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NURSING times news

‘Myths’ could leave nurses in danger of sharps injuries

SALLY GAINSBURY AND CLARE LOMAS
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Nurses will remain at risk from unnecessary sharps injuries because half of trusts are unlikely to switch to safer needles, despite new European legislation.

Myths around the cost of safer devices will hinder their introduction, according to documents seen by Nursing Times.

European ministers ruled last week that risk assessments should be done in all areas where sharps are used and that safety devices, such as retractable needles, should be introduced where a risk of injury is found.

A similar law was adopted in the US almost a decade ago and led to all hospitals adopting safe devices. An NHS trial of safety-only needles at University Hospitals Birmingham Foundation Trust led to needlestick injuries falling by 70 per cent over four years.

Campaigners hope the EU law – which must be adopted by the UK within three years – will have a similar effect across the NHS.

But calculations made in 2008 by the Health and Safety Executive, seen by Nursing Times, show that it expects only 40-50 per cent of trusts to switch to safety devices over 10 years.

The HSE said that would mean that only half of the estimated 63,750 preventable needlestick injuries a year are stopped. That would be the equivalent of a 38 per cent reduction in injuries, well below the 70 per cent achieved in Birmingham.

The HSE said this was down to a “perception” that safety devices were very expensive, which would influence those undertaking risk assessments to decide that costs outweigh the benefits of switching.

The HSE estimated in 2008 that safety devices cost on average 5p more than a standard one, which would work out at an extra £6.2m a year for the NHS if all trusts used them.

South London and the Maudsley Foundation Trust deputy nurse director Jane Sayer told Nursing Times the trust had decided four years ago to use only retractable safety needles.

She said: “They were more expensive, but it’s a risk issue so the decision was very clear – we were going to use retractables.”

However, Royal Devon and Exeter Foundation Trust senior infection prevention and control nurse Judy Potter said the trust “hardly uses” retractable needles because “they are not as sharp, [so] the patients find them much more uncomfortable”.

Miriam Farley, senior healthcare litigation solicitor at Hempsons solicitors, said much of the directive was already implicit in UK law and regulation, but there was a perception that EU law was needed to make NHS employers “take more action”.

She said the most significant change for the UK was the “immediate” ban on “recapping” or resheathing needles.

Although directors of nursing say this is already “a no-no”, resheathing accounts for up to 30 per cent of reported needlestick injuries a year.

The new law puts an onus on both employers and employees to eliminate resheathing. For directors of nursing, that means ensuring adequate training, as well as providing enough sharps bins so needles do not need to be resheathed when being carried to a distant bin, she said.

70%
Reduction in sharps injuries where safety devices used

RESHEATHING INNOVATION COULD HALVE INJURIES

A device to stop nurses manually resheathing needles could significantly reduce the number of needlestick injuries.

Nurses using the StickSafe device (pictured below) do not have to touch contaminated needles. The device, which looks like a small tray, separates the needle from the syringe before disposal.

It is estimated the new device could cut needlestick injuries by more than 50 per cent.

Anne Marie Rafferty, dean of the Florence Nightingale School of Nursing and Midwifery at King’s College London, said: “The potential contribution of this innovative device couldn’t be more timely.”

The device is one of many new ideas nurses can learn about at the NHS Innovation Expo 2010 event, which runs from 6-7 October at the Excel Centre in London.

The largest healthcare innovation event in the UK, Expo 2010 will bring together more than 10,000 delegates to share innovative ideas, evidence and best practice. It is intended to help drive the adoption and diffusion of new ideas by encouraging and inspiring nurses and other clinicians to adopt and spread innovation in the NHS.

www.healthcareinnovationexpo.com

Nursing Times 16 March 2010 Vol 106 No 10 www.nursingtimes.net
Unions slate heavy handed regulator

CHARLOTTE SANTRY
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The head of a new super regulator has told Nursing Times it will not consult nurses it is considering barring from practice until it has already decided they pose a potential risk to patients.

The Independent Safeguarding Authority was set up to improve the identification of people who should not be working with children and vulnerable adults, but unions have criticised it for being too heavy handed.

Under its new vetting and barring scheme, which came into force for NHS staff in October, employers will refer to the ISA any staff they fear could pose a risk. The ISA will carry out an investigation, without speaking to the person concerned, and then write to anyone it is “minded to bar”, explaining the decision and setting out the next stages.

As a result it will decide whether it is “minded to bar” staff referred to it before they have had a chance to put their case forward.

ISA chief executive Adrian McAllister said it was unnecessary to alert nurses to the fact they were being investigated. He told Nursing Times: “There would be little point in putting them in that position before we were thinking about barring them. In the vast majority of cases we don’t bar people.”

But Unison head of nursing Gail Adams said the potentially huge impact of an ISA ruling on someone’s career meant nurses should have a say earlier in the process.

She said: “If we look at it in the employment context, [there is normally] a general investigation before… a judgement. The difference is that the ISA can stop people working in a significant number of jobs, potentially precluding them from ever working in the public service.”

She said there were problems with the system that still need to be “ironed out”, but discussions with the ISA had been “positive”.

Mr McAllister also confirmed the ISA would be able to overrule fitness to practise decisions by the Nursing and Midwifery Council and the body that oversees all health regulators, the Council for Healthcare Regulatory Excellence.

This could mean nurses being cleared of any wrongdoing by the NMC or CHRE but then barred by the ISA. Mr McAllister said: “There could be circumstances like that. These are going to be relatively few in number.”

Conservatives urged to unveil plans for nursing

A leading nurse academic has called on the Conservatives to set out firm policy on nursing before the election.

The Tories have criticised some of the recommendations made by the Prime Minister’s Commission on the Future of Nursing and Midwifery (news, page 4, 9 March). But it is yet to release the findings of its own nursing consultation, which took place between May and August last year (news, page 1, 12 May 2009).

There are now calls for the party to either accept the recommendations of the PM’s commission, or unveil its own vision. It follows confusion in recent months over the party’s plans for education and its definition of “nurse” (news, page 1, 9 February).

Lincoln University professor emeritus of healthcare workforce innovation Tony Butterworth, who contributed his views to the Tory consultation, said: “If they’re not going to adopt [the commission’s report], what are they going to do instead?”

Leaders must engage ‘generation Y’ to avoid cuts

Senior nurses must win the “hearts and minds” of staff to boost productivity and avoid cuts.

NHS South Central chief nurse Katherine Fenton said the profession had not done enough to improve productivity over the past decade. This had to change, she said, as the alternative was cuts and poor quality care.

She said: “We could return to slash and burn and start doing things that are wrong and not in the patient’s interest. But we have got time this year to start doing the things that are right.”

Speaking at a Nursing Times conference on nursing productivity last week, Ms Fenton highlighted the chief nursing officer’s high impact actions – which include reducing falls and pressure ulcers – as methods of cutting costs by improving care (news, page 1, 17 November).

Ms Fenton said nurse leaders had to win the “hearts and minds” of frontline staff to change how they work. In particular they had to engage young nurses, “generation Y”. She said: “Unless we do engage them we will be back to just doing cuts.”

“There is a lot of negativity out there, because we haven’t communicated to our nursing and midwifery workforce as well as we could. They feel things have been ‘done to them’ a lot of the time.”
Emergencies to get standard checks

Nurses will have to follow a standard list of clinical checks for all NHS hospital emergency patients, under plans being developed by the Department of Health.

The DH is working with the Royal College of Nursing and other professional organisations to draw up the checklist, which will require clinicians to record whether checks such as venous thromboembolism risk assessment, vital signs recording and pain management have been carried out for every patient.

The plan is part of the NHS quality, innovation, productivity and prevention (QIPP) programme, which is intended to prepare the NHS for spending cuts while protecting and improving care. The list, which is expected to be launched in the next one or two months, is intended to improve safety by ensuring checks are carried out.

Trusts that can show they are carrying out these checks will also qualify for bonus payments on quality. From April, trusts will receive extra funding, for example, if they can prove they are assessing all patients for VTE risk.

RCN acute and emergency care adviser Alan Dobson, who has been involved in developing the tool, said it would prevent checks being repeated unnecessarily, thus helping improve productivity as well as safety.

He said: “There is some evidence that, if we do this right, we will get better outcomes and less duplication. We have been saying that these checks should have been happening for years and, in some places, it does happen every time. It shouldn’t be hit and miss, it should be standardised.”

Mr Dobson added that the plan reflected a shift to an approach motivated by clinical quality in acute emergency care, which would be supported by nurses.

Nursing Times understands the checklist may also be used to improve end of life care by requiring clinicians to answer what is known as “the surprise question” for each patient admitted. This refers to whether the clinician would be surprised if the patient died within a year of admission; if the answer is “no”, the clinician should plan for palliative and end of life care.

Out of hours GP concern

Health minister Mike O’Brien has said he is concerned that out of hours patients are being seen by a nurse when they expect to see a GP.

Speaking at a round table meeting on out of hours care at the Royal College of GPs, Mr O’Brien said: “Most members of the public, if they want to call for a GP, expect to call for a GP, expect to get a GP. It may be that if they have a particular problem, a nurse may well be suitable. But they must know a nurse is coming, not expect a GP and get a nurse.

“I’m concerned that may well be happening in some parts of the country and it just shouldn’t be happening.”

Tory fury over Labour targets

The Conservatives and Liberal Democrats have said it is unacceptable that nurses are having to treat patients in non clinical areas to meet targets, following a major Nursing Times survey.

In the poll of more than 900 Nursing Times readers, two thirds said patients were treated in areas such as cupboards, corridors, full wards and, in one case, a kitchen (news, pages 1-3, 9 March).

Some nurses said they were told to use these areas so their hospital could admit patients and meet the four hour A&E target.

Conservative shadow health minister Anne Milton said the findings were “truly shocking”.

She said: “Nurses must be free to make decisions about where and when to treat people on clinical grounds. They should not be forced into treating people in a cupboard or a kitchen just to meet Labour’s bureaucratic targets.”

Liberal Democrat health spokesman Norman Lamb said: “Labour’s failure to put patient care above its obsession with targets has meant that nurses are being forced to treat people in completely inappropriate places.”

Dave West

Nurses take the lead in ensuring single sex wards at Suffolk trust

Senior nurses at Ipswich Hospital Trust in Suffolk are encouraging their colleagues to make sure patients are treated in single sex wards, in line with government guidelines.

The “Mixed sex accommodation: not on my ward” campaign is intended to ensure patients only share sleeping, toilet and washing areas with people of the same sex.

Trust director of nursing and quality Gwen Collins said: “We are committed to treating all patients with privacy and dignity in a safe, clean and comfortable environment.”

Pictured is healthcare assistant Ian Jasper with patient Gladys Davies in a same sex bay.

Nurses take the lead in ensuring single sex wards at Suffolk trust
MONDAY

MPs back specialist care
The Royal College of Nursing said MPs from all the main political parties backed employing more specialist nurses to care for people with long term conditions. Nearly 60 MPs have signed a cross party early day motion calling for specialist nursing provision for all patients with long term conditions, the college said. Specialist nursing is one of the RCN’s six health priorities for the next government.

TUESDAY

Family health campaign
The Welsh Assembly launched the Change4Life public health campaign in Wales. The campaign, which has been running in England since January 2009, is intended to help families “eat well, move more” and “kickstart a lifestyle revolution for every family in order to halt the rising tide of obesity”. Members of Cardiff’s Buggyfit class (pictured), a physical activity class for parents with babies, helped launch Change4Life in Wales. Every week, parents do gentle circuits with their children in pushchairs, offering physical activity without having to worry about childcare.

Passionate about statistics
Outgoing chief medical officer Sir Liam Donaldson called on nurses to be passionate about statistics, as Florence Nightingale was. Speaking to Nursing Times after an event to celebrate 10 years since regional public health observatories were set up, he said the founder of nursing “certainly could hold her own with medical statisticians of the day”. “She was described in one of her biographies as the passionate statistician and I think we still want nurses to be passionate about statistics,” Sir Liam said.

WEDNESDAY

Working mothers penalised
Unison called on employers not to use the economic crisis to penalise working mothers. In a motion put to the TUC women’s conference in Eastbourne, Unison national women’s officer Sharon Greene said: “We believe that the recession has been used as an excuse – to fire pregnant women and new mothers and to postpone the proposed maternity pay extension to one year.”

Fitness hearings speed up
The Nursing and Midwifery Council said there had been significant reductions in the length of time it takes to process fitness to practise cases. Its latest figures show that, between April 2009 and February 2010, the average length of case has been reduced by more than seven months, from 20 to 13. It released the figures after the Council for Healthcare Regulatory Excellence published a highly critical report on the NMC’s previous performance (news, page 3, 2 March).

Spirituality and practice
The Royal College of Nursing launched a survey to improve its understanding of nurses’ views on spirituality. RCN members are invited to say what they understand by spirituality and spiritual care and whether they consider these to be legitimate areas of nursing practice. Specific questions will be about training and support to deal with spiritual issues.
Nursing promoted at school
Two senior nurses from Great Ormond Street Hospital visited sixth formers at a school in Tower Hamlets to promote nursing as a career. Chris Caldwell, assistant chief nurse, and Andrea Stephenson, practice educator, spoke to students on a range of issues including compassion and end of life care.

THURSDAY
Sacked over relationships
The Nursing and Midwifery Council said it would shortly be investigating a cancer care specialist who was sacked by a trust for alleged “inappropriate relationships” with the widowers of her patients. Sara Dale, 39, of King’s Lynn, Norfolk, worked as a nurse at Queen Elizabeth Hospital in King’s Lynn in a post paid for by Macmillan Cancer Care. She was sacked in January.

Cash fails to stop inequality
The Audit Commission said there was little to show for the £21bn in annual NHS spending allocated to reduce health inequalities. Its report, Healthy Balance, said that, although outcomes had improved overall, extra funding for the poorest areas had coincided with an increase in health inequalities. It said information about how much was spent on direct public health interventions was scant. Managing director of health Andy McKeeon said “most” of that £21bn was spent on tackling the results of health inequalities — such as higher hospital admissions — rather than the causes.

Training to tackle abuse
All NHS staff should have and apply a clear understanding of the risk factors for violence and abuse when interacting with patients, according to a report from the government’s Taskforce on the Health Aspects of Violence Against Women and Children. It recommended: basic training for all staff to meet the needs of women and children who have experienced violence and abuse; more advanced education for “first contact” staff and those working in specialties who are more likely to be caring for women and children who have experienced abuse; and training in awareness of the associations and presentations of abuse and how to broach the issue sensitively and confidently.

FRIDAY
College backs collective care
The Royal College of Nursing said nurses supported a “comprehensive” funding model for social care, where everyone over retirement age with sufficient savings or assets paid into a state insurance scheme. It is one of three funding options being considered for the new national care service. Responding to a commons health committee report on social care, RCN executive director of nursing and service delivery Janet Davies said: “Nurses have told us that they would prefer a comprehensive model of funding – the only option where everybody would pay collectively for social care, sharing the risk equally and fairly.”

Out of hours costs vary
The Patients Association said there was significant variation in out of hours spending. Freedom of Information results from 90 primary care trusts showed the average spend per head of the registered patient population was £9 but there was significant variation with the lowest spending less than £1.50 and the highest more than £20. Association director Katherine Murphy said: “This degree of variation is worrying – it is hard to understand how one PCT might be spending 16 times more on out of hours care than another.”

SKILLS PUT TO TEST AT NURSING TIMES CONTEST
More than 130 senior nurses attended the latest Nursing Times Challenge in Coventry. Groups of nurses competed over managing scenarios to test skills in decision making, flexibility, negotiation and persuasion. The team that won the category of “best health economy” comprised staff from Great Ormond Street Hospital for Children Trust, Coventry Community Health Services, NHS Haringey and St George’s Healthcare Trust. Pictured with the winners is Professor Tamar Thompson (far left), external relations adviser/ lead nurse at the NHS Institute for Innovation and Improvement, which sponsored the event.

‘I really, really love my hair, and am very particular with it. I straighten it every day and won’t go out if there’s a single hair out of place. The shortest I have ever had is when I had it cut into a bob once’
NHS Liverpool Community Health skin care nurse Michelle Gallagher, who shaved off her hair to raise money for the Macmillan nurses who looked after her brother
**MATUREITY AND NEONATAL**

**Chinese therapy no benefit**
There is no evidence that acupuncture or Chinese herbal medicine can boost fertility in men and women, according to guidelines from the British Fertility Society. Researchers assessed 14 trials on acupuncture and found no significant effect. They could find no relevant trials on Chinese herbal medicine.

Writing online in the journal Human Fertility, BFS professor Adam Balen said: “There is currently no evidence that acupuncture or Chinese herbal medicine, when used in conjunction with assisted fertility treatment, have any beneficial effect on live birth rate, pregnancy rate or miscarriage rate. Patients should be made aware of this fact.”

**Unlawful cord blood danger**
Unlawful umbilical cord blood collection may breach safety and quality standards, the Human Tissue Authority has warned. This follows cases of parents collecting cord blood unlawfully and clinicians feeling pressured to collect cord blood unlawfully. HTA director of communications Dr Shaun Griffin said: “We know of incidents where parents have brought cord blood kits into the delivery room and put pressure on untrained medical professionals to collect cord blood.”

**CHILDREN AND YOUNG PEOPLE**

**Behaviour link to adult pain**
Children with severe behaviour problems are twice as likely to experience chronic pain in adulthood as children without behaviour problems, according to University of Aberdeen researchers who studied almost 20,000 children for more than 50 years. One possible reason is that both childhood behaviour and adult chronic pain are due to “a long term neuroendocrine dysfunction beginning in early life”, the researchers said online in the journal Rheumatology.

**LONG TERM CONDITIONS**

**New guidance in latest BNF**
The latest edition of the British National Formulary has been published. BNF 59 features new guidance on community acquired pneumonia, the safe use of cytotoxic medicines, the withdrawal of sibutramine and a revised layout for prescribing information relating to hepatic and renal impairment, pregnancy and breastfeeding.

**TNP cheaper at home**
Home topical negative pressure therapy may have clinical and economic benefits. A Birmingham study followed 20 subjects with a variety of acute and chronic wounds. Ten received TNP in hospital, five at home and five in both settings. There was a reduction in wound surface area and improved appearance of the wound bed in 19 patients, with treatment lasting two to 74 days. Treatment cost less for subjects treated at home (mean cost per day £46) and highest where care was delivered exclusively in hospital (mean cost per day £239).

**Diabetes drug approved**
The Scottish Medicines Consortium has approved saxagliptin (Onglyza) as an add-on combination type 2 diabetes therapy with metformin, when metformin alone with diet and exercise does not provide adequate glycaemic control. It is restricted to patients for whom sulphonylureas are not appropriate and is an alternative to other agents such as thiazolidinediones.

**Ventilation in MND guide**
NICE has published draft guidance on non-invasive mechanical ventilation in patients with motor neurone disease. It looks at how clinicians should identify and monitor respiratory impairment, when they should consider offering non-invasive breathing support and when to discuss end of life care. A NICE spokesman said: “We welcome feedback from all professionals involved in the care pathway, as well as from those with motor neurone disease and their carers.” The consultation closes on 23 March, with final recommendations due in July.

**Arthritis drug trial halted**
Roche and Biogen Idec have suspended a research programme into the use of ocrelizumab for rheumatoid arthritis. The decision follows the discovery of a higher number of opportunistic infections in trials than expected. Roche associate head of medical affairs Dr Ben Porter-Brown said: “These specific clinical trials have suggested that the drug benefits do not outweigh the side effect risks at this stage.”

**Acute Care**

**Alerts on slings and hoists**
The Medicines and Healthcare products Regulatory Agency has issued an alert on all types of Oxford slings and standing harnesses made by Joerns Healthcare. The agency said the instructions were “unclear”, and it had received reports of occupants being injured as a result of incorrect use or inadequate inspections of slings before use. It has also issued a separate warning on several models of hoists and standing aids manufactured by BHM
Medical. There is a risk of electric shock when the hoist is connected to the mains supply with a single insulated power cable for battery charging.  

Alert on dialysis lines  
Nurses working in renal units should check dialysis machines to ensure that colour coded Hansen type dialysis fluid line connectors have been correctly fitted, the Medicines and Healthcare products Regulatory Agency has warned. If the red and blue line connectors are configured incorrectly, dialysis would be significantly less efficient, it said.  

Public Health and Wellbeing  
Home HPV test advised  
More high risk cases of human papillomavirus infection could be detected by offering home testing kits to women who do not come forward for cervical screening. Dutch researchers studied 28,000 women who had not responded to two invites for screening. They found more than a quarter of those who were asked to conduct a home test complied with the request, compared with 16 per cent who attended an appointment for screening at the third request. Home testing would lead to “twice as many cases of cervical cancer being diagnosed than with the regular screening programme”, the researchers said online in the BMJ.  

Combined cause for liver  
Obese men who drink alcohol have a significantly increased risk of developing liver disease, according to UK researchers who studied the combined effects of body mass index and alcohol consumption on liver disease in more than 9,000 men in Scotland. Obese men who drank 15 or more units of alcohol a week were 19 times more likely to develop liver disease than non-drinkers who were underweight or of normal weight. A BMI specific “safe” limit of alcohol consumption may need to be defined for men who are obese, the authors said in the BMJ online.  

Psychotherapy standards set  
National occupational standards for psychotherapy and counselling have been published by Skills for Health, in a project funded by the Department of Health and the UK Commission for Employment and Skills. These cover cognitive and behavioural therapy, psychoanalytic/psychodynamic therapy, family and systemic therapy and humanistic therapy. While not mandatory, these set minimum standards and can be used to identify gaps in learning.  

Surgey  
Alert over anaesthetic hoses  
The Medicines and Healthcare products Regulatory Agency has issued a warning about all makes of anaesthetic gas scavenging systems. The agency said there was a risk of serious harm to patients from excessive pressure in anaesthetic breathing systems caused by blockage of AGSS hoses.  

End of life care  
Advance decisions advice  
A “quick check” guide for healthcare staff detailing the difference between care planning and decisions made in advance has been published by the National End of Life Care programme. The four page guide covers general care planning, advance care planning, and advance decisions to refuse treatment or resuscitation.  

Sign up for a daily newsletter at nursingtimes.net
Evidence is piling up that nurse leaders who really care about patients must pay attention to how their staff feel about work

The research evidence that links staff engagement with enhanced patient outcomes and experience is powerful. We know that organisations with satisfied staff score well on patients’ experiences. We also know that teamwork is good for the mental health of both staff and patients, and that hospitals with good human resources and management practice, with training, appraisal and team building, have higher levels of patient satisfaction and staff motivation and, importantly, lower patient mortality than others.

Those investigating NHS hospitals where patients have suffered very poor care have all found: remote and inaccessible managers who refused to listen to staff and would not involve them in decisions; bullying; low staff morale; fatalism among clinicians about management; and a reluctance to raise concerns.

There is much more to learn about the quality of relationships between managers and staff and how they affect patient outcomes and experiences. What exactly is it that connects the way nurses feel at work to the way they look after patients? There is much we do know: evidence tells us nurse leaders who care about patients and about their organisations pay attention to how their staff feel about work and about their employing organisation.

Consulted kitchen staff, they find they can provide milk in pitchers. They decide they will take patients their breakfast trays and remain briefly to check whether they need help with pouring.

The ward staff are stunned to discover the variation among patients on such a small matter, a revelation that clearly has implications for other aspects of care.

The message the charge nurse has communicated is that patients’ experiences matter; that he is actively interested in helping staff to provide compassionate care; and that it is possible for the team to reflect together on the nature of their work and solve practical problems.

Is this a trivial story? No. Patients’ stories are full of “small” things. Cumulatively, it is the small things that serve to reassure, to build trust and confidence or, conversely, to fuel anxiety, mistrust and tension.

For me, the story speaks volumes about leadership that manages to communicate – through the behaviour of the charge nurse – that it does not take caregiving for granted. What could be more important?

Staff engagement brings together “how staff feel” about work with “what managers do” and describes the two together in terms of the presence or absence of “engagement”.

You can find and measure engagement in staff surveys where it shows up in positive employee attitudes, commitment to and belief in the organisation and a willingness to go the extra mile.

In business terms, it matters because it correlates with positive attitudes towards change and innovation, as well as higher productivity. It is associated with higher satisfaction, which means that staff are less likely to want to leave, and therefore with lower staffing costs.

There are multiple connections between what happens at the top of the organisation and the shop floor. The behaviour and conduct of leaders is critically important. There is a host of reasons why nurse leaders should be interested in staff experience. Even the act of taking an interest will improve staff engagement.
What do you think? Please let us know at www.nursingtimes.net/spring-debates

aligned to good patient outcomes, should measures of staff experience be given greater prominence by nurse leaders – or does this undermine the emphasis on the patient?

2. Collaboration Should NHS organisations develop leaders for the whole NHS collaboratively or focus their efforts on their own future leaders?

3. Positive action Should the NHS identify potential leaders for development to build representative talent pools or is this best left to individual aspiration?

‘Do we always understand what matters to patients? If the answer is yes, do we always act upon this information?’

real time feedback from patients to inform improvements and, from April, their income will be directly linked to patient satisfaction.

Across England there are managers who, by changing the way they work to better understand both patients and staff, are finding new ways to improve their services and people’s experiences of them.

However, while NHS managers should pay close attention to staff experience, it is more important to pay attention to the patient. Although care delivered by the NHS has always focused on the patient, their needs have sometimes been assumed and the powerful role their views can play in improving services has often been overlooked.

This does not mean we have not been collecting information on “experience”. For years, feedback has been collected via face to face interactions, surveys, focus groups, public consultations and a host of other mechanisms.

However, the NHS has only recently started to understand the need to be smarter about how we use this invaluable information. Do we always understand what matters to patients? If the answer is yes, do we always act upon this information?

In recent years, some critical measures have been introduced to help reshape the relationship between patients and services. The NHS constitution clarifies what patients should expect from the NHS. Hospitals should already be using this information?

In the NHS, where a close working relationship between clinician and patient is vital, the association between patient and staff experience is likely to be all the more important.

However, while NHS managers should pay close attention to staff experience, it is more important to pay attention to the patient. Although care delivered by the NHS has always focused on the patient, their needs have sometimes been assumed and the powerful role their views can play in improving services has often been overlooked.

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However, the NHS has only recently started to understand the need to be smarter about how we use this invaluable information. Do we always understand what matters to patients? If the answer is yes, do we always act upon this information?"
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*ABC (Jan–Dec08)  **Fusion research 08

For more information please call Tim Verbrugge on 020 7728 3736 or email tim.verbrugge@emap.com
Nurses should not let themselves be defined by their uniform

It is time to stop focusing on nurse uniforms as a means of professional identity and base our self worth on the importance of the profession’s work, argues Sara Morgan.

The nursing uniform debate rages on, with strong opinions held on all sides. As the research report on page 21 demonstrates, these views develop before nurses have even qualified.

The specific topics of conversation change – such as nationwide uniforms, scrubs or unisex uniforms – but the basic underlying questions remain the same. What does our attire say about our profession? How does our appearance affect our interactions with patients and colleagues? The uniform discussion, seemingly trivial on the surface, is actually a proxy argument for many of the challenges that are facing the nursing profession today.

A common argument for keeping more traditional uniforms is that they allow nurses to look and feel like professionals. While this may be true for some, the nurses who are helping with the disaster relief efforts in Haiti and Chile are undoubtedly doing a fine, professional job in whatever clothes are on their backs, probably covered in mud, blood or the sweat of several days’ work.

Nurses demonstrate that they are professionals by their knowledge, their skills, how they care for their patients and how they treat their colleagues, not by what they wear. Actions speak far louder than thread count, colour or tunic shape.

Doctors, pharmacists, speech and language therapists, dietitians and many other members of the healthcare team wear their own clothes to work and are respected as professionals by both patients and other members of staff. Why is it only nurses who feel that clothing is responsible for demonstrating professionalism?

Another frequently held belief is that without uniforms, patients will be unable to identify us. Again, I refer back to our doctor colleagues who, now deprived of their traditional white coats, must introduce themselves to patients. Nurses should be doing this anyway, but it becomes too easy to occasionally skip the introduction if we think patients know us already based on the colour of our uniforms. The truth is, we cannot and should not expect this of our patients: their job while in hospital, in clinic or at the surgery is to focus on their health, not memorise uniform variations. We may say that uniforms help patients to identify us, but does this absolve us from having to proactively (and politely) introduce ourselves to them?

The worst case scenario is if nurses are not identifiable either by appearance or by introduction. Is this so bad? It may prompt patients to ask questions, such as: Who are you? What is your role in my care? What is the plan for my care? The more questions patients ask, the more empowered they become and the more engaged they will be in their own care. Both nurses and patients should be focusing on this therapeutic relationship, rather than concentrating on who is wearing what.

Instead of being caught up in the finer details of epaulette colours or stripes and piping – a dilemma that really is best left to London Fashion Week – we should focus on why these issues spark such fierce dialogue. Why are we letting ourselves be defined by what we wear? The patients’ lives with which we are entrusted are far too valuable for us to let our self worth and performance rest on something as fickle as fashion.

Regardless of what we wear while at work, we cannot let our uniforms do the talking for us. Our role is to speak up for ourselves and, even more importantly, for our patients.

‘The nurses in Haiti and Chile are undoubtedly doing a fine job in whatever clothes are on their backs’

Sara Morgan is lead nurse, Imperial College Healthcare Trust, London.
Integrated care pilot programme: ensuring people with dementia receive joined up care

The government is piloting several models of integrated working in health and social care. A nurse led pilot improved support for older people with dementia.

INTRODUCTION

The Department of Health announced 16 integrated care pilots (ICPs) in April 2009, aimed at testing different models of integrated working in health and social care. The pilots, which are located across England, will run for two years and evaluated against a set of national and local measures (DH, 2009a). They will test a number of diverse models, focusing on innovation, improving quality and patient satisfaction.

Bournemouth and Poole Community Health Services is an ICP initiated in September 2009 and coordinated by Bournemouth and Poole Primary Care Trust and Bournemouth and Poole local authorities. As a community based model, it is designed to improve early intervention and signposting to services for people with memory loss and diagnosed dementia.

The multidisciplinary team includes GPs (four local surgeries are involved in the project), acute care consultants, specialist nurses, social workers, mental health intermediate care assistants, a dementia support worker, third sector agencies and local community groups.

Bournemouth and Poole has a higher percentage of older people than the English average. The proportion aged over 60 is approximately 25% in Bournemouth and 27% in Poole; 8.5% of the population of both areas has dementia, according to the Projecting Older People Population Information System (www.poppi.org.uk).

AIMS AND OBJECTIVES

In the Bournemouth and Poole areas, health professionals identified that a number of people with memory problems were not being fully supported to manage their health and wellbeing effectively. Historically, local GPs would refer people presenting with short term memory problems to the community mental health team. However, this team did not primarily focus on those with low level needs who did not require ongoing support from a community psychiatric nurse (CPN). This resulted in a number of people living unmonitored in the community, with no way of supervising their health, or dealing with any deterioration until it presented as a crisis, often in a hospital admission.

Developed from the national dementia strategy (DH, 2009b) and taking guidance from the Transforming Health and Social Care agenda (DH, 2009c), this ICP project aims to draw up an effective local dementia pathway that joins up health and social care.

It aims to offer high quality, person centred specialist care that responds specifically to the needs of people with memory loss and dementia. A fully integrated, community based team offers both crisis and low level care to improve interventions for service users, ensuring that often “hard to reach” residents access appropriate services at the earliest opportunity. As part of this, the team hopes to increase the number of people listed on GPs’ dementia registers. It also aims to provide support and interventions to prevent hospital admissions, speed up successful assisted discharge and to work with service users and carers to enable people to remain in their own homes.

PRACTICE POINTS

Services considering implementing a similar programme should:

- Understand their local population and identify unmet needs;
- Involve nurses and other health professionals in the initial planning and service design period;
- Set clear objectives and measurable outcomes;
- Promote integration as a team philosophy;
- Devise the most effective and efficient way to integrate working practices to offer a seamless service for clients, and review its success regularly;
- Review outcome data regularly and frequently to enable improvements to be implemented at the earliest opportunity.

The ICP team also plans to engage local businesses and community networks to raise awareness of memory loss and provide an informal infrastructure to support the project. This includes promoting the scheme and communicating the benefits to the local economy of supporting service users (and carers) to remain in their own homes.

ESTABLISHING A MULTIDISCIPLINARY TEAM

The pilot has three main elements. The first is that a multidisciplinary intermediate care team is established to proactively identify clients using GPs’ registers for carers, vulnerable people and dementia, together with hospital admission lists. The team has developed a clear pathway to enhance patients’ experiences. The aim is to test the efficacy of the pathway and the supporting organisational structure, to deliver better care and effectively use resources.

A nurse lead manages the integrated team, and coordinates team roles for both health and social care professionals. This includes managing a social worker, registered mental health nurse, mental health intermediate care assistant and dementia support worker.
The team leader assesses all referrals and, depending on physical and mental health issues, allocates the first assessment to an appropriate team member(s). The pilot receives referrals from the four GP practices that are involved.

At the beginning, the team presented the structure to GPs, outlining the new service and how they could make referrals. In October, the project’s first full month, the team received 46 referrals. These included one-off assessments for low level support or urgent care requests, which are referred to the ICP team social worker and then on to the team’s care assistant for immediate implementation. A client could be in the team’s care for up to six weeks at a time, or for more short term care, such as when a carer is ill and the client needs prompting to take medication or help with personal care. While the team deals with immediate issues, it also considers any longer term care that might be needed in the future, potentially from mainstream social services care or floating support facilities.

Local GPs have so far been enthusiastic supporters and found the system beneficial, particularly because of its joint approach. The ICP team works in a truly integrated way, with social care staff and health professionals taking equal responsibility for liaising with district nurses and GPs.

**Working with the voluntary sector**

One of the activities launched as part of the pilot is a monthly “Singing for the Brain” club, which was developed by the Alzheimer’s Society. The club is run by the dementia support worker and a mental health nurse, and aims to provide both therapy and social activity for people with dementia and their carers. It provides an opportunity to participate in enjoyable singing sessions in an informal and friendly setting, which stimulates the mind and body. Using music – one of the earliest human memories – clients often find they remember tunes and lyrics, which help them to remember significant portions of personal history and to learn to socialise again.

**Working with a dedicated dementia support worker**

The pilot’s second element is a dedicated dementia support worker, who acts as a key worker for people identified as having memory loss. Seconded from the Alzheimer’s Society, the key worker provides a low level of ongoing support, such as education and plans for crisis management, for clients with early memory impairment. This is an ongoing process, which might mean the key worker refers clients back to the team if their condition deteriorates and they need a higher level of support to avoid a future crisis.

Local service users have responded well to this service, all benefiting from one to one, continuous support. They are able to develop relationships with the dementia support worker, who has been particularly successful in engaging some of the most distant male clients. The support worker takes a personalised approach to building relationships, which might include taking a client out for a coffee or playing snooker in a local club.

Another part of this role involves completing life diaries for clients. These consist of clients’ personal details, contact information for friends and family, favourite media such as television or radio programmes, personal history, and hobbies and interests. By capturing such information early on, if clients need a higher level of care in the future, particularly in residential settings, they have a personalised booklet outlining who they are and their life history. One example of how this has helped to provide personalised care is a male client living in residential care, who used to be a milkman. He would wake up at 4.30am every day and, without a life diary, care staff would have encouraged him to go back to bed. However, thanks to the care diary they knew getting up early was ingrained in his behaviour and would not change, so they accommodated his habit.

**Engaging the local community**

The third element of the project involves developing new and innovative ways of delivering low level dementia support for service users and carers, using partnerships with the third sector, local businesses and existing community networks.

The nurse lead is developing relationships with a range of community stakeholders to ensure the wider community can contribute. At the beginning of the project, leaflets were produced and a community launch event was organised so local businesses could get involved. The event was well attended and allowed the ICP team to talk about the project and open communication so local businesses could refer people they were concerned about. It also allowed the team to pass on advice about how to manage clients with memory difficulties who might visit local shops, and helped address the general stigma of dementia. Consequently, local pharmacies and a local bank became involved in the programme.

Since the launch event, a local cafe owner has offered to set up a memory cafe, to complement the existing three held in a village hall, church hall and local library. Attended by around 20 people, these informal sessions take place once a month and are run by the dementia support worker and the mental health intermediate care assistant. A local guest is invited to each session; these have included local police officers and police community support officers who distributed handbag ties to tether a purse or wallet to a bag.

The ICP team also works with other partners, such as Rethink (Borough of Poole Social Services), a floating support service for people with dementia. Two allocated workers from Rethink provide support to people who need lower level assistance with non-personal care activities, such as shopping, household tasks or help with financial affairs, free of charge. Faithworks Wessex, a local faith group, also offers a service to carers, which includes emotional support and companionship. The ICP team has used this service with successful results.

**NURSE INVOLVEMENT IN PILOTS**

The ICP project has benefited from a high involvement of nurses from a range of disciplines, including mental health and community nursing. The nurse leader has developed team management and coordination skills, and all members have benefited by learning from professionals from other disciplines. The pilot has also allowed nurses to become involved with new areas of the community, such as local businesses and third sector partners.

Nurses have found that their experience of using reflection techniques, particularly in
team meetings, has helped to consider both the short and longer term needs of clients. Working in an integrated way has also allowed each team member to build confidence, giving greater decision making power as a team, while also allowing flexibility to change direction if a client’s condition deteriorates.

**CHALLENGES**

Due to its innovative nature, the ICP has encountered some challenges. Initially, confronting people’s stereotypical views of dementia was an enormous challenge but initiatives, such as local business engagement, have proved useful in helping to educate local residents. Community engagement is, however, time consuming and requires frequent communication in an effort to maintain momentum.

The team is conscious of future capacity issues, particularly for the dementia support worker role. The national dementia strategy (DH, 2009b) requires every patient to have a single point of contact but the level of monthly referrals and the fact that clients remain on the support worker’s caseload until they die means it could become unmanageable. This situation is being monitored on an ongoing basis.

Another issue is how to effectively engage clients who do not require services immediately but may do so in the future. Many do not have any insight into their current or future needs; they may be able to make the decision not to request support immediately, but they may lack the capacity to change that decision in the future. In the past, teams might have completed a capacity assessment and concluded there were no immediate needs, resulting in that particular client being lost from the system. The ICP model involves recording such clients’ details, and then a team member revisits them after a suitable interval to assess health or care requirements.

**EARLY RESULTS AND BENEFITS**

The ICP programme has allowed adequate resources to become available, which allows it to respond to proactive and reactive needs and take both a short and long term view. With an intermediate care assistant available, clients can receive care as soon as they need it. Wider healthcare resources also available to the team include: occupational therapy and physiotherapy support from the team at Woodlands Intermediate Care Unit; the psychiatric liaison teams in both Bournemouth and Poole acute hospitals; and the Bournemouth (Kings Park Hospital) and Poole (Alderney) community mental health teams. As well as being able to direct clients to the third sector organisations Age Concern and the local voluntary agency Help & Care, the ICP also works closely with the Poole Intermediate Care Service team and refers clients to the Community Assessment and Rehabilitation Team in Bournemouth. Both local authorities are actively involved in the project.

Team members feel the integration model has been extremely successful, with GPs, other health and social care professionals and agencies, including third sector organisations, working together effectively.

**Box 1. Providing Carers**

A local couple referred themselves via the social services helpdesk. Social services informed the integrated care pilot team, who provided an immediate response, which averted a crisis. The woman had diagnosed dementia but the couple did not have any care, support or family. The social worker conducted an assessment and the team provided careers to help the woman with her personal care needs, along with support from the Poole Intermediate Care Team, a general nurse (due to some physical health issues) and physiotherapy support. The couple wanted to write an advanced care plan, with advanced directives, owing to their lack of family. The social worker contacted a local solicitor who is now completing advanced directives for both. In addition, the dementia support worker is providing ongoing low level support and completing life diaries with both clients.

Anecdotally, the team has also received supportive comments from clients, carers and relatives by telephone and letter. The case studies in Boxes 1 and 2 show how the ICP team has supported clients.

**ONGOING EVALUATION**

While the project is still in its early stages, a rigorous evaluation system has been put in place to measure and track results, in one joined up IT system, which can be accessed by all ICP partners.

The DH has set up performance indicators and, as part of the project, a data analyst collates monthly data, which the team can access to identify successes and areas for improvement. Information includes where a referral has come from, the diagnosis and any relevant hospital admissions or residential care information. Indicators include whether the team has prevented a patient going into hospital or residential care, as well as minimising risk and support.

Monthly assessment will continue until the end of the project in August 2011, when recommendations will be made on how learning from the ICP programme can be implemented on a wider scale.

**Due to the success of these pilots the DH announced an expansion in February 2010, to enable more sites to set up projects in a range of sectors, such as children’s services, education, criminal justice and housing. To apply go to www.dh.gov.uk/integratedcare**

**REFERENCES**


**How can community nurses improve quality of life for patients with leg ulcers?**

Leg ulceration can cause a range of problems. Community nurses need tools to assess patients’ subjective experiences so they can improve their quality of life.

Research studies have shown that patients with leg ulcers have a poor quality of life (QoL) (Price and Harding, 1996). They can experience multiple problems such as pain, discomfit, social isolation, malodour, altered body image, leakage, reduced mobility and the discomfort and inconvenience associated with wearing bulky bandages (Stevens, 2006; Ellis, 2004; Persoon et al, 2004). Box 1 outlines the effect of leg ulceration on QoL.

**EXTENT OF THE PROBLEM**

Leg ulcers are defined as any skin damage below the knee that takes more than 4-6 weeks to heal (Royal College of Nursing, 2006; Benbow, 2005). They may take several months to heal but some patients live with them for many years (Nemeth et al, 2007; Moffatt et al, 2006; Graham et al, 2003). Two thirds of patients whose ulcers have healed will have at least one recurrence (Morris and Sander, 2007).

It is estimated that 1-2% of the general population in the US, Canada, the UK, Europe and Australia will suffer with a leg ulcer at some point in their lives (Myles, 2007; Edwards et al, 2005a).

As older people are at increased risk of developing arterial and venous incompetence – which are underlying causes of leg ulceration – improved life expectancy means the number of people with ulcers is likely to rise (Franks and Moffatt, 2007). Even at their current incidence leg ulcers are a major economic burden; it is estimated that treating them costs £400m-600m of the UK health budget per year (Hopcroft and Forte, 2008; Myles, 2007).

There have been major advances in our knowledge about how to treat leg ulceration and in the range of dressings available. Nursing care usually focuses on wound care and the application of compression bandaging (Persoon et al, 2004), so there is concern that nurses focus on the ulcer rather than the whole patient (Heinen et al, 2007; Persoon et al, 2004).

There has also been considerable research into the negative effects of leg ulcers on patients’ QoL but there is little practical guidance on how to address the problem.

**MEASURING QUALITY OF LIFE**

The World Health Organization (1998) defined QoL as “an individual’s perceptions of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns”.

Studies that focus on leg ulcers and QoL have used a range of QoL assessment tools (Palfreyman, 2008; Franks et al, 2003; Smith et al, 2000; Walters et al, 1999; Garratt et al, 1993), which is a measure of general status. Five used the Nottingham Health Profile (Franks and Moffatt, 2001; Franks et al, 1999a; Franks et al, 1999b; Harmer et al, 1994; Lindholm et al, 1993). The other research studies did not use an established assessment tool to assess QoL. Jones et al (2008) used the Hospital Anxiety and Depression Scale.

The study on the impact of QoL by Palfreyman et al (2007) was aimed at developing an effective QoL assessment tool for this patient group. Using a QoL assessment tool designed specifically for people with leg ulcers addresses all the factors related to these wounds. Examples include the Venous Leg Ulcer Quality of Life (VLU-QoL) questionnaire (Hareendran et al, 2007) or the Sheffield Preference Based Venous Ulcer-5D (SPVU-5D) (Palfreyman, 2008).

**PRACTICE POINTS**

- Nurses need to take a proactive role in the assessment of quality of life (QoL) in patients with leg ulcers.
- Leg ulcer assessment documentation should include consideration of QoL.
- Pain should be assessed using validated pain assessment tools.
- Nurses need access to user friendly QoL assessment tools designed specifically for patients with leg ulceration, such as the Venous Leg Ulcer Quality of Life (VLU-QoL) questionnaire or the Sheffield Preference Based Venous Ulcer-5D (SPVU-5D).
- Community nurses should be aware of services that can support and improve QoL for patients with leg ulcers.
College of Nursing (2006) have all published guidelines on the assessment and management of leg ulcers. While these emphasise the need for competent practitioners who assess the physical effects of leg ulcers, they do not address the importance of assessing patients’ QoL in detail.

The recommendations of these guidelines will ultimately help to improve QoL and its assessment, but how QoL is affected by leg ulceration is not specifically addressed.

**EFFECT ON DAILY LIVING**

Patients’ experiences of living with leg ulcers have been explored in detail (Persoon et al, 2004; Krasner, 1998; Walshe, 1995). Researchers have looked at single issues affecting QoL, for example the impact of exudate and odour from chronic venous leg ulceration (Jones et al, 2008). Research evidence suggests that chronic leg ulcers have physical, psychological and social costs for patients and therefore reduce their QoL. (Franks and Moffatt, 2006; Walshe, 1995). The effects on QoL are summarised in Box 2.

The research studies reviewed for this article did not consider how leg ulceration affects patients’ QoL or community nurses’ duties and responsibility in managing this aspect of care. In addition, there is little guidance on how nurses could use QoL assessment tools in their clinical practice. It is important to question whether nurses should use objective patient QoL assessments specifically designed for those with leg ulceration, such as the VLU-QoL (Hareendran et al, 2007) and the SPVU-5D (Palfreyman, 2008) as part of their everyday patient assessment.

**Improving documentation**

A longitudinal study (Nemeth et al, 2007) and a case report (Lay-Flurrie, 2001) both identified that patients’ assessment and documentation is being compromised by lengthy assessment tools which community nurses find difficult to use and time consuming to complete. There are a number of possible reasons why nurses experience these problems, including a lack of training on how to use the tools and the use of standard clinical assessment forms rather than those for specific diseases.

QoL is subjective and depends on a number of social factors that give it a personal meaning for the patient (WHO, 1998). This can be difficult to capture on standardised forms.

While researchers have explored factors that can alter QoL, community nurses need practical tools to help them to consider how these factors affect patients’ activities of daily living (Barret and Teare, 2000). Standard nursing leg ulcer assessment forms do not always allow for a comprehensive social and psychological assessment, making it difficult to evaluate patients’ QoL (Lay-Flurrie, 2001).

While many patients with leg ulcers experience pain, and this can have a marked effect on QoL (Stevens, 2006) and Persoon et al (2004) pointed out that pain assessment tools are rarely used for patients with leg ulcers compared with those who are terminally ill. Stevens (2006) suggested that practitioners could design a specific pain assessment tool for patients with leg ulcers; on the other hand, they could use existing pain assessment tools to improve patients’ QoL.

**RECOMMENDATIONS FOR COMMUNITY PRACTITIONERS**

Community nurses need to take a proactive role in assessing the QoL of patients with leg ulcers. To do this, they need user friendly nursing QoL assessment tools designed specifically for this patient group.

Further research is required to explore community practitioners’ role in promoting QoL for patients with leg ulcers. Community nurses spend approximately 50% of their time treating patients with leg ulcers (Morris and Sander, 2007) and witness the impact of these chronic wounds on patients’ everyday lives. They need to use this experience to influence local leg ulcer assessment guidelines and nursing assessment documentation to ensure that they incorporate QoL.

Tissue viability specialist nurses should be asked to work with community teams to set up ongoing quality improvement measures and clinical audits aimed at improving patients’ QoL.

Thorough and regular pain assessment and the use of pain assessment tools could help to improve pain management and also have a positive impact on patients’ QoL. (Benbow, 2008; Stevens, 2006).

Lorimer (2004) and Lorimer et al (2003) suggested that standardised assessments and regular scheduled patient reassessments were important in managing QoL in patients with leg ulcers. These can be incorporated into local guidelines and patients’ care plan.

Research studies and reports have shown that leg clubs have been successful in promoting health by improving socialisation and reducing isolation in patients who have leg ulcers (Gordon et al, 2006; Edwards et al, 2005a; 2005b). Community nurses need to be aware of such services in their areas that can support and improve patients’ QoL.

**CONCLUSION**

Community nurses have an important role in assessing and improving patients’ quality of life.

However, this is not a responsibility they can take on alone – they need to collaborate with other members of the multidisciplinary team and develop assessment tools designed for use in clinical practice with patients who have leg ulcers if they are to promote their patients’ QoL.
REFERENCES
Rheumatoid arthritis 2: exploring treatment options to achieve early control and remission

Long term disability and unemployment are common in people with RA. Aggressive treatment on diagnosis promotes symptom control and aids remission.

INTRODUCTION
Rheumatoid arthritis (RA) is an autoimmune systemic inflammatory condition that causes pain, swelling and stiffness in many joints. It is a long term condition that varies in severity and is unpredictable, with fluctuating episodes of disease activity (Arthur and Hill, 2006). RA can also cause flu like symptoms and fatigue. Treatment aims to control the inflammatory process, reduce symptoms and delay joint destruction. Early management through a combination of drug therapy and multidisciplinary team input aims to promote disease control/remission and self management (Luqmani et al, 2006).

Patients’ individual needs must be assessed if optimum care is to be provided by the most appropriate healthcare professional(s).

An understanding of the possible impact of RA is essential before assessing and planning care, as its effects can be wide ranging, including physical, psychological, social and financial wellbeing.

THE IMPACT OF RA
Chronic inflammation, muscle wasting and joint destruction, which contribute to deformity and altered body image, can occur in more established RA. However, the physical effects are not always visible, especially in the early stages. Although synovitis may be present, it may not be evident without the use of specific examination tests; recently synovitis has been identified through the use of ultrasound technology (Kane et al, 2004).

The absence of obvious signs of arthritis can lead to misunderstandings with work colleagues and cause friction in family relationships, particularly if pain is affecting the person’s social functioning.

Other visible physical changes may occur as a result of specific or prolonged drug treatments, such as glucocorticoid steroid therapy, which can cause weight gain, muscle wasting and hirsutism. These are also likely to damage patients’ self-esteem and body image.

The psychological impact of RA varies as people may respond in different ways following diagnosis. Some feel relieved at being given a diagnosis whereas others may experience feelings of disbelief similar to feelings of grief, working through shock, distress, fear, denial, anger and finally adjustment (Griffith and Carr, 2001). Feeling systemically unwell can affect confidence in coping with everyday events, which over time can lead to feelings of helplessness and depression (Ryan et al, 2003).

Copings and adaptation can be influenced by many factors including family and social support (Homer, 2005). There is evidence that patients with good social support cope better than those who are isolated (Affleck et al, 1988).

LEARNING OBJECTIVES

- Know the multidisciplinary team members who may be involved in managing people with rheumatoid arthritis.
- Be able to identify the different groups of drugs used to control the condition.

While such programmes may provide relevant information from a variety of practitioners, they cannot guarantee changes in behaviour (Hill, 2006). Evidence suggests that the timing of information giving is important, as providing too much information immediately after diagnosis can increase anxiety in some people and ultimately contribute to depression (Donovan et al, 1989). Depression has been estimated to affect 21-34% of people with RA and is often unrecognised and untreated (Dickens and Creed, 2001). The relationship between pain, disability and depression has been recognised, highlighting the importance of a biopsychosocial approach to care, rather than purely managing the physical effects of the condition (Ryan, 2006).
MANAGEMENT OPTIONS
Rheumatology nurse specialists often coordinate patients’ care with the multidisciplinary team. The initial aim is to control pain and inflammation through drug therapy, which is complex as different groups of drugs are often used simultaneously.

DRUG THERAPY
Analgesia
Pain control is achieved through regular analgesia and, where appropriate, non-steroidal anti-inflammatory drugs (NSAIDs), although these must be used cautiously as they may exacerbate hypertension, cardiac and renal impairment, and asthma. Short term NSAID use only is recommended in older people, as they may be taking medication for comorbidities.

It could be argued that people taking numerous medications are more prone to mistakes in taking their drugs in terms of either dosage or frequency, at risk of drug interactions and may be reluctant to adhere to prescribed regimens. There is also a risk of duodenal ulceration with NSAIDs, especially with prolonged use or if taken without food.

Glucocorticoid steroid therapy
Glucocorticoids are used sparingly but are helpful and quick in reducing inflammation. They may be given by intramuscular depot injection, intravenous infusion, directly into a joint or soft tissue, or in tablet form. They are often used as “bridging” therapy to reduce pain and inflammation until long acting drugs (disease modifying anti-rheumatic drugs) begin to work. However, glucocorticoids cannot be given if infection is present as they can exacerbate the problem.

Disease modifying anti-rheumatic drugs
DMARDs are used to control the immune system, slow down the inflammatory process and delay joint damage. They are powerful in suppressing the body’s defence system but can take up to three months to become effective. They require careful administration and monitoring to prevent over-suppression of the immune system.

Regular blood tests enable rheumatology nurses to identify any early complications such as neutropenia, haemolytic anaemia and renal or liver toxicity. The consequences of late identification of any of these could result in hospital admission or, in serious undetected cases, death.

Biological therapy
Biological therapy is used in adults when active RA remains uncontrolled despite conventional DMARDS having been used (see NICE (2009) guidance for full details on the necessary criteria for initiating each drug). Biological therapy approved by NICE includes the tumour necrosis factor alpha inhibitors (anti-TNF therapy) adalimumab, etanercept and infliximab and the B-cell depletion therapy rituximab.

Anti-TNF therapy targets specific cells in the immune system called cytokines. The treatment aims to reduce the elevated level of tumour necrosis factor alpha, present within joints, which in excess contributes to joint damage. Rituximab is prescribed when patients do not respond to anti-TNF treatments, and it dramatically reduces B cells in the immune system. These cells are a type of white blood cell responsible for producing auto-antibodies.

Biological medicines are administered by either infusion or injection. These have been shown to be effective in approximately 70% of recipients (Emery et al, 1999). However, there are potential risks, such as an increase in infections, reactivation of latent tuberculosis and malignancy. Consequently, patients taking this treatment are closely monitored.

General principles
NICE (2009) advocated early diagnosis and treatment with combination therapy (two or three DMARDs taken simultaneously). More aggressive treatment on diagnosis is believed to aid remission of RA, with the possible future withdrawal of medication. This aims to avoid joint damage and disability, preserving independence and reducing work disability. Table 1 outlines pharmacological treatment options for RA.

HEALTHCARE PROFESSIONAL ROLES
Pharmacists play a vital role in providing information for both patients and healthcare professionals about medicines used in rheumatology. However, it is the rheumatology nurses who are often involved in explaining possible benefits and side effects to patients. While individual assessment helps to identify the most effective drug for each person, it is ultimately their choice whether to comply with drug regimens.

DMARDs require regular blood monitoring for adverse reactions and toxicity. Many patients are monitored in the community so practice and district nurses need to develop skills in these areas. Rheumatology nurse specialists remain a useful point of contact for advice about side effects and monitoring issues. Most UK rheumatology departments run a telephone advice line for direct access to the department (Thwaites et al, 2008; Arthritis and Musculoskeletal Alliance, 2006).

Patients can be given psychological support via this advice line, although support may be sought from the multidisciplinary team.

NICE (2009) recommended that all people with RA should have access to physiotherapy, and to occupational therapy and podiatry if required:

- Specialist physiotherapy aims to promote general fitness and exercise for people with the condition, as well as teaching specific exercises for joint flexibility, muscle strengthening and managing functional impairments. Hydrotherapy and “land” exercises may be offered. Pain control may also be addressed through non-pharmacological methods such as acupuncture, transcutaneous electrical nerve stimulators, wax hand baths, and hot and cold treatments. It is recommended patients continue with many treatments at home;

- Specialist occupational therapy offers support to both newly diagnosed people and those with longstanding disease. Functional ability is assessed and aids to maintain independence may be suggested. Problems with hand function are evaluated and appropriate management advice given. Aids to assist with daily living may include gadgets to help with washing and dressing. Many OTs provide advice on coping and

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**TABLE 1. GROUPS OF DRUGS USED TO MANAGE RA**

<table>
<thead>
<tr>
<th>Analgesics</th>
<th>Paracetamol, co-codamol, co-dycladrol, dihydrocodeine, tramadol</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSAIDs</td>
<td>Ibuprofen, naproxen, diclofenac, meloxicam, etoricoxib</td>
</tr>
<tr>
<td>DMARDs</td>
<td>Methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, sodium aurothiomalate (Myocrisin), ciclosporin, azathioprine</td>
</tr>
<tr>
<td>Glucocorticoids</td>
<td>Prednisolone, methylprednisolone, triamcinolone, hydrocortisone</td>
</tr>
<tr>
<td>Biologics</td>
<td>E-cell depletion therapy rituximab and the anti-TNF therapy adalimumab, etanercept and infliximab</td>
</tr>
</tbody>
</table>
Managing pain and fatigue, and some offer relaxation sessions; specialist podiatrists provide advice about footwear and foot care. The feet are often affected in RA, causing mechanical damage and pain. Insoles and suitable footwear can be discussed.

At times other members of the multidisciplinary team may be involved in patients’ care, for example, psychologists or psychiatrists in cases where people may have mental health issues. Many rheumatology nurse specialists provide psychological support for those struggling to come to terms with their diagnosis.

In addition, people with arthritis run local patient support groups, including those organised by Arthritis Care and the NRAS, and they can support people in a similar situation to themselves.

**PATIENT CHOICE**

Treatment options must be discussed with patients to enhance concordance. Many rheumatology services are hospital based and these are not always convenient for those with severe functional impairments or those who are working. Some rheumatology teams provide satellite clinics in primary care, and some can provide community support in the form of rheumatology nurses making home visits for monitoring or administering injections. Practice nurses may become more involved if they provide a local phlebotomy service.

In general fewer hospitals now provide inpatient care on designated rheumatology wards. Many of the newer treatments enable patients to attend on a daily basis and, as a result, rheumatology day case units have been set up. Evening clinics aim to meet the needs of those who work regular hours. Services are continuously evaluated to improve patients’ journey through the healthcare system.

**CONCLUSION**

Early referral to rheumatologists means the diagnosis of RA can be confirmed and treatment with disease modifying drugs can be started. The aim of early treatment is to interrupt the inflammatory process and control synovitis within joints. NICE (2009) recommended using more than one DMARD on diagnosis to achieve symptom control earlier. Quicker progression to more advanced treatment in the form of biological therapy should take place if indicated, irrespective of where in the UK patients live. Earlier control of RA can delay joint damage, reduce pain and disability and lower the incidence of work disability.

Caring for people with RA involves a team approach, relying on the expertise of the multidisciplinary team as well as input from patients themselves. Their values, beliefs and opinions must be considered when planning care to meet individual needs and promote concordance. Confidence in self-management is paramount in maintaining independence and psychological wellbeing.

**REFERENCES**


Exploring how nursing uniforms influence self image and professional identity

Nurses often have strong feelings about their uniforms. This study examined student nurses’ views and how to balance modernity with nursing’s heritage.

Tradition has a strong influence on nursing and there is an “inextricable link” between uniform and the profession’s history (Houweling, 2004). This deep rooted history has a profound effect on nurses, as they seek to formulate an identity that is modern but does not forget the profession’s heritage.

LITERATURE REVIEW

Professional identity has become an increasingly important concept in nursing (Page and Lawrence, 1992). Fagermoen (1997) strongly associated it with nurses’ self-esteem, defining professional identity as “the values and beliefs held by the nurse that guide her/his thinking, actions and interactions with the patient”.

However, whether nursing is a profession in its own right has been a contested issue (Etzioni, 1969). Its professional image has been defined as the perceptions, impressions, beliefs and ideas that people have about nurses and nursing (Ginzel et al, 1992). Over the past century the image of the nurse has changed substantially, and the media has played a significant role in creating often derogatory images.

Nursing uniforms are a “nonverbal, conscious statement that nurses have the skills and knowledge to care for others” (Spragley and Francis, 2006). However, wearing a uniform does not automatically mean that a nurse acts as a professional and is a good nurse (Newton and Chaney, 1996).

A common concept is that uniforms give nurses a certain level of confidence to carry out their role and prepare the individual nurse psychologically for work. This implies that nurses play a role when they put on their uniform and removing it is a symbolic sign that they are able to take up their other life roles (Pearson et al, 2001). It appears that this is an important process to help them leave the issues and responsibilities of their nursing role at work. On the other hand, Sparrow (1991) found that when nurses did not wear a uniform, their assertiveness with doctors increased and they felt doctors were more willing to involve and talk to them.

Not only can a uniform contribute to nurses’ self confidence but also, it is suggested, it instils reassurance and confidence in patients (Sparrow, 1991). However, uniforms can be frightening to some patients and can sometimes form a barrier to communication (Richardson, 1999). Although extensive literature on nursing uniforms confirms their importance to both nurses and others, only a limited number of empirical studies examine this phenomenon.

The nurses in Sparrow’s (1991) study, who did not wear uniforms, said how important uniforms are often looked on with fondness by many nurses to form a positive professional identity.

PRACTICE POINTS

- A return to a more structured system of uniform, including clearer distinctions between healthcare professions, could be beneficial for the nursing profession.
- Nurses need to be consulted more on what they want from their uniform.
- A promotional campaign should be launched, based on the model used to recruit teachers, to eradicate persisting stereotypes of nurses and to promote the more modern face of the profession.
- Further research on uniforms and their relationship with professional identity and image is needed.

AIMS

This study aimed to do the following:
- Formulate a picture of student nurses’ views on the nurses’ uniform;
Investigate the impact of nurses’ uniforms on their performance, confidence, view of self, feelings of pride and overall professional identity.

METHOD
The study used an opportunistic sample of 14 pre-registration students on diploma, BSc or (pre-registration) master’s courses at a university in England. Participants were of varying ages, years of training, branch of nursing and included both men and women. Semi-structured interviews allowed the interviewer to probe for more information and gain clarification (Parahoo, 2006). Interviews are flexible and allow interviewees to follow their train of thought while the researcher maintains an element of control (Green and Thorogood, 2004). The interview schedule was derived mainly from the literature, with some questions added based on our experience.

A pilot study was carried out to establish whether the schedule and themes discussed were appropriate. The study was explained to participants and any questions answered.

Staff nurse Kate Shaw conducted the interviews, which lasted 30-45 minutes, during autumn 2008 in the school of nursing. These were digitally recorded then transcribed verbatim.

The findings were formally analysed using thematic content analysis. The data was organised into codes and these were then categorised into common themes (Green and Thorogood, 2004).

The school of nursing internal ethics review panel granted ethical approval before the study started and the head of school gave permission to approach students.

All participants signed a consent form to ensure they were aware of the nature of the project; this made clear what was involved, whom to contact, the study’s purpose and any risks involved, and ensured participants knew they could withdraw at any time. Participants were anonymised at transcription.

RESULTS AND DISCUSSION
Four main themes were derived from the transcripts and, within these, sub themes were formulated. The findings are presented and discussed at the same time.

Differentiating professions and level of experience
Many participants highlighted that it was important to be able to distinguish between professions and level of experience.

“I feel a little bit annoyed that someone would mistake me for someone who works in a nursing home” (participant 13).

Confusion was evident both in terms of profession/role and grade or level of experience. Participants felt that professions needed to be clearly delineated by their uniform not only to reduce confusion but also to maintain strong professional affiliation and pride.

In addition to a clearer system for identifying professions, participants wanted students to be clearly identified visually by their year of study to prevent confusion over their level of experience. Some suggested a national uniform for England, as has been agreed for Wales and Scotland.

Some participants felt the more modern uniforms still encouraged nurses’ subordination to doctors. Although the relationship between the two professions has changed significantly over the past century, issues of gender and power remain and the nursing uniform can sometimes emphasise these.

Many participants thought uniform played a vital role in creating unity in the profession and equality between other professions. They suggested that introducing a uniform for all healthcare professionals would be beneficial to team dynamics and promote a more equal and productive working environment.

Uniform style and historic changes
A large proportion of participants said they would prefer to wear scrubs than tunics. It has been suggested that scrubs portray a competent and trustworthy image and command a certain level of respect as they are often associated with “prestigious” areas such as intensive care or accident and emergency (Rafaeli and Pratt, 1997; Newton and Chaney, 1996).

Those who preferred dresses and tunics thought these were smarter. Some discussed the perception that nurses in the past took a lot more pride and care in their appearance and had a stronger identity. They commented that because nurses used to look smarter, they appeared more professional.

Other participants felt that the nurses’ uniform was not as special as it used to be and were even in favour of the traditional form being reintroduced:

“I’d have it all, the white dress with the white hat and the cross. I want the badge and the cape” (participant 13).

Two participants discussed the importance of their job watch. They and others described it as symbolic of the profession and many women participants were disappointed it was gradually being removed.

However, Wright (2008) questioned whether the older symbols should still be necessary to formulate nurses’ identity, adding that key symbols of nursing have not been lost but have changed to things such as “facial expressions or tone of voice”.

The impact of uniform on individuals
A number of participants said they were proud to wear the nursing uniform because of what it represents.

They discussed the idea that the way in which nurses present themselves in their uniform sends out a message to patients and staff about their attitude to their job:

“To me, your uniform reflects the pride you have in your job… you don’t have pride in yourself, you don’t have pride in your job, therefore you are not going to be as willing to provide good care” (participant 10).

One participant had worked as a healthcare assistant for 20 years and used to wear a hat and belt in that role. She said:

“I was proud to wear it… It was really special and I felt really privileged to wear it… I used to feel great. I loved it” (participant 5).

Conversely, one male participant said he did not feel proud wearing his uniform, which was largely influenced by his peers. It appeared that, because of his friends’ stereotyped associations, he felt embarrassed rather than proud. Another male participant described how he did not want to be seen in his uniform as he would easily be associated with the nursing profession. If an organisation’s external image is negative, then the individual is likely to reduce their affiliation as much as possible (Kahn, 1990).

The interviews showed that female participants were more likely to speak fondly of the traditional uniform, which is not usually associated with male nurses.

Participants acknowledged that feeling like a professional was important to self image and uniform played a large part in this. One highlighted that the uniform did not make her feel very professional because it was poorly fitted and generic.
“I don’t feel very professional – I feel more like a cleaner” (participant 5).

Some mentioned that “feeling good” about themselves in their uniform was important and that they would prefer uniforms to be measured to size and of better quality. Several participants explained that if they had a good self image, felt comfortable in their uniform and had pride in their role, then they would perform better as nurses:

“It’s about self esteem – if you feel awkward because something doesn’t fit properly, then you’re less likely to be assertive” (participant 8).

Several also found it difficult to define the concept of professional identity. Forming professional identity can be a complex and difficult task, as nurses have to juggle between personal and public perspectives (Hallam, 2000).

It could be argued that there are two groups of nurses: modernisers and traditionalists.

“Nursing is caught between wanting to still be that [stereotyped image] so that it has all the positive stereotypes that are associated with it and wanting to push for more rights” (participant 4).

Students may be more likely to subscribe to the “traditionalist” identity as society influences them more than nursing culture (Milward, 1995).

However, they may be accepting and open to a “modernising” identity and it is possible that nurses who have been working for a long time are more likely to prefer “traditional” images of nursing.

Students’ position and identity develop as they settle into areas of work and become exposed to the politics and ethos of colleagues around them.

**Stereotypes and the profession’s image**

The majority of participants acknowledged that stereotypes of nursing still existed and were prevalent in the media:

“The associations that the media or the public have with nurses haven’t really changed much since… Barbara Windsor” (participant 6).

More recently modern medical dramas have obviously influenced opinions on uniform:

“…the media also helps… in terms of ER because… scrubs are cool” (participant 2).

Stanley (2008) suggested recent feature films are beginning to represent nurses more accurately and present a more “modern” image that many student nurses admire.

All participants thought uniform was an extremely important issue and that it directly affected practice and therefore should have attention paid to it.

In order to retain staff and enhance nurses’ job performance, it is vital to improve their self image and the public’s perception of nurses (Takase et al, 2006). This has been recognised by the Prime Minister’s Commission for the Future of Nursing and Midwifery (Department of Health, 2010).

Participants recognised that a new image or identity for nurses would help to remove old fashioned stereotypes further and promote a more autonomous and professional image. However, they also made it clear that remembering nursing heritage and traditions are important and fundamental parts of identity.

**REFERENCES**


Wright J (2008) The important symbols of nursing have not been eradicated – they have changed. Nursing Times; 104: 5, 12.
We can’t let crucial end of life choices be impaired by silence

The needs of a dying person can be complex and emotionally sensitive. They can also be incredibly simple; being with a person to support and care for them can be all they would like. However, we will only know what people want if we explore our own wishes and talk with those around us. Whatever a patient’s dying wishes entail, it is vital they are empowered to express them. Openness and communication are fundamental to compassionate end of life care.

Failure to acknowledge the elephant in the room can mean that dying people feel shut out of social circles and distanced from their communities. It is only by discussing our wishes early on with those we love and making such conversations a part of everyday life that we can alter this sense of isolation and offset the difficulties that may arise in the final stages of our life.

The Department of Health’s 2008 end of life care strategy called death “the last great taboo in our society”, and identified a “lack of openness and discussion about death and dying”. The Dying Matters coalition, which aims to change public attitudes of death, dying and bereavement, is launching a coordinated effort to address this, starting this week with a national awareness week. The support of all health and social care professionals is crucial to the success of these efforts. Helping staff to empower patients to talk more openly about their dying wishes is one of its main priorities.

Nurses have an important role in breaking down the wall of silence around end of life care and are the perfect ambassadors for a more open, communicative approach to it. The compassion that is fundamental to the nurse’s role is invaluable in helping patients and their families discuss their wishes. Death can be an infinitely complex and emotive matter, and addressing it with the right balance of frankness and sensitivity can be a challenge – but it is the sort of challenge nurses must overcome every working day. The end of life care strategy helps in this task with e-learning modules developed around communication skills and advance care planning (accessed via www.e-eca.org.uk).

There are clear benefits to ensuring openness and communication are linchpins of end of life care. It is of indisputable worth to the NHS that patients enter hospitals having considered and discussed their own needs and wishes. Breaking down barriers to thinking and talking about death will help patients make clearer, better informed choices about their care. This clarity is hugely helpful when difficult decisions must be made about organ donation, say, or resuscitation. It is also crucial to meeting the most personal of patients’ wishes, such as whether they would prefer to die at home. The issue of where patients would prefer to die is illustrative of how important choices can be impaired by silence. If we do not know how to communicate what we want, and those around us do not know how to listen, it is almost impossible to express a clear choice. A recent survey conducted on behalf of Dying Matters found that 70 per cent of people in this country would prefer to die at home, yet 60 per cent still die in hospitals. This is clearly an undesirable and unsustainable imbalance, the redress of which could make high impact cost savings while ensuring the delivery of high quality care.

The NHS Institute for Innovation and Improvement’s High Impact Actions for Nursing and Midwifery report highlighted that an alarming number of terminally ill patients are being admitted to hospital despite having no medical needs that require care in an acute setting. It judged these admissions to be “not only expensive but... often inappropriate and preventable” and went on to argue that patients and families “would benefit by having an opportunity to discuss preferences and choices of where to die and have this supported and recorded”. Reducing these numbers will require the coordinated efforts of all health and social care staff. Nurses are crucial to this. While some health professionals may deal with death and bereavement every day, an understandable separation exists between their clinical and personal perspectives. The King’s Fund found that more than two thirds of GPs have not discussed the type of care they would like when they die, with 42 per cent of them having “just never thought about it”. They argued that “enabling [health professionals] to have clear and informed discussions on death and dying will be a major step on the road to improving end of life care in England”. To empower patients to talk more freely about death and dying, nurses must ensure they have considered their own wishes with the frankness they would encourage in their patients.

As end of life care in England focuses more on openness and communication, nurses’ compassion and expertise will be invaluable. For this to be harnessed effectively, nurses must be properly supported. A more coordinated approach to end of life care will be crucial, with greater partnerships between frontline nurses, primary care trust end of life care leads and end of life care groups. These partnerships should be formed where they do not already exist, and nurses would benefit from identifying and making contact with the end of life care lead in their area. Support for wider conversation around death, dying and bereavement cannot, however, be purely institutional. Our entire society must engage in these issues.

Lucy Sutton is associate director for end of life care at NHS South Central
The NHS is going the same way as a Swiss ski slope

I have never been to Switzerland but I like to think of it as a neat and tidy country with skiing facilities and interestingly shaped chocolate. They tend not to get involved in the nonsense of wars, which I think marks them as civilised, and so I assume they are engaged in more progressive things like bobsleighing or philosophy. This caricatured perception was borne out this week with news that the Swiss are having a national referendum to decide if animals should be given the constitutional right to be represented in court.

It is, of course, a brilliantly absurd idea and we can only hope the Swiss vote “yes”. Who doesn’t want to see a group of kittens take a man to court for trying to drown them in a weighted sack? And how cool will it be when every cow in Europe mounts a collective case against all meat eaters demanding not only the banning of beef, but also fiscal remuneration for the brutal oppression of cows throughout history? And full voting rights.

Except, legislating against cruelty won’t save the cows. We’ll still kill them – but there may be some rules put in place to ensure we don’t tease them first. Because essentially that’s what modern rules are for: to temper behaviour that will not change. Or to put it another way: to halfheartedly put fingers into dams and hope that, when the water crashes through, the wet people won’t blame you.

According to last week’s Sunday Times Former health minister Lord Darzi commissioned three reports to assess the progress of the NHS as its 60th birthday approached in 2008. We shouldn’t be surprised, I suppose, that the less than kind conclusions were not made public.

At the heart of the reports was the failure of the targets system introduced over the previous 10 years to make healthcare provision better. The reports observed that: “the patient does not seem to be in the picture”. Essentially, our healthcare system cannot see the wood for all the pesky processes and reorganisations. We have quangos and managerialism; we have jargon, self important senior administrators and a culture of fear among clinicians to oppose unhelpful directives. What we don’t have is a clear and simple investment in processes and language that support patient wellbeing.

I have said it before and will say it again – to rescue the NHS, we need it to become independent of the meddling of petty minded self interested politicians.

Want to read more of Mark Radcliffe’s opinions? Just log on to nursingtimes.net and click on Forums, Blogs, Ideas, Debate.

Comments from NursingTimes.net

When Nursing Times’ US nurse blogger hit out at early warning scores, readers emphatically agreed

- You are 100 per cent correct. The additional tick boxing makes matters worse. Patients become failure to rescue statistics when staffing is poor. Additional paperwork will never solve this problem.
  Anonymous (7 March)

- Nurses should be trained to be critical thinkers and problem solvers, not number crunching computers. They should not need a chart to tell them that a patient is deteriorating.
  Jennie Lynch (7 March)

- You might want to know that some of us practise the common sense you are discussing. We tick the boxes afterwards.
  Anonymous (7 March)

- Unfortunately the old times are gone, and even the good clinical nurse with expertise in patient assessment needs a tool like this to motivate others to act.
  Iain Wheatley (7 March)

- I have been asking the same question since 1981 – why do staff incapable of interpreting results still take and record patients’ vital signs?
  April Davies (7 March)
Sexual and reproductive health nurses play a vital role in preventative strategies and also lead the way in many aspects of treatment

An opportunity to make a real impact on public health

Sexual and reproductive health nursing was once something of a ‘Cinderella’ specialty, practised in ‘special clinics’ and spoken of in hushed tones. However, increased openness about sexual health issues means this has changed, and nurses working in this field can have a varied and interesting career that makes a major contribution to public health.

Sexual and reproductive health nurses play a vital role in assessing and treating sexually transmitted infections, and in supporting women with unplanned pregnancy – whether or not they have a termination. However, there is far more to the role.

Of course, people who have an STI or unplanned pregnancy need help, but prevention is by far the better strategy. Sexual and reproductive health nurses play a key role in public health initiatives to achieve these goals, by offering sexual health and family planning advice and education, and supplying contraceptives. They also undertake cervical screening, assist with vasectomies and undertake contact tracing to inform people who may be at risk of having an STI.

While preventing STIs and unplanned pregnancies are the ideal, this is not always possible. When these problems do occur, patients turn to sexual health nurses for help with treatment, advice and support. This is generally provided in specialist clinics, run either by the NHS or independent providers.

One of the biggest independent providers of sexual and reproductive healthcare services in the UK is Marie Stopes International. This registered charity has a nationwide network of clinics providing reproductive healthcare, but also operates overseas in 43 countries. Surplus funds from its UK clinics are used to help support vital sexual and reproductive healthcare programmes in some of the world’s poorest regions.

Sue Smooker is manager of a Marie Stopes International clinic in Manchester. The clinic employs 20 whole time equivalent staff, including nurses and healthcare assistants, and provides a range of sexual and reproductive health services. Most clients are funded by their local PCT, although the clinic also takes private clients.

Sue spent most of her career in the NHS, working mainly in trauma and orthopaedics. She progressed up to ward manager level before leaving eight years ago to join an independent healthcare provider as a clinical services manager. Five years ago Marie Stopes was moving its central Manchester clinic to a larger facility in Fallowfields, and recruited Sue to oversee the move.

In addition to the main Manchester clinic Sue’s service has two early medical units, in Preston and Blackpool. These offer medical terminations up to nine weeks’ gestation. The Manchester clinic offers medical terminations and surgical terminations using local or general anaesthetic or conscious sedation. It also performs vasectomies, STI testing and contraceptive services such as implantation of long acting reversible contraceptives and insertion of intrauterine devices, as well as emergency contraception.

Like other Marie Stopes facilities, the clinic is very much nurse led. While it employs surgeons and anaesthetists, nurses provide most of the care along clients’ pathway through the service. They carry out initial consultations with clients, gain informed consent for treatment and provide pre and post operative care for those having surgery as well as supporting surgeons and anaesthetists during surgical procedures. Unusually, the organisation’s nurses also carry out ultrasound scans, for which they are given specific training.

A large proportion of the clinic’s clients are women with unplanned pregnancies, who are seeking a termination. This is always a difficult situation for women. “It is vital that our nurses have good interpersonal skills,” says Sue. “They see women at a very emotional time and they have to be able to pick up whether the women need counselling or if there are protection issues to address.”

Nurses do not need any clinical experience in sexual and reproductive health to work for Marie Stopes, as the organisation provides training in all the necessary competencies. As a result it recruits nurses – and healthcare assistants – from a range of settings.

“We have a closed day once a month for staff training,” explains Sue. “We take training very seriously and devoting a whole day to it every month allows us to do either the mandatory training or meet people’s individual needs.”

This focus on training means Sue can recruit nurses who she believes have the right interpersonal skills for the job rather than looking for staff with specific clinical skills. Sue says Marie Stopes is an excellent employer. “It’s the best job I ever had,” she says. “It’s a very open organisation without a rigid hierarchy. People have a voice here. “It’s very innovative but also a good change manager, so while the service is constantly evolving they take the staff with them rather than imposing change from above.”

The field of sexual and reproductive health offers fulfilling careers to nurses motivated by the opportunity to prevent ill health and ensure women are able to make reproductive choices. It is also a field where the right personal qualities take precedence over past experience when it comes to recruitment.
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**How to make a difference in people’s lives**

At Marie Stopes International (MSI) we’re dedicated to improving the sexual and reproductive health of clients around the world. It is MSI’s vision to be the biggest and best family planning organisation in the world and we recognise that our continued success depends on the talents and commitment of our team members.

We’re looking for passionate nurses who are ready for a challenge and who will embrace the opportunity to grow and develop with MSI. In return we can offer you career development (in clinical and managerial areas), a competitive salary, bonus scheme, contributory pension scheme, 25 days annual leave, reduced gym membership and a child care voucher scheme.

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Please note that we reserve the right to close this vacancy early should we have an overwhelming response.

Closing date: 29th March 2010.

Heart of Birmingham teaching Primary Care Trust (HoBtPCT) provides health services to around 300,000 people living in the centre of Birmingham and the surrounding areas. Our population is one of the most diverse in the UK. It is also one of the most impoverished. Our staff work here because they want to make a difference.

Lead Nurse Contraceptive and Sexual Health

Ref: 05/10

Department: Provider Directorate – Sexual Health St Patrick’s
37.5 hours per week; permanent
Band 8b, £44,258 to £54,714 per annum

We are looking for a resilient, energetic, patient centred Lead Nurse for our Wide Contraceptive and Sexual Health service.

We require a clinical leader for nursing staff and Allied Health Professionals with a remit to implement the Pan Birmingham sexual health strategy with a particular emphasis on the sexual health integration agenda.

The role requires a clinical expert in Contraception and Sexual Health, responsible for management, training and development of the Contraceptive and Sexual Health Nursing and Allied Health Professional teams.

The post holder will be a Registered Nurse with degree qualification or equivalent, LARC qualifications and a nurse prescriber along with significant experience of working as a senior contraceptive and sexual health nurse and with significant line management experience.

For further information please contact: Sharon Myring, Head of Sexual Health Services on 0121 255 0435.

To apply please visit www.jobs.nhs.uk and click apply now. Please note that only ONLINE applications are accepted, however in some exceptional circumstances, alternative formats can be provided upon request from the Human Resources Department on 0121 255 0500 or email HR.Recruitment@hobtpt.nhs.uk stating which post you are interested in and quoting the reference number.

Closing date: 23 March 2010.

The Trust is committed to Equal Opportunities in Employment. HoBtPCT is an improving Working Lives Practice Plus accredited employer, that values the contribution of staff to improved patient care. The Trust is committed to equality of opportunity, life long learning and work-life balance for all our employees.

The Trust offers a range of benefits to staff that includes access to a subsidised travel pass scheme, tax incentivised childcare vouchers, a bike ‘loan’ scheme & negotiated discounts for PCT staff with locally recognised companies.

Heart of Birmingham Teaching Primary Care Trust

www.hobtpt.nhs.uk

Brownlands Nursing Home,

Based in Daventry, Northants. Requires full time Deputy Manager, must be registered Nurse level I. Covering various shifts which will include night duty and weekends. Must be flexible. Duties will include: providing full medical care to all residents, you will be expected to deputise as required in Managers absence. You will be required to undertake relevant training and develop the carers role. You must be an excellent communicator, and assist in providing excellent care within a homely atmosphere. You must also have the ability to lead team, requires advanced disclosure and POVA. Please contact Carol Knight 01327 876985.
Where do you want your healthcare career to take you?

Sometimes, it’s just that feeling of a job well done. Knowing that you have made a difference in somebody’s life, that you helped them out. Knowing that all of the training and the hard slog has been worth it. That you are great at what you do.

With thousands of jobs here at home and all around the world, no matter where you want your healthcare career to take you, make HCL International your first destination.

HCL International
Global healthcare recruitment
0800 376 4899
www.hcl-international.co.uk

Does your employer give you the rewards and recognition you deserve? We do.

Event: Nursing Open Day
Date & Time: Tuesday 30 March 2010, 10am – 8pm
Venue: Newcastle, Marriott Hotel Metro Centre, Metro Centre, Gateshead NE11 9XF

To find out more please call Kamila, Recruitment Representative on 020 7632 4966 or email nursecv@aramco.uk
Please pre-register for the Open Day via our website or feel free to drop in on the day with your CV.

We are also holding Nursing Interview Workshops in London in May. Apply via our website to be considered.

Saudi Aramco is one of the Middle East’s leading employers of medical staff. We’re looking for nurses to join our world-class hospital and help us continue providing the highest standards of care.

Our nurses have a fantastic lifestyle and live within one of the four secure and modern communities of Saudi Aramco, housing thousands of employees and their dependants. Our nurses are provided with their own apartments and there is always something happening outside of work.

We believe the key to a productive workforce is having happy and healthy employees. This is why we value and reward our nursing professionals with an outstanding salary (our Staff Nurse starting salary ranges from £35,900 - £45,000 and for our Senior Nurses, starting salary ranges from £39,500 - £49,000), Cash Benefits Supplement and Settling-in Allowance.

To apply, you must have significant nursing experience and the relevant qualifications. www.jobsataramco.eu/ntp
**No more unsociable hours**

Registered General Nurses – Disability Assessment

£28,500 to £32,700 pa depending on experience and location

Excellent benefits (relocation assistance provided)

New opportunities in Birmingham, Bradford, Cambridge, Colwyn Bay, Glasgow, Leicester, London, Manchester, Newcastle, Norwich, Peterborough, Plymouth, Reading, Southend-on-Sea, Swansea and Thornaby

Due to the Government’s increased focus on individual ability for work, we are looking to attract additional high calibre RGN’s to join our team.

No more unsocial shift patterns. We offer Registered Nurses a 37 hour working week, Monday-Friday, along with a comprehensive benefits package. Part-time positions (min 22.5 hours per week applies) are also available.

If you are an NMC registered RGN with a minimum of 3 years’ post registration general medical experience, we would like to hear from you.

Meet with our practitioners and recruitment team for an informal chat at our Open Evening 5.30pm - 7.30pm, Monday 15th March, Nottingham

To apply and for further information on all our vacancies or to register your interest in our Open Evening, please visit atoshealthcare.com/careers ref: 102388. Alternatively, please contact our team on 020 7830 4660 or email crd@atoshealthcare.com

atoshealthcare.com

Atos Healthcare does not discriminate on the basis of race, religion, colour, sex, age, disability or sexual orientation.

All recruitment decisions are made on the basis of qualifications, skills, knowledge and experience and relevant business requirements.

Successful candidates will undergo a Criminal Record Bureau check.

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**Cygnet Hospital Stevenage, Hertfordshire - SG1 4YS**

Cygnet Hospital Stevenage, a purpose built 90 bed medium and low secure hospital is looking for RMN Team Leaders and Staff Nurses to join its expanding teams:

**RMN Team Leaders**

Salary £37,057-£42,832pa

(dep. upon experience, fully inclusive of leads & enhancements)

**RMN Staff Nurses**

Salary £29,064-£35,631pa

(dep. upon experience, fully inclusive of leads & enhancements)

Successful applicants will work as members of a full multi-disciplinary team and will possess superb clinical, team and communication skills together with vision and enthusiasm to develop the hospital’s services.

Previous forensic experience is preferable for both roles and applicants for the team leader role should have at least 16 months’ experience as a senior staff nurse preferably working in a forensic/secure setting.

Cygnet offers an extensive benefits package that includes ongoing career development opportunities, study leave and budget, contributory pension scheme, free life assurance, share incentive plan, childcare vouchers and paid birthday and anniversary leave.

For further information, please call

Angela Morrison on 01438 342942, e-mail angelamorrison@cygnethealth.co.uk or apply online via our website.

Closing date: 2 April 2010.

www.cygnethealth.co.uk

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**The Queen Alexandra Hospital Home, Boundary Road, Worthing, West Sussex, BN11 4LJ**

Registered charity: charity number 1072334.

With proud military connections spanning the last 90 years The Queen Alexandra Hospital Home provides supportive therapeutic care and rehabilitation to disabled ex servicemen and women, aged between 23 and 99. Situated in Worthing, West Sussex, just a few minutes from the sea front we offer a great working environment, competitive salary and benefits including 27 days basic annual holiday, generous overtime enhancements, subsidised meals, a contributory pension scheme and death in service benefit. We will also fund accredited studies and, for the right candidates, support your relocation.

To apply please download an application form at www.qahh.org.uk and send it with a covering letter explaining how you suit this role to: Tara Lennon-Jones, Human Resources Manager - hr@qahh.org.uk; 01903 213458.

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**Life is good in Worthing**

At The Queen Alexandra Hospital Home we believe that there are some things worth striving for. Important things like taking care of each other, recognising individualism, and letting people spread their wings.

We are looking for a Ward Sister and a Registered Nurse (band 5) who share our philosophy on life - nurses who recognise that everyone is unique and that when it comes to disability, it’s what you can do, not can’t do that counts.

With proud military connections spanning the last 90 years The Queen Alexandra Hospital Home provides supportive therapeutic care and rehabilitation to disabled ex servicemen and women, aged between 23 and 99. Situated in Worthing, West Sussex, just a few minutes from the sea front we offer a great working environment, competitive salary and benefits including 27 days basic annual holiday, generous overtime enhancements, subsidised meals, a contributory pension scheme and death in service benefit. We will also fund accredited studies and, for the right candidates, support your relocation.

To apply please download an application form at www.qahh.org.uk and send it with a covering letter explaining how you suit this role to: Tara Lennon-Jones, Human Resources Manager - hr@qahh.org.uk; 01903 213458.

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Nursing Times 16 March 2010 Vol 106 No 10 www.nursingtimes.net
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**FULL/PART-TIME PRACTICE NURSE**

Required for Gravesend Surgery. Experience in Health Promotion, Family Planning & Cervical Cytology preferred.

Hours negotiable

Join our team in a mixed area, two-centre practice covering 15,000 people in Gravesend and Northfleet.

To apply, please send CV to yvonne Barker 2@nhs.net

For informal Enquiries Phone 01474 325413 (am only)

Closing date 24th March 2010

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**Nursing Times**

**the UK’s most popular independent nursing publication**

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**PRACTICE NURSE REQUIRED FOR BUSY PRACTICE**

Calling both Full Time/Part Time Applicants

Salary Negotiable. Must be available to start ASAP

Please send CV for the attention of the:

Practice Manager, LINWOOD MEDICAL CENTRE

2a-6 Lynwood Drive, Romford, RM5 3QL

Closing date: 4th April 2010

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**Part time Practice Nurse** required for large busy practice in Ealing. Knowledge of cervical cytology, travel and childhood immunisations essential. We are an EMIS practice. Salary dependent upon experience. Please send CV either via email: aggic.rawlings@gp-E85026.nhs.uk or via post to Fionnuala O’Donnell, 78 Martock Lane Ealing W13 9NZ.

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**West London Mental Health NHS Trust** provides a full range of local mental health services to the London boroughs of Ealing, Hammersmith and Fulham, and Hounslow as well as specialist forensic mental health services, including high secure services to a much wider catchment area.

**The Cassel – Specialist Service for families and people who have personality disorder**

Employment based Part-Time Fixed Term Postgraduate Course in Psychodynamic Psychosocial Nursing (Validated by University of East London)

Band 6 £28,555 - £37,692 p.a.

37.5 hours per week

Do you enjoy a challenge and like to work actively as a nurse with service users as well as study? Are you a qualified nurse with RMN or equivalent professional qualification with UKCC reg, with at least 2-3 years post qualification experience?

If so, why not apply for either:

(a) A Band 6 post at The Cassel and study at postgraduate level in Psychodynamic Psychosocial Nursing. The role is 37.5 hours per week including attendance on the course and shift work. This is a two year fixed term contract/secondment.

OR

(b) Remain in your nursing post and come to The Cassel one day a week to study at postgraduate level in psychodynamic psychosocial nursing, commencing October 2010. If you do not have a degree - you will be required to write an essay (300 words) that will be used to confirm that you are able to work academically at post graduate level.

Being a Psychodynamic Psychosocial Nurse requires a creative approach to working with people with mental distress. Give an example of a problematic situation from your nursing practice and describe how you resolved this. What did you learn from this situation?

The Cassel Hospital is a national specialist NHS psychotherapeutic outreach, day and residential therapeutic community service for adolescents with emerging personality disorders, adults with severe personality disorders, and multi-problem complex families. As part of its work, the Cassel offers a part-time Postgraduate course in Psychodynamic Psychosocial Nursing, validated by the University of East London.

To find out more, or to arrange an informal visit, please contact Rebecca Neeld, Lead Nurse on e-mail: rebecca.neeld@wlmt.nhs.uk tel 020 8483 2900 or 020 8483 2947.

For further details and an application form, please contact: Adriana Zacharova, Training and Consultancy Administrator at the Cassel Hospital, 1 Ham Common, Richmond, Surrey TW10 7JF. Tel: 020 8483 2947 or e-mail: adriana.zacharova@wlmt.nhs.uk

Please apply online at www.wlmtjobs.nhs.uk or alternatively to request a job pack for this position telephone our recruitment line 020 8354 8122, or email HR-Admin@wlmt.nhs.uk quoting your name, address and job ref: 222-WL8107.

Closing date: 2nd April 2010.

If you have not heard from the Recruitment Team within 14 days of the closing date please assume that you have not been short-listed. However if you require feedback on your application please write to the Chair of the short-listing panel c/o of the Recruitment Team including the reference number of the vacancy.

The Trust will apply for an enhanced CRB disclosure for the successful candidate prior to appointment. For more information visit www.crb.gov.uk

The Trust welcomes applications from all sections of the community who fulfil the criteria for the post. We are keen to ensure that our workforce reflects the community it serves, particularly in terms of ethnicity, gender, disability and experience of mental illness.

The Trust is committed to equal opportunities and where practicable facilitating flexible working arrangements. The Trust operates a No Smoking policy for all staff.

West London Mental Health

Many viewpoints. One vision.
Senior Registered Nurse (SR RN)

£30,000 (pro rata, inclusive of enhancements)
1 x WTE Flintshire & Wrexham Internal Rotation
1 x WTE Conwy & Denbighshire Internal Rotation
35 hours per week

Marie Curie Cancer Care provides free specialist support and care for cancer patients and their families. We aim to give patients the best possible quality of life, meeting all their medical, spiritual and social needs, while also providing their families with all the emotional support they need.

An exciting opportunity has arisen for 2 experienced Registered Nurses looking to develop their clinical, leadership and management skills. The SR RN role will incorporate aspects of direct and indirect clinical care as well as leading a team of RN’s & SHCA's across our services, which incorporate Planned, Reactive and Palliative Care Rapid Response Services.

Working alongside all members of the multi-professional team both in and out of hours, including the NHS and other voluntary and statutory agencies, you will be responsible for ensuring high quality care is delivered for patients and families at end of life enabling them to spend their last weeks of life at home. As part of the local management team you will also be expected support the Nursing Service Manager to maintain the day to day running of the service, lead and participate in relevant meetings and follow current developments in medical and nursing practices in order to maintain and improve professional knowledge and competencies for both yourself and the team.

You will come with recent experience of palliative care, oncology and/or community nursing and hold a valid NMC Level 1 Registration. Relevant degree, management/leadership experience will be beneficial but not essential. In return, you will have the opportunity to access a generous portfolio of training and education, bursary scheme, management support, clinical supervision and an occupational pension scheme (NHS pension is transferable). Job share/secondment will be considered for this role.

For an informal discussion please contact Emma Groves, Nursing Service Manager on 07798 655133.

For an application pack please visit our website www.mariecurie.org.uk, email recruitpontypool@mariecurie.org.uk or call the recruitment line on 01495 740806 quoting reference WA291.

Closing date: 26th March 2010.

This post is subject to an Enhanced Disclosure from the Criminal Records Bureau. Marie Curie Cancer Care is committed to equal opportunities in employment.

www.mariecurie.org.uk/jobs

Lecturers/Tutors (6 posts)

Florence Nightingale School of Nursing and Midwifery
King’s College London

Having enjoyed considerable and sustained success in research and teaching innovation over many years, the Florence Nightingale School of Nursing and Midwifery at King’s College London is building on this momentum by expanding its capacity for research-based teaching with the appointment of six new Lecturers or Tutors.

We envisage appointment of suitably qualified nurses in the following specialties:
- Mental Health Nursing
- Primary and Intermediate Care
- Adult Nursing
- Specialist Care.

King’s College London has an outstanding global reputation for teaching and research excellence and is a member of the distinguished Russell Group of 20 major research-intensive universities. One of the top 25 universities in the world (Times Higher 2009), King’s is also home to the largest centre for the education of healthcare professionals in Europe and five Medical Research Council Centres, more than any other university.

In addition to working in a vibrant and exciting learning environment in the heart of London, you will benefit from King’s College London’s position at the forefront of academic health science with the launch of King’s Health Partners Academic Health Sciences Centre (AHSC) last year.

You should be a registered nurse with appropriate clinical experience. Applicants for a Lectureship must hold a doctoral degree or be close to submitting their thesis and ideally be research active. We will also consider appointing experienced nurses who hold a Bachelor’s or Master’s degree in Nursing or a related subject as a Tutor.

These posts are permanent appointments offered on a full or part-time basis.

The appointments will be made, dependent on relevant qualifications and experience within the Grade 6 or Grade 7 scale, currently £33,070 to £47,478 pa inclusive of London Allowance.

For an informal discussion of these posts, please email Professor Ian Norman (Associate Dean, Staff Development) at ian.j.norman@kcl.ac.uk

Further information is available on the College’s website at www.kcl.ac.uk/jobs or by emailing Human Resources at cress-recruitment@kcl.ac.uk. All correspondence should clearly state the job title and reference number AS-03N/047/10 – HK.

Closing date: 8 April 2010.

Interviews are scheduled for 10, 11 and 14 May 2010.

Please note that we would also welcome expressions of interest for forthcoming Lecturer-Practitioner appointments jointly between KCL and local NHS Trusts in the following specialties:
- Liver Specialist Nursing
- COPD Nursing.

Equality of opportunity is College policy.

MAIDA VALE W9. Full/Part Time Practice Nurse(s) required (salary according to experience). Good communication & organisational skills essential together with enthusiasm. Professional and personal development encouraged. Apply in writing with CV and covering letter to Dr S Honey, Woodfield Road Surgery, The Medical Centre, 7E Woodfield Road. London W9 3XZ or e-mail: susan.honey@nhs.net. For further information tel: (020) 7266-1449

Please mention Nursing Times when replying to these advertisements
Clinic Haematology (CPG6)
Clinical Nurse Specialist
(Haemoglobinopathies)
Band 7 £35,747 – £45,345 inc.

An exciting nursing opportunity has arisen to join the adult Haemoglobinopathies multi-disciplinary team at Imperial College Healthcare NHS Trust.
As a Clinical Nurse Specialist working in this area you will be involved with the management of patients with Sickle Cell and Thalassaemia at all stages in their pathway. The role will be working autonomously in an inpatient and outpatient setting, providing expert advice and clinical assessment.

It’s in our blood.

You will also be educating and have the opportunity to contribute to research in this area.
The successful applicant will have the post registration qualification in the related subject and be able to demonstrate their ability to work in a team, as well as independently.

Is it in your blood?
For more information or an informal visit please contact Jennifer Duff-Cole, General Manager – Clinical Haematology on 020 3133 8118 or email jennifer.duff-cole@imperial.nhs.uk

You can apply online at www.jobs.nhs.uk using reference number 290-CIS-H-14. To learn more about the trust, you can visit www.imperial.nhs.uk

Closing date for applications is Tuesday 30th March.
UCL Division of Infection and Immunity

Research Nurse

The appointment will be full time on UCL Grade 7. £31,778 - £38,441 per annum (inclusive of London Allowance). Professor Breuer and Professor Akbar head virology and immunology research teams primarily interested in Varicella-Zoster Virus (VZV), the cause of chickenpox and shingles. The post holder will be working on research projects which aim to establish how immunity to VZV infection differs by age. Ultimately the aim will be to gather data which will be used to improve vaccines against both chickenpox and shingles. The post holder will work with Professor Breuer and Akbar's research groups, in the Division of Infection and Immunity, University College London as well as with colleagues in Infection control at UCLH and Dermatology at the Royal Free Hospital. He/she will have the opportunity to travel to the USA (Arizona and New York) to help train collaborating nurses and dermatologists who are setting up similar research projects.

Applicants should be RGN qualified, be trained in the principles of Good Clinical Practice (GCP) and have experience of clinical research nursing (Grade E or above). Applicants should also demonstrate good communication skills in both written and spoken English, the ability to work unsupervised and good team working skills. The post is initially funded for 2 years.

For further details about the vacancy and how to apply online please go to http://www.ucl.ac.uk/hr/jobs/ and search on Reference Number 1130954.

If you have any queries regarding the vacancy or the application process, please contact Isabel Lubeiro, email: i.lubeiro@ucl.ac.uk.

We particularly welcome applications from black and minority ethnic candidates as they are under-represented within UCL at this level. This is in line with section 38 of the Race Relations Act 1976.

Closing date: 1st April 2010.

Latest time for the submission of applications is 5.00 pm.

How to make a difference in people’s lives

At Marie Stopes International (MSI) we’re dedicated to improving the sexual and reproductive health of clients around the world. It is MSI’s vision to be the biggest and best family planning organisation in the world and we recognise that our continued success depends on the talents and commitment of our team members.

We’re looking for passionate nurses who are ready for a challenge and who will embrace the opportunity to grow and develop with MSI. In return we can offer you career development (in clinical and managerial areas), a competitive salary, bonus scheme, contributory pension scheme, 25 days annual leave, reduced gym membership, and a child care voucher scheme.

So if you’re ready for an exciting new opportunity we want to hear from you. We currently have vacancies across the UK for Registered Nurses – £23,094 p.a. and if you would like to do sessional work this is £14,92 per hour. Clinical Leads – £30-33k dependant upon skills, experience and location, Clinical Supervisor – £34,281 p.a. In addition positions in London attract a nurse supplement equal to 10% of base salary.

If you want to use your experience to really make a difference, do something about it. For further information on all of our vacancies, visit our website at www.mariestopes.org.uk and apply online.

Contact: Lieutenant Alison Embleton
RN Nursing, Medical and Dental Recruiter
T: 02392 727 745
E: FLEET-CNROPSNMDSO3@mod.uk
or visit royalnavy.mod.uk/careers

* Taxable bonus

Looking for a change in direction?

Healthcare Career Evening for Nurses and Allied Health professionals
London – Friday 5th March

Are you looking for Temporary or Permanent work in Australia, New Zealand, USA, Canada, Middle East, Singapore or Hong Kong?

Medacs Healthcare specialise in finding jobs for healthcare professionals. We have permanent, contract and temporary opportunities – whatever suits your needs.

For more information:
Call: +44 (0)207 611 1691
E-mail: jobs@medacs.com

www.medacs.com
**SCHOOL NURSE**

Godolphin and Latymer is an independent girls’ day school of 700 pupils aged between 11 and 18 with 200 in the Sixth Form. Based in Hammersmith, the school was founded in 1905, and is a lively and warm community where girls are made welcome from the time of their arrival.

The school has an excellent medical department which consists of two part-time registered School Nurses and a School Doctor who is on site weekly.

A vacancy currently exists for an experienced Registered School Nurse to join the medical department from September 2010. The position is part-time (one day per week) during term time. Key responsibilities of the post include, dealing with accidents and illnesses of girls and staff, arranging medicals with the School Doctor for girls and staff, arranging booster vaccinations and liaising with the teaching staff and parents about individual or general health issues.

The successful candidate should have experience of working with children and / or have a background in primary care.

Salary will depend upon qualifications and experience.

A job description and application pack for this post is available from the Personnel Manager. Please telephone 020 8735 9555 or email recruitment@godolphinandalatymer.com or download from www.nursingtimes.net

Closing date for application is: 19 March 2010

The Godolphin and Latymer School is committed to safeguarding and promoting the welfare of children and applicants must be willing to undergo child protection screening appropriate to the post, including checks with past employers and the Criminal Records Bureau.

THE GODOLPHIN AND LATYMER SCHOOL

Iffley Road, Hammersmith, London W6 0PG

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**HABERDASHERS’ ASKE’S SCHOOL FOR GIRLS**

Aldenham Road, Elstree, Herts WD6 3BT (020 8266 2300)

**Assistant School Nurse**

Required for May 2010, a full-time Assistant Nurse with some general office duties, at this large and thriving independent girls’ school.

Minimum qualification RGN. The Assistant School Nurse will support the School Nurse to provide first aid care, treatment and advice for pupils, staff and visitors at the School.

This post has a starting salary from £20,700 pro rata, from 8.30 am to 5.30 pm term time only, plus some additional weeks to be agreed. All staff are entitled to a free lunch and membership of the school’s contributory stakeholder pension scheme.

Applications should be sent to the Bursar by Friday 26th March. Interviews are expected to take place during April.

Further details and application forms are available from Caroline Pluck on 020 8266 2346 or via our website www.habsgirls.org.uk.

Haberdashers’ Aske’s School for Girls is committed to safeguarding and promoting the welfare of children and young people. The successful candidate will be subject to an enhanced CRB record check.

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**RECRUITED NURSES**

**WE’RE RECRUITING**

**300 REGISTERED NURSES**

**IN MARCH**

**8 Recruitment Days**

will be held nationally from 17th - 25th March

(London, Glasgow, Manchester and Oxford)

For further enquiries: Call 0845 450 7707 or email nursingrecruitment@nhsprofessionals.nhs.uk or visit www.nhsprofessionals.nhs.uk

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**Helping people with alcohol problems.**

**Take your career one step further.**

**Nurse**

£24,831 - £33,436 | Lewes Prison, East Sussex

Action for Change has secured a three-year contract to provide a significantly larger and more responsive alcohol service across East Sussex. As part of this innovative new service, a dedicated alcohol team will be based in the Healthcare Team, Lewes.

It’s a fast paced and challenging environment where no two days are the same so you’ll have to think on your feet and have a real understanding of the needs of this client group. Working with the Lead Nurse, you’ll carry out assessments, run clinics, liaise with other health care professionals and prepare prisoners for discharge and on-going treatment.

We’re not necessarily looking for an experienced Substance Misuse Nurse – what is more important is to find someone who has the right balance of empathy, clinical competence and a drive to make a real impact in this unique setting.

We offer first class training and development and will support you every step of the way in an organisation that’s dedicated to improving health and delivering high quality treatment.

For a job pack, please email reception.hh@action-for-change.org or visit www.action-for-change.org for more information.

Closing date: Monday, 29th March 2010.

All posts are required to have the Prison Service Enhanced Security Clearance and an Enhanced CRB check. Action for Change seeks to be an Equal Opportunities Employer, and welcomes applications from all sections of the community. Registered Charity No. 1043142. Company Registration No. 2920770.

www.action-for-change.org

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**Boost your job search with job alerts**

Visit www.nursingtimesjobs.com/alerts
Registered Nurse
St Mary’s Convent runs a small 17 bed infirmary run by the Nursing and Care Manager and a dedicated team of Registered Nurses and Care Assistants
An opportunity has arisen at the Convent for a full time Registered Nurse

The ideal candidate will have
• experience of working with the elderly
• experience working in Mental Health
Working hours would be 37 ½ hrs over 7 days
Hourly rate £12.51 an hour
Immediate start
A CRB disclosure is required for this post
Closing date for applications is Friday 31 March 2010
CVs + applications in writing please to:
HR Manager, The Community of St Mary the Virgin, Wantage, OX12 9SU
e-mail: hrmanager@csmv.co.uk

Newbridge House, 147 Chester Rd, Streetly, Sutton Coldfield B74 4NE;
Please apply in writing, enclosing a CV to Sarah Johnson, HR Administrator,
For an informal discussion please call Dr Richard Newland 07956 196535.
The salary will be above average with the potential to earn a significant bonus dependent on performance.
Closing date 2nd April 2010

We require a
LEAD CLINICAL NURSE – COMMUNITY OUT-REACH SERVICES
Compton Hospice Band 8a
Wanted: an effective leader/manager with expert palliative nursing knowledge and skills practicing at Masters level.
To lead and manage our highly committed, motivated team you will need to be: organised, compassionate, patient focused, solutions orientated, a visionary, resilient with self belief and a sense of humour. Innovation and change management will excite you! You will maintain a small caseload, undertake patient admissions and contribute to the Nursing and Medical On-Call rotas.
You will be RGN, with a Registered Community Nursing qualification and non-medical prescriber.
Informal visits welcome
For application pack and any further information telephone 01902 774509 (voicemail when unattended) Quoting job ref. LCN/COS
Closing date: 16.04.10

We wish to recruit staff nurses to work on day duty.
• Small ratio of nurse to patient allocation.
• An in-house education programme delivered by our Clinical Tutor. The hospital also helps to train nursing students from Anglia Ruskin University and is therefore dedicated in the training and education of the nursing workforce.
• Opportunities to attend training programmes delivered by outside providers
• A competency based three month orientation programme
• Support from mentors
• Contributory pension scheme
• Private Healthcare
We will be looking for nurses who are:
• Working with young people and/or eating disorders is an advantage but what is essential is that you are an organised, self motivated, outgoing and friendly team player with the skills, empathy, judgement and enthusiasm to make a real impact on people’s lives and that you have good leadership qualities.
The ideal candidate must have:
• Good written and verbal communication
• Basic Computer skills
• Experience of working with people with learning disabilities
• Experience of working in a Community/out-reach setting

PLEASE MENTION NURSING TIMES WHEN REPLYING TO ADVERTISEMENTS YOU HAVE SEEN ON THESE PAGES
Faculty of Health & Human Sciences
We are seeking two enthusiastic and motivated Child Health Lecturers, to join our dedicated team.

Based in Brentford
Lecturer/Senior Lecturer in Child Health Nursing
(1.0 FTE)
£33,846 - £46,873 pa incl
Ref: FHHS273
Your main role would be to lead the Paediatric Intensive Care course and to support teaching on other programmes including the Pre-registration Child branch programme. You would need to have substantial experience at a senior level in Paediatric Intensive Care Nursing and a qualification in Paediatric Intensive Care would be desirable.

Based in Berkshire
Lecturer/Senior Lecturer in Child Health Nursing
(0.5 FTE)
£15,298 - £21,811 pa
Ref: FHHS274
You would need to have excellent experience in general paediatrics and teaching experience. Your main role will be to support teaching and learning on programmes offered by the Child Health team.

For both posts, you will contribute to enriching the learning experience of students on our various programmes of study. You will facilitate learning at all academic levels and also support student learning in practice. You will work within the Child Health team in ensuring quality and innovation in teaching and learning and take responsibility for your own academic and professional development. You will lead / support colleagues in the delivery of modules and actively seek to incorporate student evaluation as part of their continuing improvement.

Part time posts will be considered.

For an informal discussion about these posts, please contact Debby Price, Field Leader, Public Health, Primary Care and Child Health, on 020 8209 4173 or send an e-mail to: debby.price@tvu.ac.uk

Closing date for receipt of applications: Tuesday 23 March 2010.

In return, TVU offers you the benefits of a final salary pension scheme, excellent financially supported development opportunities and generous holiday entitlement.

For further details and an application form, please contact www.tvu.ac.uk/vacancies or the Human Resources Department on 020 8231 2456 (24 hour voicemail) or e-mail hr@tvu.ac.uk quoting the relevant reference number FHHS273 or FHHS274.

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changing practice
Using supported learning to give nurses access to care skills
Nurses often lack confidence and skills to care for patients who are acutely ill. A trust set up a learning programme to enable applicants to develop their skills while on a fixed term contract.

guided learning
Joined up mental healthcare for people with dual diagnosis
The incidence of substance misuse is high among people with mental health problems. This one part unit examines why, and discusses assessment methods and the importance of providing integrated treatment.

practice review
Providing practical support to older people with stomas
Older people who have had a stoma for many years may encounter problems caused by ageing. This article outlines some of these problems and nursing strategies that can help people to cope.

What really are our rights?

Columnist Mark Radcliffe reflects on our obsession with “rights”. Where has the “right” to know what Jon Venables has done, or the “right” to opt out of computerised patient records, come from? Surely these are made up rights and are not the same as the “right” to treatment.

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