week period and where at least one of the symptoms is depressed mood or loss of interest or pleasure, most of the day, nearly every day. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

The nine symptoms are the following:

- Depressed mood – indicated by subjective report or observation by others
- Loss of interest or pleasure in almost all activities – indicated by subjective report or observation by others
- Significant (more than 5% in a month) unintentional weight loss or gain or decrease or increase in appetite
- Sleep disturbance (insomnia or hypersomnia)
- Psychomotor changes (agitation or retardation) severe enough to be observable by others
- Tiredness, fatigue or low energy, or decreased efficiency with which routine tasks are completed
- A sense of worthlessness or excessive, inappropriate, or delusional guilt (not merely self-reproach or guilt about being sick)
- Impaired ability to think, concentrate or make decisions – indicated by subjective report or observation by others
- Recurrent thoughts of death (not just fear of dying), suicidal ideation or suicide attempts.

(*WHO, 2022b; American Psychiatric Association, 2013*)

The community nurse may not have specialist mental health skills and knowledge but is likely to know the individual circumstances of the person and their family and is well placed to undertake an initial assessment and identify the level of need. An understanding of the NICE guidelines along with the ICD-11 and *DSM-5* definitions for depression will enable the community nurse to identify co-morbid depression and refer the person living with a long-term condition to specialist mental health services, if appropriate (NICE, 2022, 2009). Community nurses can begin by asking the two Whooley depression-focused questions discussed earlier when they suspect that the individual with whom they are working may have depression (NICE, 2022). If the person answers 'yes' to either of these questions this could trigger a more comprehensive assessment using tools such as the Patient Health Questionnaire (PHQ)- 9 (Figure 10.1; Kroenke et al., 2001). It is important to remember that the NMC Code requires community nurses to work within their scope of practice and recognise and work within the limits of their competency (NMC, 2018b, p. 15)

APPENDIX

Nine-symptom Checklist

Name_____ Date _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: Total Score _____ = _____ + _____+ _____)

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at *rls8@columbia.edu.* PRIME-MD is a trademark of Pfizer Inc. Copyright 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Figure 10.1 PHQ 9 symptom checklist.

When considering common mental health problems such as depression it is also important to consider anxiety disorders as these two disorders often coexist in people with long-term conditions. The guidelines for *Common Mental Health Problems: Identification and Pathways to Care* (NICE, 2011) highlight that clinicians need to be alert to the possibility of an anxiety disorder. Assessment informs the next steps which may include referral to mental health services. Community nurses can utilise two focused questions, set out in the Generalised Anxiety Disorder 2 Scale (GAD-2; Kroenke et al., 2007) if they suspect that the individual with whom they are working may be experiencing an anxiety disorder (Box 10.3).

Box 10.3 GAD-2 questions

- Over the last 2 weeks, how often have you been bothered by the following problems?
  - Feeling nervous, anxious, or on edge - (Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3)
  - Not being able to stop or control worrying - (Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3)

If the person scores 3 or more on the GAD-2 scale, consider an anxiety disorder and follow NICE (2011) recommendations for assessment. However, even if the person scores less, this does not mean the absence of anxiety. In this case, consider asking:

- Do you find yourself avoiding places or activities and does this cause you problems?

If the person answers 'yes' consider assessing or referring for further assessment

Source: NICE (2011)

As with depression, for community nurses working in partnership with people with long-term conditions, consideration of the individual as a whole person, including their social and psychological circumstances and history will strengthen the ability to appropriately diagnose anxiety. The recognition of anxiety and an understanding of the diagnostic system enables the community nurses to address the situation and, if necessary, refer on to general practice or an appropriate mental health service (Box 10.4). Community nurses working with a range of health and social care professionals have a good understanding of local NHS and third-sector services. When considering referrals to other services it is important to consider all options, for example, the potential of social prescribing and linking informal carers with community resources, such as Tai Chi classes, to improve their wellbeing (Richardson et al., 2023).

Box 10.4 Signs and symptoms of anxiety

- The ICD-11 groups anxiety- or fear-related disorders into eight categories: Generalised Anxiety Disorder, Panic Disorder, Agoraphobia, Specific Phobia, Social Anxiety Disorder, Separation Anxiety Disorder, Selective Mutism, Other Specified Anxiety or Fear-Related Disorders.

The following is a summary of some of the main signs and symptoms of Generalised Anxiety Disorder and Panic Disorder which are most commonly diagnosed:

Generalised Anxiety Disorder:

- General apprehensiveness or worry
- Muscle tension or motor restlessness
- Sympathetic autonomic overactivity as evidenced by frequent gastrointestinal symptoms such as nausea and/or abdominal distress, heart palpitations, sweating, trembling, shaking and/or dry mouth
- Subjective experience of nervousness, restlessness or being 'on edge'
- Difficulty concentrating
- Irritability
- Sleep disturbances (difficulty falling or staying asleep or restless, unsatisfying sleep)

Panic Disorder:

- Recurrent panic attacks, which are discrete episodes of intense fear or apprehension characterised by the rapid and concurrent onset of several characteristic symptoms. These symptoms may include, but are not limited to, the following:
  - Palpitations or increased heart rate
  - Sweating
  - Trembling
  - Sensations of shortness of breath
  - Feelings of choking
  - Chest pain
  - Nausea or abdominal distress
  - Feelings of dizziness or light-headedness
  - Chills or hot flushes
  - Tingling or lack of sensation in extremities (i.e., paraesthesias)
  - Depersonalisation or derealisation
  - Fear of losing control or going mad
  - Fear of imminent death

As with depression, some of the symptoms of anxiety, particularly panic attacks, can be similar to those seen in many physical health conditions. Therefore, it is important to rule out any physiological cause before diagnosing anxiety.

Source: World Health Organisation (2022b)

ACTIVITY 10.2

Having examined the ICD-11 and *DSM*-5 definitions of depression and anxiety along with the list of signs and symptoms, take some time to review the assessment and care of the two people who use the services you identified in Activity 8.1. How could the NICE guidelines from 2009, 2011 and 2022 support assessment and decision-making in each case?

MENTAL HEALTH CONDITIONS ACROSS THE LIFESPAN

While depression and anxiety are often experienced by people living with a long-term condition it is also likely that community nurses will be involved in working with individuals with other mental health conditions which impact people across the life span such as self-harm or eating disorders in children and young people (CYP), post-natal depression in women or dementia in older people. According to Kesseler et al. (2005), half of mental disorders will start to develop by the age of 14, with 1 in 5 CYP aged between 8 and 25 having a probable mental health disorder (NHS Digital, 2023). A recent report by NHS Digital (2023) which surveyed 2370 CYP found that those aged between 8 to 24 with a probable mental health disorder were more likely to self-harm with rates of self-harm increasing from the ages of 17 to 24. Self-harming behaviours increase the risk of suicide in children and adolescents (Hawton et al., 2012), with sexual and gender minority adolescents having high rates of self-harm and attempted suicide (Litvin et al., 2020; Stonewall, 2017). The survey highlights that eating disorders were also common in CYP with 12.5% of 17- to 19-year-olds identified as having an eating disorder and rates in young women were four times higher than in young men. CYP with probable mental health disorders were also less likely to exercise, spend time in green spaces and take part in groups or clubs. These CYP were more likely to feel unsafe at school or enjoy learning. They often experience bullying either in person or online and come from households with financial worries. Within this context, the NHS Long Term Plan (2019) has committed to providing mental health support in schools and colleges for CYP with a focus on identification, early intervention and ongoing help. Interestingly, young people are also identifying climate change as another source of worry which highlights how current world problems may impact the mental health of young people. Although it is not within the scope of this chapter to discuss mental health interventions for CYP, it is important for community nurses to be aware of some of the mental health difficulties affecting CYP when working in community settings.

The NHS Long Term Plan (NHS England, 2019) highlights that during pregnancy and the first 24 months after giving birth, one in four women will experience mental health problems. The plan calls for increased access to evidence-based care for women with perinatal mental health difficulties, with access to specialist perinatal mental health services delivering evidence-based psychological therapies. The role of the community nurse may be in identifying

initial mental health issues during the perinatal period, supporting families and/or referring on to specialist perinatal mental health services. Often the community nurse will need to work collaboratively with mental health services in supporting the parent–infant, couple, co-parents or family during this period. According to Howard et al. (2018) when assessing depression in early pregnancy, the 10-item Edinburgh Post-Natal Depression Scale (EPDS) is better at identifying depression than the two-item Whooley questions discussed earlier. However, the specificity of both tools is high, and therefore, the difference in diagnostic accuracy is not large. Howard et al. (2018) support the use of either instrument in routine practice. In their study, they suggest that during early pregnancy, in environments where face-to-face questions can be asked as part of a general health discussion, a positive response to the Whooley questions may suggest that a woman may have a mental health disorder (not only depression). This highlights the usefulness of the Whooley questions in identifying various mental health issues and in allowing for further clinical assessment of mental health problems or onward referral to specialist services.

The National Dementia Strategy for England and Northern Ireland (Department of Health, 2008) identified that assessment and diagnosis are the 'gateway to care'. In 2022, the Health and Social Care Secretary for the UK announced that a new 10-year plan would be published focusing on dementia. However, a decision was later made that dementia would be considered within a new major conditions strategy (Department of Health and Social Care 2023), indicating a shift to integrated whole-person care. While England no longer has a specific dementia strategy, dementia is named as one of the six major conditions. Dementia in Scotland: Everyone's Story (The Scottish Government, 2023) sets out the need to provide person-centred care with a focus on 'doing with' individuals and care partners rather than 'doing to'. Dementia in Scotland: Everyone's Story also acknowledges the need to recognise that a diagnosis of dementia can also have an impact on mental health and wellbeing of not only the individual but also their care partner, family and friends. The Welsh Government Dementia Action Plan (2021) published in response to the COVID-19 pandemic also sets out the importance of the multidisciplinary team in providing person-centred care with 'teams around the individual'. Community nurses are well placed to support individuals experiencing memory problems to access services in order to be assessed for a possible diagnosis of dementia and support the individual to express their preferences for support and care.

Early identification of dementia can be challenging as the symptoms may overlap with those of depression and delirium. The use of a recognised assessment tool can enable the community nurse to identify where there may be changes in cognition in order to refer to the GP for further investigation. Knott and Willacy (2022) identify the importance of cognitive and mental state examination alongside history taking, physical examination, medication review and any other appropriate investigations. Cognitive and mental state examination

can be undertaken using a range of tools including the Abbreviated Mental Test (AMT), the Mini Mental State Examination (MMSE) and the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) which utilises a range of activities, including history taking, physical examination, medication review and cognitive and mental state examination (Knott and Willacy, 2022).

ACTIVITY 10.3

Access the IQCODE (Knott and Willacy, 2022). Consider how this would support the community nurse team to facilitate appropriate and timely referral to specialist services.

When working with individuals who have dementia and their families it is important to ensure that the care is person-centred. Watson (2019) explored the interactions between residents living in a care home for people living with dementia and their care staff. The research was underpinned by ethnography with Watson working, in part, as a care assistant. The research used the Senses Framework (Nolan et al., 2006) which proposes that person-centred care requires everyone, the individual, family carers and paid carers to experience the various aspects of the Senses Framework. For example, everyone needs to feel a sense of security and belonging (Figure 10.2). Watson (2019) identified that people living with advanced dementia continue to be present and interact with those caring for them. For example, the importance of two-way interaction between people living with dementia and carers as well as responding to their distress may provide a sense of security and belonging. The Senses Framework can support person-centred care providing guidance for people with dementia and staff at an individual and organisational level in the community. For example, John's campaign, supported by Age UK, highlights the importance of ensuring informal carers are involved in care when someone living with dementia is admitted to hospital.

When there is concern about an individual's ability to make decisions about their own treatment and healthcare, perhaps as a result of Alzheimer's or

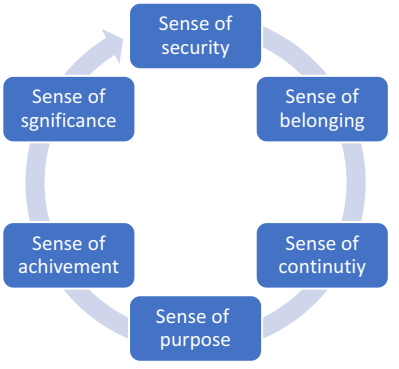


Figure 10.2 Development of the Senses Framework (Watson, 2019, Nolan et al., 2006).

another form of dementia, community nurses must consider if the individual has the capacity for decision-making. Various legislation addresses capacity across the four countries of the UK: Adults with Incapacity (Scotland) Act 2000 (AWIA), the Mental Capacity Act (MCA, 05) for England and Wales and the Mental Capacity Act (Northern Ireland) 2016. The Acts are similar in supporting the rights of individuals who lack capacity setting out principles which enable substitute decision-making on behalf of the individual and in their best interest (Wilson, 2017). These principles include the assumption that an individual has capacity until proved otherwise, all practicable steps must be taken to support the individual with decision-making before lack of capacity is considered and any decision taken on behalf of someone who lacks capacity must be in that person's best interest.

MENTAL HEALTH INTERVENTIONS

Having asked about mental health and assessed the person's needs, community nurses need to engage in the management of mental health difficulties, for example depression and anxiety. It is important that the management of mental health difficulties is undertaken by an appropriately skilled healthcare professional. If the individual with whom the community nurse is working in partnership requires general advice and monitoring or more active treatment in primary care, there are a number of possible treatment options available which are discussed next.

Pharmacological treatment for depression in people with one or more long-term conditions is not necessarily the first treatment of choice. For example, people with long-term obstructive pulmonary disease and depression can benefit from education about long-term pulmonary disease as well as mechanisms to help them cope with anxiety and depression (Heslop, 2014). This, in turn, increases the individual's ability to exercise choice and self-manage their care; furthermore, cognitive behavioural therapy and counselling are treatment options that can be used in conjunction with education (Heslop, 2014). The risk of morbidity and mortality is increased for people with Type 2 diabetes who have depression; furthermore, poor diabetes control exacerbates the symptoms of depression (The Academy of Medical Sciences, 2018). The use of cognitive behavioural therapy (CBT) can be effective both in the management of some long-term conditions, for example diabetes, and diabetes-related stress. A systematic review with metanalysis including 22 randomised control trials found that CBT significantly reduced diabetes-related distress and depression. Third-wave CBT (Box 10.5) for diabetes-related distress was found to help with anxiety (Jenkinson et al., 2022). The range of evidence-based options and indications for the treatment of anxiety and depression are provided in Box 10.6 and Table 10.5 – bearing in mind that referral to specialist mental health services will need to be considered by the community nurse for individuals who have an inadequate response to treatment or more severe forms of anxiety and depression.

Table 10.5 The stepped-care model for Generalised Anxiety Disorder (NICE, 2011)

Focus of the intervention	Nature of the intervention
STEP 4: Complex treatment-refractory generalised anxiety disorder (GAD) and very marked functional impairment, such as self-neglect or a high risk of self-harm	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care
STEP 3: GAD with an inadequate response to step 2 interventions or marked functional impairment	Choice of a high-intensity psychological intervention (CBT/applied relaxation) or a drug treatment
STEP 2: Diagnosed GAD that has not improved after education and active monitoring in primary care	Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups
STEP 1: All known and suspected presentations of GAD	Identification and assessment; education about GAD and treatment options; active monitoring

Box 10.5 CBT – an explanation

CBT focuses on how maladaptive thinking can influence our emotion and behaviours. Third-wave CBT does not just focus on maladaptive thinking but on the person's relationship to thoughts and emotions. The focus shifts away from what we think and feel, as in classic CBT, to how we relate to what we think and feel. Third-wave CBT utilises therapeutic approaches such as mindfulness, visualisation, acceptance, personal values, self-awareness and metacognition.

Box 10.6

The stepped-care model listed in Table 10.5 is also used for depression in the NICE guidelines for Common Mental Health Problems: Identification and Pathways to Care (NICE, 2011) *and* Depression in Adults with a Long-Term Physical Health Problem (NICE, 2009). *However, the more recent guidance on depression published by* NICE (2022) *moves away from the stepped model of care and lists recommended treatments for less severe and more severe depression.*

First-line treatment for less severe depression:

(Listed in order of clinical and cost-effectiveness, with considerations of implementation factors)

- Guided self-help
- Group CBT
- Group behavioural activation
- Individual CBT
- Individual behavioural activation
- Group exercise
- Group mindfulness and meditation
- Interpersonal psychotherapy
- SSRI antidepressants
- Counselling
- Short-term psychodynamic psychotherapy

First-line treatment for more severe depression:

(Listed in order of clinical and cost-effectiveness, with considerations of implementation factors)

- Individual CBT and antidepressants
- Individual CBT
- Individual behavioural activation
- Antidepressant medication
- Individual problem-solving
- Counselling
- Short-term psychodynamic psychotherapy
- Interpersonal psychotherapy
- Guided self-help
- Group exercise

Source: Taken from Depression in adults: treatment and management NICE NG 222. For more information, see National Institute for Health and Care Excellence (2022) Depression in Adults: Treatment and Management NICE NG 222

Motivational interviewing is another approach to working with people who wish to do something different to improve their health (Ryrie, 2018a). Central to motivational interviewing is the philosophy that underpins the approach of healthcare practitioners as they engage in discussion with individuals. The approach is collaborative, evocative and honours the person's autonomy (Rollnick et al., 2008). Change regarding health can only be actioned by the individual and taking this into consideration, it is important that partnership working between the community nurse and people who use services is collaborative and decisions are made jointly. When utilising motivational interviewing skills, the community nurse should draw out, evoke, the person's reasons for change, thus identifying the motivators for making a change. Mindful of the fact that only the person can make a change, it is important that the community nurse respects their autonomy (Ryrie, 2018a). The philosophy of

motivational interviewing is reflected in the principles which have been arranged into the acronym RULE: resist the righting reflex, understand the motivations of the individual, listen to the person and empower them (Box 10.7; Rollnick et al., 2008).

Box 10.7 RULE

Resisting the righting reflex
Understanding the motivations of the person
Listen to the person
Empower the person

Rollnick et al., 2008

Whilst applying the RULE principles, the core skills of motivational interviewing are asking, listening and informing. These are within the repertoire of expert communication skills utilised by community nurses. Open questions can be used to ask about any challenges and gain a shared understanding of the situation to identify the motivation for change. This could be explored further by asking what is good and what is not so good about the situation. If there is to be a shared understanding it is important that the community nurse is actively engaged in reflective listening (Miller and Rollnick, 2002). By effectively listening it may be possible to identify how the person is talking about change. Rollnick et al. (2008) identify six types of change talk which indicate consideration by the individual of wanting to make a change (Table 10.6) which

Table 10.6 Types of change talk

Type	Statements about	Examples
Desire	Inclination for change; for example, I want, wish, like to	I want to exercise more
Ability	About capability; for example, I could, can, might be able to	I could include exercise in my daily routine
Reasons	Explicit reasons for change; for example, I would probably feel better if	I would feel better if I exercised outdoors
Need	Obliged to change, for example, I must, should	I have got to reduce my weight to help with my diabetes
Commitment	Probability of change, for example, I am going to, I will	I will go for a 15 minute walk every day
Taking steps	Action taken; for example, I tried., I have…	I have stopped using the lift and climb the two flights of stairs to the flat now

Source: Ryrie (2018a: 545).

includes examples of types of change talk. The first four types of change talk (Desire, Ability, Reasons & Need) indicate that the person is contemplating change, whilst the last two (Commitment & Taking Steps) indicate determination and action to achieve change. Change talk is underpinned by Prochaska and DiClemente's (1986) Cycle of Change Model. Alongside asking open questions and listening reflectively, the third core skill of motivational interviewing is informing; sharing information with the individual about the situation they finds themselves in, which needs to be balanced with asking and listening. If too much information is conveyed, the person may become resistant to the discussion (Ryrie, 2018a).

Motivational interviewing can also be used effectively to help people with a long-term condition self-care. In a recently reported study across 16 primary care centres it was found that motivational interviewing provides a person-centred approach that improved older people's medication adherence (Moral et al., 2015).

Another effective therapeutic strategy that can be used by community nurses is solution-focused therapy. Solution-focused therapy is a form of brief therapy that considers the present time for the individual and focuses on specific goals that can be reached (Ryrie, 2018b). This works by enabling people to identify how they want to be different and the strengths the individual has that can be utilised to achieve the goal. Solution-focused therapy is underpinned by the view that people are unable to move forward due to focusing on the challenges of living with a long-term condition, rather than focusing on the solutions to living well with a long-term condition. By focusing on possible solutions community nurses can empower people living with a long-term condition (Webster, 2009). Solution-focused therapy is one example of an approach to behaviour change utilising a strength-based approach as set out in platform two of the Future Nurse Standards of Proficiency for Registered Nurses (NMC, 2018a) which focuses on promoting health and preventing ill health. The types of questions that can lead to considering solutions rather than focusing on the problem are set out in Table 10.7.

The use of questions to support people to change enables individuals to identify when they have been able to overcome the problem and to utilise the

Table 10.7 Solution versus problem discourse

Solution discourse	Problem discourse
What would you like to change?	How can I help you?
Can we discover exceptions to the problem?	Can you tell me more about the problem?
What will the future look like without the problem?	How has this problem arisen in light of your past?

Source: Ryrie I (2018b) In Norman I and Ryrie I (eds) *The Art and Science of Mental Health Nursing Principles and Practice*, 4th edn. Maidenhead: Open University Press, p. 532.

resources, both social and personal, that are linked to previous experiences of when they overcame a problem. This enables the person to imagine a future without the problem and identify the small steps required to change the situation (Ryrie, 2018b). This is described as a forward-looking process that empowers people without becoming trapped within the problem (De Shazer, 1985). While this section of the chapter has briefly explored two possible approaches that can be used to work in partnership with people and their carers, it is important to acknowledge that the community nurse may at times need to refer to, and work collaboratively with, specialist mental health services. This would include occasions when the person has not responded to treatment for mild to moderate depression or has severe and complex depression or anxiety.

COLLABORATIVE WORKING

Changes in service delivery provide an opportunity for further developing integrated working between community nurses involved in working with individuals with long-term conditions and mental health staff. In order to deliver effective care for people with long-term conditions, effective multidisciplinary team working is key. Working with individuals to provide person-centred care requires the expertise and competence of a range of healthcare professionals with a focus on the impact of the long-term condition on the individual. For example, long-term obstructive pulmonary disease requires the identification and management of depression and anxiety, alongside advice regarding relaxation techniques (NICE, 2010).

ACTIVITY 10.4

Take some time to review depression in adults with a long-term physical health problem NICE CG91. You may find it helpful to discuss the role of the community nurse in managing a person's mental health difficulties at a team meeting.

- How does the team view their role in terms of depression in long-term condition care?
- Is there collaboration with the wider healthcare team, especially the GP?
- What processes support effective working between the primary healthcare team, mental health professionals and other statutory and non-statutory agencies?

Integrating physical and mental healthcare is more effective than focusing on mental health and physical health as two separate areas of care. Integration of physical and mental healthcare can result in a reduction of service use with the concomitant improvement of physical and mental health. Collaborative care is one way in which people with a long-term condition and depression can benefit from equal consideration of physical and mental health difficulties. Collaborative care requires a multi-professional approach to care with the use

of structured management plans. This is further supported by scheduled follow-up and effective interprofessional communication (Gunn et al., 2006). Inevitably an understanding of signs and symptoms, assessment tools and clinical guidelines for mental health difficulties experienced by people living with a long-term condition, will enhance interprofessional communication and access to specialist mental health services. A qualitative evaluation of multi-professional care for people with long-term conditions and depression found that case managers, practice nurses and GPs working collaboratively improved the coordination of physical and mental healthcare for those involved. This resulted in increased confidence in managing the care for individuals with complex physical and mental health needs. People using services reported that the collaborative approach enabled them to access mental healthcare that they had previously been unable to access as physical health needs had been prioritised (Knowles et al., 2015).

ACTIVITY 10.5

Reflection Point

Scenario

Emily Hobbs is 68 years old and was referred to the community nursing team by her GP following a home visit. Emily had developed a sacral pressure ulcer. The community nursing team has been visiting for 4 weeks to dress the Grade 3 pressure ulcer and has referred Emily for an assessment by the occupational therapist. The initial assessment identified that Emily has been finding it more and more difficult to manage activities of daily living because of an exacerbation in her long-term obstructive pulmonary disease (COPD). Over the 4 weeks, it has been noted that Emily is increasingly reluctant to make eye contact and appears sad and tearful when any of the nurses visit. When asked, she is not sleeping well; she complains of feeling tired and lacking energy and appears as if she may have lost some weight.

Reflection

Take some time to consider what aspects the community nurse should consider and what steps could be taken for Emily.

There are several factors that you may have identified when considering Emily and her care. It may be that prior to the exacerbation of her COPD she was able to get out and manage fairly independently. The deterioration of her COPD and the consequent reduced mobility may have resulted in a reduction in autonomy and feeling of helplessness. These are two of the factors that Keyes (2002) identified as fostering psychological wellbeing. According to the International Classification of Diseases 11th Revision, feeling sad, lacking energy, not sleeping well and weight loss are four signs and symptoms of depression (WHO, 2022b). The community nurse should ask Emily the two Whooley questions (Whooley et al., 1997; NICE, 2022).

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

It is important that depression is considered, and action taken when Emily is exhibiting subthreshold depressive symptoms to prevent further deterioration. The NICE (2009) stepped-care model identifies that the community nurse should undertake an assessment and active monitoring and consider referral for further assessment and interventions. For Emily solution-focused therapy could be a useful tool to support Emily to adapt her lifestyle in response to her COPD. Also consider assessment and interventions for less severe depression as outlined in the NICE (2022) guidelines which conceptualises depression as less severe or more severe and offers interventions for each of these criteria, rather than a stepped model of care.

CONCLUSION

This chapter has highlighted that there is a strong relationship between physical and mental health. To deliver effective quality care to people in their own home community nurses need an awareness of how mental health difficulties may present in order to assess, intervene or signpost to appropriate services, as well as facilitate referral and access to mental health services. This chapter has provided an overview of the role of the community nurse in mental health identification and assessment and examined some mental health skills that can be used in practice by community nurses. It has also explored some possible mental health treatments and interventions which the community nurse can consider discussing with the individual prior to a referral. By developing an awareness of mental health issues that people with long-term conditions face, community nurses are better able to engage in effective interprofessional working, collaborative care and referral to specialist services to meet the needs of people with complex physical and mental health needs.

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CHAPTER 11

Informal carers: the unpaid workforce

Mark Millar and Sevim Kaya

LEARNING OUTCOMES

- Define what is meant by the term informal/unpaid carer in relation to children, young people, young adults and adults.
- Critically examine the role of carers within the current four countries and wider UK national health and social care policy context.
- Critically discuss some of the emotional, physical, financial and practical needs, rewards and associated risks of being a young or adult carer.
- Critically appraise the future challenges facing carers.

INTRODUCTION

The 2021 Census identified that there are approximately 4.7 million adults (7%) of the total UK population who provide informal and unpaid care and that 120,000 of these are aged 24 and younger (Office for National Statistics [ONS], 2023). It is estimated that together these carers save the UK economy £193 billion annually (Carers UK, 2022b), with further estimates suggesting that, at the height of the COVID-19 pandemic, carers were saving the UK government £530 million per day (Carers UK, 2020).

This chapter defines what is meant by the term carer in relation to children, young people, young adults and adults in the UK before examining the role of carers within the context of current UK national health and social care policy. The chapter further critically discusses some of the many emotional, physical, financial and practical needs and risks associated with being a young carer/carer. The final section of the chapter focuses on appraising the future challenges confronting carers in response to the socio-economic challenges and changes facing the UK.

WHO IS A 'CARER'?

Whilst there is some minor variation in the terminology used, the four countries of the United Kingdom (England, Northern Ireland, Scotland Wales) broadly concur that an informal 'carer' is a child, young person or adult who provides unpaid care to a partner, family member or a friend "who, due to

DOI: 10.4324/9781003347545-12

illness, disability, a mental health problem or an addiction, cannot cope without their support" (Carers Trust, 2022a, Department of Health, Social Services and Public Safety [Northern Ireland], 2006, National Health Service (NHS) England [NHSE], 2022, NHS Wales [NHSW], 2021, Scottish Government, 2021). Anyone can become a carer at differing stages during their lifetime and may, on occasion, care for multiple individuals concurrently; for example a mother who cares for their own parent(s) then later may become the carer for their partner's parents. It is however, acknowledged that the term *carer* is also often used to identify paid employees of either local authorities or private or charitable organisations that provide personal care and/or social care support for individuals either within their home or a residential care setting. This chapter, however, focuses only on the informal carer who is not paid for the care they provide.

UNITED KINGDOM CARER DEMOGRAPHY

The 2021 Census recorded 4.7 million unpaid carers in England, approximately 310,000 unpaid carers in Wales (Office for National Statistics, 2023) and 222,213 carers in Northern Ireland (Northern Ireland Statistics and Research Agency [NISRA], 2022). Additionally, the Scottish Carers Census 20-2021 identified there were 31,760 individual carers being supported by local services across Scotland (Scottish Government, 2021).

It has been reported that the proportion of females providing informal care is generally greater than males (Figure 11.1), particularly during middle age (45–64) when individuals are most likely to take on a caring role (Department for Work and Pensions [DWP], 2022). It is critical to note that an informal carer can themselves also have underlying health conditions with evidence suggesting that up to half of carers have a diagnosed long-term condition(s) (Scottish Government, 2021). A UK-wide report published by the Joseph Rowntree Foundation (2022) also found that carers are more likely to live in social deprivation with working-age carers more adversely affected than those of retirement age.

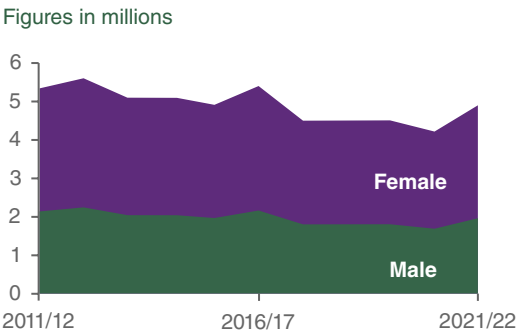


Figure 11.1 Informal carers in the UK (Department of Work and Pensions, 2023).
Source: Family Resources Survey 2021/22, Tables 5.1 and 5.3.

UNITED KINGDOM (ENGLAND, NORTHERN IRELAND, SCOTLAND, WALES) HEALTH AND SOCIAL CARE CARER POLICY

The current UK health and social care system relies on a combination of universal and means-tested benefits. Whilst healthcare services are predominantly provided free across the UK by the NHS, social care, which incorporates much of the care provided within the home or residential setting, is means tested with individuals having to contribute towards the cost of their care dependent on the total value of their estate and/or assets (Bom and Stöckel, 2021). When the total value of the estate depletes to an identified level, which is variable across the four countries, then care will be offered free. The responsibility for the assessment and provision of social care lies with local authorities or boroughs with much of the actual care provided by private organisations commissioned by the state.

Following the devolution agreements of 1999, the responsibility for health and social care is predominantly a devolved matter, with the accountability for healthcare provision held by either the Scottish or Welsh governments, the Northern Ireland Assembly or in the case of England responsibility has been primarily retained centrally by Westminster with the responsibility for the day-to-day operationalisation of the NHS delegated to NHS England centrally and the integrated care boards at a local level, with the exception of Greater Manchester, London and Cornwall, where there are additional devolution agreements in place (NHS England, 2023, Shuttleworth and Nicholson, 2020).

Regarding legislation/policy relating to carers specifically, the overarching Care Act published in 2014 places a duty on local authorities to provide care and support for adults who meet the eligibility criteria and additionally to meet a carer's needs for support as defined in the act; however, this only applies within England and Wales. Additional legislation also received royal ascent in 2023 "entitling an employee to be absent from work on leave under this section in order to provide or arrange care for a dependant with a long-term care need" (Carer's Leave Act, 2023). Additional publications add further information in relation to the support available to carers at a country level; NHS England published its 'Commitment to Carers' document (NHS England, 2014), and the Welsh government has also gone on to publish a further 'Strategy for Unpaid Carers', which outlines the national priorities for action in Wales (Welsh Government, 2021).

Comparatively, the Scottish Government published a specific Carers (Scotland) Act (2016) which provides additional provision for carers and young carers coordinated through an '*adult carer support plan*' or '*young carer statement*', the implementation of which is further elaborated upon in the National Carers Strategy (Scottish Government, 2021).

In Northern Ireland, whilst there have been no recent developments following the publications of the Carers and Direct Payments Act (Northern Ireland)

2002, it is anticipated that further policy will be published in response to the *A New Deal for Unpaid Carers in Northern Ireland* report published by a coalition of Carers Organisations highlighting the challenges faced by carers in Northern Ireland (Carers NI, 2023).

YOUNG CARERS

Current UK legislation defines a young carer as "a person aged under 18 years, who provides or intends to provide care for another person of any age (except where that care is provided for payment, pursuant to a contract or as voluntary work)" (Children and Families Act, 2014). However, several organisations working with young carers in the UK broaden the maximum age category and publish data which incorporates carers up to the age of 25 in some cases (Aldridge, 2018). As an example, Carers Trust define young adult carers as those aged 16–25 (Carers Trust, 2022b). From a legal perspective, it is, however, important to note that only those aged under 18 are legally protected and recognised as children (Aldridge, 2018). There are therefore major implications for policy development and the commissioning of services when considering those carers who are legally recognised as children and those young adult carers many of whom may still be in full-time education and yet are legally considered to be adults (Sprung and Laing, 2015).

Life for a young carer, caring alone, can be extremely isolating, troubling and stressful and this may be influenced by their life experience and maturity which can in turn have a negative impact both upon their life experiences and outcomes including their short-medium term education, and, in the longer-term, impact upon their employment opportunities and life chances (Scottish Government, 2017). Evidence has indicated that one in three young carers said that their caring role makes them feel stressed and further evidence suggested that 23% of young carers in the UK believed their caring role had stopped them from developing and maintaining friendships (Dharampal and Ani, 2020).

The Carers Trust (2016) identifies multiple studies that have indicated that young carers were considerably more likely to be bullied at school as opposed to those who were non care givers, with one study indicating that up to two thirds of young carers had been bullied at school (Carers Trust, 2016). In terms of school attendance, one in 20 young carers will be absent from school (Waters, 2019). The Carers Trust survey of 1109 Young Carers (2023) titled "*Being a Young Carer; It's Not a Choice: It's Just What We Do*" (2023) found that 33% of the young carers said they either always or usually struggle to balance their caring responsibility with their educational demands, and 40% of young carers reported that they never or do not often receive help balancing caring/educational requirements. Despite this,

research has indicated that parents reported that young carers were happy in school with good attendance and, in some cases, were performing above the average (Chesborough et al., 2017).

Young carers have also reported that they find caring very rewarding, bringing emotional and psychological benefits (Cheesborough et al., 2017); this is alongside other positive outcomes associated with caring, which include feeling a sense of maturity and having an opportunity to learn new skills which lead to a sense of preparedness for life. Taking on the carer role also provides a circumstance where it is possible to develop close and strong relationships with both the person being cared for as well as other family members (Gowen et al., 2021; Robison, Inglis and Egan, 2020).

ACTIVITY 11.1

Case Study

Natalie is a 45-year-old single mother who has one daughter, Lilly, aged 16, who is currently preparing to take her exams. Natalie was diagnosed with multiple sclerosis 10 years ago. Natalie's condition has deteriorated gradually, and she is no longer able to work and requires support with many activities of daily living. Natalie and Lilly live in a two-bedroom, housing association–owned ground-floor flat.

Lilly is regularly absent from school when her mother is unwell and does not want to be left alone. Lilly's teachers are concerned about the impact on Lilly of caring for her mother. Natalie currently has no health and/or social care package in place and is reliant on Lilly to provide her care.

The family has been referred to your community school nursing team for assessment.

- What assessments need to be carried out in this home?
- What support could be offered to Natalie and Lilly?
- What other agencies and organisations could be involved in this situation if appropriate?

ADULT CARERS

The UK Care Act (2014) identifies that a "Carer" is "*an adult who provides or intends to provide care for another adult (an "adult needing care")*". An adult in UK law is defined as an individual aged 18 and older. It is important to note that evidence suggests that women are more likely to provide informal care than men (Carers UK, 2023). However, men aged 75 years and older are more likely to provide informal care (Foley et al., 2022). A complete breakdown of informal carers by age and gender is presented in Figure 11.2.

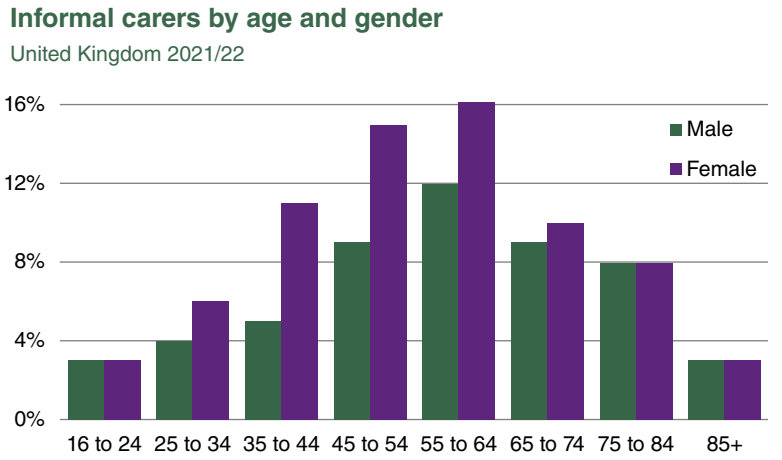


Figure 11.2 Informal carers by age and gender (Department of Work and Pensions, 2023).

Source: Family Resources Survey 2020/21, Tables 5.2.

ACTIVITY 11.2

Case Study

Adio and Lourdes have been married for 50 years and have two older children/grandchildren living and working abroad. Adio (80) and Lourdes (78) are both now retired; however, previously, Adio was an electrician and Lourdes a teacher. Adio was diagnosed with Alzheimer's disease 5 years ago and is no longer able to care for himself. Lourdes has become the main carer for Adio. The couple live alone in a two-bedroom terraced house.

Lourdes is now struggling to continue caring for her husband as his needs are increasing – he has become incontinent of urine, and he is becoming increasingly aggressive and, at times, can become violent towards her. The couple currently have no social care package in place and have been managing independently until this time.

The family has been referred to your community mental health nursing team for assessment.

- What assessments need to be carried out in this home?
- What support could be offered to Adio and Lourdes?
- What other agencies and organisations could be involved in this situation if appropriate?

THE EMOTIONAL IMPACT OF CARING

It has been identified that the demands of caring can cause carers increased levels of stress, which can subsequently impact a carer's mental health (George et al., 2020).

For young carers, studies have indicated that having to take on caring responsibilities whilst in childhood or adolescence can have significant adverse consequences for young carers' mental and psychosocial development (Casu et al., 2021). Studies have identified that, in comparison to their peers, young carers are more likely to report feelings of unhappiness, decreased self-esteem, sleep disturbance and depression (Janes et al., 2022, Robison et al., 2020). Caring has also been associated with increased levels of multiple mental health conditions, including stress, anxiety and depression and self harm with female young carers found to be at an increased risk including depression and self-harm; this is particularly concerning as it has been identified that mental health conditions that commence during adolescence are at an increased risk of continuing into adulthood (Casu et al., 2021, Janes et al., 2022). Young carers providing care for a specific individual or individuals with alcohol and/or substance misuse and mental health illness are also at an increased risk of experiencing a lower level of emotional connectedness with peers, teachers and affiliation with the wider educational environment, impacting their attendance and outcomes (Casu et al., 2021).

Similar equivalent studies considering adult carers have also identified that those carers who are living with higher levels of poverty and/or providing an intensive level of caring, particularly for those with complex neurological/mental health conditions, such as dementia, whilst not receiving adequate support and/or respite care, are at greater risk of developing depression (Cottagiri and Sykes, 2019). This has also been found to be more prominent in females and younger carers (Cottagiri and Sykes, 2019).

It has been identified that a combination of periods of elongated stress accompanied by increasing pressure to provide care whilst continuing to attend to other personal and/or employment responsibilities can result in a carer burning out, whereby the carer presents with a combination of physical, emotional and mental exhaustion (Cottagiri and Sykes, 2019). It is interesting to note that the evidence suggests that male carers are likely to have a greater level of satisfaction as they view the role from a stoical perspective whereas females feel under greater pressure to provide a very high standard and arguably unachievable standard of care (Cottagiri and Sykes, 2019).

As mentioned earlier, a few days of respite care can have immense benefits for the carer. Currently, in the UK, carers who access respite care will have a carer's assessment to ascertain if they need a break from caring. However, the evidence suggests that many carers have raised concerns regarding the variable standard of the respite services available, which has resulted in many carers feeling unable/unwilling to access these services for their loved one. Despite this, some other studies have shown that the majority of carers are willing to use and are generally satisfied with respite care, which has also been shown to reduce depression and stress levels while allowing them to recuperate physically as well (Cottagiri and Sykes, 2019).

Regarding prevention, it has been proposed that it would be advantageous to implement initiatives that highlight and raise the psychological impact of

caring upon those who are carers. A potential solution to this situation is to offer support groups at a local level that bring together carers in a forum-type environment where experiences can be shared and support offered (George et al., 2020).

THE PHYSICAL IMPACT OF CARING

Whilst the impact of caring on mental health has been arguably well researched, it is acknowledged that there has been significantly less research into the physical impact of caring (Cottagiri and Sykes, 2019). The "2022 State of Caring Report" (Carers UK, 2022b) completed by 13,400 carers reported that a fifth of carers identified that their physical health was bad or very bad. The report also identifies that whilst many carers are providing numerous hours of support to the person they care for (Figure 11.3), many carers report not being able to take regular breaks, and therefore, this results in tiredness and, in some cases, can lead to exhaustion and, in extreme cases, burnout (Carers UK, 2022a). This has been found to be more prominent in older carers who themselves experience the symptoms associated with long-term conditions, for example chronic pain which places them under increased pressure (Gérain and Zech, 2019).

As has been previously identified, caregiving can be stressful and, whilst it is acknowledged there are beneficial effects of stress involving the preservation of homeostasis, if not effectively identified and managed, exposure to high levels of prolonged stress can lead to the adoption of poor behaviours. These behaviours may include disturbed/reduced sleep patterns, smoking and poor diet, leading to varying medical conditions related to decreasing immunity and a greater risk of developing cardiovascular disease (Yaribeygi et al., 2017).

It is not surprising, given the nature of their lifestyle discussed, therefore, that carers find it challenging to maintain their health and wellbeing with many adopting poor health behaviours. For example, reports have indicated that carers are at an increased likelihood of delaying healthcare treatment, poor and disturbed sleep patterns and an irregular and imbalanced diet (Carers UK, 2023, Cottagiri and Sykes, 2019).

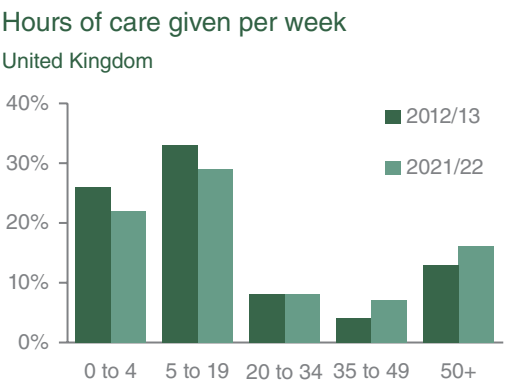


Figure 11.3 Hours of care given per week (Department of Work and Pensions, 2023).

The nature of caring therefore also places carers at an increased risk of developing musculoskeletal disorders. However, musculoskeletal disorders were found to be mainly dependent on the functional and cognitive characteristics of the person being cared for. The greater the physical dependency of the person being cared for, the greater the risk to the carer of developing musculoskeletal disorders, with the most frequently reported condition relating to back pain, shoulder pain and pain in muscles and joints similar to those involved in caring within professional settings (Cottagiri and Sykes, 2019). Similarly, carers who are exposed to extensive physical exertion over a protracted period can result in muscle strain, injuries to joints and skeletal systems, low back pain, joint pain arthritis, chronic pain and discomfort (Cottagiri and Sykes, 2019).

Evidence has shown, however, that where manual handling and mobility support equipment are available, this has reduced the physical exertion required by carers and increased the patient's independence. From a positive perspective, many carers have identified that they would be keen to participate in greater levels of physical activity to improve their health but have reported that they simply do not have the time to do so (Carers UK, 2022a).

From the specific perspective of young carers, it has been identified that young carers were at an increased risk of falling asleep during the school day with 12% of parents of 12- to 15-year-old carers identifying that they were aware their child had fallen asleep at school at least a few times in the preceding 12 months (Cheesbrough et al., 2017). Parents of young carers are also less likely to report that their child is in 'very good' health. This is particularly notable with parents of 5- to 11-year-olds, of whom only 49% of young carers were reported to be in 'very good' health compared to 66% of those in the comparison survey (Cheesbrough et al., 2017).

ACTIVITY 11.3

Case Study

Mehmet and Serap have been married for 10 years and have two children, a boy named Atlas aged 8 who has autism and a girl Alara aged 6. Serap was a highly successful investment banker in the city until 18 months ago when she developed Long Covid, having required an extensive admission to intensive care for COVID-19. Serap is no longer able to care for herself or the children, and Mehmet has become the main earner as well as carer for Serap and the children.

Mehmet is struggling to continue working whilst caring for his wife and children.

The family has been referred to your community nursing team for assessment.

- What assessments need to be carried out in this home?
- What support could be offered to Mehmet and the family?
- What other agencies and organisations could be involved in this situation if appropriate?

THE FINANCIAL IMPACT OF CARING

Becoming a carer can place individuals under considerable financial strain due to the high financial costs that are associated with caring (Cottagiri and Sykes, 2019). For over half of carers, it has been identified that their main source of income was earnings from employment. Remaining carers either relied on income from state or private pensions, while approximately 20% of carers drew most of their income from other benefits or tax credits (Carers UK, 2022a). The UK Poverty Report 2022 (Joseph Rowntree Foundation, 2022) found that informal carers are '*more likely*' to be living in poverty than those without caring responsibilities. Carers who are of working age are also at a higher risk of experiencing poverty than those in receipt of a pension. Those who have been caring for five years or more are also more likely to be in debt because of their elongated caring role (Carers UK, 2022a). Carers who spend more time caring have also been found to have higher poverty rates: with 44% of working-age adults caring for 35 or more hours a week identified as being in poverty compared to 17% for those caring for 20 hours or less a week (Department for Business, Energy & Industrial Strategy, 2021).

In the summer of 2023, individuals providing informal care in the UK for 35 hours and more became eligible (dependent on their circumstances) to receive a Carer's Allowance of up to £76.75 weekly (GOV.UK, 2023). In certain circumstances, carers may also be eligible to receive other benefits from the government. In Scotland, the Scottish Government also provide two additional supplementary payments totalling £541 annually (£10.40 weekly) to support carers receiving Carer's Allowance (MYGOV.SCOT, 2023).

Evidence indicates, however, that the 'cost-of-living' crisis experienced in the UK in 2022/23 had a significant impact on the finances of carers, forcing them to cut back on essential items such as utility bills, food and/or caring equipment (Carers UK, 2022a). A study by Carers UK (2022a) found that half (49%) of adult carers had a weekly disposable income (after taxes and benefits) of less than £300 per week.

THE PRACTICAL SUPPORT NEEDS OF CARERS

As previously acknowledged whilst many carers report that they find the role rewarding it has been acknowledged that there are practical matters that have to be addressed if carers are to feel supported to be able to continue to undertake this role over an extended period of time.

The "2022 State of Caring Report" (Carers UK, 2022a) found that 36% of the carers who replied said that "*not knowing what services were available was a barrier to accessing support*". This indicates that currently services are failing in their duty to ensure that carers are provided with the support they require.

It is critical that, when any health and/or social care professional identifies that an individual is undertaking an unpaid caring role, a 'Carer's Assessment'

is completed as per the legislation in force within that jurisdiction. The Health and Social Care system should also be adapted to support carers to navigate the complex nature of the differing health and social care systems, for example through the use of health checks and 'Carer Passports' to ease identification. It is essential that the system is reconfigured to enable carers to provide care without placing their own health in jeopardy (Carer Passport, 2023).

The provision of sitting, break and other day services alongside respite care, providing either home-based or residential care for short periods to enable carers to have a break both physically and mentally, is also essential (Cottagiri and Sykes, 2019). Research has, however, indicated that many carers do not use or have access to these services (Carers UK, 2022a). Carers living in rural areas in particular have highlighted in many cases that provision is much more limited or challenging to access due to geographical location and lack of availability (Carers UK, 2022a).

Carers have also identified that they would greatly benefit from access to support with navigating and completing official documentation. In response to this situation, there are many local charities who are supported by local government and healthcare services that have been established to offer carers information and advice, opportunities to access support and network and share experiences. Details of local charities providing these services across the UK can be accessed at https://carers.org/help-and-info/carer-services-near-you.

THE FUTURE OF CARING IN THE UNITED KINGDOM

On 5 May 2023, the World Health Organisation (WHO) declared an end to the COVID-19 pandemic as a public health emergency of international concern. In closing, the director-general stated, "*If we all go back to how things were before COVID-19, we will have failed to learn our lessons, and we will have failed future generations*" (World Health Organisation WHO, 2023). In the UK, the government has established an independent public inquiry to examine the UK's response to and impact of the COVID-19 Pandemic, and the Inquiry Team has announced that there will be dedicated 'modules' examining both the 'Care Sector' and 'Education, Children and Young Persons'. It is therefore anticipated that the impact of COVID-19 on carers will be considered (UK Covid-19 Inquiry, 2023). The final report is due to be published following the completion of the hearings in 2026. Interim reports are due to be published following the completion of each module and will be available from the Inquiries website https://covid19.public-inquiry.uk/ (Booth, 2023).

In the interim, the limited information that has been published indicates that the impact and ongoing legacy of the COVID-19 pandemic, alongside the cost-of-living crisis, has made the financial situation for those on lower incomes significantly more challenging (Carers UK, 2022a, Patrick et al., 2022). This is alongside the increased pressures on the education, health and social care

services leaving carers "*feeling lonely, isolated, undervalued, unrecognised*" and not receiving the critical support they require (Carers UK, 2022a).

Carers have also been left fearful that should a similar situation occur in the future, they could be separated from the individual(s) they care for, leaving them either isolated or left to die alone. This has resulted in carers failing to resume/engage with activities and support services (Muldrew and Fee, 2021).

CONCLUSION

This chapter has demonstrated the critically important and arguably highly undervalued role that unpaid carers have in supporting those living with long-term health and social care needs in our communities. It has also sought to demonstrate the significant value carers bring in terms of reducing the financial obligation that would otherwise be placed upon the NHS and wider health and social care and associated systems.

The chapter has also critically discussed and highlighted the positive and negative impacts on those young and adult carers in the short, medium and long term. Whilst it was acknowledged that taking on a carer role can be rewarding, it has also been proven that there are some situations where life opportunities can be significantly impacted by taking on a caring role. There has also been recognition of differing levels of limited support currently available across the UK. Further significant investment is required to meet the increasingly challenging and complex situations carers face, particularly in light of the ramifications of the cost-of-living crisis and the COVID-19 pandemic.

FURTHER RESOURCES

Carers Northern Ireland (NI) – https://www.carersuk.org/ni/
Carers Scotland – https://www.carersuk.org/scotland/
Carers UK – https://www.carersuk.org/
Carers Wales – https://www.carersuk.org/wales/
Carers Trust – https://carers.org/
Carers Trust Near You – https://carers.org/help-and-info/carer-services-near-you (provides access to a directory of local carer support and replacement care services available across the UK).
Department of Health Northern Ireland Carers – https://www.health-ni.gov.uk/articles/carers
GOV.UK Carers – https://www.gov.uk/browse/disabilities/carers
NHS England Carers – https://www.england.nhs.uk/category/carers/
Scottish Government Unpaid Carers – https://www.gov.scot/policies/social-care/unpaid-carers/
The Kings Fund Carers – https://www.kingsfund.org.uk/topics/carers
Welsh Government Strategy for Unpaid Carers – https://www.gov.wales/strategy-unpaid-carers-collection

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CHAPTER

12

Spirituality: its place in a holistic approach to care

Ann Clarridge and Alan Gibbon

LEARNING OUTCOMES

- Critically explore the concept of 'spirituality' and spiritual care within community nursing.
- Appraise the benefits of listening and reflection, drawing on the NAVVY tool as a basis.
- Describe the principles underpinning spiritual assessment and evaluate the associated tools and interventions available.
- Critically discuss how, as a community nurse, developing self-awareness can enhance spiritual assessment.

INTRODUCTION

This chapter is concerned with the concept of spirituality in the care provided by community nursing professionals. Reference is made to some of the relevant research and literary reviews which offer a useful context for this complex subject area. Some definitions of spirituality are outlined and the place of spirituality within community nursing is considered. The consequent implications in terms of spiritual assessment and possible interventions are discussed. The need for self-awareness and its development in nurses is explored. Finally, the competence of nurses to deal with the spiritual aspects of care is considered together with the importance of observational skills and communication, essential tools in the repertoire of all nursing professionals.

SPIRITUALITY

The place of spirituality in a holistic approach to care is no longer the neglected aspect of nursing that it was when discussed in the first edition of this book over 10 years ago. More recent literature acknowledges the undoubted importance of its role in an individual's care. The issue now is how the concept of spirituality might be incorporated into nursing practice and this in turn has implications for education and training.

A study undertaken by Cooper et al. (2021) referred to a growing body of evidence marking the positive effect of spirituality on health and wellbeing. In

DOI: 10.4324/9781003347545-13

the small-scale study by Schreiber et al. (2022) the value of spirituality was seen as one aspect of person-centred care and, as such, in a place equal to that of cultural, physical and mental health. Both studies referred to the value attributed by nurses not only to spirituality as one aspect of holistic care but also to their ability to support the spiritual needs of those for whom they care. However, Schreiber (2022) emphasised that such support should be at the instigation of the individual and should be given with due respect for the individual's spiritual beliefs. Recognition of an individual's spirituality was seen as positively affecting that person's spiritual resilience and consequent health and wellbeing (Koenig, 2020; Britt et al., 2022).

Further research referred to by Southard (2020) has shown that spiritual care when embedded within a holistic approach can enhance the development of resilience and the move to recovery. The COVID-19 pandemic with its time of great uncertainty resulted in experiences that can inform practice development in the future. (Koenig, 2020). It appeared that people with their own faith who were receiving person-centred care from committed nurses experienced positive benefits to their immune system and ultimate recovery.

A critical element of early research by the Royal College of Nursing (RCN; 2010) was nurses' perception of their ability to meet the spiritual needs of people. The majority of nurses confirmed that they were happy to listen to or simply be present with a person and refer specific needs to other appropriate professionals. Whilst the nurses who were aware of their own spirituality, values and beliefs felt confident in supporting the spiritual needs of the individual, there were those who expressed doubts as to their competence and felt the need for guidance. Research by Ross (2018) highlighted the importance felt by nurses of developing confidence in understanding what was meant by spirituality and having an awareness of their own spirituality.

In an exploration of nurses' communication skills, Minton et al. (2017) identified a positive effect of this knowledge and confidence on nurses' ability to communicate effectively and engage in meaningful interactions with carers and the individual requiring care who was nearing the end of life. Martins and Caldeira (2019) were also concerned with the need for nurses to have an awareness of their own spirituality, especially the ethical implications of offering spiritual support without imposing their own beliefs. At the same time, nurses needed to be aware that a lack in the guidance or training they had received could create an obstacle to the effective delivery of spiritual support.

The work of both Minton (2017) and Martins and Caldeira (2019) has served to underline the pressing need for nurses to acquire an understanding as well as the specific knowledge and skills associated with the provision of spiritual care. To this end, Rogers et al. (2020) presented a way of working designed to help nurses in their own self-development as practitioners which would further enhance the quality of holistic care. The focus was on nurses being available as needed and being able to admit to their own vulnerability.

A relationship could then develop between the nurse and the person requiring nursing care where shared humanity was a key component.

The value of a spiritual dimension in the provision of nursing care is no longer an issue. However, the complex nature of spiritual care referred to by Tavares (2022) can present serious obstacles to its inclusion in a holistic approach to a person's welfare. Lack of time and clear guidance when coupled with a lack of confidence add to the difficulty experienced by some nurses in the implementation of a spiritual aspect to caring practice. Schreiber (2022) noted that nurses in general practice welcomed the time needed to develop a therapeutic relationship with those living with long-term conditions. In contrast, some nurses, as noted by Bornet and Edelmann (2019), experienced misgivings when confronted with the prospect of serious and meaningful conversations with the individual.

Kelly and Swinton (2020) discussed the practice of reflection and self-awareness in educational programmes, a method developed and incorporated into the work of healthcare chaplains in Scotland, which is discussed later in this chapter. More recently, Britt et al. (2022) referred to the advantage of including such self-reflective and self-awareness techniques in the education and training of nurses. Furthermore, it was suggested that there should be a safe environment where nurses would have opportunities to practise those specific skills associated with empathetic and meaningful interaction that form part of a holistic approach to care.

The exploratory study by Prentis et al. (2014) into the understanding of spirituality by healthcare educators reported a positive response, with providers expressing a willingness to incorporate aspects of spirituality into their teaching curriculum. Following their investigation into the availability of nursing texts dealing with spirituality, Timmins et al. (2015) suggested that spirituality and spiritual care should be included in all key nursing textbooks rather than limited to specialist texts.

ACTIVITY 12.1

What are your thoughts on a nurse delivering spiritual care?
What barriers might there be for a nurse providing spiritual care?
Revisit this at the end of the chapter to see if there has been any change in your understanding.

DEFINING SPIRITUALITY

The concept of spiritual care is equivocal. In order to offer some insight into this complex area it is necessary to define spirituality and its role in nursing care.

Whilst definitions of spirituality are constantly under review much of what was revealed in earlier research continues to find resonance in more recent studies. In a literature review concerned with the practice of spiritual care,

Appleby et al. (2018) refer to the definition by Puchalski et al. (2009) and its use as a tool in their study. Cooper et al. (2021) found that a lack of clarity regarding the term *spirituality* as applied to its place in nursing care. The terms *spiritual* and *religious* are often used to mean the same thing. However, as indicated by Clarke (2009), not everyone would agree that an individual needs to be religious in order to be spiritual or vice versa, despite the overlap between the two concepts. Caldeira and Timmins (2017) reiterate the distinct differences outlined by Koenig (2007) in their definitions of religion as 'an organised system of beliefs, practices, rituals and symbols' and of spirituality as the personal quest for understanding answers to ultimate questions about life, meaning and a relationship to the sacred or transcendent. The latter may or may not lead to or arise from the development of religious rituals and the formation of community. It could be argued that humans find a way to relate to the sacred by the practice of their religion, that all humans have a spiritual dimension but not all humans practise religion (MacKinlay and Hudson 2008:140). Richie et al. (2018) concur with this differentiation in their definition of spirituality that does not have to include a religion.

'Spiritual but not religious' is a phrase that has been used by many people to express the belief that true spirituality is the concern of the individual (Sulmasy 2009), a view endorsed by Murgia et al. (2020) and cited in a later study by Cooper et al. (2021). Those who hold this view will affirm that a relationship with supernatural beings represents the foundation of happiness that will then form the basis of spiritual practice. Where there is no such belief, a different form of practice may provide a way to manage those thoughts and emotions which would prevent happiness.

The definition of spirituality in its application to nursing care lacks certainty. The study by Cooper et al. (2021) showed that the personal beliefs of some nurses shaped and defined their perception of spirituality. There was agreement regarding its personal nature but differences in the meanings used to refer to it. Nurses' understanding tended to be based initially on their own religious faiths, then on the outcome of discussions around physical and mental features and finally on feelings of empathy and compassion. Tavares (2022), when undertaking a concept analysis of 'spiritual comfort, spiritual support and spiritual care', found that most agreed on the broader implications of spirituality as a dimension of life compared with those who draw on their religious beliefs when defining spirituality (Cooper et al., 2021:2). Many techniques and practices have been explored and developed in religious contexts, such as meditation or contemplative reading, and have been proved to be immensely valuable as skills for managing aspects of the inner life (Koenig, 2020; Shreiber et al., 2022).

The collective view of recent literature is that spirituality would seem to refer to that universal characteristic by which individuals seek the purpose and meaning of their lives, their place in the environment, their relationship with others, with the natural world and with the sacred (Caldeira and Timmins, 2017; Cooper et al., 2021; Britt et al., 2022).

It would seem appropriate in the context of the present chapter to accept Chochinov's (2006) simple definition without necessarily invoking religion. Thus, spirituality may be understood to be the search for inner peace and the foundation of happiness which requires some form of spiritual practice which is essential for the promotion of personal wellbeing. Chochinov (2006) identifies a person who speaks of loss of hope, dignity and the will to live and feels spiritual distress.

A helpful way to understand the difference is that when applied to care, the term *spiritual care* is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation, whereas *religious care* is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community.

> Spiritual care is not necessarily religious.
> Religious care at its best, should always be spiritual
> (*National Education for Scotland 2021a:18*)

SPIRITUALITY AND COMMUNITY NURSING

Spirituality and all its associated vocabulary are terms much in vogue: they sound significant, with a touch of mystery. As with all jargon, however, it provides us with a language that enables us to think and talk about issues and concepts which are otherwise difficult to articulate. Individual spirituality as an important element in nursing practice is now being generally and officially recognised.

The demand for healthcare services to meet complex needs in the community is growing. The pressures are not lost on those working in the sector, and the Queen's Nursing Institute (2022) states that

> [a] growing and ageing population, deprivation, communication issues, social isolation, acuity, multimorbidity, 'rookie' factor (number of inexperienced staff), travel time, frailty, cognitive issues, lack of other services and lack of home support systems all affect the demand for healthcare delivery in the community.

Recent evidence from the work of spiritual care within a primary care setting has shown the benefits that it can have in reducing anxiety and helping people's self-management (Snowden, Gibbon and Grant 2018). Further to this, spiritual care can empower and benefit both carer and cared for, nurturing the individual to celebrate and flourish during times of joy and growth and supporting people to find strength and comfort during times of transition, uncertainty, and illness (Scottish Government, 2023).

The importance of addressing a person's spiritual needs with an emphasis on competence in spiritual care is highlighted within the professional requirements of nursing's regulatory body, the Nursing and Midwifery Council, such

Table 12.1 Parish Nursing

Parish nurses are registered nurses with a certificate in parish nursing, employed or working in a voluntary capacity for a church or Christian organisation. The focus of parish nursing is the promotion of health and wellbeing and the prevention or early detection of ill health. In not replicating statutory health services, parish nurses provide an additional layer of bespoke, evidence-based health advice and support to individuals and communities of all faiths or none. Parish nursing, therefore, maps to local population needs, the nurse's scope of practice and the vision of the employing organisation.
Intentional spiritual care is fundamental to parish nursing practice. Using a holistic understanding of health, parish nurses assess and plan support for those aspects of an individual's health needs that are important to the person, including spiritual needs. Effective preparation and support are essential to achieving good standards of practice. During the certificate in parish nursing, definitions of spiritual care are revised and spiritual care assessment tools and bespoke documentation proformas are studied. Once in parish nursing practice, ongoing professional and spiritual supervision is stipulated in recognition of the importance of supporting the nurses' own wellbeing and spiritual health when offering intentional spiritual care to others.

as *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives* (NMC, 2018); *Future Nurse: Standards of Proficiency for Registered Nurses* (2018); *Standards of Proficiency for Community Nursing Specialist Practice Qualifications (SPQ)* (2022); and *Standards of Proficiency for Specialist Community Public Health Nurses (SCPHN)* (2022).

Other forms of community nursing, such as parish nursing, place emphasis on the importance of the spiritual nature of care (Table 12.1).

Whilst the specialist work of parish nursing is to be celebrated, it is the duty of all to develop awareness and the necessary skills to support the delivery of spiritual care. In 2010, the RCN identified four key priorities one of which is the need 'through liaison and collaboration with the Nursing and Midwifery Council (NMC) and the government health departments to build on existing work and advance the area of spirituality within nursing and health care' (RCN, 2010:28). Health boards and government policies also support the importance of meeting the spiritual needs of people. The International Council of Nurses (ICN) specifies 'an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected' (ICN Code of Ethics, 2000:5). More recently, Barber (2022) affirmed these beliefs.

Community nurses would argue that holistic care of the individual and not just physical need has always been their concern. Indeed, their claim is justly supported by the plethora of nursing models of care. A holistic approach to care reflects the underlying principles and philosophy that all nurses draw upon to shape the way in which they act and carry out their nursing practice. Although

conceptual models of nursing differ quite significantly because nurses have different ideas about what nursing means for them, fundamental to most models is the person or the individual. Each model has something to say about a holistic approach, especially in the assessment for proposed care. It is here, within this area of the model, that the spiritual needs of the person can be addressed (Shreiber et al., 2022).

Research undertaken by Perry (2005) identified four areas that were of importance to nurses: 'affirming the value of the person, defending dignity, enabling hope and helping people find meaning' (Perry 2005 in McSherry and Ross, 2010:155). A recent study undertaken by Ross and McSherry (2020) endorses these values.

It is the experience of community nurses that, during challenging times, people turn to those who are caring for them for answers, help and support. Spiritual care may be said to be 'that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament or simply for a sensitive listener' (NHS Education for Scotland, 2009:6), a view endorsed by Minton et al. (2017). A key aspect of this is how people understand how they relate to the world around them, which can help them be aware of their own spiritual needs. In being aware of this for themselves, they become more self-aware, which helps them relate better to others. This is often described in therapeutic listening as the intentional use of self, which is best understood as the way in which the listener is aware and draws on their own feelings and experiences in a way that enhances the therapeutic process with the carer and the cared for. It is with this in mind that the skills of active listening can be seen to underpin effective spiritual care (Gibbon and Baldie, 2019).

LISTENING

At the heart of healthcare, there is an expectation that all staff, as part of their practice, take time to listen to the people that they are working with. (McKenna et al., 2020). More often than not, staff are under pressure, and therefore, they are not in a position to spend the time that they might like with people in that listening capacity (Snowden, Gibbon and Grant, 2018).

Listening is rightly perceived to be a fundamental part of care and when there is the time and space to listen it is noted to also enhance the quality of care that is given (Weiner and Schwartz, 2023). Studies have highlighted that there is sometimes a limited understanding of spiritual care among some staff groups (Booth and Kaylor, 2018), and it has often been said that there is a lack of knowledge or even interest in spiritual care. Indeed, there is evidence from within mental health practice that staff have often reported that conversations with people around spiritual care are counterproductive, even though people

themselves find it helpful (Shojaei et al., 2015). What is most interesting is that these concerns are not actually evidenced in reality (Shojaei et al., 2015). There is, at times, a real disconnect between the views of healthcare professionals (the carers) and people (the cared-for) over the place and value of spiritual care.

SUPPORTING SELF-REFLECTION (LISTENING TO YOURSELF)

Within the Scottish context, there has been the development of Values Based Reflective Practice (VBRP) in the last few years (Kennedy and Kennedy, 2022). VBRP is about the re-humanising of health and social care through the recovery of, and dialogue between, personal and organisational vocation (National Education for Scotland, 2021b). It is also about evaluating the ordinary everyday experience of providing care, enabling staff to reflect on the past (the care they have delivered), in the present, in order to ensure quality care in the future. A central part of VBRP is the NAVVY tool, and this is offered as a practical spiritual care reflective process that can aid spiritual assessment and values the carer and the cared-for (Table 12.2).

Staff who have worked in a care setting know the very real temptation when faced with a tricky situation, of jumping to a solution focus without actually stopping to consider any proposed alternatives that might be available. This is often brought about by the lack of time and a genuine desire to help the people. NAVVY gives the opportunity to use a spiritual care approach in these situations.

Table 12.2 The NAVVY tool (National Education for Scotland, 2021b)

The purpose of the NAVVY tool is to create a space between 'issue' and 'solution' by creating a space for reflecting in a more intentional and thorough manner than people's default responses might suggest. The NAVVY tool asks five questions of any situation:
Needs • Whose needs are being met? • Whose needs are left unmet? • Whose needs have not been considered in a particular situation or line of action?
Abilities • To what abilities or capabilities does the situation draw attention? (This question includes issues of competence, human resources, skills, etc. Do those involved have the abilities or capabilities to enact change?)
Voices • Who/what has a voice in the situation, and who/what is silent or silenced? (This question includes the voices of those immediately involved but also the voices of professional bodies, strategy, policy, ethics, etc.)

(*Continued*)

Table 12.2 (Continued)

Values • What is being valued here? • What is being overvalued or undervalued in this situation? • Where is value being placed; for example, where it does not belong and so on? • If there are competing values at work in the situation, how are these being managed?
You • What does the situation have to say about you, the individual worker? • What does the situation have to say about you, the team? • What does the situation have to say about the wider context in which practitioners find themselves (the collective 'you' of the NHS or the care agency)?
These five questions are not intended to be pursued in a linear fashion but rather to act as a guide to care staff when faced with disorienting practice dilemmas.

ACTIVITY 12.2

Use the NAVVY tool to consider an episode of care with a person:

- Identify the different stages.
- Consider new insights that you are aware of.
- Reflect on what you have learnt about your practice and what you might do differently in future.

The RCN survey (2010) has raised some pertinent issues relating to the personal and professional boundaries that need to be drawn by nurses when providing spiritual care. Many nurses expressed the need for help when distinguishing between their own values and their professional judgements as providers of care. Nurses need to be clear about how they express their beliefs in their own lives, whether through doctrine, ritual or membership of a religious community. Such clarity is essential if they are to remain objective when assessing, planning and delivering holistic patient care. Those nurses who professed to a personal belief were aware of the need for objectivity and that, while providing support to the person, they should not allow their own values and beliefs to impinge upon or influence the person in any way (Barber, 2022).

Nurses should be able to demonstrate an interest in and a willingness to discuss issues of a spiritual nature with people without the necessity of a wide-ranging knowledge of the doctrines, rituals and practices of the many religions. A review of research established that the level and amount of spiritual care given by a nurse were related to the amount of time available for listening and the spiritual awareness, sensitivity and communication skills of the nurse

(Ross, 2006). These findings were endorsed in a recent review of the literature exploring the competency of a self-assessment tool for nurses and midwives (Giske et al., 2023).

ACTIVITY 12.3

To explore your spiritual beliefs and feelings about other people's beliefs:

Write a short passage that sums up what you believe in.

Some helpful questions include the following:

- What do you consider to be the purpose of your life?
- How did you develop your beliefs and where have they come from?
- How might you respond if colleagues said (1) They did believe in God or (2) did not believe in God?
- How might you respond if a person were to tell you that life is meaningless or hopeless?
- You might like to discuss what you have written or discuss the questions with a friend.
- Share your thoughts and ideas and note the degree to which you agree or disagree with each other.
- Consider what it might be like to take the opposite approach to the one that you hold and what that might mean to you.

(*Adapted from Burnard, 1992:16,17*)

SPIRITUAL ASSESSMENT AND INTERVENTION

The importance of assessment in the approach to care is paramount with the inclusion of the spiritual needs of the person as an integral element of a holistic approach. In the past, there were fewer examples within nursing literature, but the situation continues to change (Giske et al., 2023). In recognition of the importance of a person's spirituality, the number of published guidelines and models in the nursing and spirituality literature is now increasing (McSherry, 2006; Narayanasamy, 2006; Koenig, 2007; Timmins and Caldeira, 2017a). Indeed, Nissen et al. (2021) assert that the literature is 'teeming' with research concerning tools for an assessment of spiritual care. Tanyi (2006) and more recently Campbell et al. (2023) affirm that, when assessing the needs of people and their families, there are three major goals to spiritual assessment:

- To support and enhance families' spiritual wellbeing and development
- To discern spiritual distress and its effect on overall family health
- To ascertain ways to incorporate family spirituality when providing care (Tanyi 2006; Cambell et al., 2023)

Table 12.3 Guideline questions for spiritual assessment

Strengths
• What has helped you in the past to deal with crisis?
• What gives you strength?
• What do you do to rebuild your strength?
Meaning and purpose
• In your daily life, what gives you meaning?
• What gives you peace, joy and satisfaction?
Relationships
• Who is the most important person in your life?
• To whom do you turn when you need help?
Beliefs
• Do you have a relationship with God/deity, universe or other?
• If yes, how would you describe it, and what does it mean to your health?
• Do you practise rituals such as prayer, worship or meditation?
Personal spirituality and preference for spiritual care
• How do you express/describe your spirituality?
• Do you consider anyone as your spiritual leader, and if necessary, can this person be contacted/would you like us to contact this person?
Do you have any spiritual/religious/cultural practices and/or customs that can better help us take care of you?
These questions are provided as a general guide and can be adapted for use according to the individual and the nurse's preference.

Source: Tanyi 2006; McSherry and Ross 2010; Campbell et al., (2023).

However, the nurse must feel comfortable and have already established a relationship of trust with the client before being able to undertake a thorough spiritual assessment and plan appropriate care.

Tanyi (2006) provides a series of questions and spiritual interventions that can be adapted and used as a guide by nurses to undertake a spiritual assessment and to plan a person's care (Table 12.3). In line with recent literature, additional questions are added which reflect the potential for a referral to a chaplain (Campbell et al., 2023).

PREPARING TO GIVE SPIRITUAL CARE

Just as you would assess a person's physical needs, an initial assessment of their spiritual concerns is important. You may find questions such as these helpful:

- Do you have a way of making sense of the things that happen to you?
- What sources of support/help do you look to when life is difficult?
- Would you like to see someone who can help you?

- Would you like to see someone who can help you talk or think through the impact of this illness/life event? (You don't have to be religious to talk to them; RCN, 2010; Barber, 2022).

McSherry (2006:905) offers a model that includes several components ('the Principal Components Model') and suggests that familiarity with it is likely to give nurses the confidence to tackle some of the difficulties inherent in undertaking spiritual care. For example, it is recognised that when assessing a person's spiritual needs, the nurse must develop a relationship of trust which takes time – the very commodity not always available to busy nurses. If sufficient resources are to be made available to enable nurses to support people appropriately, it is necessary for the medical practice or other directing 'organisation' to recognise the value of the relationship and to credit as worthwhile the time spent in listening (McSherry, 2006; Britt and Tove, 2019).

The person's spiritual history is a critical element in the background information that needs to be taken into account when planning nursing care. It ensures an understanding and recognition of the person's own beliefs and value systems. In particular, religious beliefs and practices are clarified so that any intervention by the professional is appropriate. By identifying individual spiritual needs the individual is given a clear message of the respect that will be shown in the delivery of the proposed care. Furthermore, significant information may be gathered that sheds light on the motivation underpinning the person's behaviour. Such information can provide a useful resource when identifying the person's support network, with the added potential of identifying the person's ability to comply with care. Additionally, the information provides a baseline from which the situation can be monitored (Koenig 2007; Timmins and Caldeira 2017).

Koenig (2007) and, more recently, Nissen (2021) suggest a number of criteria to be considered when choosing an appropriate model. Perhaps the most important is that questions should be open and brief and focused on the beliefs and value systems of the person, not of the nurses. Based on this premise, Koenig (2007:44) offers a single question: 'Do you have any spiritual needs or concerns related to your health?' and this question has resonance with work undertaken by Panczyk et al. (2022). This simple question acknowledges to the person that this is an area of importance for the professional. At this point, however, one might take issue with Koenig and Panczyk as an individual who needs care from a nursing professional almost certainly will have spiritual concerns related to health without necessarily being able to articulate them in such terms in response to a blunt question. By listening to what is said and by hearing what is left unsaid, it is for the professional to tease out the spiritual concerns of the person.

The use of a mnemonic can provide the nurse with a helpful tool when making an assessment based on a series of questions that explore 'spiritual and religious themes' within an 'empathic dialogue' (Hodge, 2001; Timmins and Caldeira, 2017a). Validation for this approach was found to be an important

Table 12.4 FICCA (Koenig, 2007) & HOPE (Puchalski, 2002)

FICAA:	
F—Faith	What is your faith tradition?
I—Important	How important is your faith to you?
C—Church	What is your church or community of faith?
A—Apply	How do your religious and spiritual beliefs apply to your health?
A—Address	How might we address your spiritual needs?
HOPE:	
H—Hope	What are your sources of hope, strength, meaning, peace?
O—Organised religion	What role does organised religion have for you?
P—Personal	What is your personal spirituality, and does it involve any specific practices?
E—Effects	Does your spirituality affect your decisions regarding medical care?

aspect in a research project considering the relationship between spiritual domains and palliative care outcomes (Balboni et al., 2017), which is an approach supported by Campbell (2023). The following examples of FICAA (adapted by Koenig, 2007) and HOPE (Puchalski, 2002 in McSherry and Ross, 2010) when suited to the linguistic register of the person could prove to be useful as a mental blueprint (Table 12.4).

Building on their earlier work in this field, McSherry and Ross (2010) have devised a model for 'actioning spiritual care using a systematic approach' (McSherry, and Ross, 2010:164). Caldeira and Timmins (2017) have further developed a model describing how nurses can use clinical reasoning and the nursing process to implement spiritual care (Caldeira and Timmins, 2017).

ACTIVITY 12.4

Action point

Try using the mnemonic FICAA or HOPE with a friend or colleague.

Draw a spiritual genogram, map or tree for yourself detailing your spiritual history and development. Include the significant people, literature and experiences that have influenced that development.

SELF-AWARENESS

Who we are, what we are like and what other people think of us are all questions that relate to our 'self'. We are made up of many parts, 'our bodies, our thoughts, our feelings, our perceptions of ourselves, our beliefs and our actions'

(Burnard, 1992:6). The more we come to know our 'self' – by enhancing our self-awareness – the more integrated we become as people and the more able we are to offer effective spiritual care.

Gardner (2011:89) suggests that 'practitioners need to be aware of their own spirituality and the assumptions they may make from their own experience' and states that 'we are less likely to be able to hear about other people's if we are not aware of our own'. Thus, it might be concluded that nurses above all professionals should have a highly developed sense of self-awareness if they are to function successfully (Timmins et al., 2017).

Reflection is a commonly used term in nurse education and provides a useful way to learn about oneself. Much has been written on the subject that is particularly valuable in the development of self-awareness when applied to the richness of experience in nursing practice. Nurses can observe the effect they have on people and the impact of treatment and care. A vital tool in the nurse's repertoire must be the ability to keep feelings and thoughts from private life separate from the issues of the workplace. Although personal experiences can enrich and enhance a nurse's empathy for a person's situation, they should not impinge on decisions taken relating to assessment or care. Instead, they should inform and guide responses to situations in practice, especially when approaching a sensitive area such as undertaking a spiritual assessment.

Becoming self-aware, according to Rungapadiachy (1999), is essential to effectiveness and comprises three interrelated perspectives: thinking, feeling and acting. If nurses are to be effective practitioners, they need to include people's spiritual needs when addressing all other aspects of a person's care. Therefore, it is essential that they are clear about their own spiritual beliefs and can avoid the pitfall of assuming that everyone else thinks about things spiritual in the same way that they do. Nurses who have little understanding of their own spirituality and feel uncomfortable discussing such issues are more likely to avoid conversations concerning a client's spiritual needs, whereas those who are secure in their beliefs are less likely to be uneasy when faced with a person expressing anxieties about the meaning of life and the loss of a sense of purpose (Burnard, 1992). In a professional situation, a nurse has a duty of care to the person, but it does not include trying to influence or change the beliefs and values of the person (Burnard, 1992). Spirituality is a very personal matter: individuals reach their own understanding of what it means for them in the context of their own lives and Caldeira and Timmins (2017:56) identify this as 'handling one's own beliefs' when implementing spiritual care. This was one of the areas of particular interest to be addressed by the RCN and was investigated in an exploration between 'the associations that may exist between religious belief and the RCN members' understandings of spirituality and the provision of spiritual care' (RCN, 2010:6). Among the conclusions was the statement that 'many of the qualitative responses indicate nurses are acutely aware of the need not to impose their own personal beliefs and values on persons' (RCN, 2010:27).

However, nurses are in a privileged position and those who have considered their own beliefs and values are more able to help others think and talk through theirs (Burnard, 1992) and be 'intentionally present people' (Britt et al., 2022:49). Recognising limitations such as self-knowledge gives the nurse the opportunity to be prepared and plan ahead for those situations in which clients need to express their fundamental concerns in the face of a crisis of illness. It enables the nurse, when providing care for people and their families, to develop the necessary coping skills rather than evasive strategies (Gardner, 2011).

Effective communication with people is crucial and most nurses would state that they feel very skilled in this area. Furthermore, when challenged, most nurses would be able to give examples of how and when they had been successful in communicating with people. They might also be able to state with honesty that they had blocked a conversation with a person when they felt the level of disclosure by the person was entering an area in which they were not comfortable. When confronted by a person who might wish to express anger or fear concerning their current situation or to question the ultimate meaning of life, the nurse with a well-founded knowledge of self and an ability to be 'open and ready to respond to someone's needs' (Rogers et al., 2020:13) would be better equipped to offer spiritual care (Koenig et al., 2001).

Ross et al. (2014), when considering 'spiritual care competency' within nursing, found several studies that raised fundamental questions regarding the extent to which spiritual care is indeed influenced by the personal characteristics of the carer. Furthermore, Ross acknowledged the importance of self-awareness and the ability to clarify personal values and beliefs.

Self-awareness is not a state that can be attained completely (Burnard 1988) but is rather an ongoing journey of enlightenment. Narayanasamy (2006) undertook an empirical study relating to the impact of spirituality and culture on nurse education. The resulting model incorporates 'communication – verbal and non-verbal; cultural negotiation – being sensitive to and aware of aspects of other people's culture and an understanding of clients' views; establishing respect and rapport and enabling clients to feel culturally safe' (Narayanasamy, 2006:841). An adaptation of the original model by Ellis and Narayanasamy (2006) offers a valuable approach to the consideration of a nurse's own self-awareness and spirituality in a way that is helpful and open to adaptation (Table 12.5), encouraging a nurse to develop greater confidence when undertaking and identifying a person's spiritual needs.

If we wish to become more self-aware and therefore more effective practitioners, Rungapadiachy (1999) suggests that there are three layers of self-awareness that we should consider. The first layer is superficial and related to acknowledgement and awareness of our age and our gender. The next layer is more in-depth and is related to those elements of which we need to be aware if we are to be effective, such as our appearance and attitudes and how they affect

Table 12.5 Guideline questions for self-awareness and spiritual nursing

Strengths
• What are my personal beliefs, values, prejudices, assumptions and feelings?
• Am I aware how these might influence the way in which I care for a person?
Beliefs
• What is the extent of my knowledge and understanding of the rituals and practices of different religious or non-religious beliefs and is it important that I know?
Relationship
• Am I enabling a person to express their spiritual beliefs?
• Am I providing a supportive and trusting relationship within 'outside' constraints?
• Do I involve other professionals when appropriate to meet the spiritual needs of the person?
Meaning and purpose
• Deliness or hopelessness?
These questions are provided as a general guide and can be adapted for use according to individual preference.

Source: Adapted from Ellis and Narayanasamy (2009).

For further source/guidance/reading, see 'Exploring Spirituality and Practice' (Gardner 2011:92).

our behaviour. The third layer is the deepest and represents those issues that are known only to ourselves, our deepest secrets and our thoughts.

A way to explore these layers is by means of the Johari window (Luft, 1969, in Jack and Smith, 2007:50). The 'window' comprises four areas of the 'self': open, blind, hidden and unknown. The 'open' area covers what is known to me and to others: feelings, attitudes and behaviours, likes and dislikes. In the 'blind' area is what is not known to me but might be revealed by others: mannerisms or habits of which I am not aware. The 'hidden' area is concerned with those things which I know about myself but would not wish to disclose to others. In the 'unknown' area, there are those aspects of the self which are within my deepest self and not brought to the surface except when unexpectedly triggered by a word or circumstance, for example a sudden irrational anger felt following a comment made by another (Jack and Smith, 2007:50; Table 12.6).

NURSING COMPETENCE AND SPIRITUAL CARE

In an extensive study undertaken by Van Leeuwen et al. (2006:878), a person noted that it was not possible 'to expect a nurse to be an all-rounder' and questioned 'whether a nurse should be an expert in psychology and religion as well

Table 12.6 Johari window

	Known to self	Not known to self
Known to others	Open area *Example*: This is what I know about myself and what others know of me, for example – I am a nurse and hard-working	Blind area *Example*: My friends may have a view of me of which I am unaware. I can uncover these views if others tell me about them. This will increase my 'open' area. For example – my friends may think I do not actively listen to them and I am unaware of this fact.
Not known to others	Hidden area *Example*: This is what I know about myself but hide from others. As I disclose more about myself, within a safe environment, my 'open' area will become larger and I may learn more about myself in the process. For example – I am finding my work very tiring.	Unknown area *Example*: This is the area that is unknown to me and to others. As we tell others more about ourselves and receive feedback this area will decrease in size. We will become more self-aware.

Source: Adapted from Luft (1969) in Jack and Smith (2007).

ACTIVITY 12.5

Action point

Draw a Johari window and fill in each of the quadrants.

You might wish to discuss your observations with a friend or colleague, particularly noting how your view of yourself differs from that of your friend/colleague and recognising that your own view may be the one that you think you should have rather than the one that is truly you.

Make notes on what you have learned about yourself and how this is relevant for practice.

as health care'. The data for the study were collected from focus group interviews with people, nurses and hospital chaplains. Certain limitations were acknowledged by the team in that many of the participants were interested in the topic and so were very willing to join the study. In addition, the participants were not culturally or religiously diverse, so they could not be said to reflect a representative cross section of the population. However, within these limitations, some interesting factors emerged that have particular relevance to spirituality and spiritual care. People in general required a nurse who could provide

good professional skills in physical care. There was also an expectation that the nurse would 'be there' for people, have time for them, be sensitive to their needs and enable them to express emotions. It is interesting to note that conversations between nurses and people frequently started spontaneously and were often initiated by people. Of equal importance to these conversations was whether the people and the nurses 'shared the same ideology' and the same 'religious language'. When asked about actions taken in spiritual care, nurses emphasised how important it was that they did not breach the boundary of an individual's personal limits, their own or the person's (Timmins and Caldeira, 2017b; Barber, 2022:559–560). Praying with a person was found to be acceptable but only at the person's request and if the nurse felt able to do so. Koenig (2020) identified prayer as one of six recommendations to help individuals during a time of crisis in health. It must be emphasised that nurses should not initiate a process that they cannot then follow through (Van Leeuwen et al. 2006).

Prentis et al. (2014) and Britt et al. (2022) in considering healthcare lecturers' perceptions of spirituality in education found that the 'development of the intellect, emotion and spirit is an essential component of good teaching' and that 'spirituality involves more than subject knowledge; it implies personal development for students and lecturers' (Prentis et al., 2014:49; Britt et al., 2022). A longitudinal study involving nursing and midwifery students concurred with the views of Prentis and Britt (Ross et al., 2022).

It has been established that the goal of spiritual care in nursing is to help people find meaning and purpose during times of illness. Unfortunately, spiritual care cannot be administered like a dose of medicine but depends on the quality and success of the relationship between the client and the professional. It is, for the nurse, a privileged situation to be able to support another in a time of distress (MacKinlay and Hudson, 2008:21). Participants in a study by Cooper (2021:6) said that 'spirituality as empathetic care is about connecting with an individual' and 'listening to what that might mean to her' about the loss of hair.

It has already been concluded that if they are to deliver spiritual care in a professional manner, community nurses must be competent (Ross et al., 2018). The literature and research on the provision of competencies through education and practice continue to develop; however, the four nursing competencies identified by Baldacchino (2006) remain valid for the nurse who wishes to deliver professional spiritual care. (Baldacchino, 2006:885; Ross et al., 2018). The nurse who wishes to deliver professional spiritual care is required to exhibit the four nursing competencies identified by Baldacchino (2006):

- Role of the nurse as a professional and as an individual person
- Delivery of spiritual care by the nursing process
- Communication with people, the interdisciplinary team and clinical/educational organisations
- Safeguarding ethical issues in care (Baldacchino, 2006:889; Celderia et al., 2017)

To assist in the difficult task of delivering spiritual care there is a need to explore Baldacchino's identified competencies in a little more detail, taking first the role of the nurse as a professional and as an individual. Baldacchino's study was undertaken with nurses caring for people who had had a myocardial infarction. Some nurses reported that they were prepared and felt competent in their knowledge, both physiological and medical, but did not feel confident or competent dealing with the spiritual aspect of their people's care. As a result, they were more inclined to leave that aspect to the chaplain, especially when a person had expressed anxieties about life and the life-threatening nature of the illness. Those nurses who considered themselves to be well developed in terms of both their clinical and their life experiences stated that they felt competent in undertaking spiritual care. However, they also indicated that the support of the chaplain was important to them as well as their professional support. On the basis of these findings, there is clearly a need to include in their training an opportunity for nurses to develop their skills to meet the spiritual needs of people. Several authors' (MacKinlay (2010; Martins and Caldeira, 2019; Barber, 2022) confirm this need when referring to the required sensitivity of nurses when providing spiritual care 'with all its variations according to culture and religion' (MacKinlay 2010:20).

The use of a structured approach to care has long been advocated within the nursing profession. Certainly, the processes of physiological and medical assessment, planning, implementation and evaluation are relatively straightforward. However, it is more problematic to apply a structured approach when a person who may be experiencing spiritual distress speaks of fear of the unknown, loneliness or hopelessness. In the study undertaken by Baldacchino (2006), it was found that it was difficult to evaluate the effectiveness of any spiritual care given because people did not necessarily give feedback to nurses regarding their state of wellbeing. What is possible to evaluate is whether nurses were able to spend time developing a trusting relationship with people listening to their expressed anxieties in a private environment. Here the issues depend upon the communication skills of the nurses and their ability to facilitate strategies or rituals for coping with spiritual dilemmas. The relevance of these issues continues to be valid and needs further investigation (Caldeira and Timmins, 2017).

The remaining competencies refer to the involvement of other professionals and the relevant ethical issues of care, especially in relation to an 'acceptance that beliefs vary between individuals' (Calderia and Timmons, 2017:56). The involvement of other professionals, religious or not, at the right time and in the right manner is another sensitive issue (Baldacchino, 2006). Several nurses in the study reported that they felt it was the role of chaplains to undertake the spiritual dimension of a person's care since they did not feel themselves to be sufficiently well prepared. A further difficulty that was reported was how to document a person's spiritual concerns without breaking the trust and confidentiality that build between a person and a nurse: a fundamental issue within *The Code of Conduct, Standards and Ethics for Nurses and Midwives* (NMC, 2018). This then becomes an issue of ethics and presents the problem of how much should a

nurse 'hand over' to other professionals where the spiritual status of the person is concerned. Additionally, a lack of comprehensive referral processes and record-keeping procedures were found to be issues by Campbell et al., (2023).

CONCLUSION

The place of spirituality in a holistic approach to nursing care is no longer an issue. The last decade has seen a significant advance in educational training programmes which include the spiritual aspect of nursing care. Further research is needed to assess the efficacy of tools to be used in the identification of spiritual needs. The value of such research would be to give nurses greater confidence in decision-making and provide an evidence base to support their own judgement and practical experience.

FURTHER RESOURCES

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Values Based Reflective Practice – https://learn.nes.nhs.scot/21027

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CHAPTER

13

Collaborative working

Susie Gamble and Carol Russell

LEARNING OUTCOMES

- Explore the definition of collaborative working.
- Reflect on collaborative working frameworks.
- Evaluate the political drivers influencing collaborative working within community nursing.
- Appraise the knowledge, skills, attitudes and behaviours required for successful collaborative working.

INTRODUCTION

Collaborative working is a workforce priority following the promotion of the integration of health and social care systems over recent years (Glover et al., 2022). It is essential to work collaboratively across professional and organisational boundaries to meet the needs of people in the community and deliver effective person-centred care (Jobe, Lindberg and Engstrom, 2020; Wei et al., 2022). Over recent years, all four governments within the UK have recognised the need for health and social care organisations to work collaboratively across boundaries to meet the increasingly complex needs of people, families and communities.

Current literature identifies a variety of factors which contribute to successful collaboration (Alderwick et al., 2021; Millar et al., 2023). However, it is also acknowledged that there are notable barriers to effective collaborative working including competing priorities, power imbalances and incompatible organisational structures and cultures (Auschra, 2018; Hendry et al., 2021; Bangsbo et al., 2022). Despite these barriers, the unprecedented crisis of the COVID-19 pandemic brought to the fore many examples of effective collaborative working across sectors and organisations, including the National Health Service (NHS) and the local government (Hendry et al., 2021; Bell, Whelan and Lycett, 2022).

Effective collaborative working can benefit everyone including, individuals, families and health and social care providers (Wei et al., 2022). Evidence suggests working collaboratively can have a positive impact on people's outcomes, improving safety, efficiency and the quality of care (Bollen et al., 2019;

DOI: 10.4324/9781003347545-14

Millar et al., 2023). Conversely, the negative impact that poor collaboration has on the outcomes for people is also highlighted in the literature (Reeves et al., 2017). Therefore, it is important that community nurses have the knowledge, skills, attitudes and behaviours required for successful collaborative working.

This chapter aims to explore collaborative working within health and social care integration. First, the terminology is examined and then the political drivers influencing collaborative working within health and social care in each of the four countries of the UK are explored. Frameworks supporting collaborative working will be appraised. Finally, the knowledge, skills and behaviours necessary for collaborative working will be considered.

DEFINITIONS OF 'COLLABORATIVE WORKING'

Collaborative working between or across professionals in the health service and across organisations within an integrated health and social care system is not a new phenomenon. Over the years, a variety of terms have been used to describe collaboration with researchers proposing it as both a structure and a process (Keyton, Ford and Smith, 2008). Furthermore, studies examining collaborative working and partnerships between health and social care organisations found many interchangeable terms were used when describing collaborative working including *integration*, *collaboration*, *joint working* and *partnering* (Warwick-Giles and Checkland, 2018; Rohwer, et al., 2023). The literature also identifies a range of different types of collaborations (Aunger et al., 2021; Wei et al., 2022). For example, interprofessional collaboration describes healthcare professionals from different disciplines working collaboratively to meet the needs of people, their families and communities. Whereas inter-organisational collaborations describe organisations working collaboratively together across health and social care boundaries to achieve common goals. Within these organisations collaboration can take place at any level of the organisation. Valentijn (2015) developed the Rainbow Model of Integrated Care to grasp the multidimensional nature of integrated care. In it he identified three levels where integration can take place: the macro, meso and micro levels (Figure 13.1). *Macro level* refers to integration at the system level, where integration is considered to ensure governance and enhance the quality of care; *meso level* refers to integration at the organisational and professional levels, which considers partnerships within and between organisations and the extent to which the services are joined up; and *micro level* refers to integration at the clinical level, referring to the coherence of care delivery to individual people. Furthermore, Auschra (2018) states inter-organisational collaborations can take many different forms, including networks, partnerships, alliances and mergers, and can take place between two different organisations or several different organisations.

The Cambridge English Dictionary (2023) defines collaborative working as the act of two or more people or organisations working together for a particular

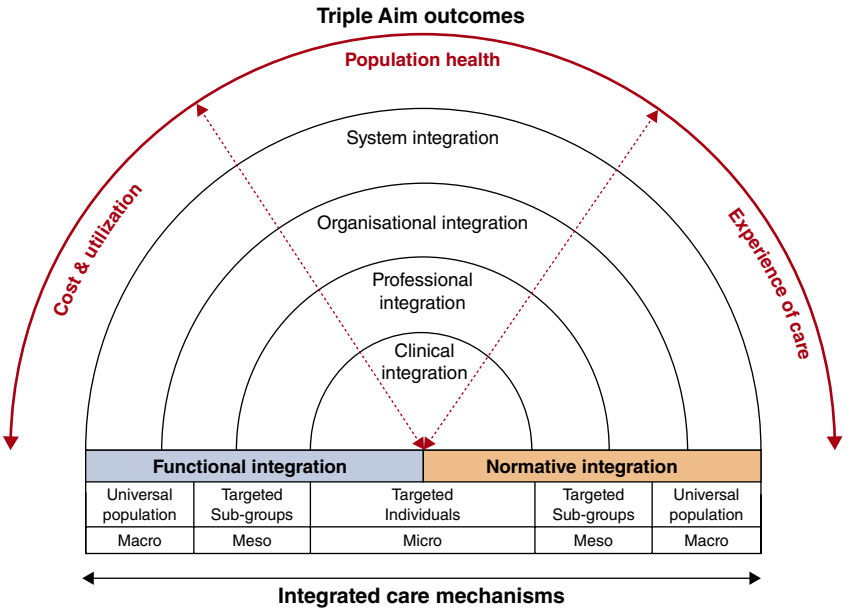


Figure 13.1 Rainbow model of integrated care. (Valentijn, 2015).

purpose. Elston (2013:526–583) supports this definition while adding that the process should be mutually beneficial and work towards a common goal. In a dated yet more comprehensive definition, Keyton, Ford and Smith (2008) extend this point and add further detail of the mechanisms required in their definition of collaborative working within an inter-organisational collaboration:

> it is the set of communicative processes in which individuals representing multiple organisations or stakeholders engage when working interdependently to address problems outside the spheres of individuals or organisations working in isolation. The outcomes of these processes have the potential to benefit or harm the parties to the collaboration, as well as others.
>
> (*p. 381*)

Notwithstanding the recognition of the benefits of collaborative working and the increased focus on collaborative working within health and social care systems, the literature acknowledges the complexities and difficulties associated with collaborative working where organisations are required to forego a competitive approach and adopt one based on collaboration, both between professionals and between organisations (Alderwick et al., 2021; Aunger et al., 2021; Sims et al., 2021). However, despite the challenges of collaborative working, it is essential for all community nurses to be able to work collaboratively across the health and social care system.

The World Health Organisation (2010) defines collaborative practice as occurring when "Multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their

families, carers and communities to deliver the highest quality of care across settings". Recognising the importance of interprofessional collaboration in practice, the World Health Organisation (2010) calls for nurse graduates to be "collaborative practice-ready" to ensure the workforce is ready and prepared to meet the needs of people, families and communities.

Effective collaborative working requires the combined effort of organisations, teams and individuals. Whether community nurses are working collaboratively within teams or between organisations, common to all definitions is the concept of working together to achieve goals that would otherwise not be achievable alone (Aunger, Millar and Greenhalgh, 2021).

ACTIVITY 13.1

Action point

Compile a list of words that help define 'collaborative working' for you. Include in your list not only what you think 'collaborative working' is but also the main features that need to be in place in order to implement it in your community nursing setting.

COLLABORATIVE WORKING FRAMEWORKS

Considering the various definitions outlined earlier, it is evident that collaborative working is a complex activity. Furthermore, there are suggestions that collaborations are seldom static with changes in memberships, resources and commitments influencing types of collaborations (Miller and Millar, 2017). There is not one single model, framework or form of collaborative working that is common to all collaborations or can indeed explain this phenomenon. Various authors describe collaborations across a continuum. For example, Sullivan and Skelcher (2002) categorise collaboration across a continuum, based on relationships ranging from informal relationships (networks) to formal partnerships (integration). Similarly, Hudson et al. (1998) classify collaboration across a continuum from isolation, where there is no joint activity or communication between partners, to integration, where partners no longer see their identity as separate.

The Northern Ireland Audit Office (2019) also describe different forms of collaboration by their degree of integration. They discuss the spectrum of integration with networks at the lower end characterised by low commitment through to cooperation, coordination, collaboration and onto partnerships at the higher end of the integration spectrum which are characterised by sustaining relationships and interdependence. However, Aunger, Millar and Greenhalgh (2023) suggest that despite a number of models attempting to depict the stages of collaborations in linear form, many of them fail to emphasise the complex and dynamic nature of collaborations.

The degree of integration is a key concept in a number of collaborative frameworks however in addition to this concept, Miller and Millar (2017) in

their typology of partnering reflect on two other important factors. They highlight two dimensions: first, the nature of the collaboration, that is the degree to which the collaboration is voluntary or not, and, second, the scale of the collaboration, that is the proportion of organisations involved in collaboration (Aunger et al., 2020). Miller and Millar (2017) suggest the nature of the collaboration can range from working together voluntarily through to partnerships mandated by government. The second dimension they suggest is the scale of collaboration which may range from collaborative working among individuals to larger scale numbers through formal structures.

These models and frameworks are used to describe collaborations and partnerships, but no matter which framework or model is used, or their limitations, they all have a common aim which is to achieve successful collaboration.

ACTIVITY 13.2

Reflection point

Consider the collaborations within which you are working at present. Take some time to reflect on the frameworks underpinning them.

POLITICAL DRIVERS INFLUENCING COLLABORATIVE WORKING

There has been an increased focus on the integration of health and social care services across the four countries of the UK over recent years. Since devolution in the 1990s successive governments have prioritised integrated policy reform. This follows the recognition that the separate and often fragmented health and social care systems which delivered health and social care in the past, were not only associated with negative outcomes but could also no longer meet the increasingly complex needs of the population who require coordinated, person-centred integrated health and social care (Hendry et al., 2021).

Recent changes to policy and legislation intend to better integrate health and social care services, enabling them to work collaboratively with the third sector, the independent sector, people, their families and communities to deliver integrated services to people at the right time and in the right setting. The aims of integrated policy reform across the four countries of the UK are consistent with the Institute for Healthcare Improvement (IHI) Triple Aim which is an approach to optimizing health system performance (Berwick, Nolan and Whittington, 2008). This aims to do the following:

- Improve the individual experience of care
- Improve the health of populations
- Reduce the per capita costs of care for populations

Collaborative working is key to achieving these aims of integration (Timmins, 2019); moreover, the successful delivery of good-quality integrated care is dependent on collaborative working within health and social care systems (King et al., 2017; Reeves et al., 2017).

Health has been a devolved function in the UK since 1999; however, successive governments in each country of the UK have introduced a range of approaches to achieve integrated health and social care. The focus on integration is evident in the recent changes to legislation, which are outlined in the following sections. Although all four UK countries have taken different paths in their approach, the focus on strengthening collaborative working is apparent in the policies within each government.

ENGLAND

There have been a plethora of policy commitments and legislation in England over recent years which have encouraged greater collaborative working. The initial piece of legislation following devolution was the Health Act (1999), which created opportunities for joint work arrangements between health and social care. This was followed swiftly by the NHS Plan (Department of Health, 2000) which encouraged health and social care professionals to collaborate to reduce fragmented care and improve patient outcomes. Up until this time, health and social care delivery and commissioning remained separate in England; however, the Health and Social Care Act (2001) established some care trusts which sought to formally merge health and social care delivery and commissioning.

Over the subsequent decade, further policy initiatives and the Health and Social Care Act (2012) introduced approaches, programmes and new powers which demonstrated commitment to collaborative working. These included pooled budgets, health improvement programmes, partnership agreements and health and wellbeing boards; however, these initiatives failed to improve patient outcomes and achieve the desired goal of effective collaborative working (Millar et al., 2023).

The publication of the NHS Five Year Forward View (Department of Health, 2014) established the vision for care that was integrated and coordinated around the needs of people in communities. It encouraged inter-organisational and cross-sectoral collaborative working stating that barriers, which can prevent collaborative working, need to be broken down and more health and social care services should move into the community. This was followed five years later by the NHS Long Term Plan (Department of Health, 2019), which strengthened this commitment to collaborate and better integrate health and social care. It committed to establishing integrated care systems (ICSs) across England by April 2021. ICSs are partnerships between health and social care providers, clinical commissioning groups, LAs and third-sector organisations which aim to improve population health, reduce health inequalities and ensure integrated and coordinated health and social care services. In a qualitative study, undertaken in the early phase of ICS implementation, Bell, Whelan and Lycett (2022) found that health and social care professionals worked together effectively within an ICS to respond to the needs of people in the community.

They concluded that intentional collaboration must be maintained in leading and delivering effective ICSs. However, it must be highlighted that this study was undertaken during the unprecedented crisis of the COVID-19 pandemic when it was crucial to work across health and social care boundaries in order to respond to the needs of people, families and communities at pace. Nevertheless, lessons from the pandemic response can offer a valuable contribution to the future development of ICSs.

More recently, the Health and Care Act (2022) accelerated the shift from competition towards greater collaborative working with the establishment, on 1 July 2022, of 42 ICSs as statutory organisations across England. Buckingham et al. (2023) point out that the terminology relating to ICSs can be confusing as the legislation formalising the powers of an ICS introduced and established two statutory bodies: integrated care boards and integrated care partnerships. Integrated care boards are composed of NHS bodies and local authorities whereas integrated care partnerships are expected to have wider memberships including community organisations. While ICSs will promote joint working and equal partnership between NHS and local partners, there is no single blueprint model for an ICS, and structures may be modified locally to meet the needs of people, families and communities.

In recognition of the challenges with partnership working between the NHS, local authorities and third-sector organisations, the King's Fund, an independent charitable organisation working to improve health and care in England, published A Reflective Learning Framework for Partnering, as part of their Healthy Communities Together programme (The King's Fund, 2022). The reflective framework provides an evidence-based practical tool for partners within organisations to use together to enhance collaborative working and reach their full potential.

NORTHERN IRELAND

Northern Ireland has had an integrated structure of health and social care services since 1973, however this was in response to a local government reorganisation, and not particularly for the purpose of strengthening integration of health and social care (Ham et al., 2013).

The policy and vision in the early 2000s in Northern Ireland focused on integrated action with the requirement for all boards to enter into a partnership with statutory, voluntary and community organisations. The focus of these partnerships was to work collaboratively to develop health and wellbeing plans. However, the Independent Review of Health and Social Care in 2005 highlighted issues of slow progress of the health and social care system (Reed et al., 2021).

A number of years later, the legislation (Health and Social Care (Reform) Act (Northern Ireland), 2009) enacted the development of a single large Health and Social Care Board. This one Health and Social Care Board was responsible

for the commissioning and performance management of five health and social care trusts, which provide health and social care services across Northern Ireland on a geographical basis.

Transforming Your Care: Review of Health and Social Care was undertaken in 2011 (Northern Ireland Assembly, 2011). It concluded that, similar to other countries in the UK, the increased, complex needs of the population were not being met by the current system. The review set out a renewed vision for the future of health and social care in Northern Ireland with a greater focus on the delivery of care for older people and those with long-term conditions. Part of the vision was the creation of integrated care partnerships (ICPs) to join together the full range of health and social care services across 17 areas; however, they had no statutory basis. Although the ICPs were viewed as positive, they had limited impact on health and social care integration.

Subsequent reports and strategies published during 2016 (Bengoa et al., 2016) and throughout 2017 (Department of Health, 2017; Kelly and Kennedy, 2017) highlighted the continued challenges of integrating structures alone and recommended more collaborative working with people, partners and organisations within local communities. Yet, the instability in government during these years led to a delay in implementing these strategies.

However, the 2020 New Decade, New Approach (Northern Ireland Office, 2020) power-sharing agreement committed to addressing the recommendation set out in previous policies and a new Integrated Care System was consulted on during 2021. The Integrated Care System approach would bring together health and social care professionals, local councils and the voluntary and community sectors to work collaboratively with people, families and communities to provide better outcomes and results for all. It would provide a commissioning framework to plan and manage health and social care services, in a more collaborative less bureaucratic way. This approach would have an emphasis on integrating by agreement rather than through structures alone (Reed et al., 2021). The proposed reforms would replace the one large Health and Social Care Board with five Area Integrated Partnership Boards (AIPBs) coterminous with the five health and social care trusts. AIPBs will have responsibility for local planning and will be supported by a Regional ICS Partnership Forum. Informed by both the local and regional Partnerships the Department of Health's Strategic Planning and Performance Group (SPPG) will commission integrated care and services across the system. It is proposed this new approach, the Integrated Care System Northern Ireland (ICS NI) will be updated in 2024.

SCOTLAND

In Scotland, the initial piece of enabling legislation was the Community Care and Health (Scotland) Act (2002). This provided NHS Health Boards (HB) and Local Authorities (LA) with the legislative powers to make payments for certain functions. These powers intended to remove barriers to joint working

between HBs and LAs to work more collaboratively. However, in the years following this act, it was evident there had been limited use of these new powers with no significant change apparent, except for one HB and LA which had integrated adult health and social care (Taylor, 2015).

Further legislation was introduced in 2004 to encourage partnership working between HBs and LAs. This legislation (National Health Service Reform (Scotland) Act, 2004) disbanded NHS Trusts and established Community Health Partnerships (CHPs) within NHS Boards. Despite some evidence of good partnership working and a membership including LA elected members, Taylor (2015) reported limited progress in the shift of the balance of care from the acute setting to the community following this legislation. Many believed this was due to the CHPs being viewed as health constructs, with all CHPs being committees or subcommittees of HBs and therefore accountable to their NHS board rather than the LA or an independent body. It was also recognised that there was limited opportunity for local communities to contribute to local planning of service provision. Furthermore, Audit Scotland (2011) concluded that complex issues could not be fully addressed, and changes could not be implemented, within the CHPs, due to the lack of authority. It was determined that these two pieces of legislation resulted in limited progress of the integration of health and social care (Audit Scotland, 2011).

A number of policy initiatives followed in an attempt to improve quality, promote integrated approaches and encourage closer collaboration between HBs and LAs and with the third and independent sectors. Some of these initiatives made a positive impact and were viewed as constructive; however, overall, it was concluded that progress was slow (Audit Scotland, 2016).

A further response to the challenges within health and social care was the publication of the Christie Commission Report on the Future Delivery of Public Services (Scottish Government, 2011). It recognised the gravity and challenges of the changing health and care needs of people, their families and communities. It made key recommendations for an urgent reform of the further delivery of public services, recognising that if services were to be effective, they would need to be designed with and for people in communities, not delivered 'top down'. Furthermore, it was recognised that the whole system of public services – public, third and independent sectors – must work together. This influential commission shaped subsequent government policies (Connolly et al., 2020) and ultimately led to the introduction of the legislation which underpins the integration of health and social care in Scotland, bringing together health and social care into a single, integrated system.

The legislation (Public Bodies (Joint Working) (Scotland) Act, 2014) requires HBs and LAs to integrate adult social care, adult primary healthcare and unscheduled adult hospital care, through the creation of Integration Authorities (IAs), with the option to include Children's Health, Children's Social Care and Criminal Justice Social Work services. The aim is to ensure

services are designed and delivered with and for people in local communities and in partnership with the community, third and independent sectors. The act received Royal Assent in April 2014 after which the HBs and LAs had one year (until April 2015) to submit their arrangements for integration to Scottish ministers. IAs had one further year to ensure all services were fully integrated prior to the statutory deadline of April 2016.

A degree of flexibility in creating an IA enabled HBs and LAs to integrate health and social care services in one of two ways, the 'Body Corporate' (also known as the Integration Joint Board model) or the 'Lead Agency' model. In the 'Body Corporate' model, the HB and LA could delegate the responsibility for planning and resourcing service provision for adult health and social care services to an Integration Joint Board. With the alternative option, the 'Lead Agency' model, the HB or LA takes the lead responsibility for planning, resourcing and delivering integrated health and social care services. Throughout Scotland 31 IAs have been formed. Each IA is aligned to a Health and Social Care Partnership which is the delivery arm for implementing the functions that have been delegated to the IA. All but one IA chose the Body Corporate (Integration Joint Board) model.

In the years following 2016, subsequent reports continued to highlight a lack of collaborative leadership and collaborative working between the IAs, LAs and NHS Boards indicating this was having a negative impact on the success of integration. In agreement with these challenges and recognising the need to improve the Scottish Government's Ministerial Strategic Group for Health and Community Care made a number of proposals with the aim of improving collaborative working within health and social care (Scottish Government, 2019). This included proposals to ensure leadership development was focused on shared and collaborative practice and strengthen relationships and collaborative working between all partners, including with colleagues in the third and independent sectors. In January 2020, a progress update was provided by the Ministerial Strategic Group for Health and Community Care (Naismith, 2020). The report indicated that, although some progress had been made, there was still more to do to ensure effective collaborative working within health and social care in Scotland.

Similarly, an Independent Review of Adult Social Care in Scotland (Scottish Government, 2021) outlined significant challenges in the Scottish social care system and highlighted a lack of collaborative practice. It recommends the creation of a National Care Service to bring together all adult social care in Scotland. Subsequently, the National Care Service (Scotland) Bill (2022) was introduced with the aim of improving the quality and consistency of social services and further integrating community health and social care in Scotland. It recommended that IAs be reformed and funded directly by the Scottish government. However, the legislative progress is slow, and ministers of the Scottish parliament are set to continue to debate the National Care Service (Scotland) Bill.

WALES

Since devolution, Wales has promoted collaborative working as a means of delivering integrated care. The legislation (The Health, Social Care and Well-Being Strategies (Wales) Regulations, 2003) set the requirement for HBs and LAs to work together to meet the needs of people, families and communities. HBs and LAs worked collaboratively to develop a joint health, social care well-being strategy within each area.

Following this, the vision was set to unify local HBs, requiring them to work together with LAs and other public services to meet the needs of people, families and communities. This requirement to work collaboratively became statutory when the Social Services and Well-Being Act was introduced (Social Services and Well-Being Act (Wales) Act, 2014). This legislation formalised these partnerships into seven Regional Partnership Boards (RPBs) to strengthen integration across health and social care. This enabled part of the system to work better together through the joint and collaborative commissioning arrangements which were in place for some services including care for older people with long-term conditions and complex needs.

The Parliamentary Review of Health and Social Care in Wales (Welsh Government, 2018) found that despite the efforts to work collaboratively, health and social care services in Wales were not yet delivering integrated health and social care sufficiently to meet the needs of the population. This led to a renewed focus to speed up the delivery of integrated health and social care through the creation of a new national Transformation Programme. *A Healthier Wales: Our Plan for Health and Social Care* (Welsh Government 2021a) was published and set out a future vision of a whole system approach to health and social care. The aim was to build on the RPBs, which brought together LAs, HBs and third-sector providers to work collaboratively and develop seamless models of integrated health and social care across Wales. *Rebalancing Care and Support* (Welsh Government, 2021b) proposed changes to strengthen the RPBs. These included establishing RPBs as legal entities and legislating for a wider membership of them. The Welsh government consulted on these changes during 2023 and published responses in November 2023. The Consultation report advises the responses will inform the further development of policy and legislation.

Alongside these proposed statutory reforms, The Strategic Programme for Primary Care (SPPC), an all-Wales health board–led programme, is working in collaboration with the Welsh government to address the wider priorities highlighted with 'A Healthier Wales'. One of its key strategic priorities is the Community Infrastructure (CI) programme which aims to define the fundamental infrastructure required to enable Primary and Community services to work more collaboratively to deliver integrated person-centred care. Central to the CI programme is the recent development of the Multi Professional Vision and Framework for Integrated Working (SPPC, 2023). This framework aims to

support primary, community and third-sector organisations to create collaborative working conditions across community professions. It aims to achieve this through a nationally agreed framework of multi-professional working which includes a nationally agreed definition and Standards with underpinning quality statements and an evidenced-based Development Matrix which can be used as an evaluation tool at multiple levels either individually or collectively as a team or service. The Development Matrix will enable professionals to reflect, assess and develop their practice over time. It is hoped this will develop high-level functioning multi-professional teams who can work collaboratively across community professions and ultimately enable people to live well and closer to home.

SIMILARITIES ACROSS THE FOUR NATIONS

The previous sections have reviewed collaborative frameworks and the political drivers which demonstrate the continued policy focus on strengthening collaborative working within health and social care. All four UK countries share the same aim to improve the outcomes for people, families and communities by encouraging collaborative working within health and social care (Aunger et al., 2021; Millar et al., 2023; Rohwer et al., 2023). Furthermore, all four nations agree there has been limited evidence of successful collaborative working despite the emphasis on collaboration and integration across health and social care systems (Naismith, 2020; Alderwick et al., 2021; Lewis et al., 2021; Reed et al., 2021).

A common thread across all four nations, over the years, has been the focus on creating structures to support collaborative working within health and social care. However, even under similar structures, the effectiveness of collaboration varies greatly (Kee et al., 2023). Furthermore, there is consensus that integrated structures on their own, whether statutory or otherwise, do not necessarily enable greater collaborative working (Hendry et al., 2021; Reed et al., 2021; Buckingham et al., 2023). It is clear that there are other key elements required for successful collaboration, and it is important that community nurses have the underpinning knowledge, skills and behaviours relating to collaborative working and can use and nurture these skills and behaviours effectively to meet the healthcare needs of people, families and communities.

ACTIVITY 13.3

Action point

All four countries have a similar vision to deliver integrated health and social care through effective collaborative working. Countries are at different stages of integrating their health and social care services and are working collaboratively in a variety of forms such as integrated authorities, ICSs and RPBs.

Reflect on the country and organisation within which you are working at present and consider the following:

How is it structured and does the structure support collaborative working, what are the health and wellbeing priorities specific to your area and what processes are in place to ensure they are developed collaboratively?

KNOWLEDGE, SKILLS, ATTITUDES AND BEHAVIOURS REQUIRED FOR SUCCESSFUL COLLABORATION

A number of factors have been identified which facilitate successful collaborations. Alderwick et al. (2021) found there to be a number of key elements which shape and influence cross-sectoral health and care collaborations. In their systematic review, they grouped the factors into five domains which are listed in Figure 13.2.

Although the work of Alderwick et al. (2021) provides a comprehensive list of factors influencing successful collaborations, it is acknowledged in the literature that collaboration occurs at several levels within the health and social care system. A number of authors have studied the facilitators of collaboration across organisational, team and individual levels (Mitchell et al., 2020; Zonneveld, Raab and Minkman, 2020; Wei et al., 2022). Wei et al. (2022) in their study identified similar factors to that of Alderwick et al. (2021). The factors affecting successful collaborations across the three levels are summarised in Figure 13.3. It is perhaps not surprising that there is some overlap between

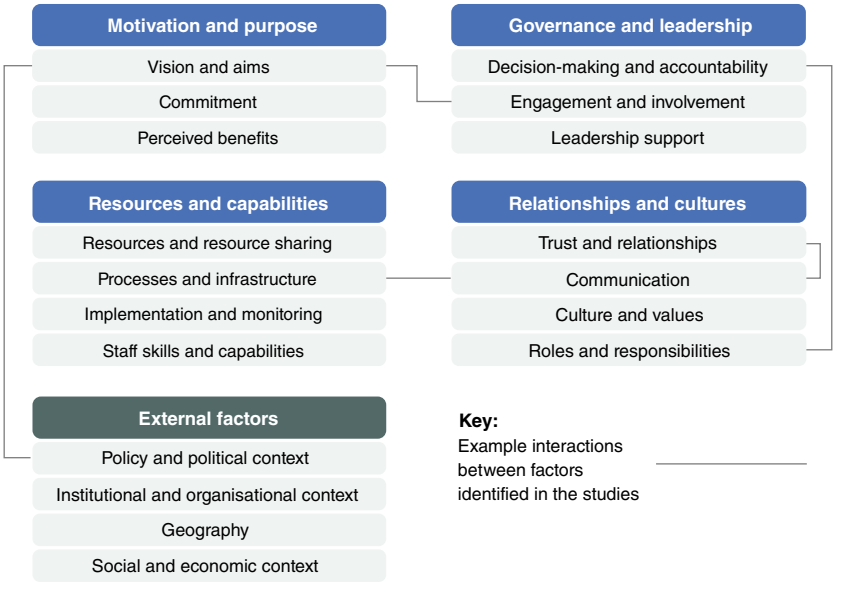


Figure 13.2 Factors influencing collaboration.
(Adapted from Alderwick et al., BMC Public Health 21:753, 2021).

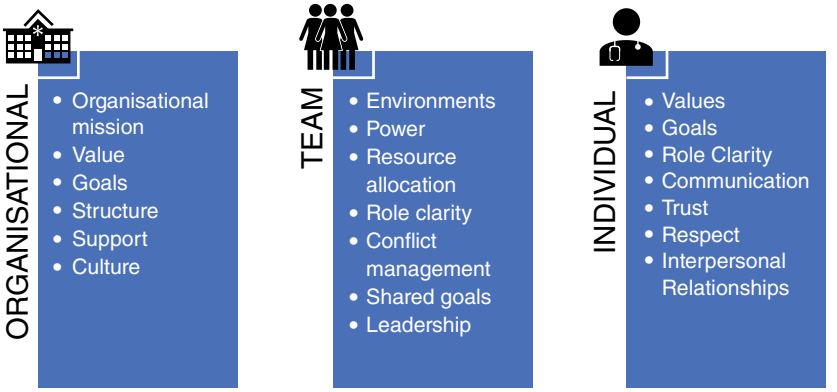


Figure 13.3 Factors affecting interprofessional collaborations.
(From Wei et al., Journal of Interprofessional Care 36(5), 735–749, 2022).

the levels. The ability to work together towards shared goals is a common factor across all levels. For example, this is evident at organisational level when LAs work with HBs to develop objectives for how they will integrate health and social care services to meet the needs of people living with dementia in the community. An example of working together at the team/service level is apparent in the many Home First/Reablement teams across communities where teams/services work together to support people to live independently at home. Finally, working together towards shared goals is also essential at individual level within, for example, an intensive community psychiatric nursing team in which the paramedic, the community psychiatric nurse, the social worker and the police work together to provide support and treatment for a person in the community with a severe mental health crisis.

Establishing a common vision and working towards shared goals is recognised as a key facilitator of collaboration (Auschra, 2018; Gray et al., 2020; Rawlinson et al., 2021). Although a shared vision and mission can enhance the delivery of effective integrated care, in reality, there are many challenges in working together (Mitchell et al., 2020). A lack of understanding of each other's roles within the integrated team or organisation can lead to conflict which can have a negative impact on collaborative working. However, sharing knowledge and interests with others and taking time to learn about the roles of others in the team or organisation can help develop a greater understanding of the perspectives of others leading to enhanced collaboration (Sims et al., 2021; Nyberg and Hemberg, 2022; Kee et al., 2023).

Working together to achieve a shared mission is also one of the Nine Pillars of Integrated Care recognised by the International Foundation of Integrated Care (Lewis and Ehrenberg, 2020). The nine pillars are described as nine opportunities for strengthening integration and can be used to support the implementation of integrated health and social care policy into practice.

Trust is another factor recognised as being a key facilitator for successful collaborations. Trusting relationships underpin collaborative working at all

levels of integration. Zonneveld, Raab and Minkman (2020) suggest trust is not only one of the most relevant values but is a key value that drives a person's behaviour and is therefore essential for effective collaborative working. While it is recognised that trust takes time to build (Miller and Millar, 2017), community nurses often have the benefit of established, close interpersonal ties with individuals, teams and organisations which can act as an effective mechanism to build mutual trust and respect.

The power of trust is also highlighted in a study exploring inter-organisational collaborations (Millar et al., 2023). The study suggested some practical actions that could lead to successful collaborations including the following:

- **Trust** – prioritising interpersonal communication and engagement with everyone involved can make a workforce more willing to experiment and take risks to try and make the collaboration a success
- **Belief** – when leaders believe that a collaboration will work, they can inspire others to get involved
- **Faith –** if a clear vision is maintained from the outset, with a logical path for achievement, then this improves trust because it helps avoid conflict
- **Leadership –** if positive leadership traits and behaviours including empathetic leadership, visibility, learning from others and fostering a positive culture are in place; then these can increase collaborative behaviour by enhancing trust and faith
- **Culture –** fostering a shared culture between organisations can improve trust because it helps avoid cultural conflicts

In reviewing the literature, it is clear there is a consensus that trusting relationships are integral to collaborative working (Seaton et al., 2018; Bangsbo et al., 2022). However, much of the literature also emphasises the important role leaders, at all levels, have in demonstrating collaborative behaviours and attitudes (Miller and Millar, 2017; Billings et al., 2019). Walsh and de Sarandy (2023) emphasise the need for leaders to encourage collaborative behaviours through role modelling and create the conditions for collaboration within their teams and organisations by addressing six key leadership practices:

- Creating safe, inclusive and trusting environments in which everyone can contribute
- Building healthy relationships between all parties involved
- Developing a shared purpose and shared group identity
- Actively managing power dynamics to enable power-sharing
- Surfacing and managing any conflict quickly and fairly
- Promoting shared decision-making processes

Although this research is focused on senior leaders, the principles are transferable to all registered nurses working in the community who are recognised as providing leadership from the point of registration (Nursing and Midwifery Council, 2018).

Table 13.1 Behaviours, values and factors facilitating collaborative working

Trust	Belief	Faith	Mutual respect
Clear role identity	Compassion	Transparency	Proactive engagement
Open communication	Appreciation	Teamwork	Shared learning
Cultural awareness	Competence	Flexibility	Meaningful recognition
Commitment	Responsibility	Accountability	Consideration

The behaviours and values discussed above are consistent with the Core Competencies for Interprofessional Collaborative Practice (2023). This competency set reflects the vision that interprofessional practice is key to effective person-centred care. The competencies comprise of the following four competency areas:

- **Values and Ethics** – work with team members to maintain a climate of shared values, ethical conduct and mutual respect
- **Roles and Responsibilities** – use the knowledge of one's own role and team members' expertise to address individual and population health outcomes
- **Communication** – communicate in a responsive, responsible, respectful and compassionate manner with team members
- **Teams and Teamwork** – apply values and principles of the science of teamwork to adapt one's own role in a variety of team settings

With a lack of progress in health and social care integration being attributed to a lack of collaborative behaviours and values, it is incumbent on all nurses across all levels in all community settings to emulate the collaborative behaviours, values and elements facilitating collaborative working, some of which are listed in Table 13.1.

ACTIVITY 13.4

Action point

Take some time to consider the behaviours, values and factors facilitating collaborative working and evaluate the current opportunities and future potential needs within yourself, your team and your organisation for wider collaborative success. Consider if there is anything restricting collaborations that needs to be addressed.

CONCLUSION

This chapter has provided an overview of collaborative working within the integrated health and social care system. The policy agenda influencing collaborative working within the four nations has been explored and some of the

frameworks have been highlighted. It is recognised that collaborative working is not just about structures, but successful collaborations are based on trust and shared beliefs. Although collaborative working is a priority within government policy, the process of collaborating has challenges and complexities and successful collaborations are difficult to achieve. However, it requires time to nurture trusting relationships and belief in collaboration. It is therefore essential that community nurses have an understanding of the knowledge, attitudes and behaviours required for effective collaborative working and can apply and nurture these in practice to meet the healthcare needs of people, families and communities.

FURTHER RESOURCES

International Foundation for Integrated Care – https://integratedcarefoundation.org/
Interprofessional Education Collaborative – https://www.ipecollaborative.org/

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CHAPTER

14

Approaches to acute care

Colette Henderson and Lauren A. Whitton

LEARNING OUTCOMES

- Critically explore the spectrum of conditions that might be of an acute nature.
- Appraise the skills and tools that will support the assessment of acute episodes of care in the community setting.
- Critically discuss the need to adapt care provision for acute presentations whilst ensuring person-centred care is delivered.
- Evaluate the options that are available to prevent hospital admission as well as support discharge planning.
- Critically discuss the application of pharmacological knowledge to support the management of acute conditions in the community.

INTRODUCTION

The transformation of community services has long been an ambition of the NHS with the policy background dating back as far as 1948 (Charles, 2019). Current policy direction continues to support the expansion of community services to reduce demand on hospitals. Across the UK, the role of the community nurse is evolving to meet this policy direction (Scottish Government, 2017a; Department of Health [DoH], 2018; National Assembly for Wales, 2019; NHS England, 2019). Whilst current challenges with investment and capacity continue to oppose complete realisation of this policy direction, there are robust examples of community healthcare transformations throughout the UK and this chapter will showcase some examples.

New ways of working are required for several reasons such as the integration of health and social care, an ageing population, complex healthcare needs and economic challenges (Scottish Government, 2017a; Department of Health [DoH], 2018; National Assembly for Wales, 2019; NHS England, 2019). The impact of Brexit and subsequent issues with access to supplies and the availability of migrant workers have also influenced the provision of care in the community (Burdett and Fenge, 2018). The global pandemic in March 2020 highlighted the crucial contribution nurses make to achieving the World Health Organisation's

DOI: 10.4324/9781003347545-15

(WHO) Sustainable Development Goals (SDGs) and universal health coverage (Rosa et al., 2020; United Nations, 2021). The pandemic needed, supported and enabled advancement in the use of technology. However, attrition and reduced investment have recently created further challenges for care provision in the community (Buchan and Catton, 2020). Buchan and Catton (2020) expressed the need to continue to safeguard investment in nursing to promote retention and enable nursing to be seen and valued as a desirable career.

Knowledge, skills and behaviours required for community nurses are embedded within four pillars of practice. These pillars are identified by NHS Education for Scotland (NHS Education for Scotland, 2021) as clinical practice, facilitating learning, leadership and evidence, research and development. The terminology relating to these pillars varies slightly across the UK (Henderson, 2021), but it is important that community nurses recognise requirements to ensure knowledge, skills and behaviours incorporate these pillars.

The evolution and continual advancement of nursing roles within the community requires ongoing review and consideration of scope of practice and competence to practice. As part of their 2020–2025 Strategy, the Nursing and Midwifery Council (NMC, 2023) committed to a review of advanced practice nursing and midwifery. The NMC commissioned independent research to ascertain if advanced nursing and midwifery practice requires regulation. Essentially, the NMC role is to safeguard the public and advanced practice and the additional skills and knowledge that are required need to be reviewed and considered. The NMC review of advanced practice is currently ongoing (NMC, 2023).

As an example of evolving requirements, Ormandy-Brooks (2020) argued for the inclusion of verification of death for district nursing teams. The author indicates that this skill rightly sits with the team who have been involved in providing care to an individual and their family. This relatively new skill not only highlights the need for community nurses to be flexible and responsive but also the complex systems within which they operate. Medical certification of death continues to remain as the responsibility of medical staff. Consideration has to be given to legal and governance requirements alongside provision of care to a person and their family. In some cases, there is a clear extension to the wider community when public health is concerned. The community nurse role has long been complex, with new and innovative developments within community settings more regularly now and these advancing and pioneering roles require careful consideration in terms of individual knowledge, skill and developing competence and capability (NMC, 2022). It is important that the community nurse is aware of policy direction and the evolution of the profession whilst also being cognisant of the significant evidence-based debates (NMC, 2018, 2023).

The aim of this chapter is to provide a contemporary critical overview of the provision of acute care in community settings and examples of innovative technology-enabled healthcare provision.

ACTIVITY 14.1

Reflection point

Reflect on your practice and consider the following:

- What are your learning needs in relation to the current healthcare policy directives within your country/area of practice?
- How can you ensure your practice is person- and family-centred?
- What tools and resources are available to support you undertaking a person-centred assessment?

ACUTE ILLNESS AND ACUTE CARE

Jones et al. (2010) provided a definition of *acute illness* indicating that whilst it tends to be short in terms of duration, the illness could be minor or serious. *Acute care* refers to treatment for any condition that may vary widely in terms of severity ranging from urgent and life-threatening to minor or self-limiting. Some examples of self-limiting illnesses are identified as colds and flu (NICE, 2017; Blanco and Matute, 2020).

The National Institute for Health and Care Excellence (NICE, 2023a) advised that self-limiting illness is one that will resolve without treatment. Blanco and Matute (2020) counsel that a perceived need to manage symptoms can lead to over reliance on ineffective treatments.

To establish whether an illness is self-limiting or acute and severe, a robust and holistic assessment is needed. Holistic assessment is required to ensure care that is delivered is safe, effective and person-centred. Chapters 8 and 9 explore nursing assessment across the lifespan. You should refer to these chapters as you consider the assessment you would undertake in the community.

Munson and Brooks (2022) identified a range of minor illnesses that may present as acute illness and community nurses may be involved with assessing or managing these illnesses. Munson and Brooks identified upper respiratory tract infections, acute pharyngitis, tonsillitis, ophthalmic conditions such as conjunctivitis, ear conditions such as otitis media or otitis externa and urinary conditions such as lower urinary tract infections.

ACTIVITY 14.2

Reflection point

Consider what you understand by acute illness and minor illness. Are these words interchangeable or do they mean different things?

Someone may present with an acute illness, but they are clinically stable enough for a robust holistic assessment. An Airway, Breathing, Circulation, Disability, Exposure (ABCDE) assessment (Resuscitation Council, 2021) may not be required, and practitioners have scope to consider a comprehensive history. When conducting assessments, you need to be cognisant that some

symptoms can present with similar clinical features to others and/or indicate an illness that is more serious (Lucas et al., 2021).

"Red flags" or "alarm bell" symptoms should prompt consideration of urgent investigation for a more serious condition. Looking for red-flag signs and symptoms during an assessment is a useful way to determine the severity of presentation. The community nurse should understand the concept of red flags and consider this application to their practice. Evidence of a red-flag presentation may provoke the need for an urgent assessment and warrant referral to a more senior healthcare professional.

To consider the provision of care for individuals presenting with acute illnesses, reflect on your practice and consider what knowledge and skills you would require assessing individuals presenting themselves to you. You may wish to refer to Chapter 9 for further consideration of the assessments required.

SKILLS AND TOOLS TO SUPPORT THE ASSESSMENT OF ACUTE EPISODES OF CARE IN THE COMMUNITY SETTING

In providing care, community nurses must ensure that it is person-centred. Eklund et al. (2019) remind us to be cognisant of the nuanced difference between 'patient-centred' and 'person-centred care'. The authors indicate the main goal of the former is a focus on a 'functional life' whilst the latter emphasises a 'meaningful life'. Patient-centred care originated as a concept in the late 1960s in a response to issues with the traditional biomedical and paternalistic approach to healthcare. Person-centred care stemmed from healthcare for those with dementia and a wide range of literature now supports further development of this construct (Eklund et al., 2019). Current policy directives across the UK support person-centred care, and community nurses should ensure they provide individualised care.

A vital part of person-centred care is shared decision-making. Spatz et al. (2017) opine that shared decision-making requires the healthcare professional with their clinical ability to work in partnership with the person who supplies the person specific ability. Bomhof-Roordink et al. (2019) identified 40 shared decision-making models in their systematic review of the literature. The authors advise that many of these models share some similarities, but they acknowledge several variations with some models being area specific.

ACTIVITY 14.3

Reflection point

Reflect on your practice and consider the following:

- What shared decision-making models are used in your area of practice?
- How will you ensure you embed shared decision-making when you assess a person who requires acute care?
- How will you ensure you involve the family if needed in this assessment?

International migration has created a diverse society where people have different cultural requirements (Sharifi et al., 2019). A lack of awareness and understanding of the variable and diverse cultural requirements impacts the delivery of safe, effective and person-centred care. Sharifi et al. (2019) proposed that cultural competence as a concept is ambiguous, and this ambiguity has enabled inequity in healthcare delivery. Clarification of the concept they argue will promote improved healthcare outcomes. Sharifi et al. (2019) argued that culturally competent care effectively requires an understanding of what is meant by 'culture' and 'competence'.

Okere (2022) advised that embracing cultural competence will ensure nurses can relate to and interact effectively with people and their families and avoid displaying behaviours that may be perceived as prejudiced. Developing cultural competence can be achieved by ensuring exposure to people from different cultures.

Whilst nurse education at both undergraduate and postgraduate levels explores the necessity for inclusion, equity and valuing diversity, little is known about how these ideologies translate into clinical care (Gunowa et al., 2020). Gunowa et al. (2020) discussed that despite pressure injury prevention being an integral part of nursing care and assessment; there is evidence of inequity in relation to care provision as people with darker skin tones have a higher prevalence of severe pressure injuries before detection of damage occurs. Gunowa et al. (2017) stated that pressure injury development has been widely researched and documented; however, much of this work does not address ethnicity or race and assumes Caucasian-ness. Therefore, nurses must be mindful of the common changes to the skin when assessing for acute care needs such as pallor, cyanosis, jaundice and flushing and how this may present in people with darker skin tones (Pusey-Reid et al., 2023). When undertaking an acute head-to-toe examination, nurses will inspect the skin for injury, trauma, perfusion and oxygenation, which will directly influence the care decisions that are made. It is vital that these differences are understood by nurses to ensure equitable care delivery.

ACTIVITY 14.4

Reflection point

Reflect on your practice and consider the following:

- What do you understand by the terms *culture* and *competence*?
- What are your specific learning needs in terms of being able to provide care that is culturally congruent?
- How might you address these learning needs?

COMMUNICATION STRATEGIES

Effective communication which includes accurate documentation is core to high-quality, safe, effective, person-centred care (NMC, 2018). Poor communication is frequently cited within NHS complaints with the consequences

leading to errors in management, delayed discharge, and complaints (Shahid and Thomas, 2018; Park, 2020). There are several tools to support the delivery of effective verbal communication. Situation, Background, Assessment, Recommendation (SBAR; NHS England and NHS Improvement, 2023) is a communication and documentation tool to aid the effectiveness of conversations during a clinical scenario that reduces avoidable errors in care (Park, 2020). It provides a framework consisting of four sections to ensure that pivotal information is shared in a timely manner, thus fostering a culture of safety (Figure 14.1).

Assessment of acute care in the community requires effective communication such as the SBAR tool identified earlier. Another consideration for

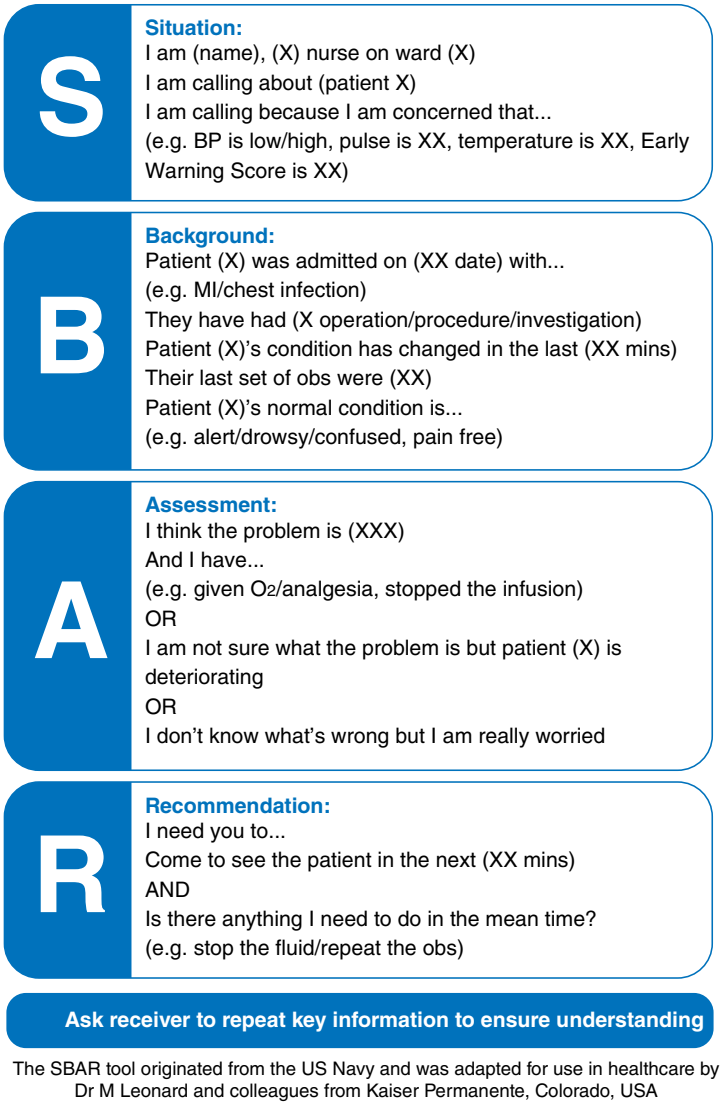


Figure 14.1 NHS England and NHS Improvement (2023) SBAR communication tool.

the dissemination of vital person-centred information is the use of technology-enabled care (TEC). LK (Leonardsen et al., 2020). In their systematic review, Leonardsen et al. (2020) considered that TEC is increasingly viewed as a solution to many of the challenges facing the healthcare sector. Across the UK, there are many examples of TEC that are implemented with the view to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them (Health and Social Care [HSC], 2022; NHS Digital, 2022; Department of Health Wales [DHW], 2023; TEC Scotland, 2023). TEC (2023) describe these initiatives to provide high-quality person-centred care through the application of technology (see Chapter 19). Community staff are enabled to look after more people at home with acute care needs via a cost-effective, evidence-based means. Chapter 19 provides further insight into TEC.

ACTIVITY 14.5

Reflection point

Reflect on your practice and consider the following:

- What TEC do you use in your practice currently?
- What TEC might be appropriate to support an individual with acute care needs?

ADAPTING CARE PROVISION FOR ACUTE PRESENTATIONS WHILST ENSURING PERSON-CENTRED CARE IS DELIVERED

Community nurses will endeavour to anticipate certain aspects of a disease progression; however, there will inevitably be unexpected acute episodes that present themselves and require urgent attention and intervention. The Health Foundation (2023) described these acute episodes as someone requiring treatment for a severe injury, period of illness, urgent medical condition or to recover from surgery. The success rates of rapid intervention to improve health and wellbeing are mainly time-sensitive and stress the importance of performing an efficient assessment of the individual (The Health Foundation, 2023). The British Geriatrics Society (2021) recognised that a multidisciplinary team (MDT) approach is required to provide the range of skills and competencies to deliver urgent care in the community.

Across the UK, there are a variety of services in place to support people through acute episodes of care in the community which helps avoid hospital admissions and enable people to live independently for longer. One such ambition is Hospital at Home. Hospital at Home has been in existence in numerous countries across the world for 25 years (Health Improvement Scotland [HIS], 2020), and the remit is to provide short-term, targeted intervention that provides a level of hospital care in an individual's own home that is equivalent to that provided within a hospital. The individual will remain in the home setting

and receive high-quality intervention that is designed to address complex health needs by accessing a range of health and social care professionals. This can include access to physiotherapy, occupational therapy, medication review and assistance with nutrition (HIS, 2020; NHS, 2022). It is well recognised that older people with frailty are at particular risk of being affected by institutionalisation and delirium (Geriatric Medicine Research Collaborative, 2023). Some 30%–56% of people have been shown to experience a reduction in their functional ability between admission to hospital and discharge (HIS, 2020). This further strengthens the case for Hospital at Home interventions. Hospital at Home services work best when the following occurs:

- There is access to a medical consultant who will have complete oversight for care planning.
- It is part of an integrated acute and community-based service model to meet local population needs.
- The infrastructure to address short-term acute care episodes is present.
- Patients are treated as though they have been admitted to hospital; they will receive urgent-level diagnostics.
- Care is delivered by multidisciplinary teams of healthcare professionals fully complying with current acute standards of care.
- A joined-up approach to care provision is present – avoiding replication, waste and gaps.
- Integration of services ensures that individuals' needs are met.

(*HIS, 2020*)

When providing care for someone with acute needs, it becomes increasingly evident that safety is a key concern from a professional and regulatory perspective (NMC, 2018, 2023).

Illness which cannot be prevented should be treated in the community wherever possible. UK-wide policy directives recommend that if hospital care is required, then its ambition is to provide treatment without individuals being inpatients, wherever possible (Scottish Government, 2017b; Department of Health [DoH], 2018; National Assembly for Wales, 2019; NHS England, 2019). When inpatient care is complete, a robust health and social care package should be organised to support individuals, families and carers at home, wherever applicable. Acute episodes of care can be returned to the community where individuals can then be supported by a team committed to providing person-centred care.

Sometimes there is a requirement for early supported discharge (ESD) for individuals who were admitted to hospital with an acute care episode, where an integrated team of health and social care professionals provide specialised rehabilitation for people within their own homes. There is a robust body of evidence to support that this is particularly effective for people who have had a

stroke. These teams can include physiotherapists, pharmacists, occupational therapists, nurses, speech and language therapists, rehabilitation assistants, consultant therapist for stroke and neuro (Williams et al., 2022). Rehabilitation goals will depend on the individual, but tasks may include improving mobility, assistance with personal hygiene, kitchen tasks, shopping, strategies to improve memory, conversation, swallowing, emotional support, education and medication support. Williams et al. (2022) suggested that ESD is the link between acute and community care which allows hospital inpatients to return home and continue to receive the necessary input from healthcare professionals that they would otherwise receive in hospital.

MANAGEMENT OF SEPSIS IN THE COMMUNITY

Rogers (2023) described sepsis as the most common cause of distributive shock that accounts for one of the largest causes of morbidity and mortality worldwide. In the UK, approximately 250,000 people are diagnosed with sepsis each year, resulting in about 52,000 deaths directly attributed to sepsis (Baker, 2022). Baker (2022) indicated that all healthcare professionals have a responsibility to ensure that they have sufficient knowledge to effectively screen patients for signs and symptoms of sepsis. Innes et al. (2023) suggested that the early detection of deteriorating patients is vital to avoid significant morbidity or mortality. Early warning systems are designed to detect severity of illness and within the UK a validated system (Figure 14.2) known as the National Early Warning Score 2 (NEWS2) is used (Royal College of Physicians, 2017).

Welch et al. (2022) discussed that the NEWS2 can be used in all adults older than16, and it is suggested that more specific scoring is required for but should be avoided for use in pregnancy. Tavare et al. (2022) recognised that an advantage of the use of NEWS2 in community settings is that it is not disease-specific and requires no expensive technology or great expertise to take a full set of observations that can be an indicator of clinical acuity. This tool, like all tools, offers an opportunity for the community nurse to consider the action required and is a useful addition to aid assessment (Innes et al., 2023).

One of the main medications to manage sepsis are antibiotics. Antibiotic resistance is a major global public health issue and a threat to the future of healthcare (UK Government, 2022). Antibiotic resistant organisms, such as methicillin-resistant *Staphylococcus aureus* (MRSA), can cause clinical unresponsiveness to treatment and are responsible for the progression to sepsis and septic shock (Rogers, 2023). Without effective antibiotics, many routine treatments will become increasingly dangerous. For nurses working in community settings, knowledge and understanding of antimicrobial stewardship is imperative (NICE, 2023a).

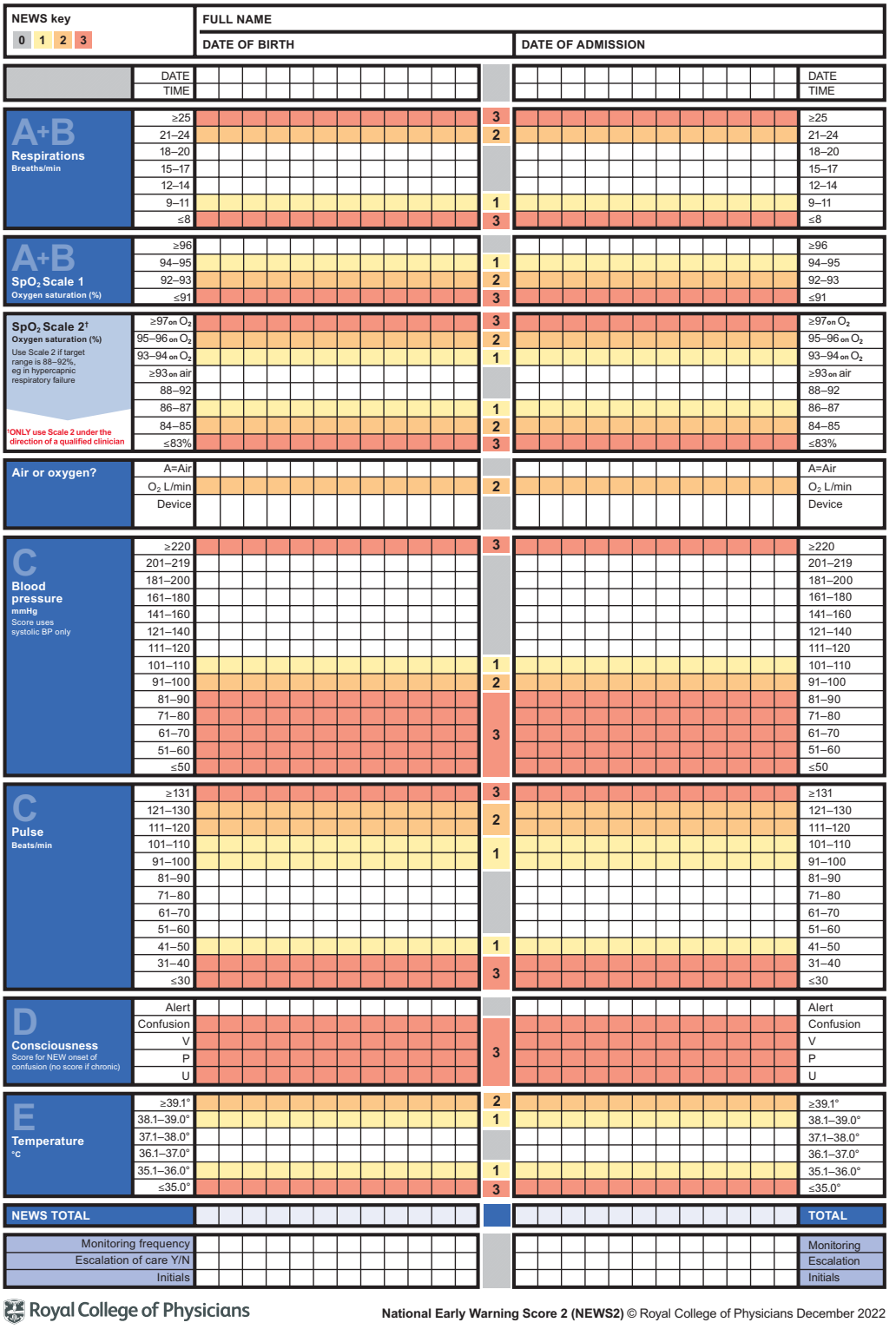


Figure 14.2 Reproduced from Royal College of Physicians.

National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

ACTIVITY 14.6

Reflection point

Reflect on your practice and consider the following:

- What is your understanding of antimicrobial stewardship?
- How will antimicrobial stewardship impact on your practice?

THE DETERIORATING PATIENT

Faced with a deteriorating patient in the community, the Resuscitation Council UK (2021) promote the application of the ABCDE approach. This stands for Airway, Breathing, Circulation, Disability and Exposure and is an expert-consensus evidence-based hierarchical approach to assessing critically ill and deteriorating patients. It has conventionally been used in hospital settings but is applicable to any healthcare setting (Smith and Bowden, 2017).

The underlying principles of the ABCDE approach are outlined by the Resuscitation Council (2021) as follows:

1. Use the ABCDE approach to assess and treat the patient.
2. Do a complete initial assessment and re-assess regularly.
3. Treat life-threatening problems before moving to the next part of assessment.
4. Assess the effects of treatment.
5. Recognise when you will need extra help. Call for appropriate help early.
6. Use all members of the team. This enables interventions (e.g. assessment, attaching monitors, intravenous access) to be undertaken simultaneously.
7. Communicate effectively – use the SBAR or Reason, Story, Vital signs, Plan (RSVP) approach.
8. The aim of the initial treatment is to keep the patient alive and achieve some clinical improvement. This will buy time for further treatment and making a diagnosis.
9. Remember – it can take a few minutes for treatments to work, so wait a short while before reassessing the patient after an intervention.

These principles should be utilised and maintained until the patient's condition stabilises. At this point you can undertake a more comprehensive patient assessment whilst understanding that, should the patient's condition deteriorate again, you should resume an ABCDE assessment.

Smith and Bowden (2017) indicated that a general assessment of the person in their surroundings is the first step in a systematic assessment. This general assessment provides an opportunity to introduce themselves, gain consent and undertake a risk assessment. Observations including skin colour, demeanour and non-verbal actions will provide relevant information about the patient's

current health status. The 'Look, Listen, Feel' approach will guide the assessment of the patient.

AIRWAY

Airway obstruction is a life-threatening emergency and may be partial or complete. Obstruction can be caused by several different reasons such as trauma, foreign body, increased secretions, inflammation as can be seen in allergic reactions or a depressed central nervous system function which may be caused by a stroke or drug overdose (Smith and Bowden, 2017). The practitioner should 'look' for signs of this such as accessory muscles use or 'see-saw' respirations, which are paradoxical chest and abdominal movements (Resuscitation Council, 2021). You should obtain help immediately and consider change of position, head tilt chin lift, and use of adjuncts such as oropharyngeal or nasopharyngeal airway or use of suctions if excessive secretions are evident (Smith and Bowden, 2017; Resuscitation Council, 2021).

BREATHING

Look, listen and feel for any signs of respiratory distress such as cyanosis or abdominal breathing. Count the respiratory rate which should be 12–20 breaths per minute and while doing this observe the expansion and symmetry of the chest wall movements (Smith and Bowden, 2017; Resuscitation Council, 2021). An increased respiratory rate may be an indicator of deterioration. The chest wall movements should be symmetrical and any deviation from this may indicate underlying pathology such as pneumonia or pneumothorax. A pulse oximeter should be used to assess the oxygen saturations (SpO2), but the community nurse should be aware that patients with chronic obstructive pulmonary disease (COPD) may normally have a reduced measurement. SpO2 should normally be >95% on air but a patient with COPD may have a measurement in the range 88%–94% on air. If available, high concentration oxygen using a mask with an oxygen reservoir should be given to reverse any hypoxia (Resuscitation Council, 2021).

CIRCULATION

The Resuscitation Council (2021) advised that hypovolaemia should be considered as the prime cause of shock unless proven otherwise. Intravenous fluids (IV) should be given to patients with cool peripheries and tachycardia. The Resuscitation Council (2021) cautioned the practitioner to remember that circulation may be impacted by a breathing problem such as pneumothorax. The Resuscitation Council (2021) has provided a step-by-step approach to assessment and management, and the community nurse should undertake these steps, but additional help may be required for access to all equipment and requirements.

CIRCULATION (C)

In almost all medical and surgical emergencies, consider hypovolaemia to be the primary cause of shock, until proven otherwise. Unless there are obvious signs of a cardiac cause, give intravenous fluid to any patient with cool peripheries and a fast heart rate. In surgical patients, rapidly exclude haemorrhage (overt or hidden). Remember that breathing problems, such as a tension pneumothorax, can also compromise a patient's circulatory state. This should have been treated earlier on in the assessment.

1. Look at the colour of the hands and digits: are they blue, pink, pale or mottled?
2. Assess the limb temperature by feeling the patient's hands: are they cool or warm?
3. Measure the capillary refill time (CRT). Apply cutaneous pressure for 5 s on a fingertip held at heart level {or just above) with enough pressure to cause blanching. Time how long it takes for the skin to return to the colour of the surrounding skin after releasing the pressure. The normal value for CRT is usually < 2 s. A prolonged CRT suggests poor peripheral perfusion. Other factors (e.g. cold surroundings, poor fighting, old age) can prolong CRT.
4. Assess the state of the veins: they may be underfilled or collapsed when hypovolaemia is present.
5. Count the patient's pulse rate (or preferably heart rate by listening to the heart with a stethoscope).
6. Palpate peripheral and central pulses, assessing for presence, rate, quality, regularity and equality. Barely palpable central pulses suggest a poor cardiac output, whilst a bounding pulse may indicate sepsis.
7. Measure the patient's blood pressure. Even in shock, the blood pressure may be normal, because compensatory mechanisms increase peripheral resistance in response to reduced cardiac output. A low diastolic blood pressure suggests arterial vasodilation (as in anaphylaxis or sepsis). A narrowed pulse pressure (difference between systolic and diastolic pressures; normally 35–45 mmHg) suggests arterial vasoconstriction (cardiogenic shock or hypovolaemia) and may occur with rapid tachyarrhythmia.
8. Auscultate the heart. Is there a murmur or pericardial rub? Are the heart sounds difficult to hear? Does the audible heart rate correspond to the pulse rate?
9. Look for other signs of a poor cardiac output, such as reduced conscious level and, if the patient has a urinary catheter, oliguria (urine volume < 0.5 mL kg^{-1} h^{-1}).
10. Look thoroughly for external haemorrhage from wounds or drains or evidence of concealed haemorrhage (e.g. thoracic, intra-peritoneal, retroperitoneal or into gut). Intra-thoracic, intra-abdominal or pelvic blood loss may be significant, even if drains are empty.

11. The specific treatment of cardiovascular collapse depends on the cause, but should be directed at fluid replacement, haemorrhage control and restoration of tissue perfusion. Seek the signs of conditions that are immediately life threatening (e.g. cardiac tamponade, massive or continuing haemorrhage, septicaemic shock), and treat them urgently.
12. Insert one or more large (14 or 16 G) intravenous cannulae. Use short, wide-bore cannulae, because they enable the highest flow.
13. Take blood from the cannula for routine haematological, biochemical, coagulation and microbiological investigations, and cross-matching, before infusing intravenous fluid.
14. Give a bolus of 500 mL of warmed crystalloid solution (e.g. Hartmann's solution or 0.9% sodium chloride) over less than 15 min if the patient is hypotensive. Use smaller volumes (e.g. 250 mL) for patients with known cardiac failure or trauma and use closer monitoring (listen to the chest for crackles after each bolus).
15. Reassess the heart rate and BP regularly (every 5 min), aiming for the patient's normal BP or, if this is unknown, a target > 100 mmHg systolic.
16. If the patient does not improve, repeat the fluid challenge. Seek expert help if there is a lack of response to repeated fluid boluses.
17. If symptoms and signs of cardiac failure (dyspnoea, increased heart rate, raised JVP, a third heart sound and pulmonary crackles on auscultation) occur, decrease the fluid infusion rate or stop the fluids altogether. Seek alternative means of improving tissue perfusion (e.g. inotropes or vasopressors).
18. If the patient has primary chest pain and a suspected Acute Coronary Syndrome (ACS), record a 12-lead ECG early.
19. Immediate general treatment for ACS includes:
    - Aspirin 300 mg, orally, crushed or chewed, as soon as possible.
    - Nitroglycerine, as sublingual glyceryl trinitrate (tablet or spray).
    - Oxygen: only give oxygen if the patient's SpO_2 is less than 94% breathing air alone.
    - Morphine (or diamorphine) titrated intravenously to avoid sedation and respiratory depression.

DISABILITY

A disability assessment requires an assessment of consciousness. The Resuscitation Council (2021) have recommended AVPU, which stands for Alert, Verbal, Pain, Unresponsive. If this indicates a reduced level of consciousness, the Glasgow Coma Scale can be used for a more robust assessment (Smith and Bowden, 2017).

The AVPU score comprises the following elements of examination of the patient, detailed in Table 14.1.

Talking to the individual will ascertain if they are alert and therefore no further action is needed. Similarly, you may require using verbal stimuli to

Table 14.1 AVPU (The Resuscitation Council, 2021)

A – Alert
V – Respond to verbal stimuli
P – Respond to painful stimuli
U – Unresponsive

ensure the person responds, and if they do, no further action is needed to obtain the assessment outcome. A trapezius squeeze where the nurse would grip the trapezius muscle in the patient's shoulder is recommended to avoid further injury to the patient (Smith and Bowden, 2017). If there is no response to this, unresponsive (U) should be documented.

The community nurse may not have access to all resources required to complete the Resuscitation Council recommended management but should understand the steps involved and have summoned help for the patient.

DISABILITY (D)

Common causes of unconsciousness include profound hypoxia, hypercapnia, cerebral hypoperfusion, or the recent administration of sedatives or analgesic drugs.

- Review and treat the ABCs: exclude or treat hypoxia and hypotension.
- Check the patient's drug chart for reversible drug-induced causes of depressed consciousness. Give an antagonist where appropriate (e.g. naloxone for opioid toxicity).
- Examine the pupils (size, equality and reaction to light).
- Make a rapid initial assessment of the patient's conscious level using the AVPU method: Alert, responds to Vocal stimuli, responds to Painful stimuli or Unresponsive to all stimuli. Alternatively, use the Glasgow Coma Scale score. A painful stimuli can be given by applying supra-orbital pressure (at the supraorbital notch).
- Measure the blood glucose to exclude hypoglycaemia using a rapid finger-prick bedside testing method. In a peri-arrest patient use a venous or arterial blood sample for glucose measurement as finger prick sample glucose measurements can be unreliable in sick patients. Follow local protocols for management of hypoglycaemia. For example, if the blood sugar is less than 4.0 mmol L^{-1} in an unconscious patient, give an initial dose of 50 mL of 10% glucose solution intravenously. If necessary, give further doses of intravenous 10% glucose every minute until the patient has fully regained consciousness, or a total of 250 mL of 10% glucose has been given. Repeat blood glucose measurements to monitor the effects of treatment. If there is no improvement consider further doses of 10% glucose. Specific national guidance exists for the management of hypoglycaemia in adults with diabetes mellitus.
- Nurse unconscious patients in the lateral position if their airway is not protected.

EXPOSURE

The Resuscitation Council (2021) and Smith and Bowden (2017) advised that a robust examination is required which entails exposing the patient. In doing this, care and attention must be provided to ensure the patient's dignity is respected and heat loss is minimal. The exposure of the patient will enable a full visual inspection which may highlight potential causes for deterioration, and the community nurse should respond appropriately to identified causes.

If admission to hospital is necessary to ensure appropriate management of a deteriorating patient, the community nurse will also need to consider steps that may be taken to prevent hospital admission. If hospital admission has been required, ensuring appropriate support is available for discharge will be paramount to ensure high-quality care is maintained across services.

PREVENTING HOSPITAL ADMISSION AND SUPPORTING DISCHARGE PLANNING

EXACERBATION OF A LONG-TERM CONDITION

Nurses working in any community nursing role will be exposed to individuals who have one or more long-term conditions. These conditions often have the potential to develop an acute exacerbation in the community setting. Some examples of these conditions are taken from Public Health Scotland (2020), NHS Digital (2023) and the National Institute for Health and Care Research (NIHR, 2021) and include long-term conditions such as asthma, COPD, cancer, chronic heart disease, heart failure, atrial fibrillation, dementia, depression and diabetes. There are many initiatives across the UK to support individuals with acute care needs to remain within a community setting. Please refer to the following text box for such an example.

The Complex Care at Home Team based in Cardiff, Wales, is a unique service providing 24/7 care 365 days a week to people requiring acute care in the community. This innovative service is led and coordinated by five clinical leads, two senior nurses, an assistant divisional and divisional nurse, 28 registered nurses, 209 healthcare support workers at band 3 level and 21 assistant practitioners at band 4 level. The team bring together expert knowledge and skills to ensure that high standards of person-centred care are delivered 24/7. Delegation is a key component of the community staff nurses' role within the team where tasks that have traditionally been undertaken by registrants, are entrusted to competent assistant practitioners that have undergone an intense package of educational competencies and met a variety of training requirements as supported by the education and training department of the service where they can carry out tasks such as providing care for individuals that are ventilated or have tracheostomies.

The people on the caseload have neurological/spinal conditions and learning disabilities. The team offer bespoke education and training to suit the needs of the complex care person. The packages of care are funded jointly by both the NHS and social work in the primary care setting. They are supported by the multidisciplinary team and have access to GPs, physiotherapists and occupational therapists, clinical psychologist and assistant psychologists. The individuals on this caseload have complex, chronic and acute needs, and can also experience acute, short-lived episodes of illness, where they require further input and specialist knowledge to support and keep them at home. The assistant practitioner and community staff nurses can escalate these issues to senior staff nurses and advanced practitioners within the team and work together to reach a goal that is desirable to the person, their families and their carers.

Exacerbations of long-term conditions can result in significant morbidity and mortality. It is vital that the community nurse adopts an appropriate multidisciplinary approach to care coordination to ensure effective care management (O'Flynn, 2022). One method of supporting effective care management of long-term conditions is anticipatory care planning.

ANTICIPATORY CARE

Anticipatory care planning (ACP), which is also referred to as future care planning, is a person-centred, proactive approach that can be implemented to help people consider what is important to them and plan for their future care (HIS, 2021; National Institute for Health and Care Excellence [NICE], 2023b). ACP is a person-centred approach that involves multiple conversations between individuals, their families, carers and professionals to communicate their preferences. These conversations can be recorded, shared and reviewed regularly to meet the changing needs of the patient (NICE, 2023b). HIS (2021) stated that undertaking an ACP is particularly relevant to those living with one or multiple long-term health conditions and/or living with disabilities and/or complex health and care needs. This partnership can be beneficial to anyone whose health and wellbeing are changing or deteriorating due to physical and/or mental health problems, approaching the end of their life, and for children and young people with life-limiting conditions (HIS, 2021). ACPs allow individuals and families to feel valued by providing them with a platform to discuss what matters to them in the context of their current and future healthcare needs (Figure 14.3).

The Universal Principles for Advanced Care Planning from NHS England (2022) as set out in Table 14.2, have been designed to drive improvements in inclusion, equality and diversity everywhere across England.

There are similarities across the four countries in terms of care planning and specific guidance is available for each country (HIS, 2021; Department of Health, 2022; NHS Wales, 2023).



Figure 14.3 Healthcare Improvement Scotland (2021) 'Four Steps to ACP'.

Table 14.2 Universal Principles for Advanced Care Planning (NHS England, 2022)

1. The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.
2. The person has personalised conversations about their future care focused on what matters to them and their needs.
3. The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals.
4. The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.
5. The person has the opportunity, and is encouraged, to review and revise their advance care plan.
6. Anyone involved in advance care planning can speak up if they feel that these universal principles are not being followed.

Anticipatory prescribing (Figure 14.3) and 'just in case' boxes are an important part of end-of-life care that enables prompt symptom relief at whatever time the individual develops distressing symptoms (HIS, 2021). By having medicines in their own home, or care home, the health professional can give medicines and get symptoms under control more quickly. It also means that the person is less likely to need to go into a hospital or hospice to have their symptoms managed (Bowers et al., 2023).

In some cases, the person's condition might deteriorate and open and frank discussions about end-of-life care planning are vitally important to ensure individual wishes are achieved. The next section will consider conversations about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

DNACPR

DNACPR can be both an emotionally and professionally challenging conversation to have. When providing care for people in the community and being mindful of both the acute and chronic conditions that may present, nurses are required to have a knowledge of local DNACPR policy and guidance. In her research, Hadley (2020) indicated that despite a nationwide desire to ensure that end-of-life care is delivered in a high-quality, seamless manner, there still appears to be a multitude of problems pertaining to the early identification of the dying person, communication regards their condition and wishes and a lack of decision regarding DNACPR. The success rate of CPR on an individual with a deteriorating and progressive illness is poor and even poorer within the community setting (Hadley, 2020). It is therefore vital that DNACPR is part of the discussion about ACPs. This enables health professionals to establish a rapport with people, carers and their families to establish their end-of-life wishes, ensuring person-centred care is the focus.

APPLYING PHARMACOLOGICAL KNOWLEDGE TO SUPPORT THE MANAGEMENT OF ACUTE CONDITIONS IN THE COMMUNITY

Current prescribing programmes for nurses' lead to registration as either a community practitioner nurse prescriber or an independent and supplementary prescriber (NMC, 2018). Community nurses may be registered as either or both types of prescribers. *Independent prescribing* refers to a prescriber who is accountable for the assessment of patients with previously undifferentiated or undiagnosed conditions and can make decisions about the management of care which may include prescribing (NICE, 2023d). *Supplementary prescribing* refers to a voluntary partnership between an independent prescriber who in this case must be a doctor or a dentist, a supplementary prescriber and a patient who together agree a clinical management plan (NICE, 2023d).

Community practitioner nurse prescribers have access to a Nurse Prescribers' Formulary for Community Practitioners (NPF). These nurses who are district nurses or specialist community public health nurses have access to a limited formulary and must prescribe items from this list for the indications specified (NICE, 2023c).

Evidence indicates that prescribing by community nurse prescribers is safe and effective and welcomed as an important element of the community nurse role (Courtenay, 2018). However, Courtenay (2018) indicated that several community nurse prescribers do not use their qualification. Courtenay (2018)

suggested that there may be some reasons for this such as centralised dressing schemes and a restricted formulary that perhaps does not reflect current practice. There is currently movement towards independent and supplementary qualifications for community nurses. Courtenay (2018) advised that this will enable less restrictive practice and support community nurses to influence key public health concerns, although, anecdotally, it is known that this role is not being embraced by specialist community public health practitioners. It could be argued therefore increased nurse prescribing capacity will need to be measured to determine any impact on public health. The NMC (2023) standards for prescribing programmes detail the requirements for entry to programmes and supervision and assessment. Community nurses who are interested in expanding the scope of their practice will find it useful to review these standards (NMC, 2023).

Another method of supporting planned care delivery is by using patient group directions (PGDs). If this is a recognised and regular occurrence you may have access to PGDs. These directions may be something you have already encountered and used in practice.

ACTIVITY 14.7

Reflection point

Consider

- What do you understand about PGDs?
- When should a PGD be used?
- Who can supply or administer a PGD?

PGDS

PGDs are written instructions to supply or administer medicines normally for planned episodes of care. Patient safety remains paramount, and PGDs can only be used as long as patient safety is not at risk. Only qualified, named and authorised healthcare professionals can utilise a PGD (UK Government, 2017). The Human Medicines Regulations (UK Government, 2012) detail legal requirements for PGDs.

There are some restrictions on what may be supplied within a PGD; for example certain controlled drugs are exempt from PGD use as are unlicensed medicines, dressings appliances and devices, radiopharmaceuticals and abortifacients (UK Government, 2017).

When using PGDs, you cannot delegate responsibility, and you must understand the pharmacology of the medicine identified in the PGD you are using and any drug interactions or adverse effects and how to manage them. Any planned follow up and documentation requirements are also required to ensure safe and effective person-centred care (NICE, 2017).

It may be appropriate for a non-prescribing community nurse to signpost individuals to the minor ailments scheme (MAS) at local pharmacies. MAS is

available UK-wide and is described by Aly et al. (2020) as an effective method for managing minor illnesses that is associated with positive clinical outcomes and cost savings.

The Health Foundation (2019) have funded a number of innovative projects that aim to support the workforce to deliver high-quality patient care. A number of these projects relate to addiction, purchase of medicines online and prescription medicines.

ACTIVITY 14.8

Spend a little time having a look at these funded projects and consider if there are areas for improvement in management of care in your local practice area.

CONCLUSION

Community nurses are faced with increasingly complex presentations. The community nurse is required to always work within their scope of practice NMC (2018). The dynamic nature of community nursing requires a broad experience base, and for some community nurses, this may mean additional education to ensure their ongoing capability.

This chapter has considered approaches to acute care in the community from a UK-wide perspective. The role of the community nurse is wide-ranging but requires specialised knowledge and care when managing acute illness, complex long-term conditions, deteriorating patients and end-of-life care. This chapter has detailed some of the key knowledge skills and behaviour required to ensure the delivery of person-centred care and provided examples of innovations in practice from across the UK.

FURTHER RESOURCES

WHO Sustainable Development Goals – https://www.who.int/europe/about-us/our-work/sustainable-development-goals

NMC Advanced Practice Review – https://www.nmc.org.uk/about-us/our-role/advanced-practice-review/

Cultural Competence and Cultural Safety – https://www.e-lfh.org.uk/programmes/cultural-competence/

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CHAPTER

15

Emerging issues in long-term conditions

Shirley Willis, Cathryn Smith and Gina Newbury

LEARNING OUTCOMES

- Identify and critically discuss current relevant government policy across the UK, considering its impact on the management of care delivery for people with long-term conditions.
- Critically examine the complex nature of multiple and co-morbidities across the lifespan, including the influence of deprivation and the social and environmental factors on people with long-term conditions, their families and their communities.
- Critically appraise case management strategies to address services delivering care to people with long-term conditions in the primary and community care setting.
- Critically reflect on your role as a community or primary care nurse in the delivery of complex care for people with long-term conditions, their families and their communities.

INTRODUCTION

The purpose of this chapter is to explore the impact of long-term conditions (LTCs) across the lifespan and give consideration to the role of community and primary care nurses in delivering services for this group of people, their carers and their families. The health policy agendas of the devolved administrations across the UK are explored in the context of the care and management of people with LTCs within the wider healthcare landscape. Key themes provide a focus for the discussions and include the value of a person-centred approach, needs assessment and care management. Self-care and the promotion of behaviour change are also explored. LTCs are known to be complex and may be further impacted by health inequalities along with social and environmental factors (Larsen, 2019; Chang and Johnson, 2022; Stagg et al., 2022), and these issues inform the chapter.

Other important topics related to the care and management of people with LTCs, including the assessment of mental health, the role of carers in supporting family members with an LTC, and the impact of digital technology on care delivery, are explored in other chapters (Chapters 10, 11 and 19).

DOI: 10.4324/9781003347545-16

The terms *LTC*, *chronic illness* and *chronic disease* are often used interchangeably in the literature. In a global context, the term *non-communicable diseases* (NCDs) is widely used (World Health Organisation [WHO], 2022) as these are considered to be long term in nature, not transmitted between individuals, but share many common lifestyle-related factors. The term *LTC* is used within this chapter to encompass the breadth of these conditions which are long term in nature, share many common factors and have a comparative impact on people, their families and their communities more widely.

According to the WHO (2022), NCDs kill 41 million people annually, equivalent to 74% of all deaths globally. Each year 17 million people die from an NCD before the age of 70, and 86% of these premature deaths occur in low- and middle-income countries. Cardiovascular diseases account for most NCD deaths (17.9 million people annually), followed by cancers (9.3 million), chronic respiratory diseases (4.1 million) and diabetes (2.0 million, including kidney deaths caused by diabetes). It is salutary to note these four groups of diseases account for over 80% of premature deaths annually. This takes on even greater significance when viewed in relation to the fact the greatest risks of dying from an NCD are largely modifiable behaviours: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets (WHO, 2022) (Figure 15.1).

In the UK, findings of the 2021 census (Office for National Statistics [ONS], 2021) suggest almost half of the UK population – 45.7% of men and 50.1% of women – reported having a long-standing health problem. Looking at cardiovascular disease specifically, it is estimated that 4 million men and 3.6 million women are living with heart and circulatory diseases in the UK (British Heart Foundation, 2023). More important is the impact of LTCs both on individuals and on the future demands and delivery of healthcare. Whilst people may be living longer, they are likely to be living with a LTC. It is predicted the number

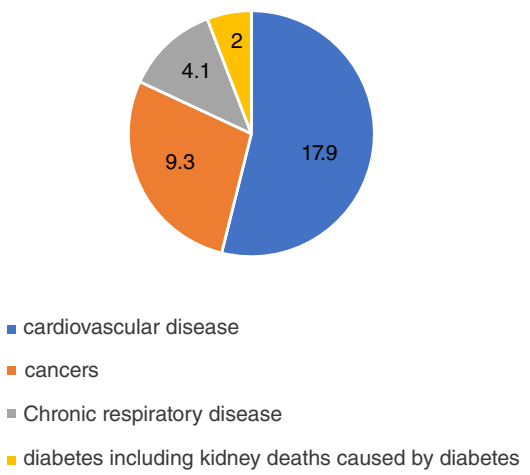


Figure 15.1 Global deaths (in millions) from long term conditions annually (WHO, 2022).

of people living with a long-term condition is likely to increase by 2.5 million by 2049 (The Health Foundation, 2023).

Diabetes presents a similar picture with 4.3 million people living with diabetes in the UK (Diabetes UK, 2023). Among people with diabetes, 90% have Type 2 diabetes, which is particularly significant when viewed in the context of the associated risk factors including age, family history and ethnicity, being overweight, social deprivation and the potential complications of the condition.

A LTC is generally accepted as a condition that lasts a year or longer and impacts on a person's life (National Institute for Health and Care Excellence [NICE], 2015). The Department of Health defines a LTC as

> a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/ therapies.
>
> (*Department of Health [DoH]. 2012*)

Whilst a definition can be helpful, Larsen (2019) suggests that from a nursing perspective, it is more important to consider how the condition impacts on the individual and their family as only they 'know' the illness experience:

> Chronic illness is the lived experience of the individual and family diagnosed with the disease.
>
> (*Larsen, 2019, pp. 5–6*)

This view suggests a move away from the traditional medical model of treating a condition towards the more person-centred and holistic approach that recognises the value of self-care and empowerment of the individual to alleviate the impact of the LTC on people's lives. Arguably, community nurses are well placed to support individuals with a LTC and their families as they are able to see the individual in the context of their daily life and so develop the therapeutic, person-centred relationships that underpin contemporary models of LTC management. 12 key LTCs are listed in Table 15.1.

Table 15.1 The 12 key LTCs (Carrier, 2023)

Coronary heart disease (CHD)
Stroke
Chronic obstructive pulmonary disease (COPD)
Depression
Lung cancer
Diabetes
Arthritis
Colorectal cancer
Asthma
Kidney disease
Oral disease
Osteoporosis

POLICY DRIVERS AND GOVERNMENT STRATEGY IN LONG-TERM CONDITION MANAGEMENT

ACTIVITY 15.1

Locate a health policy relevant to your area of practice.

Reflective points:

Having read the policy, consider how this evidence is being implemented in practice.

Can you identify any dissonance between the policy agenda and clinical practice?

How could you as a community practitioner ensure policy is reflected in care delivery?

The management of LTCs has a major impact on health and social care resources across the UK. The devolved governments of the UK all have a similar strategic aim with a focused move towards care being delivered closer to home and avoiding costly secondary care intervention. It is estimated across the UK in 2021/22 there were, on average, 1.6 million contacts with community and primary care services every day (Kings Fund, 2023) In 2019, the Queen's Nursing Institute (QNI) (2019) identified that, although £4.5 billion extra funding was allocated to support the level of primary care interaction, there was little clarity as to how this would be divided between the different streams of health and social care.

The four devolved governments of the UK each have a delivery plan spanning the next five years (Table 15.2). These policies are designed to provide a framework for health boards and NHS trusts to develop services to meet the needs of the populations they serve. It is recognised that there is a requirement to transform services and the way care delivery is organised with a move from a focus on ill health to a model of prevention and self-care. Primary and community nurses are playing increasingly important roles in leading teams, working collaboratively with colleagues from social care and allied health professions to provide care for the vulnerable and those with complex LTCs.

Table 15.2 List of policies and delivery plan

A Healthier Wales: Our Plan for Health and Social Care (2018) (Wales)	https://www.gov.wales/healthier-wales-long-term-plan-health-and-social-care
Health and Social Care Delivery Plan 2016 (Scotland)	https://www.gov.scot/publications/health-social-care-delivery-plan/
NHS Long Term Plan (2019) (England)	https://www.longtermplan.nhs.uk/
Health and Wellbeing 2026 – Delivering Together (2016) (Northern Ireland)	https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

Whilst it is not news that the population is living longer, this longevity leads to people with multiple LTCs and complex health and care needs. There is much discussion around the debate on adding years to life and life to years (DoH, 2020). There is a need to ensure support is available for the ageing population so that they remain healthy for longer whilst empowering patients to help manage their own health needs. Looking at each country identifies similarities in community nursing plans to address health and social care policy and its implementation into a deliverable service.

NORTHERN IRELAND

Over the past few years, there have been five reviews and reforms of health and social care in Northern Ireland (Transforming your Care, 2011; The Right Time, The Right Place, 2014; Review of HSC Structures, 2015; Systems not Structures, 2015; Health and Wellbeing, 2026, 2016).

The Northern Ireland District Nursing Framework 2018–2026 paves the way for the delivery of a service that has patients at its centre. The framework will enable district nurses to work towards the ambitious targets set within Health and Wellbeing 2026: Delivering Together, providing a road map for commissioning, managing and partnership working.

SCOTLAND

Scotland also recognises the need for adjustments with the focus on district nursing teams with a more integrated team approach involving a grade mix from registered practitioners and healthcare support workers to specialist and advanced practitioners. Transforming Nursing, Midwifery and Health Professions' Roles (Scottish Government, 2017) looks to shift the balance of care from hospital to community, developing new and innovative ways to provide safe and effective person-centred care and integrating teams with a range of professionals and third-sector organisations to offer seamless care.

WALES

Similarly, in Wales, the government wants to provide services which support people to stay well, not just treat them when they become ill. Health and social care services should work together with families to find out what is best for them and agree on how to make those things happen, providing a 'person-centred approach'. More services will be provided outside of hospitals, closer to home or at home, with access to hospital only necessary for treatment that cannot be provided safely anywhere else. This 'community-based approach' will help take pressure off hospitals, reducing the time people have to wait to be treated and the time they spend in hospital. Health and social care services will use the latest technology and medicines to help people get better or live the best life possible (Welsh Government, 2018).

ENGLAND

The Long Term Plan (NHSE, 2019) sets out how the NHS will move to a service model in which patients get the best support at the right time in an optimal care setting with the focus again on moving care nearer to the patients with ever-expanding community health teams. Within five years, 2.5 million more people will benefit from 'social prescribing' with added support for managing their own health in partnership with patient groups and third-sector organisations. GP practices will be funded to work together to deal with the pressures within primary care. The plan identifies community and primary care nurses are integral to its successful delivery.

The four UK countries face many shared health and social care challenges, including ageing populations, complex LTCs, pressure on health and social care funding, workforce shortages and widening health inequalities. Integrated care is a shared ambition and effective digital technology is one way forward and is going to be pivotal in supporting new ways of working.

There is clear evidence of new ways of working developing across the UK with the 'Neighbourhood Nursing Model', based on small self-managed teams of community nurses who spend 60% of their time with patients, being developed. This model of care follows the Buurtzorg principle (meaning "neighbourhood care" in Dutch). The adapted model is being used widely across the UK. There seems little consensus as to which model fits, but all contain an element of training for nurses to enable them to identify, assess and implement care for patients near their homes. This person-centred approach aims to develop goal orientated plans based on the "What Matters to Me" principle. The COVID-19 pandemic highlighted the need for patients to become more independent and community nurses have begun to move towards reenabling patients to manage their own care needs with limited support from traditional services.

The introduction of virtual wards within primary care teams is certainly assisting with the multi-professional approach to the complex nature of patient needs within the community setting. This multidisciplinary and multi-agency approach identifies patients with complex needs and provides a coordinated approach to care and the ongoing referral process. This approach is particularly relevant to the care of patients with LTCs and co-morbidities, allowing the professionals involved with their care to provide a one stop approach with all relevant clinicians able to participate in the process. NICE (2023) has recommended the use of virtual wards as a platform to treat acute respiratory infection, with evidence showing technology can be utilised to monitor conditions safely at home alongside services with a similar purpose such as Hospital at Home and Rapid Response Teams.

Government policy drivers are crucial to developing the right service at the right time for the needs of the populations served.

The Health Foundation (2023) predicts that by 2040, one in five people will have a health condition, such as dementia or cancer, and suggests that this will

equate to 9.1 million people, a rise of 37% since 2019. By comparison, the number of healthy working-age people will increase by just 4%. Therefore, a greater focus on prevention to reduce the number of people living with ill health is required.

THE COMPLEX NATURE OF MULTIPLE AND CO-MORBIDITIES ACROSS THE LIFE SPAN

The ageing population is rising rapidly as people are living longer with age-related LTCs, and, as a result, there is considerable concern for the provision of future health and social care (WHO, 2022). The popular view held by many that 'old age does not come alone' is indeed one that is not taken lightly and is widely discussed and debated (Coupland and Coupland, 1994). Whilst many of the older population are fortunate to have support from family and friends that they can lean on throughout their ageing process, for many, these relationships can be difficult ones, with poor health, LTCs and health inequalities resulting in people becoming dependent on those closest to them. There are many key factors that can influence the health of the older population, which include social and health influences across a lifespan, health inequalities, culture, ethnic minority status and wider influences such as a lesbian, gay, bisexual, transgender, queer (LGBTQ) stance. These factors alongside a long-term condition are a challenge for anyone to manage and it is important to acknowledge how the support of healthy ageing is provided (Chapter 8 explores care across the lifespan in more detail).

AGEING POPULATION

The ageing population is a key health concern both nationally and internationally, and it is well documented in literature and policies that the ageing population is growing rapidly. The ONS census in 2021 found the population in England and Wales is continuing to age (ONS, 2021), with the over-65s growing faster than any other age group (Figure 15.2).

Throughout all four nations in the UK, it is clear there is an increase in the ageing population and even though this presents opportunities for the older generations to contribute to society, the economy and the community, the key factor that determines this is their health. Whilst many people are living longer, it presents many consequences for the economy, services and society (ONS, 2021). Ageing brings with it many uncertainties; an ageing population may be accompanied by good health, or it may be accompanied by loss of independence, disability and reliance on health and social care. The demographic problems of ageing raise questions that healthcare professionals working within communities need to consider when developing services (Rudnick et al., 2020).

Common LTCs associated with older age include osteoarthritis, COPD, diabetes and dementia. LTCs require long-term treatment, adding demands to an already over-stretched health and social care system (Maresova et al., 2019). A retrospective cohort study by Salisbury et al., (2011) in the UK found a range

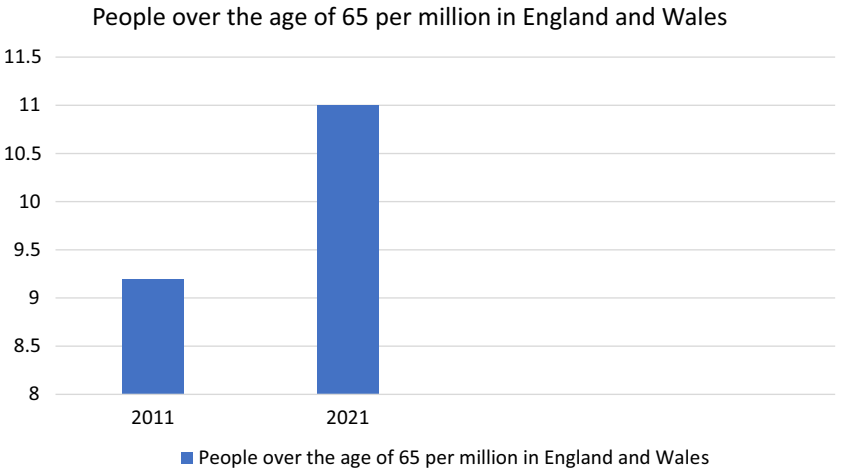


Figure 15.2 Population of people older than age 65 in England and Wales, ONS (2021).

of between 16% and 58% of people with more than one LTC, with a strong link to age and deprivation. Governments must therefore be committed to providing effective services in both health and social care delivery. The devolved governments in the UK have produced policies and frameworks that are diverse in nature, but all are set to guide and support the health and social system in the UK with a focus on ageing and LTCs (Department of Health Ireland, 2018; Welsh Government, 2018; Scottish Government, 2018; UK Government, 2023a). The message from across all four nations is to protect, prevent and improve the health of their ageing populations.

SOCIAL ISOLATION AND LONELINESS

Research has found social isolation and loneliness have been linked to the increased prevalence of LTCs and premature mortality (Holt-Lunstad et al., 2015) and are associated with higher rates of cognitive impairment such as dementia. Social isolation and loneliness are well recognised as a public health issue (WHO, 2022), not only across all populations but particularly the older population due to changes in their social life and health conditions. While loneliness is often related to the older population, it is important to note that it is also evident across the lifespan, including children and adolescents, as evidenced in a growing research base in terms of impact (Leigh-Hunt et al., 2017). It is, however, difficult to estimate the prevalence and causality of both social isolation and loneliness across the lifespan as many factors influence its exposure such as gender and willingness to talk.

One of the most significant risk factors associated with social isolation and loneliness is a LTC. Loneliness relates to all LTCs as a risk factor alongside hospital readmissions, longer hospital stays, and overuse of healthcare resources (Petitte et al., 2015). The onset of loneliness and social isolation for people with

a LTC is complex and often due to the fact that a LTC can alter a person's social network through disabling symptoms, discomfort and lack of energy. The link between them both is significant as the stigma associated with a LTC can cause a reduction in social interaction with disconnectedness and loneliness as a subsequent side effect. When a LTC is non-intrusive and symptoms are controlled and not predisposing, individuals are likely to be socially healthy, yet many LTCs are associated with 'flare-ups' and unfortunately symptoms progress and worsen over time.

It is not without surprise that the COVID-19 pandemic has exacerbated social isolation and loneliness significantly. Due to the need by governments to lessen the extent of the virus, extreme measures such as home isolation, social distancing and quarantine intensified loneliness and disrupted care for those who desperately needed it. People with a LTC were at higher risk of severe illness from COVID-19 and, therefore, due to the prolonged requirements of self-isolation, were at higher risk of becoming lonely and socially isolated (Polenick et al., 2021). Following on from this, public health policies need to prioritise vulnerable populations and the social disparities associated with living with a LTC. Community nurses are at the heart of primary and community care for people with a LTC and they are well situated to reach out to lonely socially isolated people. Their responsibility needs to include the recognition of loneliness and then subsequently signposting to services that can help – a view that underpins the social prescribing approach. Strengthening the collaboration between primary and community care and other health and social care services is also key to addressing factors associated with loneliness.

HEALTH INEQUALITIES

Ethnic minorities

Over the last decade there has been a growing number of studies globally that have examined LTCs among ethnic minority groups (Rocca et al., 2014; Kalgotra et al., 2020). The consensus among these is that although living with a LTC is a reality for many older people, considerable disparities remain in the management of these conditions across racial and ethnic groups (Hayanga et al., 2023). In a systematic review, findings confirmed that ethnic minority groups have a higher prevalence of LTCs compared to their white British counterparts. Even though the association between a LTC and poorer mental wellbeing is well reported globally (Megari, 2013), this relationship seems to vary by race and ethnicity (Lankarani and Assari, 2015). While some argue that biological, genetic and cultural influences within ethnic minority groups contribute to the inequalities in the prevalence of LTCs, it is also recognised these elements alone are not the only causes.

Regardless of the evidence surrounding LTCs and how they can impact many ethnic minority groups in the UK, it is less clear on how LTCs affect minority

groups across the lifespan. There is evidence that suggests LTCs develop earlier in some ethnic groups and the prevalence of LTCs varies at different stages throughout the life course across ethnic minority groups. When it comes to socio-economic factors, people from ethnic minority groups are more likely to live in deprived areas and thus more likely to develop one or more LTCs. Rates of overcrowding in Bangladeshi communities in Britain are 12 times higher than white British communities. Alongside this, people from Asian and Black groups had the highest rate of unemployment (UK Government, 2023b). These are challenges that must be addressed through the context of health and social policy and partnership working. Primary and community care plays an important role in the management and care of people with a LTC, enhancing outcomes, narrowing health disparities and reducing healthcare costs.

LGBTQ

In 2021, the ONS published the census on sexual orientation and reported around 3.2% of the population identify themselves with a LGB+ orientation, and a further 0.3% described themselves as either pansexual, asexual or queer (ONS, 2021). Despite the rate of higher disease burdens in the LGB community, they face more barriers and poorer access to healthcare compared to heterosexual adults (National Health Service (England), 2019). The LGBTQ community consists of a wide range of people that stem from many different socio-economic backgrounds, different ages and varied ethnicities and should therefore be seen as a heterogenous group, yet there has been a history of disproportionate access to healthcare and a gap in understanding the needs of this community.

Within a UK study, it was found the LGBTQ community were more prone to LTCs (Saunders et al., 2021), building on the findings of the National Health Interview Survey conducted between 2013 and 2014. It found LGB individuals older than age 50 had a higher incidence of LTCs compared to heterosexual individuals of a comparable age (NHIS, 2014). All healthcare professionals have a professional responsibility to reduce health inequalities, yet the LGBTQ population still report discrimination and assumptions around gender and sexual orientation that can undermine the patient–professional relationship. Negative experiences in healthcare may also put strain on this relationship resulting in many not wanting to disclose their sexual orientation, posing a difficult situation for healthcare assessment and treatment.

This population also experiences more social isolation and loneliness as they age. Stonewall (2011) found the LGBTQ population were more likely to be estranged from their family and live alone with little support from friends and family. This poses an extra challenge for public health services, which tend to focus at present on the younger LGBTQ community rather than the older population. A generic service offering support across the age groups is therefore required.

ACTIVITY 15.2

Identify a service in your local area to support patients experiencing social isolation.

Reflection:

How do people access the service?

Consider the impact of stigma and bias and how these may impact individuals accessing a service.

Considering your own caseload, what services would be helpful, and how might you influence the development and accessibility of voluntary and third-sector services?

CASE MANAGEMENT STRATEGIES

LTC models and frameworks are helpful in allowing us to understand the process inherent within the development of chronic disease and give us insight into the individual's experiences, coping mechanisms and adaptive behaviours (Strickland, 2022).

PERSON-CENTRED APPROACH

Caring and compassionate nurse–patient relationships may be viewed as the heart of person-centred nursing care. Indeed, the Nursing and Midwifery Council (NMC) place much significance on the 'nurse–patient relationship', and this is enshrined within the NMC (2018) Code:

> 3.3 Act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it.
>
> (*p. 7*)

In the context of caring for people with a LTC and their families, this person-centred approach takes on even greater significance. Strickland (2022) identifies a person-centred approach as being one that focuses on the person rather than the health condition, and in caring for this group of people, this must be a key focus of any care delivery model. Nicol and Hollowood (2019) suggest that when care is focused on the needs and preferences of the individual the outcomes of care are likely to be more meaningful with co-production and partnership in care more likely to be achieved. For people living with a LTC, it is often not the nature of the treatment itself that they remember but how that treatment was delivered. From a nursing perspective, it is about understanding how the individual is making sense of what is happening to them (Hewitt-Taylor, 2015). Person-centred care is key to the development of therapeutic relationships, and this, along with the role that leadership plays in person-centred practice, are explored further in other chapters within this book (Chapters 13 and 18).

Whilst person-centred care might be difficult to define and the association between person-centred care and health outcomes relatively unexplored (Nay et al., 2014), recognising and connecting with the person would appear to be the key elements of this approach. McCormack and McCance (2010) suggest that person-centredness is concerned with all people, including those being cared for, their supporters and colleagues and their relationships with care providers. The culture of empowerment and respect for individual self-determination is also recognised. When the focus of care is on the individual, with recognition of their needs and preferences, then the care outcomes will have greater meaning for the individual. Furthermore, ethical and moral requirement to respect people's decisions regarding their care is required as professionals (NMC, 2018), and taking a person-centred approach provides a framework to support professional practice that is particularly appropriate in caring for people with a LTC.

The Health Foundation (2016) moves away from defining person-centredness towards offering a broad framework for practice that is built on four principles of person-centred care (Figure 15.3).

In the context of caring for people with LTCs and their families, a person-centred approach is key if meaningful outcomes of care for this vulnerable population, where a cure is not the primary goal of care interventions, are to be achieved and quality of life is to be enhanced.

MODELS AND FRAMEWORKS

Traditional approaches to caring for people with a LTC have focused on the medical model of treating the disease. However, more contemporary approaches have recognised the importance of a more holistic approach to care delivery, with the individual being a partner in care. The value of self-care and self-management approaches have become evident as the underpinning ethos of service delivery models providing care for people with an LTC, which challenges the traditional medical model approach to care delivery which has become unsustainable in the face of changing demographics and increasing demands on health services. The underpinning ethos of a person-centred approach is evident.

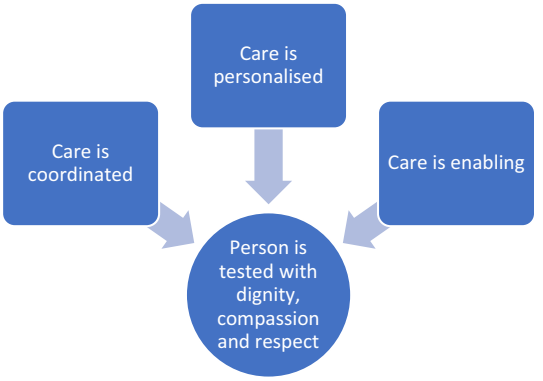


Figure 15.3 Person-centred care. (The Health Foundation, 2016).

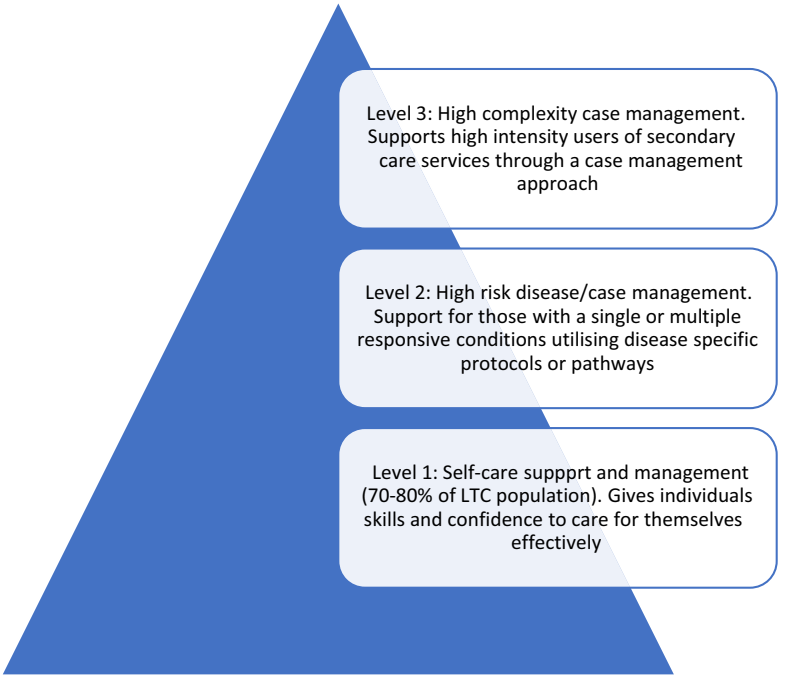


Figure 15.4 NHS health and social care LTCs model. (DoH, 2005).

Indeed, the notion of self-care in LTC management has become a key aspect in contemporary population-focused service delivery models, and this is illustrated within the NHS Health and Social Care Model (DoH, 2005). Carrier (2023) explains how this three-tier model draws on the Kaiser Permanente Triangle of care management (Figure 15.4) and attempts to inform and support clinical decision-making when identifying appropriate care packages for individuals with a LTC. Whilst levels 1 and 2 of the pyramid represent 80% of the LTC population, there is still potential for the 20% of individuals that may fall into the highest category with multiple complex health issues to engage in some elements of self-care with the right support. It is the organisational support within the health and social care systems that is key to underpin this approach if the outcomes of empowered and informed patients alongside prepared and proactive health and social care teams are to be achieved (Seddon, 2018).

THE ILLNESS TRAJECTORY MODEL

The illness trajectory model (Corbin and Strauss,1991) is one model that places the individual's experience of chronic disease in the context of a journey (Table 15.3).

Whilst this model may be primarily associated with people in the terminal phase of an illness, when explored more closely, it is clear it is of value in informing decision-making in the context of caring for people with a LTC. The model identifies eight phases of the illness journey (Table 15.3). Whilst this

Table 15.3 Corbin and Straus's (1991) illness trajectory model

	Phase	Definition
1	Pretrajectory	No signs and symptoms. Genetic factors and lifestyle place the individual at risk
2	Trajectory onset	Signs and symptoms evident, diagnostic period
3	Stable	Illness course and symptoms are under control. Illness management centred in the home
4	Unstable	Illness course/symptoms not controlled. Adjustments made. Care centred in the home
5	Acute	Active illness or complications that require hospitalisation. Life activities on hold or curtailed
6	Crisis	Life threatening or critical situation requiring hospitalisation
7	Downward	Rapid or gradual physical or mental deterioration with increasing disability or difficulty in controlling symptoms
8	Dying	Final days or weeks before death. Gradual or rapid shutting down of body processes. Relinquishing everyday life activities

may be represented in a linear fashion, the individual with a LTC may move back and forth through the phases of the model and at different times, different elements of care may be required. It is a useful tool to ensure that the right care and treatment are available at the most appropriate time and supports the identification of clear personalised goals of management.

ACTIVITY 15.3

Sarah's story

Reflection point – thinking about the illness trajectory model, consider how an understanding of this might help you to support Sarah living with a long-term palliative condition.

Sarah's story

Sarah is a 45-year-old woman who is a single parent with two teenage children. Following abdominal surgery to drain what was thought to be an abdominal abscess, Sarah was referred to the district nursing service for post-operative care. Unfortunately, a biopsy examination identified the lesion to be cutaneous metastatic deposits, and following further investigation, a primary lesion was identified within the lung. The abdominal wound failed to heal and developed over time into a significant fungating vascular lesion that bled profusely on occasions, requiring short admissions to hospital. It became evident that for Sarah, the goal of healing the wound was unrealistic and an alternative longer term approach was required to manage Sarah's long-term condition, manifested in this chronic malignant wound. Despite Sarah's deteriorating condition, her personal goal was to stay at home with her children.

Reflection points

How can an understanding of the illness trajectory model help you as a community nurse to deliver care for Sarah and her family that is person-centred?

How might this model inform the care delivered by the wider Multidisciplinary Team (MDT)? What is your role as a community nurse in coordinating care delivered by the MDT?

Thinking about the long-term but progressive nature of Sarah's condition, how might Sarah move through the different phases of the model? What might be some of the ethical and moral dilemmas for you as a community nurse in this scenario?

THE SHIFTING PERSPECTIVE MODEL

The shifting perspective model (Paterson, 2001) explores LTCs from a psychological perspective and considers the 'illness' and 'wellness' of the individual. Strickland (2022) describes how, at different times, an individual with a LTC may see themselves as 'well' and describe themselves as healthy, whilst at other times the individual will see themselves as 'unwell' or 'ill'. The underlying principle here is that the personal perception of their LTC will change according to their circumstances at the time. This, in turn, will influence the individual's behaviour in an attempt to maintain that feeling of 'wellness' or take actions to lessen the negative health impacts of their condition. Larsen (2019) suggests this shifting perspective model defines chronic illness as an ongoing continually changing process with the individual's 'experiences' of the condition at any time as the key underpinning principle.

For the health professional, an understanding of this model provides valuable insight into the lived experience of the individual living with a LTC. The 'illness' and 'wellness' perspective of the individual reflects their view of their health status at the time – a perspective that is ignored at the clinician's peril if a person-centred approach to care delivery is to be achieved.

FRAMEWORKS FOR PRACTICE

Models provide an overarching view of population-based approaches and are useful in providing a global view of the care and management of people with a LTC. Whilst the health and social care LTC model (DoH, 2005) may be viewed as a service delivery model, both the illness trajectory model (Corbin and Strauss, 1991) and the shifting perspective model (Paterson, 2001) explore more generally the individual's lived experience. However, for the health professional working with people living with a LTC, these models need to be operationalised in the form of a framework for practice.

THE CHRONIC CARE MODEL

The chronic care model (CCM) was developed by Wagner (1998; Figure 15.5) and its value lies in the fact it acknowledges the care of people with a LTC is largely delivered outside of traditional healthcare settings. Whilst this framework was first developed in the late 1990s, the approaches to practice identified within the framework have clear resonance with contemporary nursing practice. This framework of care delivery has been widely adopted globally (Bodenheimer et al., 2002a), and as Drury (2022) suggests, the strength of this model lies in the emphasis placed on self-management and empowerment, which are so important in meeting the needs of this group of people. Drury (2022) and Carrier (2023) identify a number of key principles that underpin the continued relevance of this framework within a healthcare system that facilitates a culture of safe, high-quality care (Table 15.4).

Drury (2022) and Carrier (2023) go onto assert that the framework supports people to manage their own conditions whilst empowering health professionals to deliver evidence-based self-management support and influence the development of community resources to meet the needs of people living with an LTC. These sentiments fit well with current health policy in moving care 'closer to home' and supporting this group of people to better manage their health conditions and reduce potential demand for healthcare services.

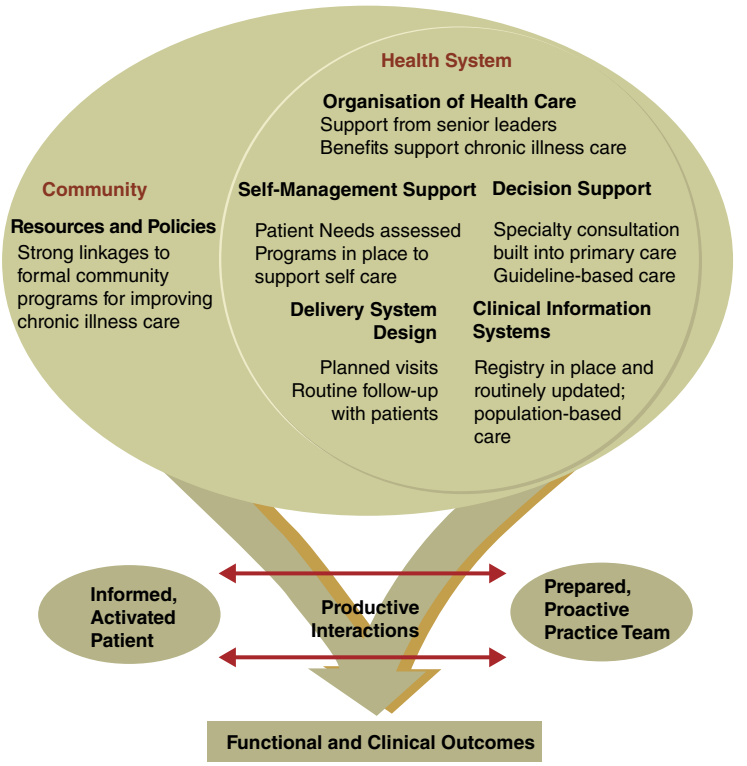


Figure 15.5 The chronic care model. (Wagner, 1998).

Table 15.4 Key principles underpinning the CCM (Drury, 2022; Carrier, 2023)

Community resources to meet the needs of people with a LTC
The healthcare system – a culture that facilitates safe, ongoing high-quality care
Empowerment of individuals and families to manage their health
Designing effective and efficient care with self-management support
Promoting evidenced-based care
Organising patient and population data to facilitate effective care delivery

Bodenheimer et al. (2002a) recognise the challenges of implementing the CCM. Acknowledging the complexity of the overlapping spheres of the community, the healthcare systems and the provider organisations, Bodenheimer et al. (2002b) suggest that elements of the model can be effectively implemented within the primary care setting. The model was revised in 2003 (Barr et al., 2003) to include recognition of the wider determinants of health, health promotion and prevention, and it is largely this expanded CCM that is utilised in contemporary practice (Figure 15.6).

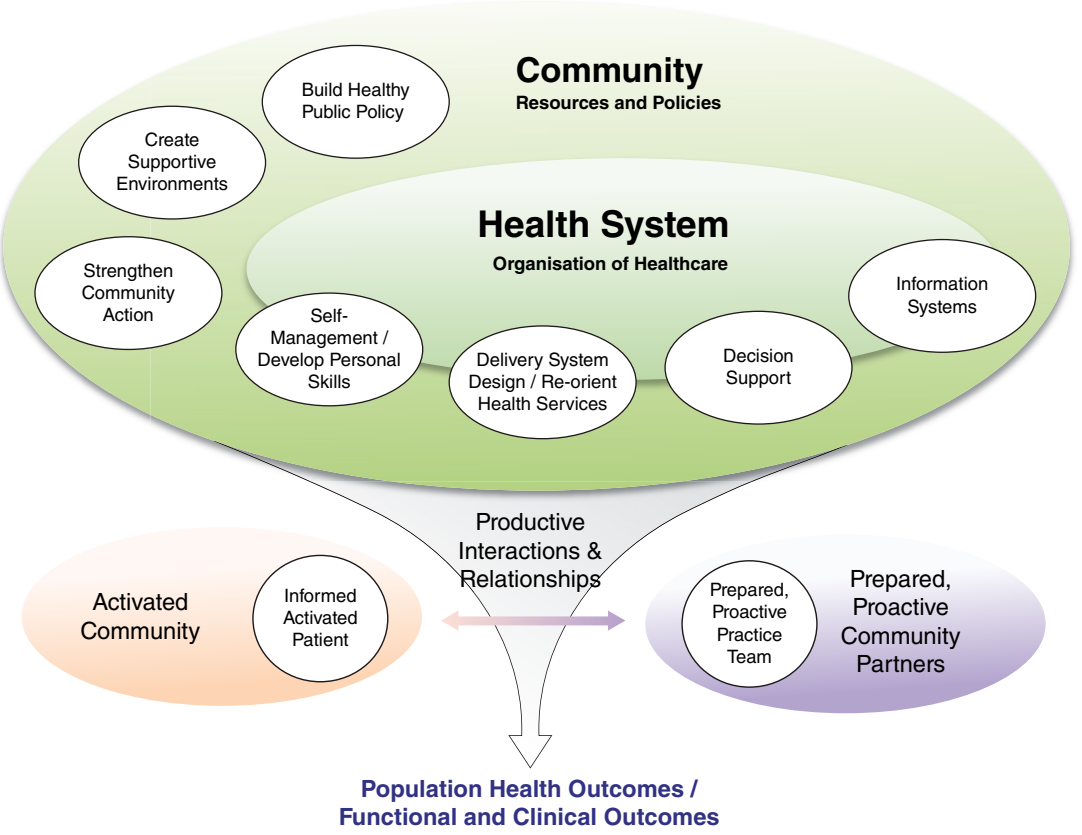


Figure 15.6 The expanded chronic care model. (Barr et al., 2003).

ACTIVITY 15.4

Reflection point – thinking about the expanded chronic care model (ECM), consider the facilitators and barriers to this service delivery model in supporting Bill's care

Bill's story

Bill is 78 years old and lives with his wife in a two-bedroom terraced house. Bill had worked as a mechanic within the public transport sector until his retirement aged 65. Bill started smoking as a teenager and smoked heavily until his early 50s when he suffered a heart attack and underwent heart surgery. He has not smoked since. Bill has suffered with a cough for many years, but over the past five years, he has become increasingly breathless, requiring more frequent interventions from the primary care team. Bill was referred by his GP for consultant review and was diagnosed with chronic obstructive pulmonary disease (COPD). Bill's ongoing care has been delivered in the primary care setting, and Bill was initially monitored on a regular basis by the general practice nurse. As his condition has deteriorated, Bill now has home visits from the community respiratory specialist team and has been provided with home oxygen and a nebuliser for the administration of inhaled bronchodilators and steroids. Bill has also been provided with rescue antibiotics, along with advice and support from a dedicated key worker to coordinate Bill's care.

Reflection points

What is the role of the general practice nurse in supporting patients living with COPD to improve their quality of life? What might be the facilitators and barriers for General Practice Nurses in caring for people with COPD in the community setting?

How has the ECM supported and informed Bill's care in this scenario?

Access the NICE guideline (NG115) Chronic obstructive pulmonary disease in the over 16s: diagnosis and management https://www.nice.org.uk/guidance/ng115 for further information.

HOUSE OF CARE

Drawing on the foundations of the CCM, the House of Care (HoC) approach was developed to meet the needs of the UK population more appropriately (Coulter et al., 2016) (Figure 15.7). Utilising the metaphor of a house it attempts to promote a whole system approach and identify the elements that are required to enable personalised care planning. The simplistic representation of the model belies the underlying interdependency of the different elements of the model and how they work together. The King's Fund (2013) suggests a strength of this model is that it encompasses all people with a LTC and, perhaps more importantly, assumes an active role being played by individuals with a LTC, thus moving away from the health professional being the 'expert' and instead becoming a 'facilitator'.

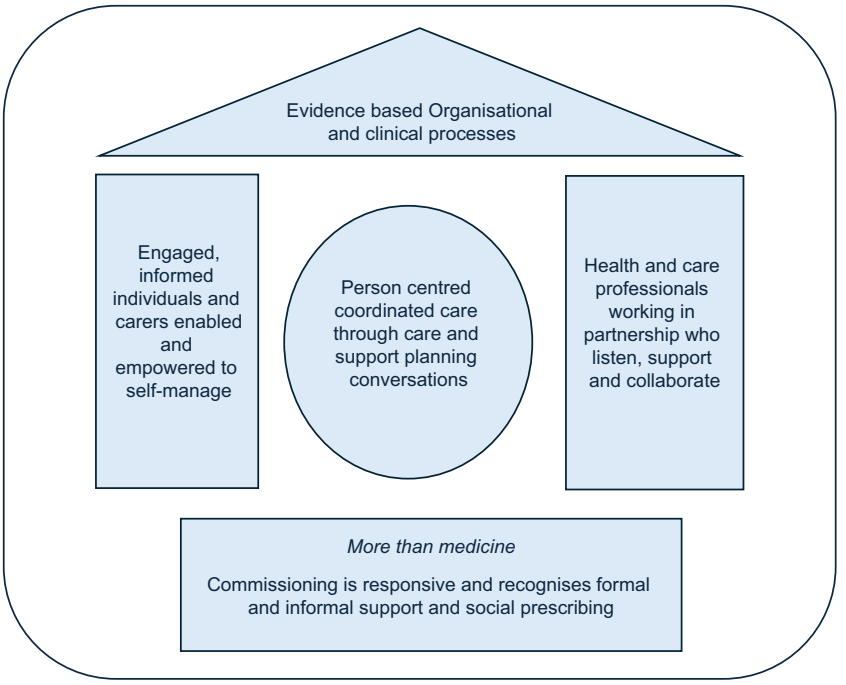


Figure 15.7 The House of Care (The Kings Fund, 2013).

The strong foundations of the HoC require healthcare professionals to recognise the personal assets that people and their families bring to the care planning process, along with the breadth of local community and self-help groups that can provide relevant support (Coulter et al., 2016) described as 'more than medicine'. Social prescribing and community signposting provide the strategic framework to support health professionals to engage with community and third-sector partners in a meaningful way. Care planning is placed at the centre of the house with the left wall referring to the engaged and informed patient, the right wall representing healthcare professionals committed to partnership working and the roof representing the required organisational systems (The King's Fund).

ACTIVITY 15.5

Considering the different service delivery models, what are the similarities and differences between the models and frameworks discussed. How might the shifting perspective model influence the care delivery in Sarah's case? What would be the benefits of the HoC approach for Bill and for the health and social care professionals involved? Comparing and contrasting the alternative models supports the development of greater knowledge and understanding underpinning your professional practice as a community and primary care nurse.

SELF-CARE APPROACHES, HEALTH PROMOTION AND BEHAVIOUR CHANGE

It is well documented in the literature that people living with a LTC are heavy users of healthcare resources (Kings Fund, 2013; Barker et al., 2018; The Health Foundation, 2023). Barker et al. (2018) undertook an in-depth cross-sectional analysis of electronic health records and concluded that more engaged patients used healthcare services less often and suggest that supporting patients with a LTC to manage their own care is not only an indicator of high-quality care but could also be associated with lower healthcare utilisation. This underlines the value of promoting self-management capability, and the challenge for health professionals is identifying the most appropriate strategy for the individual. Coulter et al. (2015) explored through a systematic review the benefits of personalised care planning and identified that a personalised approach did lead to improvements in people's ability to self-manage their care. Goal setting and elements of health coaching and education have also been found to improve engagement (Greene et al., 2016). The challenge for healthcare professionals is identifying the most appropriate strategy and implementing this within the constraints of service availability and provision both locally and nationally.

HELPING PEOPLE TO CHANGE BEHAVIOUR

The focus of the current health policy agenda across the UK in the context of caring for individuals with a LTC is on prevention, early diagnosis and engagement with individuals to achieve improved health outcomes and reduce demands on primary and secondary care services. The wider public health agenda and the role of the community nurse in delivering this agenda is discussed in Chapter 3, but here the focus is to explore how community nurses can utilise different models and frameworks to support people with LTCs to engage more fully in self-management activities with the aim of improving individual health outcomes.

The individual's perception of health and their ability to have control over their health are significant factors for individuals engaging with health-promoting behaviours. If health is not perceived as an important or valued concept, it is unlikely that individuals will act on health promotion messages (Joomun, 2023). Community and primary care nurses are well placed to understand the individual in the context of their home and community, and this presents significant opportunities to engage with people in a meaningful way when delivering health promotion messages.

Theoretical perspectives provide insight into the barriers that individuals face in changing behaviour and, more importantly, illustrate why a holistic approach is vital for community and primary care nurses in supporting people with LTCs. These are largely viewed as cognitive theories as opposed to the behaviourist approach underpinning the more practical models. The theory of reasoned action (Fishbein and Ajzen, 1975) considers the individual and the

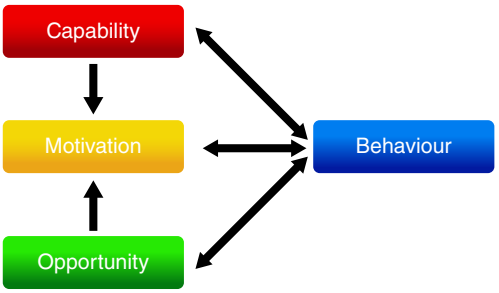


Figure 15.8 COM-B model. (Michie et al., 2011).

influence of those around them. Similarly, Bandura's (1977) social learning theory suggests that observing and learning from the actions of others influences our behaviours. So, the key point of these theories is the individual cannot be considered in isolation when thinking about supporting behaviour change, but a holistic approach is required to be able to support people to make appropriate lifestyle choices. Finally, it is worth making some mention of the COM-B model (Michie et al., 2011). According to this approach, for a given behaviour to happen, the individual must have the capability and opportunity to engage in that behaviour, and the individual is more motivated to engage in that behaviour as opposed to any other behaviours (West and Michie, 2020) (Figure 15.8)

The COM-B model would seem to make links between both the cognitive and behaviourist elements of the behaviour change whilst recognising the influences of the individual's social environment on their ability to engage in any particular behaviour.

In relation to LTCs, the health belief model modified by Becker in 1974 (cited in Naidoo and Wills, 2016) would seem to offer the community and primary care nurse a valid approach to supporting people with LTCs. The health belief model encourages the individual to explore their perceptions of their susceptibility to a condition and the potential severity of that condition. The perceptions of the individual are impacted by demographic and sociopsychological variables with the result that the person's health choices are impacted by external triggers including peer pressure, familial attitudes and media influences. This model fits well with the HoC service delivery framework as it can form the basis for that very powerful conversation between the community nurse and the individual that sits at the heart of the HoC and identifies the goals and concerns that will form the basis of the subsequent nursing interventions.

The transtheoretical model (Prochaska and DiClemente, 1983) describes the stages of change that an individual may go through in any lifestyle change journey (Figure 15.9), but the challenges of changing lifelong habits that are embedded in the individual's domestic and social practices should not be underestimated. Joomun (2023) identifies that at each stage of this model, the individual will be considering whether to make a change, thinking about the pros and cons of any

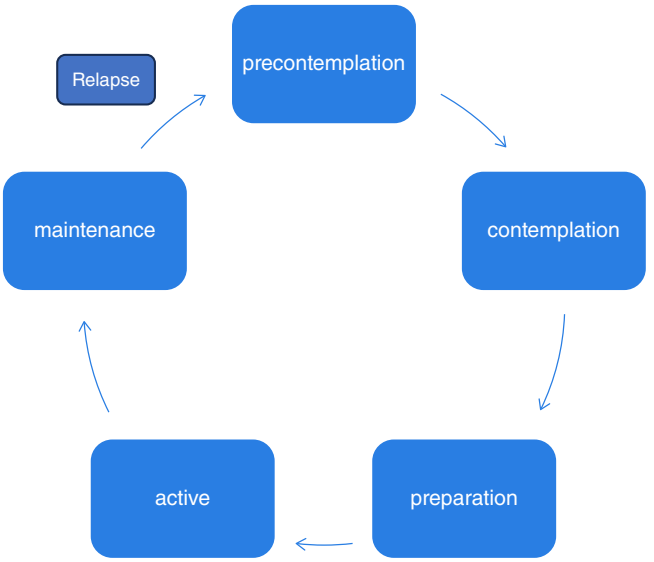


Figure 15.9 The transtheoretical model (stages of change).

change, questioning the impact of that change and exploring the support that is available whilst making that change. In the face of the individual's ambivalence about making a change, motivational interviewing (MI) can be a useful tool for the community and primary care nurse supporting individuals for whom behaviour change would be advisable. A partnership approach embracing the principles of MI – collaboration, evocation and patient autonomy – allows an exploration of this ambivalence to find a way forward for individuals struggling with the concepts of self-management of their LTC and their lives and lifestyles (Seddon, 2018).

The individual's perception of health and their ability to have control over their health are significant factors for individuals engaging in health-promoting behaviours. If health is not perceived as an important or valued concept, it is unlikely that individuals will act on health promotion messages (Joomun, 2023). Community and primary care nurses are well placed to understand the individual in the context of their home and community, and this presents significant opportunities to engage with people in a meaningful way when delivering health promotion messages.

SOCIAL CHANGE

There is a risk with any behaviour change approach that the individual will see themselves as 'to blame' for their LTC as there is little consideration given to the wider social, cultural and political influences on health.

A social change approach acknowledges the influence of the socio-economic environment on health and aims to 'make the healthy choice the easier choice' (Naidoo and Wills, 2016), but this may not always be a realistic choice due to cost, availability or accessibility. Community and primary care nurses are

themselves valuable resources in supporting people with a LTC and have a professional and ethical responsibility to understand the social change element of their health promotion interactions with individuals. At its most fundamental, drawing on their understanding of the communities in which their patients live informs realistic conversations between the nurse and the individual. This local knowledge will support the community and primary care nurse to signpost individuals to local support groups and services whilst recognising the constraints that individuals face in attempting to make 'healthy choices'. Both the HoC model and the expanded CCM service delivery frameworks recognise the impact of social and organisational issues on supporting people with an LTC.

ACTIVITY 15.6

Reflection point – the purpose of this reflective activity is to think about the challenges of behaviour change and how these influence individuals in the effective self-management of a long-term condition.

Ted's story

Ted is 55 years old and has a strong family history of cardiovascular disease and Type 2 diabetes. Ted is currently taking antihypertensive medication, and as part of his annual review, pre-diabetes was identified. Ted works full-time as a driving instructor, which he finds stressful and works long hours in a very sedentary environment. Ted has noticed that he is putting on weight and now has a BMI of 28. Whilst Ted doesn't smoke and rarely drinks alcohol, he is aware of the need to make changes to his lifestyle to prevent the development of Type 2 diabetes, but he is finding it really difficult to make changes and is becoming increasingly anxious about his health.

Ted is offered an appointment for the diabetic clinic at his surgery and asks for help and advice for addressing his health issues and, in particular, steps to prevent the development of Type 2 diabetes.

Reflection points

As a community and primary care nurse, reflect on your practice to identify areas where you engage with prevention, health promotion and education. How do you evidence this?

In Ted's case, how might you utilise the elements of the health belief model to inform your consultations with Ted with respect to his long-term condition?

What might be the strengths and limitations of the stages of change model in helping Ted make changes to his lifestyle? What might be the key issues for the practice nurse to address?

Access the NICE Public Health Guideline [PH38] Type 2 diabetes: prevention in people at high risk https://www.nice.org.uk/guidance/ph38 and Diabetes UK https://www.diabetes.org.uk/diabetes-the-basics/types-of-diabetes/type-2/preventing for further information on prevention.

SUPPORTING CHILDREN AND YOUNG PEOPLE WITH LTCS

It is important to remember that LTCs are not the prerogative of the adult population but can have a significant impact on children and young people where they present different and significant challenges. Daniel and Brimble (2021) point out that when a child is diagnosed with a LTC, this impacts not only the child but also their whole family with a consequential sense of loss – loss of control, loss of familiar lifestyle, loss of the certainty of a healthy future for the child. It is also clear that with the advances in neonatal and childhood healthcare, more children are surviving into adolescence and adulthood with complex and multiple co-morbidities (Royal College of Paediatrics and Child Health [RCPCH], 2020). In addition to this, these children are more likely to develop mental health conditions and need support to transition from child to adult health services. The needs of children with a LTC are very different from those of adults and as children grow and develop their needs and those of their families will change over time. As a result of this, LTCs in children and young people can follow a varying course of progression, which poses particular challenges for health professionals supporting children and young people and their families.

Diabetes offers a good example of the challenges faced by children and young people diagnosed with a LTC and, by association, identifies the complexity of the support required from community and primary care nurses in caring for this vulnerable group of individuals and their families. The RCPCH (2020) identifies that diabetes is increasingly common among children and young people in the UK, with an estimated 36,000 children younger than age 19 having diabetes. Whilst 90% of cases are Type 1 diabetes, Type 2 diabetes is increasingly common. It is salutary to note that children living in the most deprived areas across England and Wales have poorer blood glucose control than their peers living in the least deprived areas. Of course, the real significance in this is the greater risk of developing long-term complications associated with diabetes. The National Institute for Health and Care Excellence (NICE, 2015) make clear the importance of tailoring education programmes to meet the needs of each child or young person with both Type 1 and Type 2 diabetes to take account of their personal preferences, their emotional wellbeing, their age and maturity and their existing knowledge and understanding. Alongside this, consideration needs to be given to the individual's social circumstances and their own life goals. Much of this care will be delivered in the community and primary care setting in partnership with specialist services and again this integrated approach reflects the holistic approach advocated within the service delivery frameworks that have been discussed.

TRANSITION TO ADULT SERVICES

Whilst further in-depth discussions in relation to the delivery of care across the lifespan may be found in Chapter 8, for children and young people with a

LTC, the transition process is more than simply transferring from one hospital or unit to another. It is a multifaceted, active process to meet the needs of young people as they move from child to adult services (Crowley et al., 2011). This transition can be a difficult and stressful time for young people as they move away from the 'safety' of the care services they have grown up with and into the 'unknown world' of adult care services, emphasising the need for a coordinated and structured approach to promote a positive experience for the young person and their families (Table 15.5). Bill and Hodges (2021) suggest that the challenge for young people is not just the feeling of unpreparedness or lack of trust but that the experience is also coloured by parental views of the transition process, alongside the feeling of having to face their own mortality when they come into contact with older people who may be more unwell with more advanced disease. The psychological element of the transition process should not be underestimated, and here, the nurse plays a key role. In building effective relationships with young people and their families, the nurse can facilitate

Table 15.5 Transition from child to adult services (NICE, 2016)

Transition planning	Start planning early – think about before, during and after transition. Ensure planning is developmentally appropriate not based on a rigid age threshold – consider the Stages of Transition framework (RCN, 2004) Review frequently Inclusive approach including the young person and their family
Named key worker	Coordinate care and signpost support Facilitate meetings with a practitioner from the adult service prior to transfer. Act as an advocate Consider wider issues – education and employment, independent living
Involve young people	Utilise appropriate communication strategies to engage with young people. Ensure transition support is person-centred and not defined by age categories Involve young people in the co-production of policies and strategies
Build independence	Peer support groups Coaching and mentoring opportunities Support young people to be able to manage their own condition
Involve parents and carers	Ask the young person how they want their parents/ carers to be involved Develop confidence – Provide young people with opportunities to ask questions or raise concerns separately from their parents/ carers. Manage expectations

open communication, promote autonomy and decision-making and support the young person to set realistic and positive goals.

McCallum (2017) recognised that much of the care for young people with LTCs is delivered in the community and primary care setting and considered the role of community and primary care nurses in providing this care. Kime (2013) suggested that community and primary care nurses are well placed to take a more active role in the transition process as they see the young person in their home and community and are, therefore, able to provide a more holistic approach to appreciating the young person's lifestyle and personal goals.

THE ROLE OF THE COMMUNITY AND PRIMARY CARE NURSE

ACTIVITY 15.7

Activity – professional issues

Primary and community nurses work with complexity in caring for their patients with LTCs which requires a range of skills and attributes. What are your strengths, what might be areas requiring further development? Draw on your professional Code (NMC, 2018) to inform your reflection. In addition, utilise the NMC (2022) Standards of Proficiency for Community Nursing Specialist Practice Qualification to explore your professional practice. You might wish to make particular reference to the following:

Platform 1: Being an accountable, autonomous professional and partner in care
Platform 2: Promoting health and wellbeing and preventing ill health
Platform 3: Assessing people's abilities and needs, and planning care

Consider how these support your practice in the management of people (both children and young people and adults) with LTCs and their families.

Nursing is a largely practical phenomenon and is often defined in the context of the 'what' of our role. However, the art and science of your professional role is much greater than the sum of its constituent parts. As a professional nurse it is important to consider the much wider extent of your role and to consider the 'why' of what you do – it is this that drives the continued development of the community and primary care nurse's role. The vision for contemporary community nursing practice is to promote person-centred care and increase the individual's involvement through a model of self-care. Whilst community nurses may be seen as pivotal in supporting this for people with a LTC, a multi-professional collaborative approach is key (Chapter 13) including consideration of the role of informal carers (Chapter 11) and the value of digital technology in supporting the community and primary care nurses' care delivery (Chapter 19).

Reflection and reflective practice are accepted as valuable learning tools and a way of turning experience into knowledge (Howatson-Jones, 2016).

Reflection provides the opportunity for the development of awareness of one's strengths and weaknesses, essential in our professional lives (Mahon and O'Neill, 2020). Supporting people with complex needs requires acknowledgement of limitations in our knowledge and skills (NMC, 2018) and recognising the need to address these to deliver evidence-based care: critical reflection provides a framework to enable this. Reflection has been encouraged throughout this chapter to support the development of knowledge and understanding relating to the care of people with an LTC. Learning may be seen as reciprocal – as a community nurse education of people in our care underpins the ethos of self-efficacy and self-management. It is important also to value learning from those in our care (Seddon, 2018) which leads to enhanced shared learning, appropriate health outcomes and improved quality of life for people with a LTC.

CONCLUSION

This chapter has provided an introduction to a number of emerging issues associated with the contemporary LTC policy agenda and explored this in the context of primary and community nursing practice. If the challenges posed are to be successfully tackled, the new generations of community and primary care nurses will need to acquire, maintain and update specific skills and apply new models of intervention. The complexity of the care and support needs of people with LTCs has been explored and the importance of taking account of individual needs, preferences and capabilities has been considered in the context of informed decision-making and true partnership working. It is evident that the wider determinants of health need to be acknowledged and appropriate health promotion strategies adopted so that people can make properly informed decisions about their care. The national policy agenda has been identified along with reference to the wider global picture, and these will continue to focus on collaborative and coordinated care where the role of the community and primary care nurse will remain pivotal.

FURTHER RESOURCES

There are a plethora of materials considering the care and management of people with a LTC, and it is worth noting that almost all conditions will have at least one dedicated website which you may wish to access and share with the people you care for. Many of these consumer-led sites engage in advocacy and campaigning:

Diabetes UK – https://www.diabetes.org.uk/
British Heart Foundation – https://www.bhf.org.uk/
Asthma and Lung UK – https://www.asthmaandlung.org.uk/conditions/copd-chronic-obstructive-pulmonary-disease

For self-care and self-management, resources can be found at the following websites:

Supported self-management – https://www.england.nhs.uk/personalisedcare/supported-self-management/
The Patients Association – https://www.patients-association.org.uk/self-management

Health & Social Care Alliance Scotland - Self-management – https://www.alliance-scotland.org.uk/self-management/self-management-network/

For professionals:

National School of Healthcare Science – Self-management Handbook – https://nshcs.hee.nhs.uk/training-support/healthcare-science-self-care-handbook/what-does-self-care-mean-to-you/

For carers:

Carers UK Wales – https://www.carersuk.org/wales/
Carers UK – https://www.carersuk.org
Age UK – https://Ageuk.org
Carers Trust - Caring as a Young Carer – https://carers.org/about-caring/about-young-carers

Living with, or caring for, someone with an LTC can have significant mental health impacts and here are dedicated websites and resources to support people and their carers:

Mind – www.mind.org.uk
Young Minds – https://www.youngminds.org.uk/young-person/coping-with-life/self-care/

For the LGBTQ+ community you may find the following websites useful and informative. It is worth noting that organisations such as Age UK and Mind also have specific information on their websites that may be helpful:

Stonewall – www.stonewall.co.uk
LGBT Foundation – https://lgbt.foundation/

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CHAPTER

16

Providing quality end-of-life care

Gina King and Matthew Sunter

LEARNING OUTCOMES

- Critically explore the UK's end-of-life care policy and evidence underpinning the delivery and quality of care in the community.
- Analyse the importance of a holistic, proactive approach in assessing the needs of a person at the end of life and those important to them.
- Critically examine compassionate leadership and the importance of collaborative and coordinated interdisciplinary teamwork within end-of-life care.
- Evaluate the importance of equity and diversity within religious and cultural communities at the end of life and the impacts on grief, loss and bereavement.

INTRODUCTION

The term *end-of-life care* is now well established in the vocabulary in Health and Social Care, its importance magnified by policy direction in the past decade. Now, more than ever, it helps professionals acknowledge and more actively plan ahead for the care that may be needed to optimise quality of life and focus on living rather than dying. Policies developed as a result of the revelations from national investigations into poor communication with individuals and those important to them prior to their death have caused a change in the way care is delivered and measured (Neuberger et al., 2013). The ACT (Acknowledge, Communicate, Think Ahead) Circle is a tool that provides standardised quality person-centred care and is explored in this chapter along with key national policy drivers such as the UK Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2021–2026 (NPEoLCP, 2021), *One Chance to Get It Right* (LACDP, 2014) and Human Rights for End of Life Care (BIHR & Sue Ryder, 2017). With the complexity and emotional challenges end-of-life care places on nurses and healthcare teams, compassionate leadership is required and examined. It is also essential that community nurses are equipped with the knowledge and skills to address equality, diversity and inclusion in a sensitive and compassionate way to ensure the excellent delivery of care when there is only 'one chance to get it right'.

DOI: 10.4324/9781003347545-17

END-OF-LIFE CARE POLICY ACROSS THE UK

In 2008, the NHS End of Life Programme released an End-of-Life Strategy for England as evidence showed that the older population was living longer with more co-morbidities, and it was predicted that this would place a burden on future health and social care services. This was a key turning point in addressing and promoting end-of-life Care for all adults in England (Figure 16.1).

The 2021 Census shows that each year in the United Kingdom, 667,500 people die, and despite the recent drop in the number of people dying, the population is still ageing. The populations of England and Wales, in particular, have continued to age since 2011 (ONS, 2021). By 2039, it is predicted that over 70% of the UK's population will be 60 years of age and older, demonstrating an increase from 14.9 million in 2014 to 21.9 million (ONS, 2021). This current forecast of an older population could impact health and social care services even further because, as each person ages, it increases the individual's risk of more co-morbidities including frailty (GOS, 2016), affecting how care will be managed at home and where they choose to die. In general, death is an event that occurs in old age with 68.5% of all deaths occurring in people aged 75 years and older (NEoLCIN, 2020). The projected increase in major illness will mainly affect people aged 70 and over as the baby boomers reach old age and life expectancy increases (Watt et al., 2023). These are important demographic changes with implications for community nurses who will need to manage the care of people with more complex needs as the population ages.

The report *One Chance to Get It Right* (2014), which was the response to the "More Care Less Pathway" (2013) enquiry, highlighted that it is essential that clear and understandable communication regularly occurs to support ongoing concerns and uncertainties with all those involved in their care. The main priority is maximising comfort and wellbeing (NPEoLCP, 2015). This will, at times, include discussions around limits of treatment, including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), withholding and withdrawing



Figure 16.1 Timeline of policy direction.

treatment and preferred place of care and death (LACDP, 2014). It is important to consider that these difficult conversations for the person and those around them need to be communicated with empathy and clear recognition of any emotional stress and distress that may have been caused (LACDP, 2014). Being fully informed about the process related to decisions around DNACPR including the Mental Capacity Act (MCA, 2005) will help community nurses support individuals and those important to them in making informed choices about their future care.

The *Ambitions for Palliative and End of Life Care* (2015) was a framework established for local implementation from 2015 to 2020, which was revised in 2021 for a further 5 years. The Ambitions built on the national end-of-life care strategy (NPEoLCP, 2015) and the associated 12 key principles. It advocated the need for effective leadership and commissioning of health and social care services by Health and Well-Being Boards in 2015, and now more recently by the integrated care systems (NPEoLCP, 2021). The Ambitions also include six goals based on learning from papers such as the Francis Report (2013); *More Care, Less Pathway* (Neuberger et al., 2013); *One Chance to Get It Right* (LACDP, 2014); and the Ombudsman Report (PHSO, 2015).

The Ambitions are underpinned by 'building blocks' that provide foundations for providing high-quality care.

The six ambitions for palliative and end-of-life care

1. Each person is seen as an individual.
2. Each person gets fair access to care.
3. Maximising comfort and wellbeing.
4. Care is coordinated.
5. All staff are prepared to care.
6. Each community is prepared to help.

Elsewhere in the UK, Northern Ireland, created a new vision "Living Matters Dying Matters" (LMDM) in 2010 outlining a 5-year plan to improve the quality of palliative and end-of-life care irrespective of care setting or condition (DOH, 2010). This strategy voiced a person-centred approach, choice and options as to where their care is provided at the end of life (DoH, 2010). Northern Ireland's "Transforming Your Palliative and End of Life Care" is based on the Delivering Choice Programme approach which has been used in 19 sites across the UK, where it has contributed to improved experiences for people with palliative and end-of-life care needs and their families (HSCI, 2023).

In Scotland, its framework (2016) set out a vision for the next five years, with outcomes and ten commitments to support improvements in the delivery of palliative and end-of-life care across Scotland (Gov.Scot, 2023).

In Wales, the quality attributes of services for palliative and end-of-life care (Welsh Government, 2023) sets out domains such as "Safe", "Timely", "Effective",

"Person-centred Care", "Efficient" and "Equitable" using metrics and cross-working groups, which was last updated in 2022.

The practicality of such policy drivers can be captured by the NHS England personalisation agenda, known as the person-centred approach in the Long Term Plan (NHS England, 2019 and Human Rights for End of Life Care for the UK [BIHR], 2017). The six "Articles" of human rights interlink with the Mental Capacity Act (MCA) (2005) and have an emphasis on "Rights" of the person with or without capacity (BIHR & Sue Ryder, 2017):

- *Right to life* (Article 2)
- R*ight to be free from inhuman or degrading treatment* (Article 3)
- *Right to Liberty* (Article 5)
- *Right to private and family life, home and correspondence* (Article 8)
- *Right to freedom of thought, conscience and religion* (Article 9)
- *Right to enjoy all these human rights without discrimination (Article 14)*

ACTIVITY 16.1

Consider how national policy drivers might positively influence the delivery of end-of-life care in the community and promote possible quality improvements in your own practice.

ASSESSMENT OF INDIVIDUALS AND THOSE IMPORTANT TO THEM

The ACT tool (Figure 16.2) was first developed in 2019 as a prognostication tool for all care settings and includes the Prognostic Indicator Guidance, the Supportive and Palliative Care Indicator Tool (SPICT) and the Rockwood Frailty Score. The concept is to encourage the professional to plan ahead for the individual and those important to them (NHS England, 2019). It addresses eight disease trajectories and is laid out in a practical wheel that incorporates three main proactive phases/thought processes:

Acknowledge this person is entering their last days/weeks/months of life

Communicate the prognosis, identify wishes and discuss personalised care planning

Think ahead. Will their needs change, and how will carers manage this? Inform and plan with multidisciplinary team (MDT)/OOHs and assess their holistic needs.

Further reading is recommended on other models or tools that provides a process to deliver quality end-of-life care such as 'The Six Steps', Amber Care Bundle, Gold Standards Framework and the North West end-of-life care model.

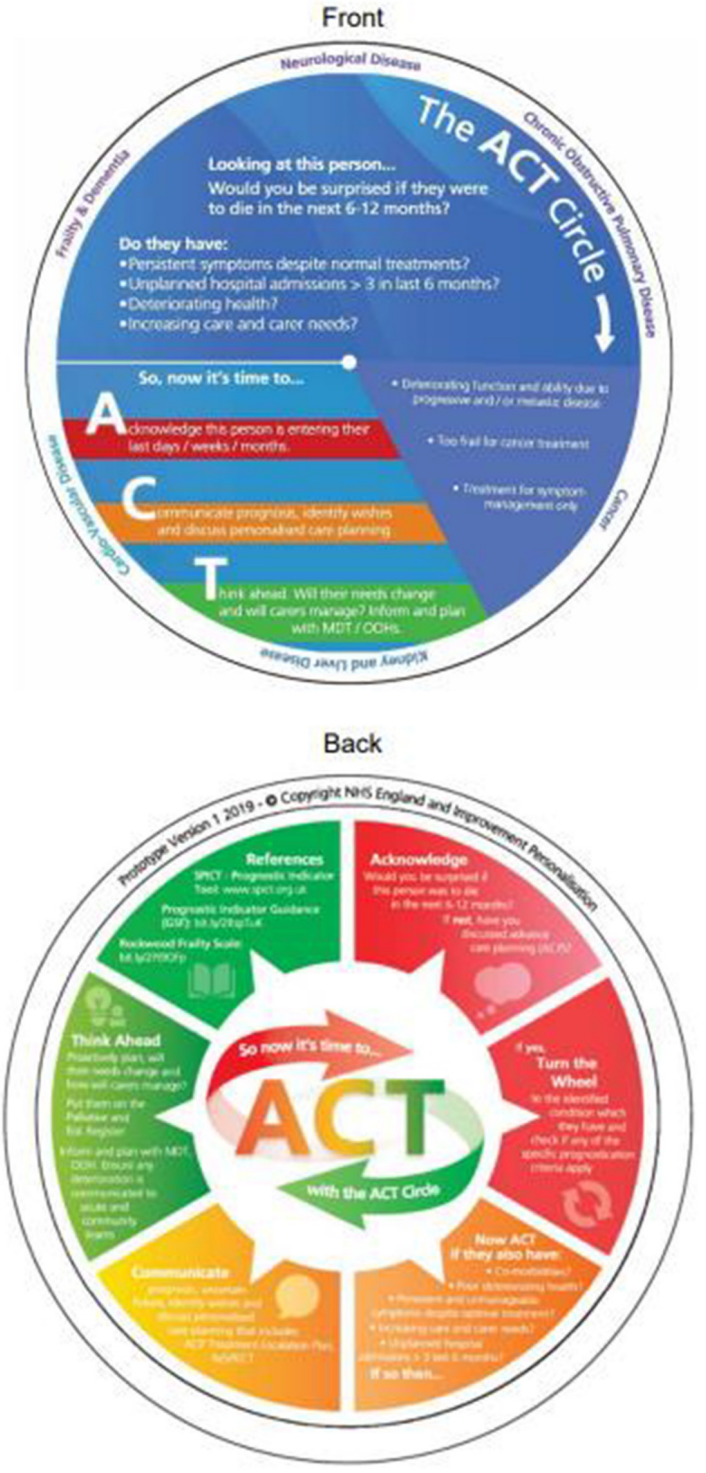


Figure 16.2 The ACT tool.

Acknowledge

Early identification of the end-of-life stage is one of the most important processes to take place to allow sufficient time for the individual to discuss their preferences and wishes (NICE, 2021). The Dying without Dignity investigations led by the Parliamentary and Health Service Ombudsman into complaints about end-of-life care (PHSO, 2015) highlighted several key themes such as the lack of recognition that people are dying, leaving insufficient time not only for care to be planned and discussed but also for open and honest conversations with the person and those important to them.

The Gold Standards Framework developed the 'Prognostic Indicator Guidance' (PIG), which outlines the Karnofsky Performance Status Score, the three main disease trajectories (cancer, neurological conditions, dementia/frailty) and, most importantly, recommended the adoption of the 'surprise question', which is, 'Would you be surprised if this person were to die in the next 6–12 months?' (GSF, 2011).

In comparison, the SPICT, produced by NHS Lothian (Scotland), advises scrutiny of general indicators of poor and/or deteriorating health, such as progressive weight loss, persistent symptoms (despite optimal treatment), increased carers need and reduced performance status. Guidance is then to review 'clinical indicators of one or multiple life-limiting conditions' and 'current care and care planning', which might include, for example review of current medication to minimise polypharmacy (NHS Lothian, 2022). The SPICT tool has been adapted in Wales, creating an 'Identifying patients for supportive, palliative and advance care planning' tool including the GSF surprise question (PallCare.info, 2023). The EoL pathway from *One Chance to Get It Right* (2014) outlines the stages of disease progression (Figure 16.3) and provides a template where the professional could be supporting care planning discussions.

The key aspect of the EoL pathway is to identify those patients who are approaching the end of their life. Historically, this has presented a challenge not only in relation to prognostic tools that can be complex to use but also in acknowledging the time when care becomes palliative as opposed to curative.



Figure 16.3 EoL pathway taken from *One Chance to Get It Right*.

Prognosing end of life can create its own difficulties; however, for the community nurse, it is about recognising that the person is deteriorating and acknowledging the need to instigate future planning. However, Bruun et al. (2022) explored that all members of the MDT must work together to share decision-making in relation to a person's care. Without such collaboration, prognostication and communication with patients, regardless of their diagnosis, can be hindered, discussions around preferences and options will not take place and families and friends will not be appropriately supported and individuals will not achieve a good death.

Communicate

Good communication skills are essential not only to initiate conversations and discussions with individuals and those important to them as end-of-life care approaches but also to provide support, help and advice to them along their journey and to help them feel valued (Marcus and Mott, 2014). It is the professional's responsibility to recognise that it is a two-way process and that the individual's information needs will vary over time and circumstances (responsive communication; NICE, 2021). This can be a challenging prospect for many health professionals as it may provoke professional discomfort based on many influencing factors, such as the professional's accountability and responsibility; knowledge, skills, attitude and expertise; workload pressures; and the fear of getting or creating upset for the patient/family (Marcus and Mott, 2014).

Everyone should have the opportunity to be offered honest and well-informed conversations about their future, which may include discussions around death and dying, and everyone must be seen as a unique individual (NPEoLCP, 2021). There is no point on the 'end-of-life pathway' that is the optimum time to initiate a discussion around end-of-life care; however, 'the earlier, the better' is advocated to allow the patient the opportunity to make informed choices and support the process of advance care planning (ACP). Zwakeman et al. (2021) found that, although people may often seem unprepared to have a conversation and to start thinking ahead about their end-of-life plans, they should still be given an opportunity by the professional. Alternatively, Compassion in Dying (2018) revealed that it was often the professionals themselves who were more reticent to have an ACP conversation. However, it is also important to respect the wishes of a person and those important to them if they do not wish to have an open dialogue about their diagnosis or prognosis, but community nurses need to recognise that this may change over time (Skills for Health, 2017).

For those people for whom English is not their first language, it is recommended to arrange appropriately trained interpreters to enable people to communicate in their preferred language (NICE, 2023). Within communication, it is worth remembering, however, that only 7% reflects the words used with tone, reflecting 38% and body language 55% (Mehrabian, 1967). Table 16.1 provides guidance on how best to communicate and have more meaningful conversations.

Table 16.1 Communication guidelines

Factors to consider	Guidelines	Positive example	Negative example
The environment	Presence of calm, private & safe space	Quiet room, arranged time, no disturbances	Noisy and busy ward/outpatients
Demonstrating empathy	Encouraging facial expressions, open posture, hold hands if appropriate, & acknowledge feelings	Nodding of head, eye contact, open arm 'I understand how difficult this must be for you'	Non–eye contact, blank expression, impatience
Listening without judgement, accepting, resecting	Being present and silent while they work out what they want to say	Using time & space after you have asked an open question	Interrupting while the person talks
Non-verbal communication	Understanding how your posture may reflect barriers in communication. Observing the patient's body language	Relaxed posture, eye contact, encouraging and warm smile	Arms and legs crossed, tapping of a foot, clenching of hands
Verbal communication	Use of simple language & Open questions – Who/ what/why/when/ where/how "**Tell me** what has"	Ask "What matters to you"/" What information do you need?"/	"Have you been doing what the doctor told you to do"
Being honest	Humanity and being open & genuine	Tell me what has been happening lately	Saying okay but
Cultural considerations	Explore individual faith and cultural needs	Use of "Opening the spiritual gate" website"	Treating every person the same
Building trust, rapport & openness – unconditional positive regard	Listening without judgement Use of reflection and silence	I am listening and I have heard you say "…"	Looking at your phone

Thinking ahead

ACP is a process of discussion between an individual and their care provider irrespective of discipline. The person is central to developing and agreeing their ACP, including deciding who else should be involved in the process (NHS England, 2022). With the individual's agreement, this discussion should be documented, regularly reviewed and communicated/shared to key people involved in their care (NHS England, 2022). The difference between ACP and general care

Table 16.2 Highlights key resources/tools that support the MCA (2005) and the Universal Principles of ACP (NHSE, 2022)

	Individual with mental capacity	Individual who lacks mental capacity (decision-specific)
ReSPECT (Recommended Summary)	A direct conversation	The completed ReSPECT documents prioritise their wishes (not wants) which need to be taken into account when making best interest decisions
DNACPR	A direct conversation – legal to consent. A second opinion can be requested if they contest but they cannot refuse	Two lawful notes: 1. If there's an Advanced Decision to Refuse Treatment (Living Will) (ADRT) ADRT for not for CPR a DNACPR is not required 2. If there's a Health and Welfare LPA or Deputy, the doctor must consult the named attorney. Disputes – second opinion should be offered. If an absence of both, doctor must speak to "those important to the individual" (and Best Interests)
Advance Statement	A direct conversation	Written or verbal account of wishes and personal preferences, which must be taken into account when making best interest decisions
Advance Decision to Refuse Treatment	A direct conversation	Must be valid and applicable to the circumstances – legally binding. Must be a specific treatment refusal and state even if life is at risk and comes into force when the person's capacity is lost. It is legally binding as long it follows the MCA
Lasting Power of Attorney	Made by the person in conversation with others	Two types (Attorney or Deputy): • Health and Welfare: see DNACPR above • Property and Financial Affairs (2 options) Check with the Office of the Public Guardian (OPG) if you have concerns over the validity and/or representative

planning is that the purpose of ACP is to clarify a patient's wishes and decisions (e.g. preferred place of death) and for these to be incorporated into a general care plan so the MDT can provide appropriate care at the right time and place. The person must only have capacity when decisions are made to refuse specific treatments even if the person's life might be at risk (MCA, 2005). Table 16.2 highlights key resources/tools from the MCA (2005) and the Universal Principles of ACP (NHSE, 2022) to support conversations with patients.

HOLISTIC NEEDS ASSESSMENT

Thinking ahead conversations with the person are part of the holistic assessment. The NICE Guidance for End of Life Care (2021) recommends that, for the person and their families approaching end-of-life care, conversations and care should involve the following:

- Provision of written and other forms of information
- Face-to-face communication



Figure 16.4 (Taken from *One Chance to Get It Right*, Leadership Alliance for the Care of Dying People, London, 2014 and supports the Ambitions goals from 1–5.)

- Individual involvement in decision-making
- Control of physical symptoms
- Provision of psychological support
- Social support
- Spiritual support
- Organ and tissue donation

This guidance is supported by the "5 Priorities for Care of the Dying Person" that provides a person-centred care plan and an individualised approach (Figure 16.4).

ACTIVITY 16.2

Case study

Joan is 78 years old and has been married to Harold for 60 years. She has had dementia for 3 years, with a history of arthritis in her hands. Harold is her main carer and has been finding it increasingly difficult to cope recently as Joan is unable to communicate her needs and has begun wandering at night. The GP has referred Joan to a dementia adviser or nurse for further support and information for Harold.

How can you as a community nurse assess Joan's and Harold's needs in coordination with the dementia adviser or nurse to identify the cause of Joan's change in condition?

What other support is available to Harold to ensure he feels he is able to manage?

This holistic assessment of the needs of the person and their family is essential to ensure that all the individual's wishes are considered and helps to identify any unmet areas of care (Gov.wales, 2023). It enables four key dimensions of person-centred care in a holistic assessment (Mills, 2017):

1. Connection
2. Caring attitude
3. Communication
4. Control

The MDT can then coordinate and communicate the best possible care dependent on the level and availability of the services as supported by the NICE Quality Standard for End of Life Care (2021). This is a joint assessment with the individual that involves their consent. It should be based on the principles of person-centred care and is a continuous process as information cannot always be gathered at one visit.

Social needs, such as potential non-means-tested benefits, are important to consider and may include, for example, the Special Rules medical form (Gov. UK, 2024) to support a personal independence allowance, if aged between 16 and 64 years, or, if older than 65 years, an attendance allowance. This is applicable if 'it would not be a surprise if the person were to die within 12 months' (Gov.Uk, 2024). An early assessment of the needs of any informal carers involved is advocated (formal assessment), along with a provision of written information (Care Act, 2014; Chapter 11).

The most important aspect of the holistic assessment is verifying the individual's and their family's levels of understanding of their diagnosis, treatment options and prognosis (Rosenfied et al., 2022). This knowledge then enables discussions in relation to their preferences and choices at the end of life, the development of a proactive and personalised plan of care and an anticipation of crises supported by contingency plans to prevent readmission to hospital and, most importantly, put their affairs in order (NICE, 2021). This can be achieved by 'planning ahead' such as ordering medication and equipment and coordinating and communicating with the MDT, especially out-of-hours (OOH) services. In some areas of the United Kingdom, the MDT use an End-of-Life Locality Register, alternatively known as an Electronic Palliative Care Coordination System, which is a template comprising a 'checklist' that is communicated to OOH services and other care providers. This lists all the key information surrounding decisions and actions in the last 6–12 months of life in a tick-box format (Birtwistle et al., 2022). The community nurse as a compassionate leader should support this process.

COMPASSIONATE LEADERSHIP WITHIN END-OF-LIFE CARE

Compassionate leadership in the context of palliative end-of-life care has been acknowledged as a core foundation for all nurses and healthcare professionals.

Effective leadership is pivotal in this context due to the added complexity the demand end-of-life care places on nurses and healthcare teams collectively. A knowledge of team members, recognising the emotional impact of the role, emotional intelligence and awareness are key aspects to fostering a culture of care. Regardless of organisational seniority, all community nurses hold a professional responsibility to lead end-of-life care with respect and compassion (NMC, 2018). It is important to acknowledge the challenges which may exist for the community nurse leading end-of-life care, such as the risk of personal and emotional involvement beyond the professional boundaries, triggering of emotional responses from personal experiences of death and often limited resources to support professionals with referrals to resources such as counselling (Hewison et al., 2019). This section of the chapter explores topics such as reflective practice, quality improvement, collaborative working and approaches to compassionate leadership.

Community nurses are frequently the professionals who know the person being cared for and the people important to them the best and therefore lead as an advocate and the responsible keyworker for coordinating services. There are undoubted challenges associated with this undertaking, particularly if conflicted ideas and preferences of people and professionals become apparent. Open and honest communication in a sensitive manner is crucial to navigating and facilitating these uncomfortable conversations that require courage. Failing to have open and honest communication can have devastating impacts on people and their trust in healthcare professionals (Francis Report, 2013).

The King's Fund report on 'Dying Well at Home' (Baylis et al., 2023) reinforces the impact and importance of communication in a compassionate and caring way for people and their loved ones at the end of life. With an increasing trend of people wishing to die at home it is crucial for community nurses to be confident to provide the appropriate emotional support and interactions to facilitate coordinated and quality end-of-life care for people at home (Baylis et al., 2023). The emotional demands of caring for people at end of life can be challenging and require community nurses to be responsive to the needs of the people they are caring for or supporting whilst also being aware of their personal and emotional wellbeing (Papworth et al., 2023).

There are recognised risks associated with nurses who are not allocated time and opportunity to evaluate their own wellbeing within the context of delivering end-of-life care. These include moral distress, burnout, compassion fatigue and death anxiety (Bailey and West, 2022; Hussain, 2021). It is important for community nurses to have an awareness and understanding of these possible challenges to enable them to identify and seek appropriate support when required.

For healthcare professionals, engaging in formalised and informal reflective practice is recognised to develop self-awareness and emotional intelligence (Lucas, 2023) by recognising positive attributes and identifying areas for further development. Using a recognised reflective model, such as Gibb's reflective

ACTIVITY 16.3

Reflection

Reflect and explore your own strategies for managing challenges, and consider what support is available to you, both professionally and personally.

cycle, provides a clear and structured guide for aiding effective reflective practice (Griffith 2018). In a similar way, access to timely debriefs, whether immediately following the event or soon after, can provide a safe environment for reflecting upon difficult and emotionally charged situations.

Sharing experiences in a small group with supportive colleagues who are understanding of the events can provide affirmation and validity of feelings and responses to trauma (Kingsley, Hussain and Ma, 2023). Fostering a safe and supportive environment and culture may include frequent team educational sessions about the psychological impacts of delivering end-of-life care from the perspectives of the professionals (Papworth et al., 2023). Community nurses, as leaders, delivering compassionate end-of-life care, must remain aware of their own emotional wellbeing. Utilising opportunities for professional and personal development can further aid community nurses to reflect and understand their actions and responses to difficult situations. Engaging in regular clinical supervision can further support professionals in managing the emotional demands of delivering end-of-life care. This can often be a formal or informal process which provides protected time and opportunity to verbalise and explore the impact on professionals and allows individualised signposting to any specific resources or wellbeing services (Hussain, 2021).

COLLABORATIVE WORKING AND TEAMWORK

Collaborative working is embedded and threaded throughout the core national strategies and policies for end-of-life care, as outlined in the outset of this chapter. MDTs play a crucial role in the landscape of end-of-life care, offering a platform where specialists from various fields converge to discuss and collaboratively address complex cases. These meetings provide a unique opportunity to invite specialist professionals and services, fostering a holistic approach to patient care. One of the primary advantages of MDTs is the chance to engage in discussions with other professionals about deaths that have occurred, allowing for a comprehensive examination of cases and the resolution of any lingering issues. This collaborative approach ensures that different perspectives are considered, contributing to more informed decision-making processes (Fernando and Hughes, 2019). The formal recording of these discussions further establishes accountability and transparency, providing a documented record of joint decisions. As introduced earlier when exploring the ACT tool, utilising an end-of-life register or electronic key information summaries to highlight important information, such as the provision of just-in-case medications, is essential in preventing avoidable hospital admissions and delivering care in accordance with the wishes of the person (The British Institute of Human Rights, 2017).

MDT meetings offer an opportunity of welfare support for staff, validating their decision-making processes and providing a platform for professional development (Borgstrom et al., 2021). Moreover, they often play a crucial role as a safe space for discussion by the professionals caring for people who are ill and/or dying. Collective decision-making and the sharing of emotional burdens are integral components of MDT working. This collaborative approach helps distribute the weight of challenging cases among team members, preventing healthcare professionals from feeling isolated or overwhelmed. The emotional support gained through MDTs contributes to the overall wellbeing of the healthcare team, enhancing their ability to provide compassionate and effective care. This ethos is embedded within the Ambitions for Palliative and End of Life Care framework (NPEoLCP, 2021).

Despite their numerous advantages, MDTs are not without challenges. Coordinating schedules and aligning the priorities of professionals from different disciplines can be logistically complex (Hickey and Williams, 2021). Communication barriers may arise due to differences in professional language and perspectives. Additionally, managing conflicting opinions and achieving consensus in decision-making processes can pose challenges. While the tangible benefits are evident in improved patient care and interdisciplinary understanding, the less tangible aspects, such as emotional wellbeing and professional validation, are equally crucial (Borgstrom et al., 2021). Bruun et al. (2022) explored how MDTs make decisions about the identification of imminently dying patients and found evidence for a partial collaborative approach, with information-sharing being more common than joint decision-making. Issues with decision-making included disagreement between staff members and the fact that doctors were often regarded as final or sole decision-makers (Neuberger et al., 2013). Thus, it is imperative that the community nurse develops their compassionate leadership skills for improvements in shared decision-making.

Figure 16.5 serves to demonstrate the wide variety of services and organisations involved in the provision of end-of-life care. Ensuring that these services are coordinated and seamless is essential to delivering successful and person-centred care at the end of life (Baylis et al., 2023). Whilst not all these services will attend an MDT, the MDT will play a crucial role in identifying and coordinating the appropriate services at the right time in collaboration with the person, carers and loved ones involved.

QUALITY IMPROVEMENT

Quality improvement in community nursing end-of-life care is a critical aspect of ensuring compassionate and effective support for individuals and their families during challenging times. Quality improvement involves a multifaceted approach, incorporating feedback from stakeholders, event analysis, strategic assessments and systematic methodologies. The application of a strengths, weaknesses, opportunities and threats (SWOT) analysis in community nursing

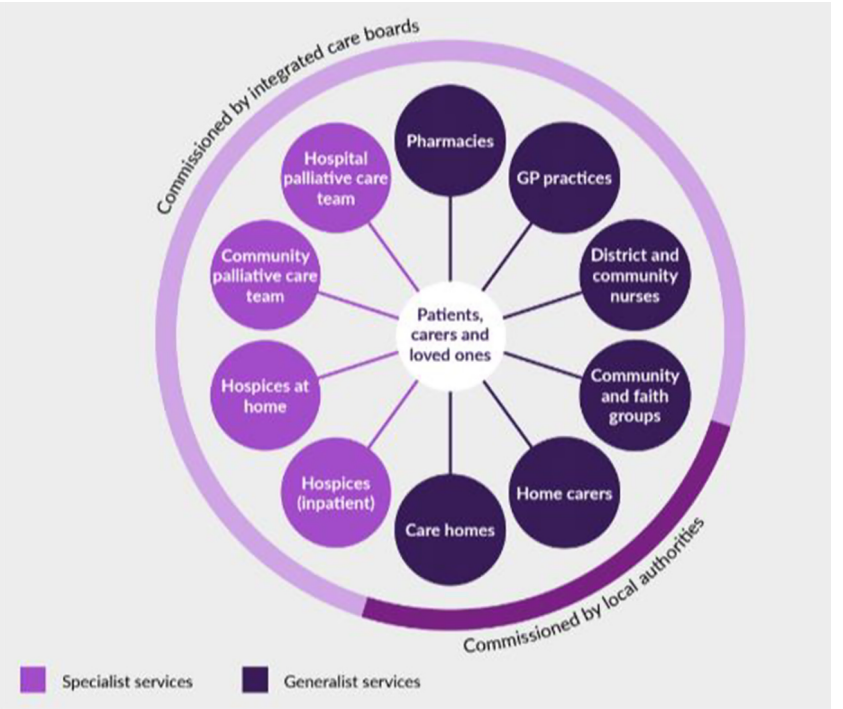


Figure 16.5 Main organisations involved in commissioning and providing end-of-life care – Baylis et al. (2023).

end-of-life care further supports the evaluation of practices, pinpointing specific areas for improvement or development (Barnes and Parfit, 2022). This strategic analysis involves assessing strengths, challenges, opportunities and threats, providing a comprehensive understanding of the current state of end-of-life care and guiding improvements.

Various methodologies and tools are employed to identify and address areas for enhancement in the delivery of end-of-life care. Ferguson et al. (2023) emphasise the value of seeking feedback from relatives and individuals receiving care as a valuable strategy for identifying areas of improvement in end-of-life care. This person/family-centred approach recognises the unique perspectives and experiences of those directly affected, providing valuable insights that can inform targeted quality improvement initiatives. Significant event analysis (SEA) within primary care is another potent tool, acknowledged for identifying areas for quality improvement. Cooper-Moss et al. (2020) highlight its pivotal role in preventing harm while enhancing the quality-of-care provision. SEA involves a systematic analysis of events or incidents, enabling healthcare professionals to learn from adverse situations and implement changes to prevent similar occurrences in the future.

As a leader, utilising tools such as Plan, Do, Study, Act (PDSA; Gillam and Siriwardena, 2013) offers a systematic approach to quality improvement. Leeson (2022) emphasises the cyclical nature of this method, involving

planning a change, implementing it on a small scale, studying its effects and then acting upon the results. This iterative process allows for continuous refinement and improvement in end-of-life care practices within community nursing. By embracing these strategies, healthcare professionals can enhance the quality of end-of-life care, ensuring that it is not only effective but also responsive to the unique needs and preferences of individuals and their families (Hoare et al., 2022). This is especially important to consider when addressing equality, diversity and inclusion in the context of end-of-life care.

EQUALITY, DIVERSITY AND INCLUSION – CONSIDERATIONS IN END-OF-LIFE CARE

Within the context of end-of-life care, it is essential that community nurses are equipped with the knowledge and skills to address equality, diversity and inclusion in a sensitive and compassionate way to ensure high-quality provision of care. This encompasses providing care which is respectful of different religious and cultural communities across the lifespan. Preferences and wishes around end-of-life care, including how grief, loss and bereavement are perceived and managed can vary significantly. Koffman et al. (2023) emphasise that is it fundamental for professionals to be educated, knowledgeable and skilled to respond and care for people equitably and with compassion, regardless of where they live or their life experiences. This section explores spiritual and religious concepts and themes related to equality, diversity and inclusion and considers their relevance and potential impact on the dying process, grief, loss and bereavement.

IMPACT ON GRIEF, LOSS AND BEREAVEMENT

Community nurses, often immersed in the emotional demands of delivering end-of-life care, play a vital role in providing bereavement support to individuals and their families. Recognising the multifaceted nature of grief, loss and bereavement is crucial, as it allows nurses to approach their care responsibilities with empathy and an understanding of the diverse ways these experiences can impact individuals. Smith, Robinson and Segal (2024) define grief as the natural response to loss and the emotional suffering felt when something or someone you love is taken away. Prolonged or complicated grief may occur following loss and result in an extended period of bereavement.

Understanding these nuanced definitions enables community nurses to navigate the complexities of grief and bereavement effectively. Grief is a complex and individualised experience, with people reacting in diverse ways. Anticipatory grief, as outlined by the Alzheimer's Society (2021), occurs when the loss is known to be imminent, such as during the diagnosis of a terminal illness. Recognising these variations in grief experiences is crucial for tailoring support to meet the unique needs of everyone.

Familiarity with grief theories enhances a nurse's ability to understand and communicate effectively with those experiencing grief. Kübler-Ross (1969)

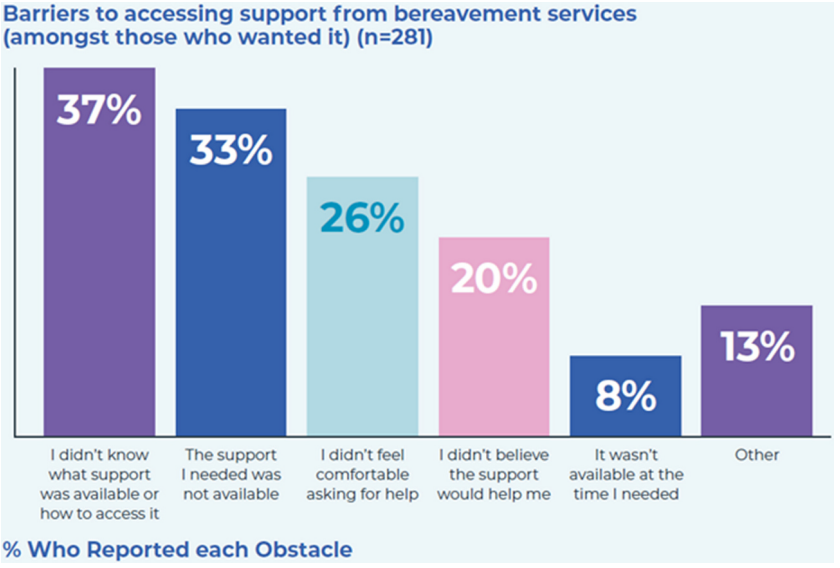


Figure 16.6 'Barriers to accessing support' – UK Commission on Bereavement (2022).

introduced stages of grief, including shock, denial, anger, bargaining, depression, testing and acceptance. More contemporary theories, like that of Klass, Silverman and Nickman (1996), describe grief as a 'continuing bond,' emphasising the ongoing negotiation of the meaning of loss over time. The UK Commission on Bereavement (2022) has highlighted challenges faced by bereaved individuals when accessing support services (Figure 16.6).

This finding underscores a deficit in knowledge about available services and a lack of accessibility to the necessary support. The Commission promotes the idea that bereavement is everyone's business, championing eight principles for change aimed at widening the availability and access to bereavement support services (Figure 16.7). Community nurses are pivotal in this process, as they need to be aware of local support services, enabling them to signpost and refer individuals to appropriate resources.

Community nurses, with their unique position as compassionate leaders in providing end-of-life care, must have an acute awareness and understanding of grief, loss and bereavement. By incorporating this knowledge into their practice, nurses can offer compassionate and tailored support to individuals and their families, ensuring that the challenges of bereavement are acknowledged and addressed with sensitivity. Additionally, by being familiar with local support services, community nurses can play a key role in facilitating access to bereavement support for those in their care.

SPIRITUAL AND RELIGIOUS CONSIDERATIONS

Recognising and accommodating diverse spiritual and religious beliefs is integral to providing compassionate and culturally sensitive support. The intersection of faith and end-of-life care is particularly crucial, considering the diverse

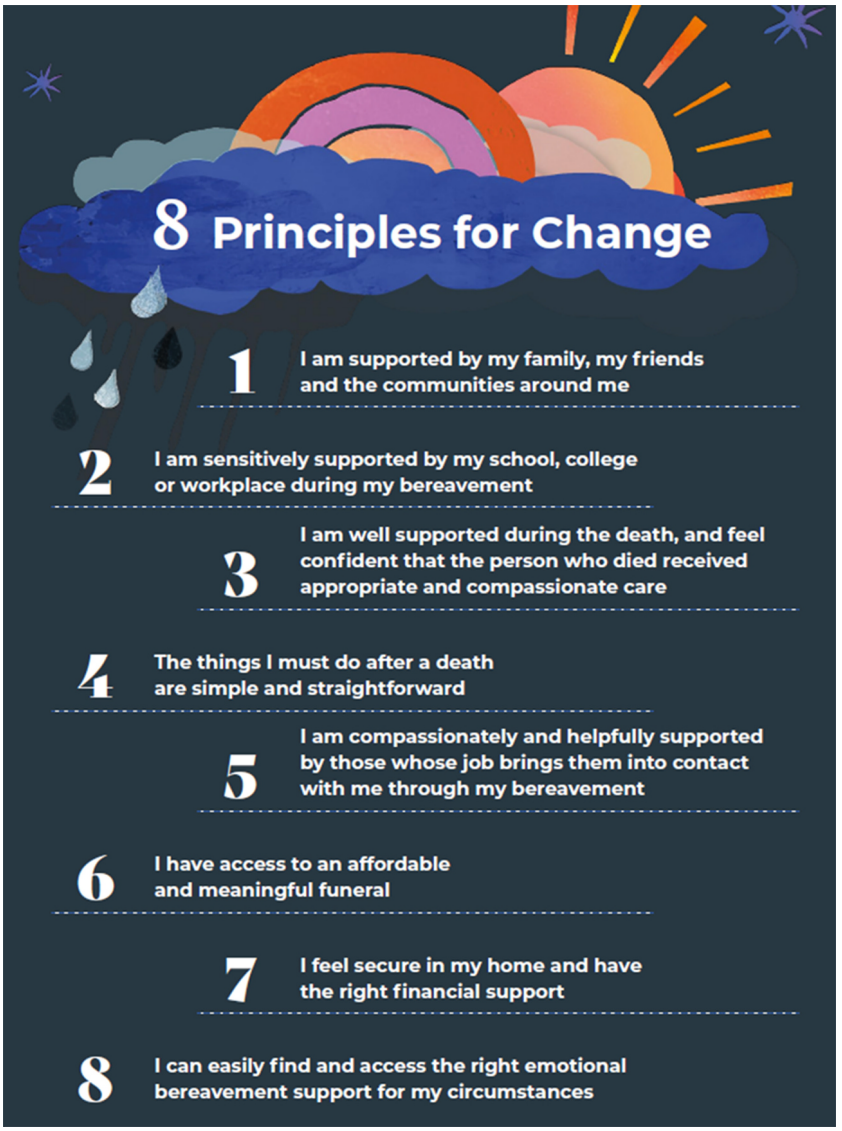


Figure 16.7 '8 principles for change' – UK Commission on Bereavement (2022)

religious landscape across the UK. Faith-sensitive end-of-life care is essential for children, young people and their families, acknowledging the rich tapestry of religious beliefs present in our communities. This aligns to the Ambitions framework, which promotes compassionate communities and communities being prepared to help (NPEoLCP, 2021). Camara and Rosengarten (2021) highlight the importance of understanding and respecting the traditions and perspectives associated with various faiths, emphasising that each faith has unique traditions and understandings of death and dying. This diversity requires healthcare professionals to be knowledgeable and adaptable to ensure that care is delivered in a manner that is respectful and aligned with the spiritual beliefs of the individuals and their families.

Different faiths have specific rituals and practices associated with death and community nurses must be attuned to these nuances. For example, within Christianity, the wishes of the family may include a baptism as part of the end-of-life care. In Jewish tradition, it is customary that the body of a deceased family member cannot be left alone immediately after death. In the Muslim faith, careful preparation of the body is required before burial, typically within 48 hours (Camara and Rosengarten, 2021). Understanding these cultural and religious practices is vital for delivering care that is both sensitive and aligned with the preferences of the individuals and their families.

Recognising the importance of spiritual and religious support in end-of-life care is not without its challenges. One significant hurdle is the lack of diversity within healthcare and palliative care leadership. Nyatanga (2022) and Camara and Rosengarten (2021) highlight this issue, emphasising that a lack of representation and understanding within leadership can impede the effective facilitation of spiritual and religious support. Within end-of-life care, healthcare professionals and leaders must actively work to bridge this gap, fostering a more diverse and inclusive environment that understands and respects the myriad ways individuals approach spirituality and religion. By acknowledging the unique beliefs and practices associated with different religions, community nurses can ensure that end-of-life care is respectful, culturally sensitive and aligned with the spiritual preferences of individuals and their families.

EQUALITY, DIVERSITY AND INCLUSION

The increasing diversity of the populations that community nurses work with needs to be considered within end-of-life care. For example, end-of-life care provision for homeless individuals is a critical but often overlooked aspect of healthcare, characterised by inequities and gaps in service delivery. Webb et al. (2020) highlight the stark reality that many homeless people die without the involvement of community nurses or specialist palliative services. This lack of engagement underscores the need for urgent attention to address the complex and unique end-of-life care needs of this vulnerable population. The end-of-life care needs for homeless individuals are intricate, often compounded by health factors such as smoking, poor nutrition, drug/alcohol dependency and inadequate sanitation (Keast et al., 2022). These challenges significantly impact the overall health of homeless individuals, making their end-of-life care needs more complex and demanding. In 2022, there were 1313 recorded deaths of homeless people in the UK, a figure that is believed to be an underestimate of the true number (Keast et al., 2022). Community nurses, with their expertise in providing holistic and community-based care, are well positioned to play a crucial role in supporting end-of-life care for homeless communities (Barnes, 2022). However, this necessitates enhanced collaboration between different service providers to ensure a comprehensive and coordinated approach to care.

There are key themes identified from the work of Webb et al. (2020) on end-of-life priorities for homeless individuals. These include a fear of being forgotten, a preference for end-of-life care to be in a comfortable environment with familiar individuals, a desire for autonomy and control, authenticity with nothing to hide and a frequently expressed preference to die suddenly. Traditional palliative care is often perceived as unattractive, and concerns extend to fears of having a 'pauper's funeral' or facing challenging funeral arrangements. To improve end-of-life care provision for homeless individuals, there is a growing recognition of the need for a 'trauma-informed' approach and increased service provision of peer support workers. Understanding the trauma associated with homelessness and incorporating this knowledge into care strategies is crucial for providing compassionate and effective end-of-life and bereavement support (NPEoLCP, 2021). Recognising and addressing the unique needs and preferences of homeless individuals at the end of life is fundamental to promoting dignity, autonomy and a sense of comfort during their final moments.

Ensuring the availability of quality end-of-life care for individuals from marginalised groups, including the LGBTQ+ community, has become a focal point in the realm of healthcare policy across the UK. The Welsh government's commitment, as articulated in its quality statement for palliative and end-of-life care for Wales in 2022, underscores the acknowledgement of the need for equitable care provision for diverse populations (Welsh Government, 2023). For community nurses to deliver quality, compassionate and equitable end-of-life care to LGBTQ+ individuals, an understanding of the unique needs and challenges faced by this community is paramount.

Hospice UK's report (2023) identifies significant barriers encountered by the LGBTQ+ community when seeking end-of-life care. These barriers include concerns about their identity being ignored or suppressed, a fear of being misgendered in death or at their funeral and doubts about the accuracy of medical record systems in detailing their identity and preferences. Moreover, addressing the unique needs of the LGBTQ+ community in end-of-life care is hindered by a lack of diversity, inclusion and education within the healthcare workforce and society at large. This deficiency is exacerbated by an overall dearth of research in the field of equality, diversity and inclusion in palliative and end-of-life care. The 'Hiding Who I Am' publication by Marie Curie (2016) sheds light on the enduring issues faced by LGBTQ+ individuals in their experiences of end-of-life care. These issues include the anticipation of discrimination, the complexities of navigating the intersection of religion and LGBTQ+ end-of-life care, assumptions about identity and family structure and the lack of support for grief and bereavement. Recognising the urgency of addressing these challenges, calls have been made to improve the provision of care for the LGBTQ+ community. Hospice UK (2023) advocates for widening access to equality, diversity and inclusion education that incorporates the UK Gender Recognition Act and gender recognition certificates. Community nurses, as compassionate leaders, play a crucial role in delivering end-of-life care to

LGBTQ+ individuals. However, this necessitates a deeper understanding of the unique needs and challenges faced by the LGBTQ+ community, as outlined by Hospice UK (2023). To bridge the existing gaps, nurses are required to be proactive in pressing for increased education, research, and policy changes to create a healthcare environment that is truly inclusive and supportive of LGBTQ+ individuals during their end-of-life journey or experiences of grief, loss and bereavement.

ACTIVITY 16.4

Identify what resources are available to you for enhancing your knowledge and understanding of delivering care for people across diverse communities, including LGBTQ+. Reflect on three small changes you can make to the way you might manage and approach end-of-life conversations with them and how you might identify an opportunity for implementing quality improvement.

FURTHER RESOURCES

Opening the Spiritual Gate – https://www.openingthespiritualgate.net/

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CHAPTER 17

Organisation and management of care

Jill Y. Gould

LEARNING OUTCOMES

- Evaluate key features of community nursing and influences on care organisation and prioritisation.
- Critically reflect on prioritisation, delegation and skill mix.
- Examine methods of caseload, workload and workforce management.

INTRODUCTION

Community health services undertake over 100 million contacts each year (King's Fund, 2023, NHS Digital, 2023a). These services range widely from universal public health (e.g. health visiting and school nursing) to targeted clinical interventions. Therefore, nursing in the community setting is seen as varied, complicated and challenging (Jackson et al., 2015a, Rafferty and Leary, 2023). Community nurses work in dynamic care environments with potentially limitless demands and are subject to external forces such as pressures on other health services and public health emergencies. On this 'ward without walls', it is difficult to apply restrictions to the amount or complexity of the work with no recommended staff ratios (Brook et al., 2021) and little control over increased workload. There is a growing gap between demand and capacity, alongside the increasingly complex care being delivered (Maybin et al., 2016, Rogers, 2021, NHS England (NHSE), 2023a). Community practitioners need to be responsive to fluctuating workload demands as well as less predictable wide-scale crises such as pandemics. In addition to managing the challenges of an ever-changing caseload, community nurses are responsible for safeguarding vulnerable groups, identifying health needs, and employing a person-centred, proactive, pre-emptive approach to service provision (NHSE, 2019, DHSC, 2021, NHSE, 2022, Nursing and Midwifery Council (NMC), 2022a, 2022b, OHID, 2023a, 2023b).

Some community nurses such as community matrons or practice nurses who work with general practitioners (GPs), have a more clearly defined population or can 'close' when their lists are full. This is not normally an option for those providing universal services or caring for the more vulnerable or

DOI: 10.4324/9781003347545-18

housebound populations, so there is a need to prioritise and organise care and make difficult daily decisions about what work gets left undone. Professional accountability encompasses clinical decision-making, delegation and raising concerns if care delivery could be viewed as 'unsafe or harmful' (NMC, 2018a, 2019a, 2019b). With the dynamic work environment, community nurses are routinely responsible for individual care decisions but must also seek out, appraise, communicate and respond to the needs of their wider populations. The management of care, prioritisation, and the need to direct resources towards areas of greatest need are a professional obligation as well as being vital to the cost-effectiveness and high quality of care provided (NMC, 2018b, 2022a, 2022b, NHSE, 2019, Health and Care Act, 2022).

There is a wide variety of community nurses with services, roles and job titles emerging or evolving in response to localised needs and the ongoing progression towards efficient, outcomes-focused services (Scottish Government, 2017, NHSE, 2019, Welsh Government, 2022, Northern Ireland Practice & Education Council for Nursing and Midwifery [NIPEC], 2022). While the diversity of services is growing to meet changing demands, community-based care is mainly delivered by district nurses, health visitors, children's community nurses, community mental health nurses, general practice nurses and school nurses who collectively hold responsibility for the population's health through the lifespan. District nurse services provide one of the few 7-day (and, in some instances, 24-hour) services in the community setting, managing the acute, long-term, complex and palliative care needs of a diverse and often vulnerable, housebound population. According to the Scottish Government (2017) district nurses are expected to take a lead in public health, anticipatory care, assessment, care or case management, complexity, frailty, intermediate care, palliative and end-of-life care. Together, health visitors and school nurses are responsible for 'universal services' normally covering ages 0–19, with different remits noted for each of the four countries (Scottish Government, 2015, 2018, 2023, Department of Health [DoH] [Northern Ireland], 2018, NHS Wales 2022). In addition to universal services, they also provide personalised or intensive support for higher-risk individuals and families. Alongside these are a diversity of specialist and generalist community nurses working to deliver essential universal or targeted health services. Examples are illustrated in Table 17.1, although it should be noted that job titles and roles vary between employing organisations, and there can be an overlap of services between the population categories used in Table 17.1.

This chapter explores the practical application of care organisation and considers the wider context and need to minimise risk, be responsive to changes, influence service provision and act as leaders to enhance the care quality in the community. Topics relating to the organisation and management of care include differences between hospital-based and community settings, how work is prioritised, service design, referral criteria, skill mix, educating for competence and workload management.

Table 17.1 Examples of nursing services in primary and community care

Population	Nurses/practitioners	Core and Specialist services
Child and family	Community midwives Health visitors School nurses Example specialist nurses: Children's community nurses Learning disability (LD) nurses Nursery Nurses Safeguarding leads	Ante-natal/community midwifery units Family–nurse partnerships Specialist infant feeding teams (breastfeeding support services) Sure Start Centres Child Health Services Children not in mainstream education (pupil referral units or home schooled) Youth offending services Family planning/sexual health clinics Child continence/bowel care Safeguarding Community paediatric Special educational needs or disability Complex case management (LD) Gypsy, Roma and Traveller Health Migrant health Children's Hospice
Adult and specialisms	District nurses General practice nurses Occupational health nurses Community matrons Care/nursing home nurses Triage/urgent care nurses Advanced practitioners Nurse consultants Sexual health nurses LD Nurses Long-term conditions specialists: e.g. diabetes, heart failure, respiratory, chronic obstructive pulmonary disease (COPD)/neurological (e.g. MS), continence, etc.Other specialists: Palliative and end-of-life care, tissue viability; intravenous therapy, tuberculosis, etc.	Community (home care) nursing Clinics/General Practice / Primary care Workplace health Homeless (and Traveller) health Care home health services Intermediate care; Step-down units Out-of-hours: telephone or video consultation (e.g. NHS 111) Enhanced care services/virtual wards Urgent care/treatment centres Minor injuries clinics Bed-based community rehabilitation Sexual and reproductive health, Genitourinary medicine (GUM clinics) Forensic, custody and prison health Community palliative and end-of-life care Hospice care Pulmonary or cardiac rehabilitation Falls prevention Incontinence services Home intravenous therapy services
Mental health	Community mental health Forensic mental health	Alcohol and drug dependency services, outreach teams; Child and Adolescent Mental Health Services (CAHMS), etc. CPN older adult home treatment Adult or child ADHD services
ALL	Public health: health promotion, health protection, tuberculosis services, infection control; smoking cessation services; community hospitals/minor injuries, community outpatients, maternity units, etc.	

THE COMMUNITY NURSING SETTING: KEY FEATURES, CARE ORGANISATION AND PRIORITIES

Care organisation by community nurses has myriad influences, some of which can be illustrated by examining key contrasts between hospital-based and community care (Figures 17.1 and 17.2). While pre-registration nursing standards (NMC, 2018b) aim to redress the imbalance between hospital and community-based education, it can be helpful to identify some of these distinctions as they impact priorities and approaches to care management. Early enquiry into these differences (Drennan et al., 2005) can be added to despite a recognised a lack of research specifically exploring the transition to primary or community healthcare settings (Ashley et al., 2016, 2018, Drennan, 2019, Cox et al., 2023).

Activity 17.1 Identifying attributes of care priorities within hospital or community

ACTIVITY 17.1

Reflection point

Nursing care organisation and priorities vary between hospitals and communities. Thinking about your experiences, consider some of the key aspects of care priorities across various settings:

- What are some of the key differences between hospital-based nursing care and that provided in community settings?
- What influence might these have on decision-making, priorities or care management?

As illustrated in Figures 17.1 and 17.2, some overarching differences between settings can be discerned, such as the hospital as a rigid, inflexible structure, whereas the community is more fluid and care can occur in a wide variety of places and through different means such as telephone, video or the internet.

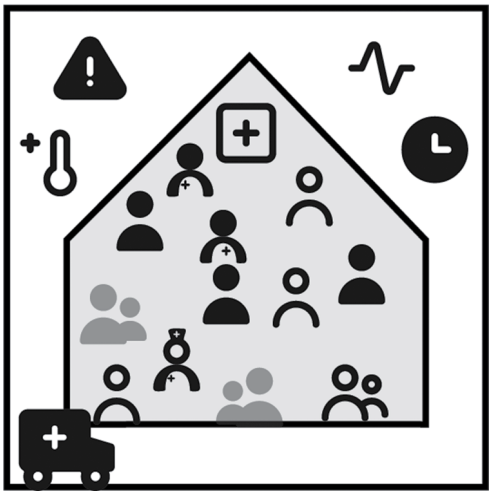


Figure 17.1 Hospital-based nursing care.

- **Locus of control**
  Care revolves around the institution; the person is a 'guest'; the nurse has responsibility and control of a defined clinical area.
- **Care decisions/delivery**
  Frequently made by 'experts' (though aim to be shared). Priorities tend towards biomedical.
  Care needs almost exclusively met by nurses/other practitioners; responsible for delegation
- **Priorities**
  The needs of 'all' vs one; ward/institution first
- **Risks**
  First principle: *do no harm*. Risk aversity may limit choice and personalisation.
- **Resources**
  Available close to the person; other nurses
- **Other**
  Available close to the person; other nurses



Figure 17.2 Home or community-based nursing care.

- **Locus of control**
  Care revolves around the population or individual; they are usually in charge of their home environment. The nurse/others are guests.
- **Care decisions/delivery**
  The person (or family) is normally in control of decisions. The bulk of needs are met by the person, family or informal carers.
- **Priorities**
  Needs of the person are first, but balanced with safe delegation, and care management

- **Risks**
  Accepted risk threshold is higher. Staff risks; lone working; clinical decisions, sometimes rapidly at a physical distance from colleagues.
- **Resources**
  Need to be familiar with available services, resources and referral routes. A wide variety of means of care/monitoring/communication.
- **Other: Public health and wider services**
  A significant difference between settings is the consideration of health determinants and access to resources that contribute to people's overall health. The preventative, proactive, health protection, and public health roles of community-based nurses allow a wider consideration of influences on a person's health and wellbeing.

A sample of specific differences is examined more closely to unpick some of the influences on decision-making for care management and prioritisation.

LOCUS OF CONTROL

Locus of control (Rotter, 1966) can be linked to better health outcomes (Luque et al., 2023) and underpins some of the principles of motivational interviewing (Day, Gould and Hazelby, 2017). It refers to the degree to which people believe their own behaviour determines what happens to them, which can impact their self-belief and confidence (Figure 17.3). People with an internal locus of control tend to attribute their abilities, health or outcomes to their own efforts or actions so feel able to influence their situation. Conversely, people with an external locus feel they have less control or influence over events. Nurses can observe this with people who strongly assert their authority over care decisions or conversely, say things like "*It's up to you, Nurse; you are the expert*". While people may be anywhere on the continuum, stress can change this. For example, someone who is usually self-assured can feel disempowered or vulnerable when they become acutely unwell and/or in an unfamiliar environment such as a hospital.

Locus of control also impacts nurses' own self-efficacy, with Padmanabhan (2021) finding that people with an internal locus of control experience higher job satisfaction, while those with an external locus were more likely to be dissatisfied in their work. Community nurses may be 'guests' in settings outside of the hospital, but their ability to work autonomously and in a supportive and positive working environment also lends itself to experiencing greater control over care decisions and the organisation of work. Community nurses may feel

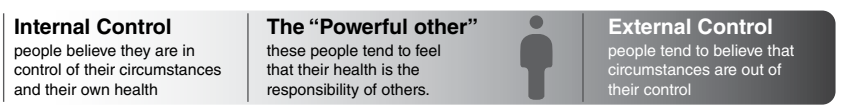


Figure 17.3 Locus of control. (Based on Rotter, 1966.)

they have less control over care organisation when there is a high workload, urgent visits or unplanned staff absence.

CARE DECISIONS, DELIVERY AND PRIORITIES

Linked to questions of control is decision-making around care and its delivery. Depending upon the community nursing role, this ideally extends beyond a narrow task-orientated approach and starts with appreciating the centrality of the person in receipt of services, taking in wider considerations and encompassing care coordination. Although there are exceptions, in the community or people's own homes, physical or mental health needs are primarily met by those closest to the person (Drennan et al., 2005, QNI, 2016, 2023, Carers UK, 2023). This implies the variety of roles nurses fulfil are normally time-limited, episodic and involve care coordination, education or support for individuals. Community nursing work centres on the identification and analysis of needs, public health promotion, enhancement of self-care and/or the coordination of services (NMC, 2022a,b). Integral to this is ensuring support is available to those providing most of the care. The economic value of the contributions made by informal carers in England and Wales has been calculated as £162 billion per year or roughly equivalent to the annual cost of funding the NHS (Carers UK, 2023). Carers, as discussed in Chapter 11, themselves have distinct needs with the legal right to their own assessment (Care Act, 2014). Maybin et al. (2016) found that 'good care' is seen to include the involvement of informal carers and family members through offering practical support and education, including them in decision-making, valuing their contributions and expertise and addressing carers' own needs and personal wellbeing. Good care was also described as 'staff caring for the whole person and providing holistic, person-centred care rather than taking a task-focused approach' (Maybin et al., 2016: 16). While core nursing tasks are also part of community nursing, and people can be acutely ill outside of hospital settings as indicated in Chapter 14, psychosocial factors are also a principal influence. For example, an urgent care service may be contacted by someone with life-threatening symptoms, but if they refuse to leave their home, respecting the person's wishes guides decision-making despite a biomedical necessity for hospital admission.

RISKS

A primary principle in any care setting is to do no harm (Beauchamp and Childress, 2013, NMC, 2018a), although risks and benefits need to be carefully considered and aligned with the necessity to respect the person's autonomy. Risk aversity may limit personalisation and choice as for example on a hospital ward standardisation of medicines delivery may be necessary for ensuring safe care organisation but not address the individual's unique needs. The community setting also poses risks associated with decision-making in potentially noisy or stressful environments and at a physical distance from colleagues

(QNI, 2016). Harvey et al. (2019) found nurses new to the community had difficulties in prioritising care and noted preparation was needed in relation to risk, while Chamberlain et al. (2019) highlighted psychosocial risks linked to the demands of the role. In skill-mixed teams, ranging abilities require more experienced practitioners delegating tasks need to be assured of the competence of each team member and aim to minimise the risk of less experienced staff performing visits which may be outside their scope of practice.

RESOURCES

Care management and organisation are influenced by the availability and access to resources. Awareness of systems, services, and resources is an integral part of care management and decision-making in the community (Drennan et al., 2005, QNI, 2016, Chamberlain et al., 2019). With wide-ranging statutory and voluntary organisations, excellent communication skills and an extensive working knowledge of these resources are needed to guide informed choice. The people most likely to be affected by resource constraints (such as cuts to social care services) are often very vulnerable, requiring nurses to advocate for services where gaps are identified. An example is social isolation, which is linked to depression (Noguchi et al., 2021), dementia (Sutin et al., 2018) and premature mortality (Holt-Lunstad et al., 2015) but could be addressed or reduced through promoting social or community networks (Day, Gould and Hazelby, 2020). An awareness of local services, such as those noted in Table 17.2, offers potential for public health interventions and improved quality of life.

Table 17.2 Example services or organisations to address social isolation

Level	Service	Research/Reference
Individual	**Befriending**: by telephone or in person	Mulvihill (2011)
	Intergenerational programmes. Mixing age groups enables older people to connect with the community and feel supported. Can involve co-location.	Teater (2016)
Individual or group	**Social Prescribing**: assigned link workers connect people to services, activities or groups in their community to meet practical, social and emotional needs affecting their health and wellbeing. It is sometimes known as community referral and aims to enable health professionals to refer people to appropriate local, non-clinical services	Buck and Ewbank (2020) NHS England (2020)

(*Continued*)

Table 17.2 (Continued)

Level	Service	Research/Reference
Group	Groups for people with specific conditions that include a social aspect (e.g. day centres, community cafes, lunch clubs, "leg clubs")	Skingley (2013)
	The "Leg Club" model entails partnership working between clinicians and volunteers to embed social prescribing by introducing activities from walking and photographic activities, chair aerobics to knitting groups and social Leg Club outings	Lindsay (2016)
	Voluntary schemes, such as choirs, walking or gardening clubs	Gardening: Whear et al. (2014) While (2020)
Community	Libraries, gardens, arts, outreach programmes	Arts: Fancourt and Finn (2019)

Based on Day, Gould and Hazelby (2020)

OTHER: PUBLIC HEALTH AND WIDER SERVICES

Table 17.2 suggests care priorities include helping people move beyond illness, to more recent definitions of health encompassing physical, mental and social wellbeing as discussed in Chapter 3. Prioritisation and care management are dependent on a variety of factors that are constantly fluctuating and influenced by the perspective of both the individual (or population) and community nurse. The skills of community nurses are wide-ranging and are seen to include proactive strategies, the targeting of services where most needed, tackling wider causes of ill health and managing risks, including potential unsafe decisions which individuals (with assessed mental capacity; MCA, 2005) have the autonomy to make. To fulfil the various responsibilities, community nurses need to maintain the currency of their knowledge and skills, not only in relation to assessment and prioritisation but also in considering the needs of carers and being familiar with local services and structures. Furthermore, an awareness of risks and responsibilities linked to delegation and skill mix within teams is needed. The next section looks more closely at skill mix, roles, responsibilities and delegation.

PRIORITISATION, DELEGATION AND SKILL MIX

The practicalities of work organisation and prioritisation differ between disciplines in the community setting. These distinct roles have been affected to varying extents by funding streams, quality outcomes, and policy agendas

(Scottish Government, 2023, Welsh Government, 2022, NHS Wales, 2022, NIPEC, 2022, DHSC, 2023a, 2023b). Policy changes have resulted in an expanding need to quantify, categorise and record clinical activity and to meet defined health outcomes. DeGroot et al. (2022) found that community nurses perceive a high workload due to documentation activities which is worsening with the rising need to perform data input across various systems. While these requirements are common across the community setting, the disciplines have discrete foci for their routine work organisation. For example, a focus on clinical needs such as acute, long-term ill health and end-of-life care by urgent care, or district nurses, can be linked to the overarching aim of more efficient services delivering care closer to home and saving 'bed days' (Leary, 2022). An emphasis on prevention suggests a less pronounced clinical role, but some public health nurses are also required to meet commissioned targets for specified contact points (Scottish Government, 2018, The Promise Scotland, 2022, DHSC, 2023c) and respond to acute situations such as mental health crises or safeguarding concerns. There is little in the literature to detail how clinical work is prioritised and delegated in these aspects of care, although numerous attempts have been made over the years to measure and quantify workload (Chapman et al., 2017, Endsley, 2017, DeGroot et al., 2022, Brown, 2023).

Care organisation, prioritisation and delegation for community nurses involve the scrutiny of diverse factors with varying degrees of importance (Wright et al., 2015, Brown and Hartley, 2021, Brown 2023). Theoretical models are widely applied to nursing, but the complex and varied nature of community nurses' knowledge makes it difficult to identify a model to capture the complexity of community nursing (Jackson et al., 2015a, 2015b, Boak et al., 2024). Community nurses need to be able to swiftly grasp and weigh the significance of the many variables that add to the intricacy of decision-making in these settings. As a starting point, community nurses need to consider appropriateness before prioritising care by determining the most significant or urgent of the identified needs. Activity 17.2 uses the example of a new staff member of a district nursing team who is undertaking care duties in a person's home.

ACTIVITY 17.2

What should Lee do?

Activity 17.2 Reflection point

Lee is a staff nurse who is new to the community nursing team and has been asked to see Mr. Singh for a pressure area assessment and to redress a small leg wound. While there, Mr. Singh says he's constipated and his catheter isn't draining properly, so it probably needs changing. Lee has done the appropriate training, but this would be his first time changing a catheter or assessing for constipation outside of the hospital setting. He has been allocated many other visits and knows the team is busy and

unlikely to be able to help today. Mr. Singh says he is worried he will become unwell if his catheter gets blocked.

- Should Lee undertake the assessment, examination and procedures?
- What would influence decision-making?
- What are the benefits of 'knowing the person' in this instance?

For Activity 17.2, factors such as previous experience of the delegated task, being able to access support, and knowing the person can have a significant influence on decision-making (Bain, 2015, Cleary and Doody, 2017). For example, knowing Mr. Singh experiences episodes of memory loss or has anxieties around his catheter that normally just require reassurance could influence Lee's decision. Conversely, Mr. Singh may be experiencing new symptoms of constipation, causing catheter blockage or the perceived problem could be the start of delirium due to an infection. If on balance it is safer to not undertake the requested care, or other work takes priority, the risks of leaving care undone need to be weighed, justified and recorded.

Figure 17.4 and Table 17.3 illustrates some of the influences on prioritisation and delegation. In this case, "Urgent" refers to requiring prompt intervention but not a medical emergency although nurses need to be alert to changing situations. Other higher priority areas include refusal of referral to other services or hospital admission identified as being necessary for wellbeing/safety.

Considering the previously mentioned influences on decision-making, undertake Activity 17.3.

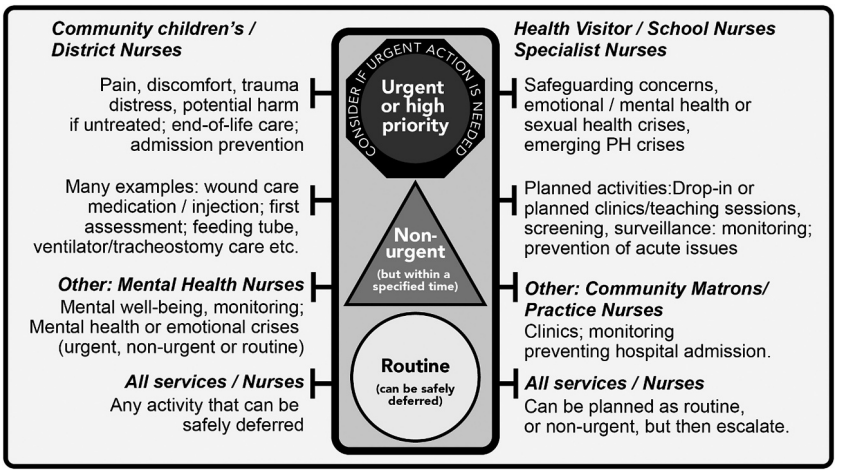


Figure 17.4 Care prioritisation.

Table 17.3 Other influences on prioritisation and delegation

Skill mix & service configuration	Working arrangements: referral criteria; service specification/commissioned services; team or individual practitioners; caseload/geographical working; community teams, or GP attached Delegation based on: Staff competence: skills, experience, knowledge, training; NMC standards; employment contracts/policies, staff availability Liaison with other services/ referral processes.
Alternative means of consultation	Considering the benefits and risks of video or telephone consultation. This may be undertaken to optimise efficiency and offer timely advice. Out-of-hours services are often based on this delivery model.
Geographic location	Visits organised to optimise efficiency within the confines of skill mix – adjustments to working in a wide or narrow geographical location.
Traffic/weather, etc.	May need to request assistance for travel; reorganise planned care/visits; floods, snowstorms, etc.
Public health 'crises'/disasters	Flu epidemics/pandemics; immunisation programmes or natural disasters; organisations should have contingency plans, policies and protocols to guide the prioritisation of care services. For example, the use of "RAG" rating or dependency scoring tools for emergency situations.

ACTIVITY 17.3

Reflection point

Jo is a specialist public health nurse (SCPHN) school nurse (SN) who covers a large number of schools in her area with two other SNs. She is undertaking a routine drop-in clinic at one of the secondary schools. The first attendee has disclosed self-harm and expressed ideas suggestive of suicidal risk. While focusing on the consultation, she is aware of other students waiting outside the office and she must attend a safeguarding case conference after the clinic.

- What would be the priorities?
- What would influence the decision-making?

As per Figure 17.4, the highest priority would be the safety of the individual in Jo's care and whether immediate referral or emergency services are needed. Knowing the person or family can help significantly with decision-making as, for example, if a trustful relationship had previously been developed, Jo may be aware of what has helped de-escalate in the past. Decision-making includes informing the parent(s) and can also be influenced by awareness of the school and available services such as the mental health crisis team. Dealing effectively with acute situations and prioritising early intervention in adolescent mental health can make a significant difference to subsequent outcomes (Day, 2016) as half of mental health problems are established by age 14 and three quarters by age 24 (Kessler et al., 2005).

While this scenario directly concerns mental wellbeing, research into adult community nursing found people in receipt of services considered 'psychosocial support' to be equally important to 'clinical expertise' (Maybin et al., 2016). In some instances, telephone or video contact can resolve issues safely and efficiently. Other factors influencing care priorities and delegation include available skill mix, clinical expertise, experience, crises, geographical location and sometimes factors such as traffic or weather conditions (NMC, 2022a, Stenner et al., 2023). Community nurses also need to consider the scope of practice and whether the referral or assigned task is appropriate (Young and Reid, 2021).

Work organisation can be seen to start with the service's referral criteria, which can be complicated due to the evolving policy agenda, and the changing, merger or overlap between services. For example, district nursing services may overlap with, urgent care, or tissue viability specialist services, or the 'virtual ward' (Leary, 2023). The 'invisible' nature of district nursing work (e.g. unplanned/unrecorded psychosocial support), has not been helped by a lack of standardised measures or clearly defined referral criteria (Young and Reid, 2021, Leary, 2022). While there are benefits to blurred boundaries between services, there are also advantages to role definition in that it may help better address capacity and demand (NHSE, 2023a). For example, Maybin et al. (2016) suggest the demand–capacity gap may be helped by the rejection of incomplete referrals but noted this poses risks of damaging or delaying care. The development of referral criteria is recommended to reduce the number of inappropriate referrals, clarify and add legitimacy to roles and help ensure the best use of skills and judgement. A lack of clear referral criteria can cause a task-orientated approach, inefficiency and inappropriate or poor-quality referrals (Young and Reid, 2021). The establishment and implementation of referral processes can thus be seen as a fundamental step in organising and managing nursing care in the community setting.

Other influences on care organisation include staffing levels and being able to fulfil service requirements. For example, there is a recognised decline in the number of specialist qualified district nurses (Leary et al., 2020, 2022, NHS Digital, 2023b), but they are largely unable to refuse referrals. The COVID-19 pandemic created unusual circumstances where some routine community care

was unavailable. For example, health visitors provide universal care as well as supporting vulnerable families and safeguarding concerns. During the pandemic, routine checks were paused which resulted in a reduction in the overall number of safeguarding referrals but an increase in the severity of incidents (Leith and Chawatama, 2021, Driscoll et al., 2022).

SKILL MIX, ROLES AND RESPONSIBILITIES

A series of policy documents have continued to propose care is moved away from the hospital setting and closer to people's homes (NHS England, 2015, 2017, 2019, 2023b; NHS Wales, 2015, Scottish Government, 2016, 2017, DHSC, 2021). Despite the resulting pressures on the community workforce, findings indicate a steady decrease in the supply of skilled nurses (Buchan et al., 2019, Senek et al., 2023), with a loss of nearly 50% of specialist qualified district nurses since 2009 and an overall reduction in the number of community nurses over the past 5 years (Maybin et al., 2016, NHS Digital, 2023b), as per Figure 17.5.

This has developed through a combination of not recruiting when posts become vacant, dilution of the workforce with practitioners who are lesser trained, and the ageing workforce. The impact has not been fully examined although research by Senek et al. (2023) shows nearly half of all community nurses (≈46%) reported job dissatisfaction. In addition to a perceived lack of managerial support, the largest factor linked to the probability of leaving was the proportion of permanent staff on the team (Senek et al., 2023).

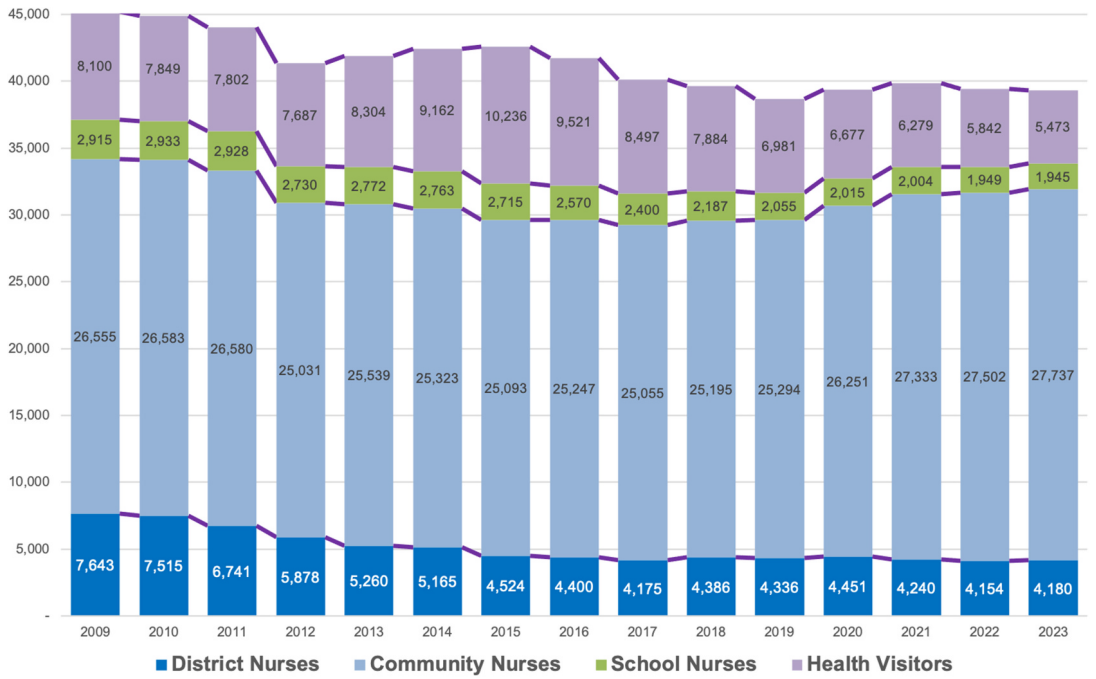


Figure 17.5 NHS workforce statistics 2009–2023. (NHS Digital, 2023b.)

Most employment contracts and professional standards (NMC, 2022a,b) indicate nurses are accountable for their own practice and for the safe and conscientious delegation of work. However, with a higher turnover of staff, team leaders may find it challenging to sustain a working knowledge of the caseload or the competence of their team which has implications for safe delegation (NMC, 2018a, 2018b, 2019b, 2022a). Delegation can be seen as subjective and based on custom and practice, but community nursing teams are moving towards the more objective, computer-aided practice of 'allocation'. Both the traditional processes and new models in which 'tasks' are allocated electronically, rely on team members articulating if they consider a visit or task to be beyond their scope of practice. This can be testing for new members of staff who are unaware of their lack of expertise until they are in the situation or in circumstances where the visit has an element of complication. Thus, team leaders can play a key role in reducing risks for less experienced staff as well as safeguarding their vulnerable populations through expert team and caseload management. In line with NMC (2022a, 2022b) specialist standards and the health policy agenda, community practitioners need to not only address immediate prioritisation of daily work but also ensure the right balance of skills and knowledge to meet the needs of their population. The next section considers some of the methods of service evaluation, caseload, workload and workforce management to help this process of matching skills to service needs.

CASELOAD, WORKLOAD AND WORKFORCE MANAGEMENT

Care organisation and caseload management vary according to geographical area, employer, and professional discipline but can be seen broadly as focusing on the identification of need and efficient use of resources to meet this need. While community nurses in the UK have little authority over budget management (in contrast, see Box 17.2 for the Buurtzorg Model), other factors such as time and caseload management can be changed to make improvements to efficiency, care and staff satisfaction. For example, efficient caseload management includes appropriate and timely discharge to avoid inappropriate visits and reduce the person's potential loss of autonomy. It is notable that proactive initiatives, such as education, reassessment and discharge, are often compromised when there are pressures on the service and staff feel they have little or no time for these activities (Maybin et al., 2016).

Box 17.2

The Buurtzorg Model

This model began in 2007 with the aim of providing a more efficient person-centred care delivery starting from the client's perspective and working towards enhancing quality of life. It has a non-hierarchical

structure with independent teams of a maximum of 12 nurses. These teams provide coordinated care for a specific catchment area. The teams organise and are responsible for the complete process. The Buurtzorg Model involves the following:

- Teams taking care of people who need support as well as managing their own work, such as planning, education and finance
- Management of their own education budget
- Holistic assessment – not just physiological aspects but includes medical, long-term conditions and personal/social care needs
- Overseeing the whole care process; assessment, interventions and outcomes
- Developing networks of informal care and close collaboration with GPs
- Promoting self-care, self-management, independence and empowerment
- Fulfilling public health and community nursing tasks
- Supporting the person in their social environment
- Multidisciplinary working

(*Buurtzorg Nederland, 2023*)

Other services such as health visiting have traditionally been arranged around a 'caseload' but there is very little research literature on the topic. The annual Institute for Health Visiting (IHV) (2023) survey shows significant increases in core work such as safeguarding, with 86% of respondents saying there is not enough capacity to pick up onward referrals. The survey (IHV, 2023) shows only 3% of HVs in England report continuity of HVs, while this figure is between 80% and 88% for Wales, Northern Island and Scotland showing a different approach to how caseloads are managed. With community services so varied, there are recognised difficulties of workload assessment and dependency scoring, with approaches seen as inconsistent or subjective (Newland, 2014). Maybin et al. (2016) recommends mechanisms for monitoring resources, activity and workforce are needed while acknowledging the difficulties in achieving this. Service review is recognised as an important element of care organisation (Pye, 2020, Brown, 2023). Maybin et al. (2016: 73) suggest the absence of 'robust national data on activity levels … makes it very difficult to demonstrate, understand and monitor the demand-capacity gap'.

Some community services have very specific remits, as for example delivering intravenous medicines in the person's home, virtual wards or centrally defined universal services such as for health visitors. The specification for health visitors in England requires them to undertake and record data on new birth visits, 6- to 8-week checks and so on, which is then published monthly by NHS Digital (2023b). These metrics exemplify the move towards outcome-driven service provision and while it is useful to have clearly defined objectives, this may impact on professional autonomy and judgement when prioritising care. Given the often unpredictable and sometimes immeasurable aspects of

community-based care, it is imperative practitioners have a degree of control over their caseload and work. This can be aided by profiling and caseload management systems that enable community nurses to access and make use of the information they collect. Rigorous data collection methods support safe staffing levels, skill mix and develop effective community services (Jackson et al., 2015a, 2016). Box 17.3 illustrates some typical features of caseload profiling.

Box 17.3

Basic caseload profiling tools normally involve providing a 'snapshot' of the types and numbers of people/families on the caseload and may include the following:

- Number of people/families on the caseload
- Referral rates (including one-off referrals) /referral source
- Discharge rates
- Case mix (types of visits/people on caseload)
- Demographics (ages/sex)

To estimate the work associated with a caseload, it also includes the following:

- Frequency of visits for each person or family on the caseload
- Duration of visits

While there is some overlap of terminology, workload tools are normally more concerned with quantifying the work associated with a caseload population or measuring dependency levels. It may also encompass the emerging issues of 'capacity and demand' and safe staffing (Fields and Brett, 2015, Jackson et al., 2016). Across the UK, tools are emerging to address demand and capacity (NHSE, 2023a). For example, the Scottish Community Nursing Workload Measurement Tool (SCNWM) advocates a triangulated approach to workload measurement (Healthcare Improvement Scotland [HIS], 2023). This uses three sets of measures including a specialty-specific workload measurement tool, a professional judgement tool using the knowledge and experience of the lead nurse and quality data appropriate to specific areas (HIS, 2023).

The use of computer-based systems for managing and recording community nursing activity, is widespread, although the use of manual paper-based systems continues. For both primary care and community services, being able to clearly capture workload and workforce data would help quantify the benefits of changing skill mix and could help reduce pressures on existing staff (Addicott et al., 2015). One impact of the lack of reliable or standardised measurement systems is late recognition of concerns around workforce pressures, staffing shortages, skill mix and caseload (Maybin et al., 2016). Addicott et al. (2015) indicate it is worrying large gaps in data on the community workforce show it has not kept pace with the policy impetus, and despite aims to raise the level and range of community services, there is no evidence of staffing increases to support this.

THE ROLE OF COMMUNITY NURSES INFLUENCING SERVICE PROVISION

It can be perceived on a continuum from 'everyday' prioritisation of care to the broader remit of service organisation is interrelated. The right staff with the right skills in the right place at the right time are required to deliver high-quality, community-based nursing care and services. Equally, it is necessary for community nurses to be aware of the changing needs of their populations to influence the way services are organised, structural systems and staffing resources are an influence on the everyday practice of work organisation. With scant research evidence to support specific approaches for assessing and determining nursing staff requirements and/or skill mix, team leaders are tasked with assuring safe and effective care using the tools adopted by their organisation and their own clinical judgement. Nurses are accountable for their own practice and as careers progress to higher levels such as specialist or advanced practice, this accountability extends beyond the confines of their individual competence towards their team, the populations they serve and, in the need, influence services and resources (NMC, 2022a, 2022b). Community caseloads comprise the most vulnerable members of society and practitioners must always consider potential safeguarding issues (see Chapter 6) the centrality of the person in their care and the need for empowerment and advocacy. The need for community practitioners has paradoxically not been aligned with the budget to support practitioner development, with a significant drop in the number of trained specialist community nurses (NHS Digital, 2023b).

CONCLUSION

Safe, personalised and efficient management of care in the community setting is one of the many challenges nurses face on a regular basis. The practitioner's accountability for care delivery extends beyond daily prioritisation and work organisation to influence the structures and systems within which care is delivered, measured and recorded. Integral to decision-making is the evaluation of services and the skill mix of the team to ensure the needs of the population are identified and addressed with high-quality care provision.

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CHAPTER

18

Leading person-centred practice

Caroline A. W. Dickson

LEARNING OUTCOMES

- Appraise contemporary leadership models to enhance community practice.
- Explore self as a developing leader in community practice.
- Promote healthful workplace cultures as an intention of leadership.
- Apply participatory methodologies to develop practice within community contexts.
- Utilise frameworks to develop self and others.

INTRODUCTION

Every community nurse has leadership qualities and the potential to become leaders within their own context. In contemporary practice, there is a need to reimagine leadership and draw on models that are caring and that intentionally promote wellbeing for all. Michael West and colleagues (2020, 2021) identified the core needs of nurses in their work around the 'courage of compassion'. They suggest, in being compassionate caregivers, nurses and midwives have three core work needs that must be met to ensure wellbeing and motivation at work and minimise workplace stress (Box 18.1)

Box 18.1 Nurses' core work needs (West 2021)

1. Autonomy – Nurses and midwives need to be given control over their work lives, enabling them to act consistently with their values.
2. Belonging – Nurses and midwives need to feel connected, cared for and able to care for others around them at work. They need to feel valued, respected and supported.
3. Make a contribution – Nurses and midwives need to experience effectiveness in what they do – deliver valued outcomes and be acknowledged for it.

DOI: 10.4324/9781003347545-19

In contemporary healthcare, the potential for nurses to assume a more significant role in designing and developing healthcare services has never been greater (Anders et al., 2021). However, continuing professional development for community nurses has tended to focus on developing technical skills and knowledge to support clinical care, rather than on the development of skills to support and enhance leadership (Dickson, 2022). The paradigm shift that is occurring, from the dominance of the biomedical model of healthcare towards humanising healthcare, reflected in national and local policies, requires collective leadership (West, 2021). Such policies advocate for patient- and family-centred care, working in partnership with service users (Department of Health, 2016; NHS England, 2019; NHS Wales, 2021; Scottish Government, 2016, 2017). In the 21st century, people expect to have their voices heard and be able to make decisions about their own health and healthcare. This is also true of the workforce. Increasingly, there is realisation that humanisation extends beyond caring for people experiencing care to include caregivers. Rather than patient-centredness, the narrative in policy is changing to person-centredness (Phelan et al., 2020). Patient-centredness suggests the needs of people receiving care are to be privileged over caregivers but, McCance et al. (2021) contend that person-centredness is a way of being in *all* relationships. It has the intention of creating 'healthful' or healthy workplace cultures, much needed to address the issues of staff wellbeing, recruitment and retention (Warren, 2022; Chamanga et al., 2020). McCormack and McCance (2017) define person-centredness as

> an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.
>
> (*p. 41*)

Cultures of empowerment are pivotal to support leadership development. Person-centred cultures value the participation and involvement of all stakeholders. Therefore, person-centred and effective leadership play a central role in shaping and developing services that ensure that service delivery is based on best evidence and is delivered in a manner acceptable to the people being cared for. This chapter supports nurses working in community settings to recognise their own leadership and role in promoting healthful workplace cultures. The starting point is an exploration of contemporary leadership models that enable person-centred community practice. Readers are then invited to explore their values and beliefs and how these shape behaviours as leaders. Key attributes of effective workplace cultures will then be unpacked to identify the intention of person-centred leadership. The last two sections offer different means of developing practices and frameworks to support the development of others in community contexts. Throughout there are different activities and exemplars to help leadership development in the community context.

PERSON-CENTRED PRACTICE

The Kings Fund (2013) published a report, 'Patient-Centred Leadership. Rediscovering Our Purpose', which identified 'unhealthy cultures' across organisations and the importance of effective leadership at all levels of organisations and across systems. This was in response to systems failings reported widely in the media across health and social care at the time, particularly the Francis Inquiry in 2013. This resulted in growing attention in addressing cultures of organisations across health and social care. According to Manley et al. (2013), negative cultures exist because of narrow, ritualistic practices which go unchallenged, whilst positive cultures have the potential to transform the quality of care, patient experience, health outcomes, staff wellbeing and commitment, as well as learning and evidence use in the workplace. Since 2013, the narrative in literature and policy has moved towards person-centred care, emphasising the need for person-centredness in all relationships (Phelan et al., 2020). Person-centredness is concerned with all persons including those being cared for as service users, their supporters and colleagues. Person-centredness also underpins professional frameworks including The Code (Nursing and Midwifery Council (NMC, 2018), the Standards of Proficiency for Community Nursing Specialist Practice Qualifications (NMC, 2022a) and Standards of Proficiency for Specialist Community Public Health Nurses (NMC, 2022b).

The Person-Centred Practice Framework (2017, 2021) is a useful framework for developing person-centred cultures (Figure 18.1). There are four domains: prerequisites, care environment, person-centred processes and outcomes. To achieve positive outcomes for service users and staff, McCormack and McCance (2017) suggest attention must be given to prerequisites and the care environment. This will, in turn, enable person-centred care processes. A particular

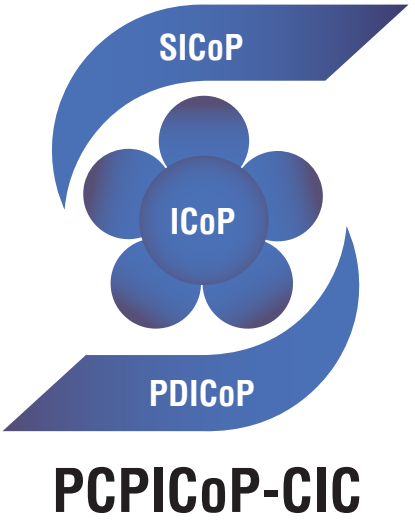


Figure 18.1 The person-centred practice framework. (McCormack and McCance 2017).

challenge for community nurses in delivering quality person-centred care is the inter-agency nature of teams involved in care and service delivery, where practitioners may have differing values and beliefs. Cultures of health and social care are different, which impacts workplace cultures. This is addressed later in this chapter.

Person-centredness and person-centred practices are linked to the concept of co-production, anticipatory care and strengths-based approaches to care and practice, important in contemporary community nursing practice. They are equally important in terms of developing practice. It is for these reasons that it is important to draw on contemporary leadership models that have person-centredness as a specific intention.

CONTEMPORARY LEADERSHIP MODELS THAT PROMOTE PERSON-CENTRED CARE

In general, leadership theories are concerned with who the leader is, what the leader does and in what context. Old paradigm leadership models, according to Northouse (2021) viewed leadership as a process that involves influencing others, occurring within a group context and involved goal attainment. The limitations of these models lie in the emphasis on one aspect of leadership, often to the detriment of the others. Conversely, new paradigm models are seen as a process of social influence which deals with the realities of constant change and places considerable emphasis on the power and importance of followers (Burns, 1978; Bass and Avolio, 1994; Alimo-Metcalfe and Alban-Metcalfe, 2005; Kouzes and Posner, 2001, 2017). Whilst James MacGregor Burns (1978) is credited with introducing the concept of transformational leadership within healthcare, and his work has undoubtedly been influential within healthcare, there has been little theoretical development of transformational leadership in recent years. In 2005, Alimo-Metcalfe and Alban-Metcalfe argued the original work was based largely on US studies of 'distant' leaders, top-level managers and chief executives rather than those close to the realities of practice directly with their followers. They proposed an alternative model of transformational leadership (Alimo-Metcalfe and Alban-Metcalfe, 2005, 2008) that examined the leadership interaction of middle managers in health and social care with followers. In this model of 'close' or 'nearby' leadership, there is a theme of ordinariness, rather than heroism, as suggested in earlier models. Follower engagement is placed at the heart of leadership and leaders are committed to building a shared vision through participation and inclusion of all stakeholders. They suggest leaders increase followers' self-efficacy and self-worth by communicating confidence and the expectation of the vision of a better future. Alimo-Metcalfe and Alban-Metcalfe (2008) claim that leaders who achieve high engagement can achieve high levels of motivation, job satisfaction and commitment among their staff. Despite this significant work, the work of Bass and Avolio (1994) is the model often used within leadership development programmes. Their four

'Is' of transformational leadership, individualised consideration, intellectual stimulation, inspirational motivation and idealised influence, are used as a framework for development based on seminal work by Burns in 1978. This was further developed by Kouzes and Posner (2017) in their five practices of exemplary leadership: inspire a shared vision, model the way, challenge the process, enable others to act and encourage the heart.

A more contemporary model of leadership that promotes engagement between leader and associate (rather than follower) is Person-centred Leadership developed by Cardiff (2018, 2021). He suggests leaders base their leadership practices on person-centred values (Box 18.2). This model is relational, involving leader and associate rather than follower or subordinate in an equal, respectful and dynamic relationship. The purpose of leadership for Cardiff (2021) is enabling empowerment and wellbeing, allowing associates to 'come into their own'. This is achieved by sensing, 'where the other is at', enabling reflexivity, balancing their needs, contextualising or helping the associate make sense of their social world, presencing and 'communing' or reaching shared visions or decisions. Leaders respond to individuals in different situations by 'stancing'. However, Cardiff (2021) suggests systems of evaluation; the availability of safe, critical and creative spaces; and the needs of the associate all have a significant impact on person-centred leadership.

Box 18.2 Core values of person-centredness

Respect for personhood
Being authentic
Sharing autonomy
Showing respect for and active engagement with a person's individual abilities, lifestyle and goals
Demonstrating mutual respect and understanding
Therapeutically caring
Committed to healthfulness as process and outcome

Another leadership model useful for community nurses to consider is the Person-centred Situational Leadership Framework by Lynch et al. (2017). Her model, developed from Hersey and Blanchard's (1997) model of situational leadership, is proposed as a means of leading person-centred cultures She suggests that while leaders adapt their leadership style from delegating, supporting, coaching and directing as advocated by Hersey and Blanchard, the aim of leadership is to enable followers to assess their practice using McCormack and McCance's Person-Centred Practice Framework (2021). This, she suggests, will be achieved through 'partnering for performance' whilst demonstrating the seven core attributes (Box 18.3). Partnering will enable followers to move along a continuum to achieve person-centred practice.

Box 18.3 Seven core attributes of Person-centred Situational Leadership

Unifying through collaboration, appreciation and trust
Balancing concern for compliance with concern for person-centredness
Harmonising action with the vision
Connecting with the other person in the instant
Relating with the essence of being
Listening to the other person with the heart
Intentionally enthusing the other person to act

Lynch et al.'s (2017) model of person-centred leadership is achieved by transformational learning (Mezirow, 1997), facilitated through critical reflection and engaging in critical dialogue whilst using inclusive and participative models of evaluation. In their study exploring the meaning of specialisation from the perspective of district nurses, Dickson et al. (2020) contend that district nurses have much to learn from such models. They found that, rather than using enabling approaches to leadership, district nurses are prone to using directive approaches. As a result, district nurses experience a 'burden of responsibility' which results in workload stress.

Michael West's (2021) work on compassionate leadership has been very influential in health and social care. This relational model of leadership proposes leaders as change agents but change agents that engage with colleagues through 'listening to understand', 'empathising with' and support within challenging work environments. This approach is intended to respond to nurses' work core needs identified in Box 18.1 – autonomy, belonging and making a contribution. He suggests the potential outcomes of compassionate leadership for staff include feeling valued, respected and cared for, so they can reach their potential and do their best work. Compassionate leadership resonates with recent work by Dickson et al. (2023). Their research aimed to investigate practising UK Nurses' and Midwives' experiences of effective leadership strategies during the 2020/21 COVID-19 pandemic. The research revealed a theory of leadership that advocated healthful leadership practices to develop cultures of wellbeing. Dickson et al. (2023) used realistic evaluation which generated tentative theories of leadership that promoted healthful cultures from contemporary literature. The six tentative theories that were generated were tested by surveying 328 nurses and midwives from a range of roles and specialities across the UK. The refined theories were further tested by analysing data from 14 interviews. The final theory revealed that

> *'leaders who promote healthful cultures know themselves as leaders and use facilitative practices. They are caring and compassionate, embody their values and are present for nurses and teams. They are able to do this when they are informed and adequately prepared for the role and the organisation privilege well-being. The outcomes of healthful leadership practices*

> *are nurses are engaged in shared decision-making, motivated to practice with confidence and competence*'. They experience increased morale because they feel valued/heard/supported, experience a sense of safety, and ultimately job satisfaction.
>
> (*Dickson et al., 2023: 996*)

From this theory, six leadership practices emerged (Box 18.4). These practices resonate with other contemporary models of leadership that promote person-centred practice (Cardiff et al., 2018, 2021; Lynch et al., 2017).

Box 18.4 Healthful leadership practices (Dickson et al., In Press)

1. Being present;
2. Being effective communicators;
3. Knowing themselves as leaders;
4. Embodying their values;
5. Being caring, compassionate and other-centred;
6. Using facilitative practices.

Being present aligns closely with partnering for performance, particularly 'listening to the other with the heart' (Lynch et al., 2017), 'presencing' and 'communing' of person-centred leaders (Cardiff et al., 2018) and empathising and helping in compassionate leadership (West et al., 2020). Being effective communicators was evident in leaders being conduits of information, enabling communication flow horizontally and vertically within organisations. However, this study revealed that, to avoid information overload, leaders curated the information they received and that they also acted as advocates for their staff. As a result, nurses and midwives shared in decision-making, and they felt heard and valued. Nurses and midwives had a developed knowledge of themselves as leaders, which they achieved through reflexivity. Dickson et al. (2023) contend this resulted in understanding their preferred leadership approach and emotional intelligence. The fourth healthful leadership practice, 'embodying values' relates to authenticity. The values shown most by leaders in this study were of compassion, honesty, openness, humility, empathy, respect, vulnerability and courage. Leaders recognising their own vulnerability also emerged, resulting in bonds of trust. Being caring, compassionate and other-centred, also features in person-centred leadership (Cardiff et al., 2018) and compassionate leadership (West et al., 2020). Cardiff et al. (2018) suggest showing vulnerability and being caring, compassionate and other-centred, help 'equalise' relationships, creating conditions for trust and collaboration. Dickson et al. (2023) proffered this practice created an environment of shared responsibility leading to others in the team to be caring and compassionate in return. West et al. (2020) describe this as 'belonging and contribution' and 'caring and feeling cared for'. Dickson et al. (2023) suggest that the outcomes of this practice are a sense of connectedness,

increased morale, job satisfaction and others taking responsibility for their own and others' wellbeing. The last healthful leadership practice, facilitative practices, refers to coaching and mentoring, resonating with a number of the core attributes of person-centred situational leadership (Lynch, 2015) and the practices advocated by Cardiff et al. (2018) that enable leaders and associates to 'come into their own'.

EXPLORING SELF AS A DEVELOPING LEADER IN COMMUNITY PRACTICE

Nursing students begin their leadership journey at the start of their pre-registration programme and often before that. Over time, leadership knowledge, skills and attributes continue to be honed as the demands of nursing roles and professional requirements expect the demonstration of leadership in care management and team working (NMC, 2018; NMC, 2022a, 2022b). McCance and McCormack (2021) contend that 'knowing self' is necessary for authenticity and working collaboratively with others. These attributes are particularly important working within community settings, where integrated working is fundamental to avoiding unnecessary hospital admissions and where delicate negotiations are needed to care for and support people to live in their homes and within the community. Brown and Tropea (2021) define 'knowing self' as 'the way a person makes sense of their knowing, being and becoming through reflection, self-awareness and engagement with others' (p. 34). Ongoing development therefore can create a sound knowledge of 'self', as well as the context and the interplay between each. Knowing self as a person is essential in developing healthful relationships, as well as in professional and leadership identity. Mackay and Jans (2022: 232) suggest healthful relationships are evident when people experience 'a sense of "being" in practice together whilst supporting each other to seek their full potential'. They describe such relationships as being mutually respectful, accepting of differences, having shared expectations, offering hope and are where actors are open to learning, unlearning and relearning (Figure 18.2). Knowing self and relationality are also central to contemporary leadership models (Dickson et al., 2023; Cardiff et al., 2018; West et al., 2020). However, according to Brown and Tropea (2021), this knowing may not align with others' perception of them, which is why feedback and reflexivity is so important.

Key to knowing self is being conscious of one's own values and virtues. Values are guiding principles people live by whereas virtues are qualities that are 'morally good'. Values are made visible in virtues or behaviours and are shaped by experiences, past and present. They are also influenced by explicit professional and organisational values. Virtues meanwhile are developed through conscious practice. Understanding values and their alignment with behaviours is the bedrock of demonstrating effective, person-centred leadership. It is also pivotal in acting consistently with espoused values in times of tension or crisis.

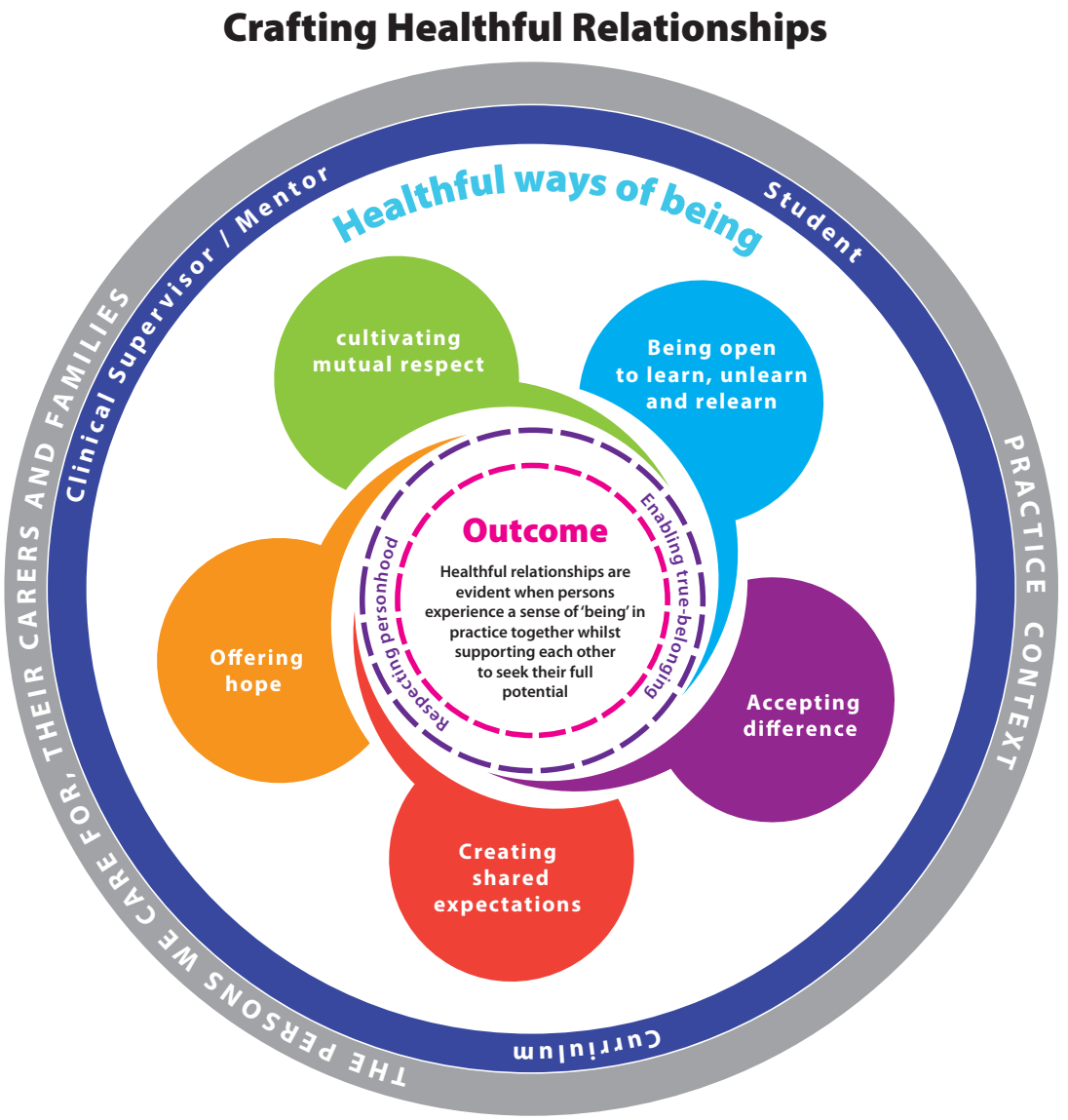


Figure 18.2 Healthful relationships.

Virtues meanwhile are part of professional identity. Professional identity is concerned with how one wants to be perceived as a professional and, in this case, a leader. Moore (2017) identified virtues associated with leadership as integrity, justice, honesty, courage, temperance, wisdom, confidence, trustworthiness and generosity.

The following 'self-portrait' activity (Activity 18.1) is adapted from the activity, 'Who am I as a person?' in the chapter by McCormack et al. (2021a) in *Fundamentals of Person-centred Healthcare Practice*. This activity is designed to help in 'knowing self,' which will be the starting point of being and becoming an effective leader in the community. The activity can be done individually or

with team colleagues. It will surface individuals' values. It will also contribute to creating shared team values as a basis for effective teamwork. This activity can evoke some emotion, so please be aware of that.

ACTIVITY 18.1

Creating a self-portrait

Individually, sit in a quiet space or go for a walk in nature to reflect on the following questions:

Who is the most significant person in your life, and why?
Where do you go to (physically or metaphorically) when you want to get away from it all?
What has been your greatest achievement so far in your life?
Who or what are you aspired by?
What is your greatest sadness/regret that you currently live with?
When are you most happy or joyful?
If you had one journey you could make, what would it be?
Who or what do you most depend on for your support, challenge and validation as a person?
What principles, values or beliefs are you willing to 'fight for'?

Think of an image that best represents you and draw it – your portrait

If you are doing this as a team activity, connect with (an)other person and share your portrait in turn.

Another means of leadership development is reflecting on leaders considered to be inspirational. The next activity (Activity 18.2) gives the opportunity to think about such leaders: who they are, their attributes, behaviours they demonstrate and the impact of their leadership. Using these insights, the reader is then guided to envision themselves as the leader they wish to be.

ACTIVITY 18.2

The leader I aspire to be.

There are many books/podcasts/videos of leaders within sport/politics/religion. Pick a leader who inspires you, for example Michelle Obama, Maya Angelou, Sir Alex Ferguson, Nelson Mandela or Martin Luther-King.

1. Read/listen to their life story and note, what you think makes them inspirational.
2. Consider their attributes, their virtues and the impact they have or have had.
3. What do you think has enabled them to be the inspirational leader you believe them to be?
4. Using creative materials, construct an image of the leader you want to be. (You will find you achieve clarity of your vision if you create an image by e.g. painting, drawing, collage, sculpting, mind mapping.)

Learning from others is another pivotal way to develop leadership. There are many ways to do this. Learning through observation is also a valuable way to develop leadership. The following activity (Activity 18.3) offers a framework to structure a shadowing opportunity and get the most out of the experience.

ACTIVITY 18.3

Leadership shadowing experience

Take time to plan your experience.

Choose a leader you admire from practice and arrange to spend time with them to observe what they do and how they approach their work.

Consider what enables and hinders their leadership approach.

To prepare for the experience you may wish to take the following steps:

1. Consider your learning objectives: what do you want to achieve?
2. What questions will you ask?
3. What would you like the leader to hear from you?

After the shadowing experience, the following questions will help you reflect:

1. What have I learned from my shadowing experience?
2. Were my objectives met, and if so, how?
3. What did I most value about my shadowing experience?
4. What feedback would I like to give the leader I shadowed?

Receiving feedback is also important for growth and development. When used as a positive mechanism, feedback can be nurturing whilst allowing commitment and/or concern to be shown. Mackay and Jans (2022) emphasise the importance of 'in the moment' feedback that is strengths-based and offers areas for improvement. In their models of Critical Ally and Critical Friend, Hardiman and Dewing (2019) highlight the importance of advanced communication skills like language, being aware of non-verbal communication and active listening. They also highlight the importance of the relationship for giving feedback, and they draw attention to the 'how to' give feedback. In their study, they emphasised the need for gentle language for growth and development, which they suggest created space for critical reflection as well as calm and attentive dialogue. This person-centred feedback requires attending to the other person with one's 'whole self,' and Hardiman and Dewing (2019) suggest this is only possible through knowing self.

The next activity (Activity 18.4) is a framework for offering 'in the moment' feedback using BOOST as an acronym (https://www.fons.org/resources/documents/Creating-Caring-Cultures/Giving-Feedback.pdf). The model was developed in 2015 by the Foundation of Nursing Studies to motivate teams, keep them engaged and ultimately create caring cultures. It is an appreciative model that notices and appreciates the good things people do every day and celebrates successes.

ACTIVITY 18.4

Practising giving feedback

Notice the good practices happening in your workplace and use the following steps to give 'in the moment' feedback. Consider the language and tone you use.

Balanced: focus not only on areas for development but also on strengths.
Observed: provide feedback based only on behaviours that you have observed.
Objective: avoid judgements and relate your feedback to the observed behaviours, not personality.
Specific: back up your comments with specific examples of the observed behaviour.
Timely: give feedback soon after the activity to allow the learner the opportunity to reflect on the learning.

What does gentle language look like?

What is the impact of the feedback you have given?

How could you encourage this to be adopted within your teams?

PROMOTING HEALTHFUL WORKPLACE CULTURES AS AN INTENTION OF LEADERSHIP

Leading person-centred practice emphasises the importance of cultures of empowerment. A definition of culture commonly used is 'the way things are done around here' (Drennan, 1992, p. 3) but this belies its complexity. The Person-Centred Practice Framework (PCPF; McCormack, 2021) identifies aspects of the practice environment that contribute to (or hinder the creation of) cultures of empowerment. It also highlights prerequisites of person-centred practices and processes that feature in person-centred practice. McCance and McCormack (2021) have further developed the PCPF, revising the outcomes of person-centred practice as healthful cultures. Their 2017 definition of healthful culture still holds:

> A healthful culture is one in which decision-making is shared, staff relationships are collaborative, leadership is transformational, innovative practices are supported and is the ultimate outcome for teams working to develop a workplace that is person-centred.
>
> (*p. 60*)

For leaders, the creation of healthful cultures must be a key objective. The healthful leadership practices in the earlier section offer a framework for leadership development. In this activity, the practices are used as a framework for reflection (Activity 18.5).

Another framework, aligned with person-centred practice and healthful leadership practices, useful for leaders to develop healthful cultures is the Guiding Lights framework developed by Cardiff et al. (2020). This framework,

ACTIVITY 18.5

Healthful leadership practices

1. Being present;
2. Being an effective communicator;
3. Knowing themselves as leaders;
4. Embodying their values;
5. Being caring, compassionate and other-centred;
6. Using facilitative practices.

Individually, choose one of the leadership practices that promote healthful cultures.

Reflect on examples from your own practice or on practices that you have observed.

In a group or in your team, discuss your reflections/observations

Agree strategies to support you to adopt this practice more regularly.

also developed through realist evaluation research, offers four guiding lights. These are collective leadership; living shared values; safe, critical, creative, learning environments; and change for good that makes a difference. Collective leadership describes the key healthful leadership practice of visibility and availability suggested by Dickson et al. (2023). It is less concerned with hierarchical leadership; rather, it holds that everyone has a shared responsibility for sustaining effective workplaces. Living shared values is fundamental to person-centred practice and aligns with the healthful leadership practices of 'embodying their values' and 'being caring, compassionate and other-centred'. However, Cardiff et al. (2020), also interpret this guiding light as, positivity, learning, interprofessional teamwork, evidence-informed practice and celebrating change for good'. Clarifying values and beliefs is fundamental to practice development which is discussed in the next section. The third guiding light, 'safe, critical, creative learning environments', could be viewed as an outcome of 'facilitative practices' as indicated by Dickson et al. (2023). They suggest the aim of facilitative practices is to foster engagement, encouraging learning and innovation. Cardiff et al. (2020) suggest this is key to effective teams and can be achieved through active learning, another practice development principle. Facilitation in both frameworks refers to enabling practices, such as coaching and mentoring, aimed at the transformation of self and others. They also highlight the need to create safe spaces where people can feel brave. According to Edmonson (2018) psychologically safe spaces are evident when people feel able to share thoughts and feelings and make mistakes without being judged. She suggests this is only possible where there is trust and respect. Brown and McCormack (2016) describe safe spaces as environments without blame or reprisal, enabling a deeper knowledge of self. Such environments are influenced by leaders. The final guiding light is 'change for good that makes a difference'. This describes a

workplace context and culture that foregrounds what matters to people, person-centred relationships and ongoing development (Cardiff et al., 2020, p. 13). They proffer that systematic approaches are adopted to transform practice and services, but change is based on the needs of stakeholders and is a shared purpose of what matters to care receivers and caregivers. The following section outlines different methodologies and methods to make such changes.

APPLYING PARTICIPATORY METHODOLOGIES TO DEVELOP PRACTICE WITHIN COMMUNITY CONTEXTS

Practice development was initially introduced as a means of developing evidence from practice to substantiate nursing as a profession in the early 1990s (Pearson, 1997) through the establishment of nursing and practice development units. Since then, theoretical understanding and the evidence to support practice development as a means of taking practice forward has grown considerably (Hardy et al., 2021). In the early years, the purpose of practice development was advocated as good-quality patient-focused care achieved through the improvement of technical knowledge and skills (Garbett and McCormack, 2002b) and through the dissemination of research into practice (Kitson, 2009). Although this approach was direct and effective in working to short-term goals, it was associated with top-down change and was often an ineffective sustainable approach. The broader, transformational view of practice development is a formal methodology aimed at developing individual and collective practice (Manley et al., 2021; Radbron et al., 2021). Hardy et al. (2021) have updated principles to help practice developers work in systematic ways to develop practice (Box 18.5).

Box 18.5 Practice development (PD) principles

1. PD is fundamentally about person-centred practice that promotes safe and effective workplace cultures, where all can flourish.
2. PD uses collaborative, inclusive and participatory (CIP) approaches.
3. PD blends creativity with learning, freeing people's hearts, minds and souls, to achieve new ways of thinking, doing and being.
4. PD utilises active work-based learning to facilitate individual practice and cultural transformation.
5. PD is a facilitated process that seeks to promote critically informed action.
6. PD uses inclusive evaluation to integrate evidence from the process and outcomes of transformation.
7. PD focuses on supportive relationships across individuals, teams and systems to stimulate effective change.
8. PD is a complex methodology that uses a variety of evidence to inform transformation for individuals, teams and systems.

Principles of PD offer a supportive framework that enables leaders to achieve a culture of transformation by moving through change as a process of enlightenment towards empowerment and emancipation (Hardy et al., 2021). Hardy and colleagues revised the PD principles previously published in 2008, through a critical review process of work carried out by practice developers across the world. The revised principles have now a stronger evidence base, and some of the complex language used in the previous version has been simplified. Radbron et al. (2021) advocate for continually analysing our own assumptions when working with PD principles to open up possibilities for new ways of working in practice. Practice developers may apply these principles together with a quality improvement framework such as Plan, Do, Study and Act (PDSA; e.g. The Health Foundation, 2021). The PD principles keep the purpose of developing person-centred cultures central to the development. Using the principles of PD as a framework to develop practice and for reflective practice will assist in the transition from novice to experienced practice developer.

The first principle highlights the commitment to developing person-centred practices that promote safe and effective workplace cultures. According to McCormack et al. (2021b) 'flourishing persons' is the ultimate manifestation of person-centredness. They suggest flourishing means living our virtues. They also suggest these can be practised and honed over time. *Human flourishing* may not be a familiar term, but it is not a new concept. Aristotle described human flourishing as being, '*when a person is concurrently doing what he* [*sic*] *ought to do and doing what he wants to do*' and Abraham Maslow (2017) identified self-actualisation as the state of wellbeing we strive for. There has also been extensive work in social psychology around the topic. One of the key researchers in this area is Martin Seligman. He offers the PERMA model, suggesting that to achieve true happiness, we should experience **P**ositive emotions, **E**ngagement where one feels a balance between skill and associated strengths, positive **R**elationships where one feels supported and valued, **M**eaning in our lives and feel like we have accomplished our **A**chievements.

The second principle is central to PD and a useful starting point for leaders (Hardy et al., 2021). It is also consistent with collective leadership as advocated by Cardiff et al. (2020). This principle advocates the use of CIP approaches to practice with the aim of democratising practice. Collaboration is a feature of community practice, although it is often forgotten when it comes to decision-making. Too often decisions are made by few people, often lead practitioners and managers; and these decisions are relayed to others. Adopting a truly collaborative approach with people experiencing care and when working with colleagues enables shared decision-making. Inclusion is concerned with actively engaging with others to invite them to participate. This will only happen in cultures in which people feel brave to contribute and space is made for reflection, dialogue and discussion.

All too often, change is not transformational as teams 'tinker around the edges' of practice processes. During the process of PD, learning about

themselves and their practices (transformation) is not given attention or realised. Principles 3 and 4 are concerned with innovation and learning in practice (Hardy et al., 2021). Practice developers use facilitation to help others think differently about practice by using creativity. Critical creativity, developed by Titchen and McCormack (2010), is a way of blending both criticality and creativity through creative imagination and the arts. It is a means by which practitioners can be helped to tap into their practical wisdom, question their own assumptions and consider different possibilities in PD. Work-based learning advocated in the fourth principle also encourages the use of creativity to see, notice and observe practice through active learning. The facilitation of critical reflection, crucial in this type of transformative learning, challenges practice learning of individuals and teams through critical questioning where enlightenment, empowerment and emancipation occur (Dewing, 2010). Emancipation or liberation from old ways of thinking together with balanced participation is required to recognise areas of practice that require attention. The principles of active learning were originally developed by Dewing (2008) and further developed by Dewing (2020) and Dewing and Lynch (2021). They advocate learning taking place in the workplace rather than being a separate activity in more didactic training study days. They contend the purpose of active learning is action, which contributes to the transformation of workplace cultures. Active learning includes using multiple intelligences, having critical dialogue with self (critical reflection) and then, with others, taking intentional action. knowing how to repeat the process and enabling the process through facilitation.

Principle 5, PD is a facilitated process that seeks to promote critically informed action (Hardy et al., 2021). Having skills in facilitation is therefore the bedrock of developing practice. Facilitative practices were highlighted in the models of leadership earlier in this chapter (Dickson et al., 2023; Cardiff et al., 2018). Skilled facilitation is required for practice transformation at individual, team and systems levels (Hardy et al., 2021). They suggest that it is the process of valuing a nurturing critical questioning environment that allows a team to learn and develop together, necessary for critically informed action. It also requires a clear vision of what is to be achieved and how. van Lieshout and Cardiff (2015) offer four principles of person-centred facilitation: being other-centred without losing self (focus), valuing a constant state of becoming (learning and growing for all in the facilitative relationship), maintaining relational connectedness and consciously working within contexts and cultures, which relates to flexibility of the facilitation. Person-centred facilitation is therefore a way of being rather than an isolated task.

Practice developers continue to draw on the seminal work of John Heron (1999). His model of facilitation offers a framework to help groups move from being dependent to autonomous in their functioning. It is also a useful framework for facilitators to reflect on their growth and development. Heron outlines six dimensions of facilitation: the planning: intervention (setting goals for the group), meaning dimension (helping the group to make sense of experience),

confronting dimension (raising the group's awareness of the gap between saying and doing and tackling resistances), structuring dimension (choosing which methods of learning are best suited to the event) and valuing dimension (creating a climate which gives people recognition). Within each of these dimensions, facilitators use either authoritative (directive) or facilitative (helping) interventions.

Principle 6: PD uses inclusive evaluation to integrate evidence from the process and outcomes of transformation (Hardy et al., 2021). Reflecting the CIP principles of collaboration, inclusion and participation, practice developers use multiple forms of evaluation to ensure the voices of all stakeholders are heard. Measures used may be those already used in practice, for example key performance indicators or audit data, but they can also be stories or reflections from people with lived experiences of care and or people giving care. Because learning is integrated within PD, continual learning from the development process ensures the methods adopted are achieving the transformation required. The supportive relationships across individuals, teams and systems to stimulate effective change, in Principle 7 highlight the context within which practitioners operate. Practice developers work in practice, where care is being delivered. This principle, PD, focuses on supportive relationships across individuals, teams and systems to stimulate effective change (Hardy et al., 2021) and advocates for a values-based approach to working together to develop practice. It also highlights innovation which comes because of continually challenging thinking and practice. The final principle, PD, is a complex methodology that uses a variety of evidence to inform transformation for individuals, teams and systems (Hardy et al., 2021) could perhaps be considered the unifying principle. Incorporating all stakeholders, active and work-based learning and continual evaluation through person-centred facilitation whilst keeping persons central to development indeed require complex methodologies and methods.

UTILISING FRAMEWORKS TO DEVELOP SELF AND COLLEAGUES WITHIN COMMUNITY TEAMS

Learning environments are implicit in healthful cultures as advocated by McCance and McCormack (2017) and explicit in effective workplace cultures (Cardiff et al., 2020). Work-based learning is visible within learning environments and such contexts enable nurses to meet statutory and professional requirements. The first activity in this section (Activity 18.6) gives leaders the opportunity to observe and evaluate the learning environment within their workplace.

Within this chapter, much attention has been given to the importance of 'knowing' and developing self and how this is developed through reflective practice and reflexivity. Reflexivity is a skill that allows persons to critically challenge values and beliefs they hold and, according to Johns (2022), is a continuous evolving process of self-inquiry towards self-realisation. The following activity (Activity 18.7) offers further insight into self as a developing leader.

ACTIVITY 18.6

Learning environment observation tool

Take some time to sit quietly within your workplace and reflect on the opportunities for learning for you and your team. Consider the following questions in relation to each learning activity within the grid.

Learning activities	**What opportunities are there for these learning activities? What am I noticing about this learning activity?**	**What questions does this raise for me, and do I want to ask? For example, *how could we create opportunities for …***	**Critical dialogue with the team *Please record your discussion points and thoughts following your discussion.***	**What does this mean for me as a developing leader? What does it mean for the team?**
Critical reflection: Self-reflection				
Critical reflection: With others				
Learning through dialogue				
Formalised ongoing CPD opportunities				
Personal development planning process				
Any other learning activities				

Getting into good habits of reflection is the first step in developing self. Reflecting on self and the impact on practice can be achieved by using creative means, the purpose of which is to use multiple intelligences (Dewing and Lynch, 2021). They suggest we make meaning from the world through sensory perception, and these perceptions can be transformed by different layers of cognitive knowledge, surfaced through critical creativity. Activities such as walks in nature, art, storytelling, poetry or journalling enable the surfacing of tacit

ACTIVITY 18.7

Hand portrait



On a sheet of paper, draw around your hand creating your own handprint.

Use each finger to identify how you see your current leadership.

1. Thumb – What do I do well?
2. Second Finger – What could I improve on?
3. Middle Finger – What do I find frustrating?
4. Ring Finger – What do I cherish?
5. Pinkie Finger – What area would I like to grow and develop?

Handprint illustration by Rose Matheson

knowledge and wisdom, leading to a new understanding of assumptions, values, behaviours and their impact on others. There are several reflective models used in nursing that support such activities, such as Gibb's Reflective Cycle (Gibbs, 1988), John's Model of Reflection (Johns, 2022) or Rolfe's Reflective Model (Rolfe et al., 2001). Finding the model that sits best with you is important. The following short blog may help to start this practice. Reflective journal writing | RCN Bulletin | Royal College of Nursing.

Arguably, deep reflection cannot be achieved alone but requires support by an experienced facilitator, which in healthcare is traditionally supported through clinical supervision. Clinical supervision has the potential to support development of both self and others. Similarly, staff appraisal, which is often in a structured format, but you can be more reflective by encouraging colleagues to use creativity. Box 18.6 describes clinical supervision where the use of creativity enabled the supervisor and supervisee to gain insight into the supervisee's experiences in practice.

Box 18.6

I could see he was still struggling with his confidence, so in clinical supervision, I invited him to reflect on the past year. He drew a timeline. At the start, he was mostly hidden by a cloud. Along the timeline were moments where he felt he had achieved or felt involved in the team. At the end, the cloud was still there, but his head was above it with one arm in the air and a leg around the side. He was so upbeat and positive having recognised his growth over the year. What was also lovely was he recognised he'd used a cloud to represent me, as a cushioning, gentle support throughout the year. (*Muriel*)

Resilience-Based Clinical Supervision (RBCS) is a model of supervision developed by Stacey (2017, 2020). It is a particular approach that draws on compassion-focused therapy (Gilbert, 2014) and focuses on creating psychologically safe spaces, mindfulness activities to reduce stress, reframing emotions, considering the inner critic and promoting compassion to self and others (Stacey et al., 2017). The intention of RBCS is to support practitioners to embrace their own wellbeing and resilience with an outcome of improved provision of care delivered by the practitioner. Resources relating to RBCS can be found on the Foundation of Nursing Studies website: https://www.fons.org/learning-zone/clinical-supervision-resources.

Other tools for supervision include the Critical Ally and Critical Friend models (Hardiman and Dewing, 2019) for one-to-one supervision and CAKE (Caring for self and others, Attending to what is happening, Keeping Connected and Enabling and empowering) resource (Dickson and MacDonald, 2023) for group supervision. The Critical Ally and Critical Friend models are frameworks to develop skilled facilitation to enable practitioners to understand how preconceptions and assumptions impact on their thoughts and actions in practice. The importance of creating psychologically safe spaces is again highlighted by Hardiman and Dewing (2019) to enable high support and high challenge. Preceptorship programmes may be available for newly qualified nurses to offer support, normally as they transition into their role as a registered nurse. They may also be available to newly qualified district nurses, health visitors and prescribers. Examples of a preceptorship programme for newly qualified nurses in

England and Scotland is NHS Flying Start (http://www.flyingstartengland.nhs.uk/ and http://www.flyingstart.scot.nhs.uk/). The programme in Northern Ireland is offered by the Practice and Education Council for Nursing and Midwifery (https://www.nipecdf.org/)/

CAKE is a digital resource which uses storytelling to promote individual and team wellbeing developed by Dickson and MacDonald (2022). The resource has also been used as a supervision and support framework. CAKE was co-designed with health and care practitioners and has eight slices: Checking In and Checking Out, Shared Ways of Working, Creating a Shared Purpose, Storytelling, Reflection, Action Planning, Self-Care and Well-Being Strategies and Evaluation. The first three slices give attention to creating a safe space, the storytelling and reflection slices help users share stories of their experiences in practice, reflect on these individually and collectively, recognise the feelings provoked and raise critical questions. Critical questions are open, curious, action-orientated questions. They begin with such questions as 'How can we …' 'What can we …' 'Who or what will help …' These questions help practitioners move towards action planning and identifying strategies to promote wellbeing. The last phase of CAKE is evaluation. Each of the slices is a vital part of the pathway towards creating healthy workplaces. The resource is freely available for teams to use (Welcome to CAKE – Listen Up Storytelling), although it requires skilled facilitation.



CONCLUSION

Community nurses are leaders. They demonstrate leadership every day when they work with people experiencing care and their families to live and die well

at home. They demonstrate leadership as they navigate the complex systems of health and social care. Knowing self as a person and as a leader are the starting points of developing person-centred practices and ultimately person-centred cultures. Having a clear vision of the preferred leadership approach and working in partnership with others by adopting collaborative, inclusive and participative principles will contribute to transforming practices that promote person-centred practices in the community.

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CHAPTER

19

Digital healthcare

Lesley S. Mills

LEARNING OUTCOMES

- Explore the meaning of digital healthcare, including the associated terminology.
- Appraise the suitability of digital healthcare for use within community nursing practice.
- Explore the professional and ethical issues in the use of technology within community nursing.
- Discuss the educational needs of the community nurses regarding digital transformation.

INTRODUCTION

The International Council of Nurses (ICN, 2023) has highlighted ways in which digital technology can support the ever-changing transformation of healthcare systems in the delivery of nursing care and for people to engage with their health and wellbeing. Its position statement, 'Digital Health Transformation and Nursing Practice,' shows how digital technologies 'have the potential to support equitable and universal access to health services, increase the efficiency and reliability of health systems, improve client and health worker safety, respond to health workforce shortages, reduce costs and, ultimately, improve people's health outcomes.' The advances in digital health, remote monitoring and virtual care along with the introduction of smart devices and developments in artificial intelligence (AI) emphasise the need for all nurses to be familiar with digital health for the benefit of the people they care for. The president of the ICN (2023) suggests that upskilling and empowering nurses to be innovators for a digital world will potentially advance gender equity and improve healthcare. However, it is important to remember that the gap between those who have access to technology and those who do not has created a "digital divide" which can and is leading to inequalities in healthcare (Makri, 2019).

Healthcare workers are now using digital technology to help transform how they can work quickly, more easily and improve access for those they are caring for. The COVID-19 pandemic was the springboard for the NHS to accelerate

DOI: 10.4324/9781003347545-20

digital ways of working and its digital capabilities, and, prior to this, the pace of change had been slow. Considering the changing demographics of society and the fact that advances in technology can save time and money, national strategies have identified digital health as an approach to improve healthcare (Department of Health and Social Care and NHS England, 2022, Scottish Government, 2021, Welsh Government, 2023).

As people live longer, but also with more long-term conditions (LTCs), there is an inexorable increase in the demand for healthcare. The workforce is also changing: millennials have new expectations and most people seek a good work–life balance through flexible careers. The NHS Long Term Workforce Plan (NHS England, 2023a) identifies the need for more healthcare workers to respond to this increasing demand. Digital healthcare technologies, defined here as genomics, digital medicine, AI and robotics, should not just be seen as an added expense but rather as a new means of addressing those healthcare challenges of the 21st century. The UK has the potential to become a world leader in these healthcare technologies. The Topol review (2019) identified how technological innovation will impact the roles and functions of healthcare staff over the next two decades. The review of the evidence leads us to suggest that these technologies will not replace healthcare professionals, but will enhance services, freeing up time to care for individuals. Some professions will be impacted more than others, but individual outcomes should in all cases be positive. Individuals will be empowered to participate more fully in their own care (Topol, 2019). It is therefore clear that digital healthcare needs to be an integral part of nursing practice, and it is important that community nurses have the underpinning knowledge relating to this technology and can use it effectively to meet the healthcare needs of individuals, families and communities.

This chapter therefore aims to explore digital healthcare within community nursing. First, the associated terminology is examined, and then the evidence base to support its use will be explored. Finally, some professional, ethical and contemporary issues will be considered specific to nursing in the community.

ACTIVITY 19.1

Action point

Before reading this chapter, draw a concept map/mind map/spider diagram outlining what you think digital transformation is. Include in your map not only what you think digital healthcare looks like but also its main features and the infrastructure that needs to be in place in order to effectively implement it in community nursing. You may wish to use this concept map to inform activities as you progress through the chapter.

DIGITAL HEALTHCARE AND THE ASSOCIATED TERMINOLOGY

The key terminology relevant to digital transformation and healthcare is explored in this section. It is not possible to cover all digital health terminology

in depth here; however, it is important that there is an understanding of the broad principles of the key terms, in order that technology can be used appropriately within the community.

DIGITAL HEALTHCARE

Digital healthcare technologies, also previously known as eHealth, have the potential to bring numerous benefits to healthcare systems and individuals alike. These technologies can support equitable access to health services, ensuring that everyone has the opportunity to receive the care they need regardless of location or socioeconomic status. By leveraging digital tools, healthcare systems can increase the efficiency and reliability of their services, enhancing the overall quality of care (World Health Organisation, 2021c). One of the key advantages of digital healthcare is the improvement in client and health worker safety. Enhanced communication and coordination enabled by digital technologies can reduce errors in diagnosis and treatment, minimising potential harm to individuals. Digital healthcare solutions can also streamline workflows and reduce administrative burdens, allowing healthcare professionals to spend more time with those they care for (NHS England, 2019). Furthermore, digital healthcare can help address health workforce shortages by enabling remote consultations, telemedicine and remote monitoring. Healthcare professionals can reach a broader client population, especially in underserved areas and regions with limited healthcare resources, which can alleviate the strain on healthcare systems and improve access to specialised care (World Health Organisation, 2021c). Cost reduction is another potential benefit of digital healthcare technologies. By optimising processes, reducing paperwork and minimising unnecessary hospital visits, healthcare systems can achieve significant cost savings. These savings can then be reinvested into improving healthcare infrastructure and expanding services (World Health Organisation, 2021c).

Overall, the implementation of digital healthcare technologies has the potential to improve people's health outcomes. By providing equitable access to high-quality care, enhancing the safety and efficiency of healthcare systems, and reducing costs, digital healthcare can contribute to better health outcomes for individuals and communities.

DIGITAL TRANSFORMATION

The term *digital transformation* is fairly new and has been used to describe the future of digitally enabled care as laid out in the NHS Long Term Plan (NHS England, 2019) Within Scotland, the pace of digital transformation has been accelerated since the pandemic (Scottish Government, 2021). The success of digital transformation is entirely reliant on people's ability to know when, why and crucially how to use digital services and technology. As new challenges continue to be faced, it is crucial to harness the potential of technology to meet

the demands of a changing society so that the highest quality care, education and training are provided to everyone who needs it.

Digital transformation in the UK healthcare sector has been reported as "slow, expensive and challenging" (Taylor, Fitzsimmons-Craft and Graham, 2020). The ambition now, however, is to empower people by improving accessibility to healthcare services, their own health records and appointments or virtual consultations. The Welsh Digital and Data Strategy (Welsh Government, 2023) focuses on digital technology having the potential to revolutionise the way we work and learn. With the help of technologies such as AI, machine learning and big data analytics, the needs of individuals, educators and healthcare professionals can be better understood and anticipated. Data can be used to identify patterns and trends and develop new strategies for improving care, training and education programmes and workforce management. For example, healthcare organisations can use predictive analytics to identify those individuals at high risk of developing an LTC, enabling clinicians to intervene before the disease progresses (Topol, 2019). Technology can also help healthcare workers to work remotely, improving access to care in rural or remote areas, reduce wait times and increase flexibility. In education and workforce training, technology can provide personalised and adaptive learning experiences that are tailored to individual learners. This technology not only helps learners acquire new skills and knowledge more quickly but also ensures that they retain the information longer. E-learning modules can also help to reduce the cost and time required for training programmes, making them more accessible to a wider range of learners. Technology and data are essential to drive innovation and transformation in healthcare, education and workforce training (NHS England, 2019, Scottish Government, 2021, Topol, 2019).

HEALTH AND NURSING INFORMATICS

Health informatics is the use of digital technology and data to support the delivery of healthcare and to promote health (NHS England, 2023b). Nursing informatics is similar in that it is the collection of data and use of information to support nursing practice. This encompasses the electronic health record (EHR), summary care record or emergency care record depending on which area of the UK you are in.

ELECTRONIC HEALTH RECORD

Record keeping is an essential element of nursing practice and includes all records that are relevant to your scope of practice (NMC, 2018a). EHRs are integral to nursing, ensuring that access aids responsive care and improves communication, reducing duplication which can save time, improve workflow and increase productivity. The EHR is, as it sounds, an electronic copy of a person's nursing or medical record. The aim within the NHS is for a single integrated EHR to be available to authorised users, including the service user

(RCN, 2012a, 2012b). In the UK, the development of the healthcare record is at varying stages, with some general practice (GP) surgeries having used electronic records for many years. However, the challenge is for the record to cross primary and secondary care boundaries and be a fully integrated health and social care record, allowing access to authorised individuals while safeguarding public confidentiality (NHS England, 2019, Scottish Government, 2021, Welsh Government, 2023).

ACTIVITY 19.2

Case study

Barbara is an 83-year-old female who lives alone in her own home. She has rheumatoid arthritis, chronic obstructive pulmonary disease and type 2 diabetes. Barbara has been assessed on numerous occasions by various health and social care professionals including the occupational therapist, social workers, the district nurse and the diabetes specialist nurse and is also under the care of a hospital consultant for her rheumatoid arthritis and her general practitioner. Until recently, Barbara has had to repeat her story every time she was assessed by a new professional. Now, using a shared electronic care record all the professionals involved in her care have access to share information and coordinate care, and if she has an exacerbation of any of her co-morbidities out of hours, there is adequate information to manage her care in a timely manner and ideally avoid hospital admission.

Reflection point

Reflect on the preceding case study and consider it in relation to the area you work in. What are the strengths and challenges of using an electronic health record?

REMOTE MONITORING AND VIRTUAL WARDS

Virtual wards (also often referred to as 'Hospital at Home') use the systems and principles of a hospital ward but allow the person to stay in their own home to monitor their healthcare needs (Hakim, 2023). National Institute for Health and Care Excellence (NICE, 2024) promote the use of virtual ward platforms, to monitor individuals with various conditions such as acute respiratory infections (ARIs) at home. These platforms consist of a public-facing app or website, medical devices for monitoring vital signs and a digital platform for healthcare professionals. By monitoring individuals' vital signs such as temperature, heart rate, oxygen saturation, blood pressure and respiratory rate, healthcare professionals can remotely assess their condition. Some platforms also include client questionnaires that provide feedback to clinicians. The use of virtual wards allows for early discharge from hospitals or monitoring of individuals without hospital admission, thus freeing up hospital beds. Additionally, this approach can reduce pressures on other parts of the healthcare system, such as primary care appointments and emergency hospital visits (Hakim, 2023).

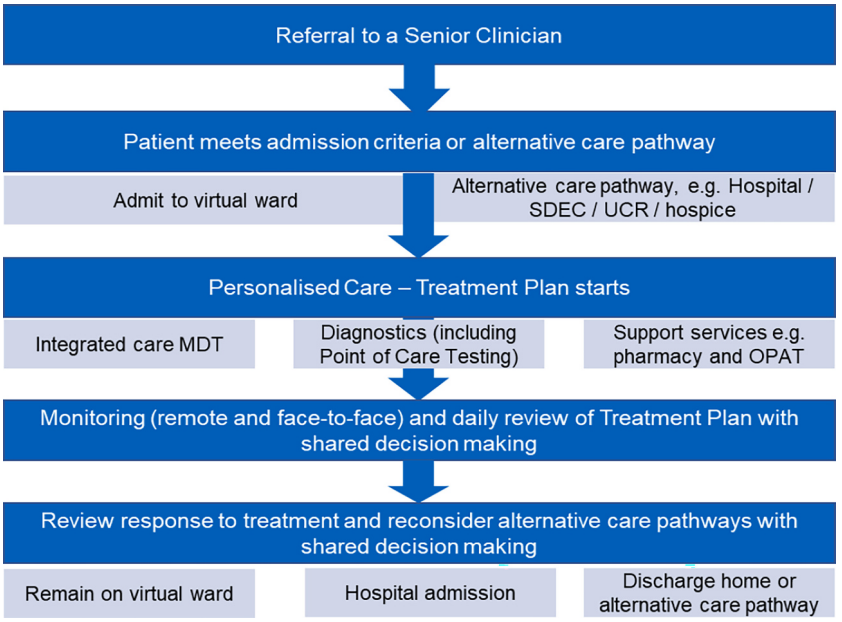


Figure 19.1 An example of a Clinical Review Pathway in a virtual ward. (NHS England, 2023c.)

Individuals are admitted to virtual wards after shared decision-making discussions between those requiring support, their carers and the clinical team (NHS England, 2023c). Figure 19.1 outlines a pathway for an individual being referred to a senior clinician who assesses whether management in a virtual ward is the most appropriate. Individuals and/or their carers may require training and the necessary skills and confidence to utilise the virtual ward (NICE, 2024). One of the advantages of virtual wards is that people who are supported through an acute illness are more likely to recover better in their own homes with less risk of deconditioning and the opportunity to stay connected to their carers and communities, resulting in better outcomes and less reliance on long-term care options (Singh et al., 2022). A case study in Box 19.1 provides an example of a virtual ward.

Box 19.1 Case study

Sangita is a 69-year-old female who has recently been diagnosed with heart failure. She has been commenced on medication from the cardiology clinic at her local hospital and has been followed up by her community nurse.

She is identified as suitable for the virtual ward remote monitoring programme until her condition is more stable. A monitor is installed in her home, and she is shown how to connect to the remote monitor for a daily review.

Sangita then carries out a monitoring session using the equipment daily. The monitor gathers her blood pressure, heart rate, oxygen levels, weight and some data from prescribed questions.

Her data are then analysed remotely by a triage nurse at the local community hospital. The triage nurse then contacts her to discuss the readings that are outside of normal limits and provides the relevant education and support. Escalation plans are followed if Sangita's condition deteriorates.

Following 8 weeks of this high intervention, Sangita's condition is stabilised and she is then confident to self-care.

ARTIFICIAL INTELLIGENCE

AI is an umbrella term encompassing software used by computers to mimic aspects of human intelligence, including problem-solving and decision-making (Maguire et al., 2021). AI is a potentially world-changing technology. It could help cure cancers, control autonomous cars and augment human intelligence (TOPOL, 2019). Large language models, like Chat GPT, have the ability to process and understand vast amounts of text data, which can be utilised to provide personalised and easily understandable health information. By analysing and interpreting complex medical jargon, these AI tools can translate it into simple and comprehensible language that individuals with low health literacy can understand. This advancement in technology can empower individuals to better comprehend their health conditions, treatment options and overall care. With clearer explanations and actionable recommendations, people are more likely to feel confident and informed when making decisions about their own healthcare. Moreover, these AI tools can also assist in self-care management, providing guidance and reminders for following treatment plans, medication schedules and lifestyle modifications. By tailoring information to individual needs and preferences, large language models can enhance public engagement and compliance. Overall, the application of AI in health literacy has the potential to bridge the gap between complex medical information and individuals with limited health knowledge. It empowers people to become active participants in their own wellbeing, leading to better health outcomes and overall improved quality of life.

Within healthcare, AI has revolutionised diagnostics by enabling faster and more accurate diagnoses. It can help identify patterns and associations in large amounts of data that are impossible for humans to detect, enabling healthcare professionals to detect subtle changes in a person's health and make informed clinical decisions. AI-powered diagnostic tools can also help reduce the number of unnecessary tests and procedures, saving time, money and reducing individual risk. Within community nursing, it is vital to understand how AI can assist in the support and, in turn, the advice and guidance to those receiving nursing care.

AI can also improve individual outcomes by enabling remote monitoring and management of LTCs (NICE, 2023). AI-powered devices can track vital signs, medication adherence, and lifestyle factors such as exercise and diet, and alert healthcare providers when there are changes outside the expected range. This tracking can help prevent hospitalisations and avoidable emergency department visits while improving people's outcomes (Bohr and Memarzadeh, 2020).

AI can help in ambient assisted living by enabling frail or disabled individuals to live independently at home. AI-powered devices can help with activities of daily living such as medication management, bathing and meal preparation and alert healthcare providers to any changes in the individual's behaviour or health status. This can help reduce the burden on caregivers and improve the quality of life for those individuals we care for. The WHO guidance (2021a) on ethics and governance of AI for health identifies the ethical challenges and risks of using AI to ensure AI works to the public benefit. AI has powered innovations, such as predictive modelling, medical image analysis and natural language processing, which have the potential to enhance healthcare in diagnosis, treatment and care delivery. For instance, machine learning algorithms can predict medical conditions and identify risk factors for diseases, allowing healthcare providers to intervene and manage symptoms early. Moreover, AI-powered chatbots can provide the public with instant support and guidance, reducing the workload of healthcare providers. However, there are ethical considerations surrounding the implementation of AI in healthcare, such as data privacy and bias in algorithms (World Health Organisation, 2021a) Therefore, the development and deployment of AI in healthcare should be carried out cautiously, considering the ethical implications. Future Advocacy (2018) did review several areas for AI use, public-facing applications and population-level applications, focusing on LTCs and epidemics to name a few. Lui et al. (2019) published a review of all studies that compared algorithm image analysis performance with healthcare professionals across a number of healthcare areas and found that their accuracy was very similar.

ACTIVITY 19.3

Action point

Consider further reading on AI if the topic is new to you.

Discuss with colleagues how AI might help in your own practice. Consider what may be required in your team to ensure that any changes are effectively implemented. You may wish to look at a quality improvement project for this.

MOBILE HEALTH AND TECHNOLOGY

The World Health Organisation (2024) has defined mobile Health (mHealth) as "Medical and Public Health Practice supported by mobile devices, such as mobile phones, personal digital assistants, wireless devices,

and patient monitoring devices". Mobile technology is, as it sounds, the use of portable devices such as mobile phones and tablets, and one key feature of mobile technology is the use of software applications known as apps. There are many apps available including, for example, tools for safer staffing and apps for speech and language interactions, allowing children to talk directly to a device to assist with improving accurate pronunciation of words. The benefits of using mobile technology are vast, such as allowing individuals to self-monitor and communicate remotely with the community nurse and empowering the mobile workforce to increase productivity. However, while there are many benefits of using mobile technology, community nurses need to consider what challenges they may face. The level of digital literacy needs to be considered, by assessing capacity and willingness to engage, and barriers to their use of technology need to be identified (NMC, 2022b, 2022c). Activity 19.4 allows further exploration of the potential usage of mobile technology within community nursing.

ACTIVITY 19.4

Action point

Access a mobile app of your choice related to your role as a nurse working in the community. Access the Digital Service Act (Regulation (EU), 2022).

Next, using the following questions critique the value of your chosen app.

Is the app primarily for health or social care purposes?

What category does the app fit into:

- Client decision-making and self-management
- Clinical decision-making support tool
- Behaviour change support
- Diagnostic or monitoring function
- Electronic health records access
- Medical devices control
- Documentation function
- Tracking device
- Other

Who are the principal beneficiaries of the app?
Is there a cost?
Are there any risks in its use such as safety or data protection?
Is the app usable and accessible?
Is the app desirable?
Is the app credible and supported by an evidence base?
Is the app reliable?
Has the app been validated by a group or organisation?
Does the app use language suitable for its target audience?
Does the app have longevity?

TECHNOLOGY-ENABLED CARE

Technology-enabled care services (TECS) encompass various health and care technologies such as telecare, telehealth, mHealth, environmental controls and telemedicine. Bhattacharya, Wainwright and Whalley (2021) carried out a study on the value and sustainability of TECS. The delivery of such services is increasingly market-orientated and subject to many challenges. They concluded that ongoing reviews of how services are provided thorough adopting a more creative and innovative approach to service provision will contribute towards delivering the "new norm" of how healthcare is provided.

Whilst the term *digital health* is now more commonly used, these technologies aim to provide personalised care and support to individuals based on their specific needs and circumstances. Telecare is a service that utilises environmental and personal sensors to monitor the safety and wellbeing of older and vulnerable individuals. It provides a 24/7 monitoring service and can escalate alarms to responders or emergency services. Telehealth systems support individuals with LTCs to self-manage their conditions and reduce hospital stays. It involves the use of a smart hub and various devices to collect vital signs data, which is then transmitted to a monitoring service for analysis. *mHealth* refers to the use of mobile phone technology and apps to access telehealth services, as it can offer greater flexibility for younger service users. Assistive technologies or environmental controls enable individuals with severe disabilities to carry out day-to-day activities independently. These devices can be integrated with telecare and telehealth systems. Telemedicine involves the use of video technology to remotely support individuals and professionals by making diagnoses and recommending treatments. It is typically used in acute health environments and allows for speedy diagnosis even in remote areas. Overall, TECS encompasses a range of technologies that can be tailored to meet the specific needs of individuals, improving their independence and quality of life.

Taking into account all the various concepts within digital services, it is clear that there are many overlaps and that all have a potential use within community nursing. The opportunities and challenges are summarised in Table 19.1. There are also many ways that digital health can be implemented, using a variety of methods, some of which are identified in Table 19.2.

Table 19.1 Summary of opportunities and challenges of digital health

Strengths	Challenges
Reinforces existing advice	May be expensive to develop
Overcomes challenges of distance	Lack of access to software and hardware
Addresses needs of remote and rural areas	Lack of consistency across services and interoperability

(*Continued*)

Table 19.1 (Continued)

Strengths	Challenges
Reduces unnecessary outpatient appointments	Technical problems and compatibility
Out-of-hours access	Relies on technical competence of staff and service users
Quicker access to specialist advice	Potential health and safety risk with equipment
Improved safety because of up-to-date recording of information	Maintaining confidentiality Usability for people requiring reasonable adjustments Reliability of evidence within apps
Improved continuity of care	
Portable information	
Improved health outcomes	
Early diagnostic capability	
Evidence-based healthcare accessible to all 24 hourly	

Table 19.2 Examples of how digital health can put people at the centre of their care

Method	Example	Uses
Telephony	Mobile phones: calls and text	Message delivered via text to reinforce health education; phone applications to monitor health status
Videoconferencing	Individual monitoring	Remote advice from specialists
Internet/World Wide Web	Use of search engines and touchscreen internet kiosks	Accessing clinical decision support systems Provide healthcare advice and education
Digital imagery	Digital cameras, webcams, podcasts	Image of wound of house-bound client can be shared with specialist
Gaming	Games consoles	Interactive games can provide education
Email	Communication at a distance	Referral between health professionals
eHealth record	Individual-held medical record	Care pathways can be shared among professionals

(*Continued*)

Table 19.2 (Continued)

Method	Example	Uses
Sensors	Fall detectors, flood detectors, smoke detectors, bed occupancy detectors	Allow high-risk people to stay in their own homes
Electronic databases	Caseload management	Audit practice and aid planning
eRostering	Use of apps	Access to health information, self-tracking fitness, fall detection, self-management of LTCs
ePrescribing	Generation of electronic prescription	Easier management of statistics to identify trends and variations Quicker access to medicines
Self-check-in kiosks	Appointments and repeat prescriptions	Quick check-ins at doctors' surgery
Social media	Twitter online chats	Peer support
AI	Software to help clinical decision-making in stroke	Care management algorithms

There have been several projects across the UK to ensure that digital health becomes an integral part of community care provision. However, one of the challenges has been to accurately quantify the benefits, due to the small scale of the projects and the differing methods of evaluation. The Office for Health Improvement and Disparities publishes a number of resources to help anyone developing or running a digital health tool or product to conduct an evaluation (see Further Resources).

APPLICATION OF DIGITAL HEALTH IN COMMUNITY NURSING

The pandemic has allowed healthcare to achieve a much more rapid digital transformation than previously envisaged. It is important that health and care providers understand what digital transformation is and have strong foundations in digital practice.

The 'What Good Looks Like' (WGLL) programme draws on local learning within England (NHS England, 2021). It builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. This, in turn, should improve outcomes, experience and safety of our patients (NHS England, 2021). Scotland's 'Care in the Digital Age' delivery plan (Scottish Government, 2023) draws on similar aims and visions, focusing on six priority areas, digital access, services,

foundations, skills, leadership and data-driven insight. Across the four nations, each has a similar vision for developing digital healthcare.

ACTIVITY 19.5

Action point

Review the 'WGLL' framework, which sets out what good looks like at both a system and organisation level. It describes how arrangements across a whole healthcare system, including all its constituent organisations, can support success, reflecting the expectation that the standards in the WGLL framework will be used to accelerate digital and data transformation.

https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/guidance-for-nursing-on-what-good-looks-like/#what-is-what-good-looks-like

The WGLL framework has seven success measures:

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

Research studies have explored the clinical effectiveness of the use of telehealthcare to support the management of many LTCs such as diabetes, mental health, high-risk pregnancy monitoring, neuromuscular, heart failure and cardiac disease (Haulman et al., 2020). Maguire et al. (2021) reviewed data on how emerging technologies such as wearable devices and smartphones are being used within healthcare settings around the world and found variable levels of evidence underpinning their use. They highlighted the need for further research regarding all emerging technologies and their impact on the healthcare system. It can be concluded that integrating digital technologies within nursing practice requires different clinical skills and approaches to care. The following practice recommendations can be made (Table 19.3).

Table 19.3 Digital technologies practice recommendations

Required Skill or Approach	Benefit/Example
Practitioners must assess the suitability of digital technology	To manage healthcare needs on an individual basis.
The use of telecommunications is feasible for the motivation and management of individuals with long-term conditions	Can be cost-effective and reliable.

(*Continued*)

Table 19.3 (Continued)

Required Skill or Approach	Benefit/Example
Digital technology is feasible and acceptable	For educating individuals, monitoring and assessing clinical outcomes.
Digital technology can be meaningful to service users	If delivered by specialised nurses and prescribers.
More complex systems such as web-based medical records and permanent healthcare professional support	Can achieve significant benefits in improving clinical outcomes.
Effective management and improved clinical outcomes	In the management of LTCs which can include medicines management.

ACTIVITY 19.6

Discussion point

Considering the terminology of digital health and eHealth and technology identified within the chapter/reflect on how it can support your role as a community nurse:

- What are the challenges?
- What are the opportunities?

ACTIVITY 19.7

Action point

Identify an area of practice relevant to your role, and then undertake a small literature review to examine the evidence base to support the use of digital technology to manage healthcare needs in your chosen area.

PROFESSIONAL AND ETHICAL ISSUES IN THE USE OF DIGITAL TECHNOLOGY

A comprehensive understanding of professional and ethical issues is a fundamental part of community nursing and is discussed more fully in Chapter 4. This section therefore focuses on some of the main issues related to digital health. The Early Digital Healthcare Leadership Programme in Partnership with Systems (Florence Nightingale Foundation, 2022) is one example of a leadership programme aimed at early digital career nurses, midwives and allied health professionals (AHP). These are professionals at any stage of their career who are taking their first steps on a digital career path and have aspirations to influence digital transformation. Their focus is on a supportive learning environment to develop leadership identity, capacity and capability. It is important that healthcare professionals develop the tools to influence organisational and client outcomes at the local, systems, national and international levels of health and social care delivery through digital transformation. This can help develop strong professional leadership which is essential to enhance the provision of health and social care through digital health.

Professional and ethical issues of eHealth can all be directly mapped to the Nursing and Midwifery Council's (NMC, 2018a) Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates and in particular to the following clauses:

2.2 Recognise and respect the contribution that people can make to their own health and wellbeing	3.3 Act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
5.2 Make sure that people are informed about how and why information is used and shared by those who will be providing care	5.4 Share necessary information with other healthcare professionals and agencies only when the interests of public safety and public protection override the need for confidentiality
5.5 Share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand	6.1 Make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services
8.6 Share information to identify and reduce risk,	10.1 Complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.4 Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed and do not include unnecessary abbreviations, jargon or speculation	13.5 Complete the necessary training before carrying out a new role.
19.2 Take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures	21.6 Cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

In reality, many of the professional and ethical issues are not different from other areas of nursing practice, but because of the evolving nature of digital health, the issues are perceived to be more challenging to address. For example, privacy and security of clients' information are crucial concerns that need to be safeguarded to ensure client confidentiality. Ethical considerations also arise around issues like consent and autonomy and ensuring that individuals are informed and have control over their data and the digital health interventions they receive.

While undertaking Activity 19.8, many professional and ethical issues will have been identified. You may also have considered the following issues.

ACTIVITY 19.8

Reflection point

Reflect on the case examples of using digital technology provided in this chapter or examples of the use of eHealth available in your area of practice, and consider the following:

- What are the professional and ethical issues?
- How can eHealth support you to manage healthcare needs in the community in a more effective and timely manner?

ACCESS TO INFORMATION

Assessment of individuals, families, carers and communities, as identified in Chapters 1, 9 and 11, is a core skill in community nursing to address healthcare needs. However, often the first assessment of a change in health status is not undertaken by a health professional, but by the individual. In 2006, the Picker Institute estimated that 89% of people actively accessing information about their health first do it through the internet. 82% of adults access the internet on a daily basis; and 70% of adults access the internet on a mobile phone (Office for National Statistics, 2016). As of September 2023, approximately 98% of the UK population has access to the internet, ranking sixth worldwide by internet penetration rate, and 95% of households have internet access (Petrosyan, 2023).

Information is most often accessed via a search engine on the internet. Although there are many benefits to this, such as quicker access to information, there is the danger that service users can access incorrect information or it can be of variable quality (Aveyard et al., 2016). However, the NHS in the United Kingdom provides much credible information to the public via sites such as the Care Quality Commission, NHS England and the Health Research Authority. For example, NHS Inform online allows users to check their symptoms online and provides advice accordingly, and similarly, there are many mobile apps which provide access to health information. This technology is changing the balance of power between health professionals and the public. However, it provides nurses with the opportunity to empower and enable people, which has always been a key aim within nursing practice (NMC, 2018a).

eROSTERING AND WORKFORCE PLANNING

The principles of caseload management and workforce planning are discussed in detail in Chapter 17. However, it is well recognised that the use of technology to support rostering, workforce planning and caseload management are not consistent across the United Kingdom. Maybin et al. (2016) identified the potential for technologies to enable remote working and to improve efficiency and productivity with timely access to, for example, an individual's health record and support caseload management. This, in turn, would release more time for professionals to deliver quality services.

ACTIVITY 19.9

Case study

There are many case studies available online illustrating the benefits from eRostering.

https://www.england.nhs.uk/wp-content/uploads/2020/08/Improving_workforce_visibility_through_e-rostering.pdf
https://www.england.nhs.uk/wp-content/uploads/2020/08/A_training_programme_to_optimise_the_use_of_e-rostering_systems.pdf
https://www.nhslanarkshire.scot.nhs.uk/erostering/

Please access a selected case study or reflect on a case example from your own area. What are the challenges of implementing electronic packages to support rostering, caseload management and workforce planning? What are the advantages?

ACTIVITY 19.10

Reflection point

Reflect on your experience of computerised decision support systems. How do they enhance your practice? What are the challenges in their use? How does it impact your ability to make a decision? What is the evidence base behind the system?

EQUITY AND ACCESS TO SERVICES

A major challenge in addressing healthcare needs within the community is the concept that everyone should have equal access to services regardless of where they live, which has been a core concept of the NHS since it began. This can be considered on two levels, first, access to clinical services and, second, equity of access to eHealth services (Ramel, 2019). Digital health with its great potential to improve access to health information and care, still has barriers to equity and there is a real digital divide which threatens its use. It is therefore necessary to build a conceptual framework of digital health interventions aiming at promoting equity and to analyse the strategies and recommendations that arise through the literature (Ramel, 2019).

SOCIAL MEDIA

As a professional, it is essential to be aware of professional and personal boundaries within online practices. The NMC (2018b) has produced additional guidance which underpins *The Code* (NMC, 2018a) that it is essential that nurses are aware of. The NMC clearly states "use all forms of spoken, written and digital communication (including social media and networking sites) responsibly" (NMC, 2018a, paragraph 20.10). A phrase that is often used is "digital professionalism on social media" O'Connor et al. (2021) carried out a review of the medical, nursing and allied health students on how they are using online

environments such as social media to communicate and share information. Some have difficulty differentiating between their professional and personal roles and can behave inappropriately online. There is a need for better education and training to help prevent these issues from arising.

ACTIVITY 19.11

Reflection point

Reflect on the social media tools that you are aware of. If you are unfamiliar with any you may choose to access http://wecommunities.org/, which is a website that supports the use of Twitter to connect professionals and share information through online chats. What are the benefits of social media to support nursing in the community? What are the challenges?

It is clear from considering the above that the professional and ethical issues in the use of digital health are similar to other areas of nursing practice and many of the skills are transferable. However, the focus can be different and there is a need to develop new approaches and additional knowledge to use digital health efficiently and effectively to address healthcare needs in the community. While government policies are increasingly recognising the importance of digital health, the practical application of these principles can be complex and demanding. Healthcare professionals, including nurses, need to be adequately educated and trained to navigate the digital health landscape and utilise technology effectively in practice. Continuous professional development and training programmes are crucial to ensure that healthcare professionals are prepared for the ongoing development and integration of digital health in healthcare delivery.

EDUCATING THE FUTURE DIGITAL TRANSFORMATIONAL COMMUNITY NURSE

In recent years educational programmes have embedded the principles of digital health within the curriculum in both undergraduate and postgraduate studies.

The NMC Future Nurse Standards (NMC, 2018c) detail those proficiencies student nurses must achieve in order to become registered nurses. These standards are updated on a regular basis to ensure they remain contemporary and fit for purpose in order to protect the public. Within the standards, reference is made to the effective and responsible use of a range of digital technologies to access, input, share and apply information and data within teams and between agencies. Nurses need to be able to demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice. In the standards of proficiency for Community Nursing Specialist Practice Qualification (SPQ; NMC, 2022a), it clearly states that community nurses with an SPQ will apply the numeracy, literacy, digital and technological skills required to deliver a safe and effective

specialist practice that meets the needs of people, their families and carers. The standards also include using digital technology to maximise the use of resources across interdisciplinary and interagency teams. Within the standards of proficiency for Specialist Community Public Health Nurses (SCPHN; NMC, 2022b), they need to use a range of advanced communication skills with people, communities, peers and interdisciplinary and interagency colleagues, including the use of digital and other modalities to support communication in virtual and remote environments. The standards also include demonstrating the advanced numeracy, literacy, digital and technological skills required to meet the needs of people, communities and the wider population, to ensure safe and effective specialist public health nursing practice.

Collaboration with community nurses is essential for effective co-design and the adoption of digital healthcare technologies. Teamwork is key to building a shared understanding of issues and achieving consensus on solutions. A culture of openness to new ideas, a willingness to challenge assumptions and a readiness to learn from others is critical in building a collaborative culture. The NHS Digital Academy now delivers a variety of digital learning programmes and opportunities. This has a suite of learning that is branded, reusable, accredited, curated and evaluated. It includes programmes and learning to support change leaders in the earlier stages of their careers and supporting local needs. Ensuring that the workforce is ready for digital working can help build more effective teams, improve communication and support cultural competency in the workforce. The adoption of digital healthcare technologies requires a culture of learning that promotes lifelong learning, encourages collaboration and effective co-design, and acknowledges the importance of human intelligence. By fostering this culture, healthcare organisations and community nurses can create a workforce that is motivated and enthused about using digital technologies to improve the quality of care for all those they look after.

ACTIVITY 19.12

Training needs analysis

Reflect on your role. Make a self-assessment of your knowledge and skills by considering some of the concepts you have explored in this chapter. You may have a tool in your local area that you can access or you may wish to develop a tool such as in the table shown that can be used within your team. Consider any supporting evidence to demonstrate your knowledge and skills, and then identify any areas where you would benefit from further training, education and development.

Outcome:	1	2	3	Evidence
1. Demonstrate understanding of how and why information technology is able to support clinical practice and ways of working.				

Outcome:	1	2	3	Evidence
2. Demonstrate understanding of how electronic health records are used in your practice.				
3. Demonstrate understanding of assessment tools used to assess the use of telecare as a nursing intervention.				
4. Demonstrate understanding of the key NHS national initiatives to support eRostering.				
5. Describe the principles of digital professionalism.				

1 I require training and development in most or all of this area.
2 I require training and development in some aspects of this area.
3 I am confident I already do this competently.

CONCLUSION

This chapter has provided an overview of digital healthcare considering some of the key terminology. The suitability of its use has been briefly explored within community nursing and some of the associated professional and ethical issues have been highlighted. It is recognised that digital healthcare is not just about technology but about using technology more effectively to address healthcare needs. Although digital health has become an integral part of government policy, applying the principles in practice can be a challenge, and it is therefore essential that healthcare professionals are provided with appropriate education and training to support them in the advancement of healthcare and how digital transformation is used. It is vital that community nurses are part of the planning and development of any technology that is used for healthcare and are empowered to influence and support the implementation with the knowledge and skills required. The need to support the development of digital health and adopt innovations will ultimately drive digital models of care.

FURTHER RESOURCES

Office for Health Improvement and Disparities – GOV.UK (www.gov.uk)
Digital transformation – https://www.england.nhs.uk/digitaltechnology/
Scottish Centre for Telehealth and Telecare – http://sctt.org.uk

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CHAPTER

20

Facing the Future

Heather Bain

LEARNING OUTCOMES

- Examine the links between research, policy and practice.
- Appraise the complexity of community nursing and the pillars of practice to promote community nursing practice across the career frameworks.
- Explore the continuing professional development requirements to develop the knowledge skills and attributes of a community nurse.
- Appraise the importance of sustainability in community nursing.

INTRODUCTION

This book has provided an opportunity for those working as community nurses to reflect on their role and analyse the knowledge, skills and attributes required to provide safe, effective and person-centred care in a variety of community settings. Society with its inherent complexities, is dynamic and constantly changing, requiring the community nurse to be flexible and responsive in their approach. The necessity to maintain currency on practice and to work from a sound evidence base is essential. The aim is to ensure that community nurses are fit for current and emerging roles to meet the needs of the population in the 21st century.

Throughout this book, the importance of policy and its implication for community nursing practice has been highlighted. The policies of the four UK countries were introduced in Chapter 1 and were considered in relation to the topics explored throughout subsequent chapters. The importance of having a working understanding of health policy in order to contextualise the changes that are occurring in commissioning, managing and delivering community services is required of the community nurse. The four nations of the UK are responsible for managing their own NHS services (The Health Foundation and Nuffield Trust, 2014). This is achieved in different ways according to the priorities set by each one, but the principles are common to all. The challenge for the NHS lies in the demographics of the population with people living longer with major health conditions and widening health inequalities, making greater demands on finite resources (Dunn et al., 2023; Audit Scotland, 2023). In addition to

DOI: 10.4324/9781003347545-21

financial pressures, workforce challenges, increasing demand on the health and social care system, the ongoing recovery from the COVID-19 pandemic and the impact of climate change are all having significant impacts on the NHS.

There is a commitment across the four nations to integrate primary and secondary care provision, aiming for a smoother transition between the two but, more importantly, trying to reduce hospitalisation by anticipating potential problems and providing support services to prevent admission. There is an increasing emphasis on public health, health promotion and self-care. It is recognised that with the changing demographics in the population, with life expectancy now extended, services must be reconfigured to respond. The nations face similar issues in trying to devise a workable framework on which to base their service delivery, which has been acknowledged in recent policy (Department of Health – NI, 2018, NHSE, 2019; Scottish Government, 2016; Welsh Government, 2018).

This chapter first briefly examines the policy context and the connections between research, policy and practice; then the complexity of community nursing is explored with consideration of advanced practice. The skills knowledge and attributes required of a nurse working in the community are then explored before the contemporary issue of sustainability is appraised.

THE POLICY CONTEXT – CONNECTIONS BETWEEN RESEARCH, POLICY AND PRACTICE

Chapter 1 explored the policies across the four countries of the UK and outlined the structure of the health system in England, Northern Ireland, Scotland and Wales (Department of Health – NI, 2016; Healthcare Financial Management Association, 2024; NHSE, 2019, Scottish Government, 2016, Welsh Government, 2018). The overall aim of health and social care policy is to improve health. Policy is not made in a vacuum and then introduced (The Health Foundation, 2024). Rather, it is the result of a complex process in which many different groups and individuals seek to exert influence to bring about change. Thus, the process of developing policy can involve pressure groups, the media, health professionals and the public, all of whom have varying levels of power to effect change (National Co-ordinating Centre for Public Engagement, 2024).

Clearly policy has implications for the evolving role of the community nurse, and it is imperative that the nurse has a sound understanding of relevant policy and all it entails (NMC, 2018a). This includes recognising the contribution that research makes to inform policy and practice. It is therefore worth exploring the connections between research, policy and practice. In considering the relationships between research, policy and practice, it is useful to consider them as three separate spheres initially (El-Khawas, 2000). It quickly becomes clear that, depending on individual circumstances, these elements have different relationships (Glasby, 2011). Two may work closely together with the other situated on the outside, or the three elements may work together equally, and many other

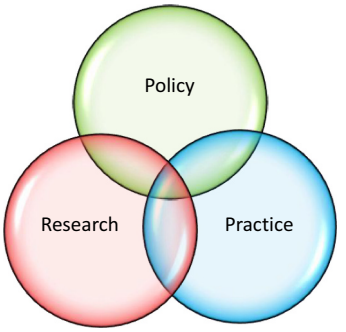


Figure 20.1 Conceptual model of policy, research and practice.

configurations are possible. What is important is that despite being separate spheres of activity they are interrelated and impact one another (Figure 20.1).

The contribution that research makes to the development of policy is not as direct and as systematic as policymakers would have us believe (Alla et al., 2017). Research does influence policy, but policy is often the outcome of conflicts between competing groups, each with their own agenda, and does not always follow a structured process (Oliver and Cairney, 2019). The way policies are developed, implemented, monitored and revised is influenced by the wider social and political contexts. Clearly, the relationship between research and policy is complex and a number of different models have been developed to explain the use of research within policymaking. Clarke (2001) describes four main models, the knowledge-driven model, the decision-driven or engineering model, the political model and the enlightenment model. A central feature of these models is that the researcher and policymakers are seen as two separate communities.

Having briefly considered research and how it fits with policy, the impact this has on practice now needs to be examined. Models to demonstrate policy implementation are often represented as two opposing positions: 'top-down' or 'bottom-up'. However, this does not represent the complexity of the process and the power and influence which individuals or organisations at either end of the scale can have. Van Meter and Van Horn (1975) developed a framework to aid the examination of policy implementation. They identified six independent variables which provide the link between policy and practice:

- Policy statements and objectives elaborate overall goals.
- Resources facilitate policy administration.
- Effective communication and enforcement strategies reduce diversion.
- Characteristics of implementing agencies influence the capacity to implement policy.
- Economic, social and political conditions affect performance.
- The disposition of implementers is affected by their interpretation of the policy, their personal opinions of the policy and the intensity of those opinions.

Consideration of these variables would suggest that successful policy implementation in practice is dependent on a consensus of goals when marginal changes are required. In order to take cognisance of the impact of policy on practice, and the consideration of how research is utilised in the process, it is necessary to move away from seeing research, policy and practice as separate spheres and on to a broader view of how these elements can come together (Bain, 2015).

ACTIVITY 20.1

- What are the major policy drivers shaping the healthcare workforce in your country of employment?
- Consider the evidence base that informed the policies.
- Do the policies have a positive or negative impact on your practice?
- How does it support your role as a community nurse?
- What are the implications of these policies for the care that you provide?
- What are the implications of these policies on your role and the role of the multi-professional team?
- How have these policies been put into practice locally?
- What evidence of these policies being implemented can you identify?

In considering the connections between policy, research and practice, it is important to reflect on the responsibilities of the registered nurses within policy as identified in the Future Nurse Standards (NMC, 2018a):

- Understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills.
- Understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the UK.
- Identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care.

In order to work in an arena that is constantly changing and manage services effectively, it is imperative for practitioners to have a good understanding of the policy context to address the complexity of community nursing.

COMPLEXITY OF COMMUNITY NURSING

The term *complexity* is often used in the literature to define systems, interactions, relationships or tasks ranging from complicated, intricate or intractable with a general meaning of being 'not simple'. Definitions of complexity are often ambiguous, subjective and context-dependent. Complexity is not a higher order level of complicated but is characterised by unpredictability and

interconnectivity, the need for flexibility and adaptation and is underpinned by relationships (NHSE, 2024). Box 20.1 illustrates what may contribute to complexity.

Box 20.1

Contributory factors of complexity

- The diversity of people
- The vulnerability of people
- The environment
- Organisational culture
- Variation in practices
- Human factors

The complexity of community nursing is increasingly being recognised (Bain, 2015; Jackson et al., 2015), and while every registered nurse is prepared to work in the community (NMC, 2018a), it is also recognised that a higher level of practice is required by some practitioners to meet the needs of the population (NMC, 2022a; 2022b). Bain (2015) undertook a study exploring the knowledge specific to district nursing in practice and how this knowledge is developed which illustrated complexity. While this study was undertaken within the district nursing service in three Health Boards in Scotland, its findings could easily be applied to other areas of community nursing across the UK (Box 20.2).

Box 20.2

The specific knowing can be described as a landscape that the community nurse must travel; crossing a variety of socio-economic areas; entering the private space of individuals and the public space of communities, as well as acknowledging professional practice; navigating the policy agenda while maintaining clinical person-centred care; and leading others across the terrain of interprofessional working.

The specific knowing in practice that characterises the expertise of the community nurse is multifaceted where the context of care is an essential consideration, but it is the relationships among and between the elements: leadership, clinical ways of working, relationship building, organisational ways of working and developing technology (Bain, 2015), not the elements themselves that contribute to the specific knowing (Figure 20.2).

One of the major themes within this study was *clinical ways of working*, which was first considered in the context of the practices of registered nurses. The fundamentals of caring and delivering person-centred evidence-based care, which are all subsumed within the practices of all registered nurses (NMC, 2018a), were

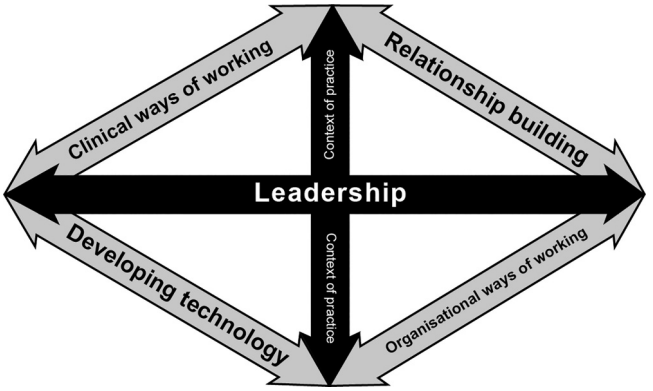


Figure 20.2 Matrix of complexity of knowing of the community nurse.

acknowledged in the findings while recognising that there are also some different levels of practices within bands of nurses. The following subthemes were then explored: the level of autonomy; advanced assessment of individuals, families, carers and communities; the complexity of care and case management approaches; interprofessional working; public health; and the context of practice. All of these elements alone could be applied to the clinical pillar of practice; however, these would still not represent the complexity of the unique knowing of district nurses.

Therefore, it was identified that the context of practice cuts through this theme as an element that contributes to the unique knowing of the district nurse. The relationship between being a guest in someone's home and the community nurse is perceived to be quite different from the relationship between a nurse and a 'patient' in the hospital setting. The findings in this study suggested a community staff nurse takes into account the context of care at an individual level. However, it is the district nurse, however, who goes beyond the individual to the population, acknowledging sociocultural and political factors that impact practice, and, as such, is demonstrating clinical expertise at a higher level that, in many instances, can be associated with advanced practice (DoH – NI, 2016; Health Education and Improvement Wales, 2024; NHSE, 2019; Scottish Government, 2017a, 2017b). Similarly, the themes *organisational ways of working*, *building relationships* and *developing technology*, when viewed independently, could be seen to provide little to support the specific knowing of the district nurse. However, when considered within a matrix and the impact each element has on one another, the specific knowing in practice that characterises the expertise of district nurses becomes apparent. The theme *leadership* can be seen as the anchor within the matrix. It is within the theme *leadership* that the seven elements of knowing can be considered (Table 20.1), as suggested by Jackson et al. (2009), but they can also be considered to interlink with all elements of the matrix.

The development of the knowing required to work in the community does not happen in isolation and it is very complex. It consists of networks, conversations, engagement with policy, understanding of professional contexts, adhering to organisational boundaries and interaction with complex and

Table 20.1 Seven forms of knowing in nursing leadership adapted from Jackson et al. (2009)

Pattern of Knowing	Description/ Qualities	Example
Empirical	Evidence-based, factual objective	Empirical research
Aesthetics	Art, vision, subjective	Visionary leadership
Personal	Relationship-based, authenticity, mutual respect	Self-awareness Relationship between leader and staff
Ethics	Justice, ethics, standards	Code of professional conduct
Socio-political	Strategy, culture, diversity	Laws, regulation, external and internal environments
Unknowing	Openness	The intensity and unpredictability of nursing in the home
Emancipatory	Transformative workplace	Governance partnerships Policy changes

challenging situations. Theory and practice are mutually dependent on each other, change is inevitable and unpredictable and practices change by having experiences; therefore, change is integral to practice (Bain, 2015).

ACTIVITY 20.2

Review the matrix in Figure 20.2 that was developed to represent district nursing practice. Consider your area of community nursing does this matrix represent the complexity?

The complexity of community nursing is clearly evident, and while the national career frameworks support a skill mix within nursing teams (Skills for Health 2020), there is clearly a move for the community leader to be at a higher level of practice underpinned by master's level education which is often described as 'advanced practice' (DoH – NI, 2016; Health Education and Improvement Wales, 2024; NHSE, 2019; Scottish Government, 2017a, 2017b). However, there is an added complexity in that the NMC has recently developed new post-registration standards relevant to community nursing (NMC, 2022a, 2022b), recognising the additional knowledge and skills required within community nursing and advocated for master's-level education. While these new standards can be seen as addressing the additional knowledge and skills required for community nurses working at a higher level and as providing career pathways, they are not badged as advanced practice. In addition, the



Figure 20.3 The four pillars of practice (NHS Education Scotland 2024).

NMC standards (2022a, 2022b) do not include prescribing as an essential element of community nursing practice. Whereas Scotland has identified (in its transforming roles) papers (Scottish Government, 2017a, 2017b, 2017c) prescribing as an essential part of the advanced role of the community nurse. Others across the UK had conflicting opinions in this regard applied to community nursing, regarding whether this should be considered as advanced practice'?

Currently, advanced practice in the UK is not regulated by a professional body, although it continues to be explored and debated (Fealy et al., 2018; Foster, 2023). However, the four countries all have their own frameworks to support advanced practice and its application to specific roles with their own nuances. In principle, they all focus on the four pillars of practice, identified as clinical practice, facilitating learning, leadership and evidence, research and development, first described in Scotland in 2008 and illustrated in Figure 20.3.

These four pillars are identified as common to all nursing, midwifery and allied health professionals' roles in the UK. However, the pillars all contain core content that can be expanded, reduced and contextualised for different roles according to the level of practice. For example, a community staff nurse at level 5 who will have a first degree will have a focus on clinical practice at the level of the registered nurse (NMC, 2018a), whereas the specialist practice community mental health nurse at level 6 will have a higher level of clinical practice and may spend more time within the facilitation of learning pillar supporting other colleagues. Advanced practice is regarded at level 7 and, depending on the role, may still have a clinical element (Box 20.3).

Box 20.3

Definition of advanced practice (NHSE, 2017)

Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by

a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.

ACTIVITY 20.3

Consider your experience of working in the community – consider the skill mix within your team and their supporting education. Do you think all your team are prepared for their roles? What does advanced practice mean in the context of where you work? Are there any recommendations you would make for the future community nursing workforce.

DEVELOPING SKILLS, KNOWLEDGE AND ATTRIBUTES FOR THE FUTURE

Acknowledging the complexity of community nursing, it is essential that the workforce is appropriately educated and trained. The Code (NMC, 2018b) emphasises lifelong learning, with the responsibility on the individual registrant. Continuing professional development (CPD) is the process and provision of formal and informal learning opportunities that nurture the development and improvement of knowledge and skills required for employment and personal fulfilment.

There are an abundance of examples of new and innovative ways of working in the community but in order for these to have an impact it is essential that the workforce is appropriately trained. Specific to community nursing, various services are led by nurses, such as telephone triage, minor illness clinics, disease-specific clinics and nurse-led units, such as those within community hospitals. However, as there is a shift in care closer to home, community nurses need to deliver and support self-care and personalised care planning, using generalised expertise in managing long-term conditions (Chapter 15), mental health (Chapter 10) and acute care (Chapter 14). Within this expertise, a holistic approach for managing health and wellbeing is required, and as previously discussed, technology needs to be embraced increasingly to supplement face-to-face care in all areas of care (see Chapter 19). Telehealth is now much more common, and patients are managing their own monitoring rather than booking appointments at the surgery. Practitioners are therefore adapting to assessing and treating clients other than by face-to-face contact. These services are heavily reliant on having the right nurse with the appropriate skills to manage them and highlight the necessity to remain up to date and be aware of current best practice to continue to meet the requirements of a registered nurse

working in the community. Chapter 4 examined lifelong learning and professional development in the changing landscape of community nursing which may be useful to revisit before undertaking the next activity.

ACTIVITY 20.4

Review your own current job description or find a role specification you are aspiring to.

- Review the essential knowledge, skills and attributes associated with the role
- What knowledge, skills and attributes do you already possess? Are there any gaps?
- What knowledge, skills and attributes do you need to develop or further develop at an advanced level?
- Develop an action plan to address any gaps or areas for development.

You may wish to use this action plan to discuss it with your line manager or use it as evidence for revalidation.

SUSTAINABILITY IN COMMUNITY NURSING

Before ending this book, there is one contemporary issue that has not been discussed elsewhere and that is the principles of sustainability. Sustainability is a broad term that considers 'social, economic and environmental activities needed to ensure a prosperous, safe and equitable world for everyone' (Royal College of Nursing, 2024). Sustainable healthcare aims to deliver quality care without damaging the environment, is affordable now and in the future and underpins current healthcare policy (Centre for Sustainable Healthcare, 2024). Therefore, an understanding of the connections between health and the environment is essential to face the future and protect the planet. Before considering sustainability in relation to healthcare, it is important that the concept of climate change is understood.

Climate change refers to long-term shifts in temperature and weather patterns (United Nations, 2024). These changes can be due to the sun's activity or volcanoes which can lead to earthquakes. However, in recent years, human activities have contributed to climate change mainly due to the burning of fossil fuels such as coal, oil and gas (United Nations, 2024). Burning fossil fuels increases the amount of greenhouse gases such as carbon dioxide and methane in the atmosphere, contributing to global warming. The consequences of climate change are highlighted in Box 20.4.

Box 20.4 Consequences of climate change (United Nations, 2024)

severe fires – rising sea levels – flooding – melting polar ice – catastrophic storms – droughts – water scarcity – declining biodiversity

The World Health Organisation (2023a) suggests climate change is impacting health in a variety of ways, including death and illness from increasingly extreme weather events. Furthermore, climate change is undermining many of the social determinants of health, such as livelihoods, equality and access to healthcare and social support structures. Additionally, these health risks are disproportionately felt by the most vulnerable and disadvantaged, including women, children, ethnic minorities, poor communities, migrants or displaced persons, older populations and those with underlying health conditions. In conclusion, climate change impacts health directly and indirectly.

Various health policies demonstrate the commitment to contribute to 'net zero' within healthcare – which means the amount of greenhouse gases added to the environment is no more than the amount taken out – and have developed 'green plans' to follow clinically appropriate principles of lower carbon to address the climate crisis while improving health (Care Quality Commission, 2024, World Health Organisation, 2023b) For example, in 2019 NHS Scotland became the first national health service in the UK to commit to being in a net-zero organisation and developed an associated strategy (Scottish Government, 2022); and the Long Term Plan (NHSE, 2019) sets the ambitious target to reach net zero by 2040. The Care Quality Commission (2024) has developed quality statements to acknowledge the negative impact of people's activities on the environment with an aim to make a positive contribution in reducing it and supporting people to do the same. The quality statement covers the following:

- Staff awareness and education
- Carbon reduction, for example within travel and transport
- Health promotion and prevention
- Estates and facilities, for example, energy saving and waste reduction
- Efficient service delivery with resource optimisation

From a global perspective, the World Health Organisation (2023b) provides an operational framework for climate resilient and low carbon health systems and proposes interventions to build climate resilience and reduce the carbon footprint. A diagrammatic image of this can be accessed (see Figure 1 in the WHO's Operational framework for building climate resilient and low carbon health systems, 9789240081888-eng.pdf (who.int)

The Centre for Sustainable Healthcare (2024) provides resources for healthcare staff to support sustainable clinical practice and is underpinned by four principles – prevention, empowerment and self-care, lean service delivery and low carbon alternatives, as illustrated in Figure 20.4.

Now sustainability has been considered broadly, it is time to consider what the implications of climate change and sustainability are for community nursing. There is a growing body of literature and resources in this subject area, and it is becoming increasingly apparent that climate change and environmental sustainability themes are required to be integrated into education and practice.

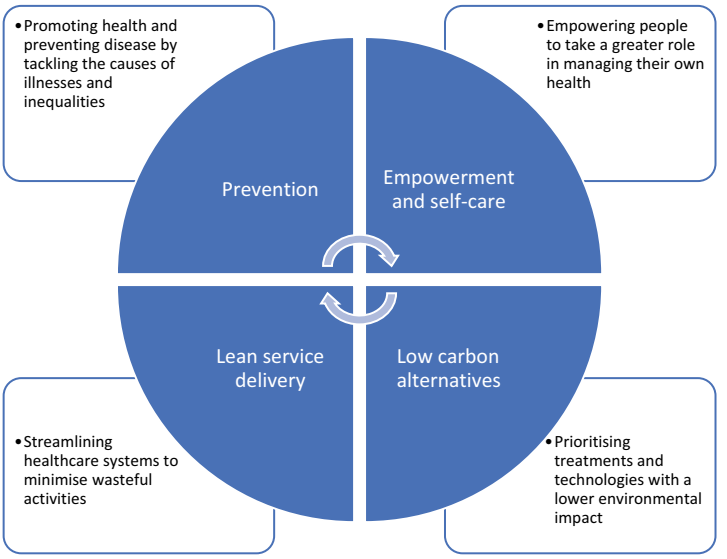


Figure 20.4 Principles of sustainable clinical practice. (Centre for Sustainable Healthcare, 2024.)

ACTIVITY 20.5

Reflect on your role as a community nurse. Are there any policies in your local area related to sustainability?

- Consider activities you and your team can take to reduce carbon dioxide and other greenhouse emissions?
- What actions can the community nurse take at an individual, organisational, national and international level to reduce the impacts of climate change?
- Consider some recent extreme weather as a result of climate change – what was the impact on you personally and your team?
- Have you an emergency response plan developed to be prepared for future extreme situations?

While not explicitly linked to sustainability and climate change there are many topics explored throughout this book which can be considered in the response to Activity 20.5, such as social prescribing (Chapter 3), managing risk (Chapter 5) organising and management of care (Chapter 17) and leading person-centred practice (Chapter 18).

CONCLUSION

Healthcare is experiencing significant challenges throughout the four countries of the UK from underfunding, understaffing to managing the health consequences of our changing population. It is being confronted with new challenges and this is the key driver for an educated community nursing workforce that has the ability to respond. The community nurse is a linchpin in supporting healthcare to face the future. Community nurses must ensure that they are

involved in the decisions about how services will be developed at a strategic level. The future is going to involve working across community and hospital-based services to offer a more seamless service. Integrated teams will be a critical factor in managing the complex needs of the ageing population. It is imperative that community nurses prepare to assert themselves as key members of the team, demonstrating the expertise that they bring to contribute to the emerging landscape and the sustainability of nursing in the community.

FURTHER RESOURCES

National Institute for Health and Care Excellence – https://www.nice.org.uk/about/who-we-are/sustainability

Queen's Nursing Institute – https://qni.org.uk/sustainablity-useful-links-and-resources/

World Health Organisation – https://reliefweb.int/report/world/operational-framework-building-climate-resilient-and-low-carbon-health-systems

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