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“The impact of cuts on care cannot be ignored”

The warning signs are mounting that cuts to NHS services are starting to have a noticeable impact on patients and the nurses who are attempting to care for them. The warnings are also mounting that we must learn the lessons of the past if we are to avoid catastrophic care failings.

An investigation this week by Nursing Times reveals the plans made by the most financially challenged trusts in England to make the massive savings required of them. It does not make for cheerful reading – hundreds of posts are earmarked to go and skill-mix reviews are in the offing (page 2).

Nigel Edwards, interim chief executive of the NHS Confederation – yes, a management voice – warns those planning the cuts should be mindful of what happened at Mid Staffs after the narrow-sighted pursuit of financial targets over care standards.

Separate figures collected by Nursing Times also reveal that the number of nurse job vacancies advertised on the NHS Jobs website has plummeted to below 1,000 (page 3).

Taken all together, this evidence should start alarms bells well and truly ringing, especially when added to last month’s King’s Fund warning that NHS waiting times are at their highest level for three years and news that a Conservative peer, Baroness Staples, had to wait for nearly five hours on a trolley at St Thomas’.

This week the bell should also ring a bit louder as Unison is due to reveal results from a survey of 2,500 nurses – 80% of whom say managers are making cuts.

So far, however, the government seems determined to turn a deaf ear to the cuts – while apparently prepared to listen with the other to concerns about its reform agenda. But ministers must be made to hear the carol of carers’ complaints. As last month’s RCN Congress showed, the profession has a very loud voice when it wants to.

We know reducing nursing staff numbers and diluting its skill mix has a negative impact on morbidity and mortality. The consequences if the cuts continue do not bear thinking about.

Steve Ford, deputy news editor
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Huge cuts ahead for frontline staff

Crispin Dowler
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Nurses at struggling hospitals are set to face major pressures this year, as managers plan to slash staff numbers and review skill mix, an investigation by Nursing Times has revealed.

Rising financial pressures have sparked warnings that trusts must not harm care standards, as occurred at Mid Staffordshire Foundation Trust. Nursing Times has analysed draft plans from 13 trusts out of 19 in England identified by our sister title Health Service Journal as planning the biggest cuts this year.

These trusts have said they need to cut costs by 8% or more in 2011-12. Those that have published plans aim to make savings through a combination of post cuts, productivity drives, reductions in length of stay, changes to skill mix, and ward and bed closures.

"The pursuit of financial targets was heavily implicated at Mid Staffs. I hope that's very much in the minds of the people developing these cost improvements" Nigel Edwards

reinforce union claims that frontline staff and services will not be protected in the NHS savings drive, despite government insistence that the health budget has been ringfenced.

Examples from the plans include proposals to:
- Cut Agenda for Change clinical staff by 192 whole-time equivalent posts – or 13% – at Princess Alexandra Hospital Trust in Essex this year, and by a total of 251 by March 2014. The trust also wants to close 42 emergency beds and one elective ward this year;
- Cut 142 posts this year at Whipps Cross University Hospital Trust in London, only 25 of which will be back-office or clinical support jobs. It plans to save £1m through a nursing skill-mix review;
- Cut 50 beds, and reduce one surgical ward from seven to five days at West Middlesex Hospital Trust;
- Slash spending on pay at Imperial College Healthcare Trust by £44m, or 8%, and cut 150 posts this year.

Many trusts whose plans were analysed by Nursing Times cited pressure from primary care trusts to reduce activity and the drive for foundation trust status among the reasons for major cost cutting.

The government wants all trusts to achieve foundation status by 2014. Acute trusts without foundation status constituted more than two thirds of the 19 trusts that were planning savings of 8%
or more, and five of the seven aiming to save 10% or more. NHS Confederation acting chief executive Nigel Edwards warned trusts not to repeat the failures at Mid Staffordshire, where care failures emerged in the midst of a drive for foundation trust status.

“It was the pursuit of financial targets that seems to have been heavily implicated in the problems at Mid Staffs,” he told Nursing Times. “I’m hoping that’s very much in the minds of the people developing these kinds of cost improvements.”

Royal College of Nursing head of policy Howard Catton said Nursing Times’ findings backed the union’s own.

Its Frontline First report said 9,650 posts – 54% of them nurses – were due to be axed in 21 trusts (news, page 3, 12 April).

Mr Catton said: “For an awful lot of nurses [this] simply means having to look after more patients, and more patients who have a higher level of dependency, because they’re in hospital for less time.”

He added: “Nursing staff will feel that the quality component of the care people are trying to deliver is squeezed out completely.”

However, the full scale of the cuts is yet to emerge. It is also not clear all trust boards will accept the radical savings programmes being proposed – Princess Alexandra’s board has so far refused to approve the trust’s 10% savings plan.

A spokeswoman for Whippys Cross said: “Our planning assumption is that any reduction in posts will be achieved through natural turnover and reducing use of agency staff.”

An Imperial College spokeswoman said: “We intend to achieve these savings by first reducing our substantial bank and agency numbers and by natural turnover and redeployment of staff into areas of growth.

Nurses’ “Dunkirk” spirit exploited

Sarah Calkin
sarah.calkin@emap.com

Nurses keep working under poor conditions, such as those at Mid Staffordshire, because of a “Dunkirk” spirit which means they are taken advantage of, an expert on healthcare regulation has warned.

Sir Ian Kennedy, former chair of the Healthcare Commission, was giving evidence last week to the Mid Staffordshire public inquiry.

Asked why he thought clinical and medical staff had not refused to continue working under the conditions at Mid Staffs, Sir Ian said there was “something of a Dunkirk spirit” within the NHS of delivering despite difficult circumstances. He said this was especially true among nurses.

He said this was “taken advantage of by others who know that nurses in particular, and some doctors, become guerrilla fighters against a system which doesn’t provide what they need.”

Sir Ian blamed bullying when asked why he thought more staff at Mid Staffs had not made use of the trust’s whistleblowing policy.

He suggested this was a wider problem in the NHS that needed to be addressed to improve care. He told the inquiry: “[Bullying] is, in my view, particularly among nurses, one of the problems that needs to be rooted out.”

Meanwhile, a senior nurse criticised the Care Quality Commission – which replaced the Healthcare Commission in 2009 – for moving away from being an assessor for the advantages of, an expert

Healthcare Commission’s West Midlands team. She was transferred to the CQC as a member of the hygiene team but was made redundant in November 2010 when that team was scrapped.

She told the inquiry she had applied for another CQC role but was told her “approach was too investigative”.

Giving evidence last Wednesday she said: “There’s... no investigative team now, and there’s no national hygiene team either. They don’t want that level of investigation, I believe, at the moment.”

She admitted that, while she had had concerns around clinical governance at Mid Staffordshire, she had not been aware of the extent of the problems with standards during her time at the Healthcare Commission. She said the trust had not stood out from others in the region.

National nurse vacancies plummet to below 1,000

The number of nursing vacancies has plunged to fewer than 1,000 across the entire country, figures collated by Nursing Times have shown.

There were only 941 nurse jobs advertised on the NHS Jobs website last week – a 58% drop and the lowest number since Nursing Times started collecting figures in August 2009.

The figures reflect job cuts and freezes as the tough financial settlements for the 2011-12 financial year start to bite (see left).

Nursing Times also started gathering figures for healthcare assistant vacancies last May. Since then, they have dropped from 442 to just 243 last week – a 45% fall.

Unison head of nursing Gail Adams said: “Every nurse I speak to says their workload increases, the number of their colleagues has reduced and they’re under immense pressure and that’s affecting their health and family life.”

A survey by Nursing Times, published last week, shows two thirds of nurses believe they have suffered the side-effects of work-related stress over the past year (news, page 2, 3 May).

On Thursday, Unison will launch results from its own survey of 2,500 nurses, of whom 80% said their employers were making cuts.

Respondents also said they were treating more patients and this has had an effect on care and patient safety.

Ms Adams said: “Nurses are struggling to provide care and the care they are providing isn’t to the standard they would wish.”

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Imposed rota causes NHS Direct dispute

Sarah Calkin
sarah.calkin@emap.com

Nurses working for NHS Direct have lodged a collective grievance after being told they will have to work more weekends to improve the organisation’s performance.

About 80 mostly band 6 nurses who work part time for the triage service are affected, Nursing Times understands.

Rota changes will require part-time staff to work five weekends out of eight - the same as full-time staff. Currently the number of weekends they work is calculated on a pro rata basis.

NHS Direct chief nurse Tricia Hamilton said the rota changes were needed to cope with the higher demand at weekends.

She said: “We appreciate that this may not be a welcome change for some of our staff and we are doing everything we can to support them and answer any questions they may have.”

The service was recently fined £1.1m and issued with a warning for persistently failing to meet the key performance indicators (KPIs) in its contract. At the end of March, it was failing to meet 17 of its 30 KPIs, including time to clinical assessment for less urgent and non-urgent calls.

NHS Direct chief executive Nick Chapman told a recent board meeting that high demand at the weekends was a factor in failing to meet KPIs.

But Royal College of Nursing employment relations officer Gary Kirwan said the imposed rota changes were “damaging morale”.

He said: “Because NHS Direct are facing problems with meeting their KPIs... what they have proposed is that all part-time staff will work the same weekend arrangements as full-time staff.

“Many of these part-time staff have got core arrangements where they would find it very difficult.”

The dispute has reached stage three of the grievance process, which means that NHS Direct board members will hold a hearing to listen to nurses’ concerns and recommendations.

Mr Kirwin said: “What we want to happen is, instead of saying ‘we will do this’, they actually engage with staff.”

The Nurses perform at Albert Hall

Four nurses sang at the Royal Albert Hall on Thursday in a Dusty Springfield tribute. The group, The Nurses, are Jo Austin, Andrea Darke, Sharon Robinson and Gaynor Wood, from the Whittington Hospital in London.

Macmillan Cancer Support gets 25p for each copy of their album sold.

Like this and want a bit more? Fancy joining in a live debate? Go online and join Nursing Times’ online Journal Club www.nursingtimes.net/journal-club where you can listen in, comment yourself and even email your own journal club entries.

Fracture warning on levothyroxine dose

www.bmj.com/content/342/bmj.d2238.full

Older people with hypothyroidism should have their medication monitored to avoid increasing their fracture risk, according to a Canadian study of 213,500 patients.

Those taking levothyroxine could require lower doses of the treatment as they age, the authors said. Patients taking too much of the synthetic hormone could develop hyperthyroidism and, as a result, raise their fracture risk.

Tablet as effective as inhaler for asthma


A little-used asthma treatment could be as effective and easier to use than conventional inhalers, UK researchers have said. A University of East Anglia study involved 650 patients with chronic asthma over a two-year period. It found tablets containing leukotriene receptor antagonists were as successful at managing the disease as steroid inhalers.

Scenery lowers anxiety in psychiatric units


Pictures of natural landscapes in mental health settings can reduce service users’ anxiety and their need for medication, US researchers have found. The number of drugs dispensed for anxiety and agitation was “significantly less on days when a realistic nature image of a landscape was displayed” in an acute psychiatric unit, compared with abstract art or no art.

Appendicitis best treated with surgery

The Lancet (2011) 377: 1573-1579

Treating acute appendicitis with antibiotics is not as effective as appendectomy, according to French researchers. They assessed amoxicillin plus clavulanic acid with emergency appendectomy in 243 patients. Peritonitis was significantly more frequent in the antibiotic group than the appendectomy group.

Support needed to cope with care home violence


Training and support in dealing with violence from care home residents with dementia, and consistent recording of incidents are essential, Irish researchers have said. They said: “Fear of being blamed, job insecurity and resignation that abuse should be accepted as part of the job is unique to this care setting.”

This leads to emotional exhaustion, they warned.

Join in!

Have your say in our monthly journal club.
I was asked if I was a doctor by the head flight attendant. No, I replied. I’m not a doctor... I am a nurse... a “registered nurse”. Irritated, I ignored the flight attendant. "registered nurse". Irritated, I ignored the flight attendant.

Registered nurse and chief executive of University Hospitals Birmingham Foundation Trust Julie Moore is a member of the new NHS Future Forum, which is currently reviewing the government’s health reforms.

"Nursing Times is campaigning for all consortia boards to contain at least one nurse. Research suggests around a third of emerging consortia currently do and requiring all to do so has been touted as a likely amendment to the government’s Health and Social Care Bill (news, page 6, 3 May).

In her first interview with Nursing Times, Ms Moore said: “There should be nursing involvement when there’s a decision that you need a nurse’s involvement for.” But she said there should not be “token” nurses on consortia boards – echoing a phrase also used by health secretary Andrew Lansley and the forum’s chair leading GP Steve Field.

Ms Moore said: “One of the things I’ve hated in my life is being a token this, that and the other. You go along to endless boring meetings and actually most of the work... is nothing to do with the work you do.” She added: “My personal view is that boards need to be small, fleet of foot and can pull on the right people at the right time.”

Ms Moore also told Nursing Times that nurses had raised the concern with her that by sitting on boards they would not be able to represent the full range of the nursing profession. She said: “It’s a hugely complex thing to make sure you get the correct representation. If you put on [the board] somebody who has a health visitor background, you’re still going to have to pull on the palliative care nurses and everybody else if you are looking at the care of the dying.”

Ms Moore is leading the education and training work stream on the forum, which is conducting the listening exercise on the NHS reforms. The government is still producing its response to a consultation that proposed NHS training be funded by a levy on providers rather than by strategic health authorities. She said the main concern had been over the “pace” of changes to NHS training in a time of financial difficulties for trusts.

Show commissioning skills, says Bennett

Deputy chief nursing officer for England Viv Bennett has called on the profession to demonstrate why it must be involved in decisions on commissioning NHS services.

Ms Bennett was speaking last week at the launch of a network for nurses interested in commissioning in London.

She said: “It’s not just because you are the biggest profession; it’s because you have a whole bunch of skills that [consortia] would really struggle if they didn’t have.” The network is part of the NHS Alliance – which represents primary care professionals – and plans to bring together nurses to influence consortia and government policy, as previously revealed by nursingtimes.net in December.

Also speaking at the launch, NHS Alliance Commissioning Federation director Julie Wood said nurses had to be involved in many of the “different elements of the commissioning cycle”, by which services are contracted. She said the alliance was helping the Department of

No “token” nurse seat on boards

Simon Lewis

Commissioning consortia boards should not contain “token” nurses but must involve the profession in relevant decision-making, a senior nursing figure on the NHS Future Forum has told Nursing Times.

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Trust empowers nurses to make consultants engage with them

Charlotte Santry
charlotte.santry@emap.com

Matrons at a large hospital trust have changed ward rounds to prevent consultants from leaving bedside until they have discussed a series of questions about the patient with nurses.

The rule has been brought in by respiratory nurses at Nottingham University Hospitals Trust following complaints from the nurses about large variations in how consultants carried out ward rounds.

A questionnaire showed that only four out of 25 nurses – mostly in senior positions – believed information and questions discussed during consultants’ ward rounds were “standardised”.

Just 11 said they felt involved in consultants’ ward rounds, with five saying they did not feel involved and nine that they were only “sometimes” involved. The vast majority said registered nurses did not attend all of the ward rounds.

As a result, consultants have been issued with a checklist of questions to discuss with nurses about every patient.

The questions include whether venous thromboembolism risk assessments have been carried out, whether the patient can move from intravenous to oral antibiotics, and whether their discharge can be nurse led.

Consultants are not permitted to move on to other patients until each question has been discussed with a senior nurse.

The trust’s specialist receiving unit matron John Gray said: “Standardising consultants’ ways of working is a very big step forward.

Their ward rounds were so variable before – some took 45 minutes, others three and a half hours. This has been very empowering for nurses.

“For more junior nurses who don’t feel as confident to challenge a consultant on [use of] a cannula or on antibiotics, this has given them a way to do that.”

The scheme has also ensured that all consultants start their rounds by 9.30am on each of the three fixed days that they carry them out, enabling earlier discharges.

The scheme, which covers three wards, was developed by the trust as part of the Productive Ward programme. There are plans to roll it out to other hospital areas.

ICU nurse jailed for sick leave pay fraud

A critical care nurse who worked hundreds of shifts for a private agency while on paid sick leave from the NHS has been sentenced to nine months’ imprisonment.

John Allen, 52, of Westminster Road, North Shore, in Blackpool, defrauded the NHS of £40,734.50 between January 2007 and October 2009, while he was employed by Lancashire Teaching Hospitals Foundation Trust as a full-time nurse in the critical care unit.

The unit had to cover his absences with nurse bank staff, adding to the cost.

Mr Allen resigned in November 2009. The following month, suspicions arose that he had been working for a private nursing agency while on certificated sick leave from the trust and in receipt of full occupational sick pay.

NHS Protect investigators established that he had worked 385 shifts for the agency since joining it in 2007. His gross earnings from the private agency work – all while on paid sick leave from the NHS – were around £113,000.

The reasons given for his sickness absence were depression and back problems. In August 2006, he had fallen at the Royal Preston Hospital while on duty and sustained a back injury that qualified him to receive a temporary injury allowance.

However, Mr Allen declared no back problems to the agency, and later submitted three annual declarations of health, stating he had no previous medical issues.

Pauline Smith, North West area anti-fraud specialist for NHS Protect, said: “We will formally refer this case to the Nursing and Midwifery Council, to consider whether Mr Allen should remain a nurse.”

Guilty: fraudulent nurse receives a nine-month sentence
The Nursing and Midwifery Council is planning to cut the number of support staff it employs for its fitness to practise hearings.

*Nursing Times* understands that clerks who attend each hearing – known as council’s officers – have been asked to reapply for their jobs.

However, a spokesman for the regulator insisted the move would not affect the speed of case progression.

He said: “The NMC is committed to ensuring that all aspects of its fitness to practise hearings continue to work as effectively and efficiently as possible.

“We are carrying out a fundamental review of fitness to practise as part of a programme of strengthening and improving the processes. The council’s officer role forms part of that review and we are looking at ways of better supporting our independent panels and the decision-making process.”

He added: “This review does not impact on the progression of a case through to a hearing. We will not comment on employment matters.

The regulator opened new fitness to practise premises in London in March 2009, with greater capacity for hearings, after years of struggling to deal with a historical backlog of cases.

A report from the Council for Healthcare Regulatory Excellence, published in July last year, commended the NMC for “great progress on improving the overall efficiency of its case progression”.

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**Anne Harris**

**“Collaboration is crucial when caring for terminally ill children”**

Caring for children with life-limiting or terminal illness in their own homes is cheaper and less emotionally stressful for family members than caring for them in hospital, but has the government’s focus on community care resulted in positive change?

Over the past few years, considerable emphasis has been placed on the needs of children with complex conditions and/or life-limiting and life-threatening illness to ensure they get the care they need in the place of their choice.

As we start the financial year amid endless cuts and budget pressures while maintaining services, it is an opportune time to review the past and look ahead.

One study found that 74% of children in hospital when they and their families have said they would rather be at home. The Better at Home campaign found children with complex care needs were staying in hospital because of delays in funding and care packages being set up.

With the focus on home care, has the situation improved and, if not, why not?

Strides have been made in improving resources to support families at home.

In 2008, the government made £2.88bn available via Aiming High for Disabled Children to provide short breaks; this allowed children with complex health needs to access leisure activities (like their healthy peers) and gave breaks to parents caring for them 24 hours a day. The funding ended at the end of March but the coalition government pledged £800m for short breaks from last month. Local authorities now have a legal duty to provide these breaks – reflecting a growing understanding that their provision is not a luxury but a necessity for families coping with caring for a sick or disabled child every day. A significant difference, however, is that the funding is no longer ringfenced, which makes it vulnerable to being used for something else.

The drive to support more children at home is led not just by funding – two recent government publications have endorsed this. The NHS white paper *Achieving Equity and Excellence for Children* has a focus on allowing more children receiving palliative care to be at home with their families, while *NHS at Home: Children’s Community Nursing Services* suggests the needs of children will be met when “families have reliable, simple and easy access to the resources required to provide optimal care for their child”, resulting in “spending more time being a family”.

To make this a reality, there needs to be professional commitment to joined-up working between health and social care. Vulnerable children have a wide array of needs that, surely, are best met by a multi-disciplinary care team, each area focusing on its particular strength. The need for such a team in paediatric palliative care was highlighted in the Department of Health’s *Better Care: Better Lives*.

The Rainbow Trust has a 25-year record of working with health professionals to offer social care to children coping with life-threatening illness – offering short breaks in the home and community and providing emotional support to all family members for as long as required. Its work with children’s community nursing teams means families have access to a wide range of health and social care services that are provided in their place of choice.

Working together in a planned way not only makes professional sense but also should improve life for families; not doing so leads to unnecessary duplication of service or, worse, some families falling into a hole and missing services altogether.

It is time for collaboration if we want to make 2011 the year that all families receive the service they need and deserve.
We asked: did you work on the day of the royal wedding?

Many people enjoyed the extra bank holiday for the royal wedding. But for most of you it was just another day, particularly in England, where many trusts did not give extra pay (news, page 4, 8 March). Those of you in Scotland, Wales and Northern Ireland were luckier, getting at least 60% extra.

Next week: do you think nurses have received adequate training to discuss dying, death and bereavement?

Vote at nursingtimes.net

Pressure area care gaps seen in nursing home

I recently completed a tissue viability course and my research in nursing homes highlighted gaps in pressure ulcer care.

Nurses did not know what EPUAP meant (European Pressure Ulcer Advisory Panel), nor how to grade pressure ulcers or assess wound bed percentage. Documentation did not often correspond to wound status and action plans were not always carried out or monitored.

Karen Thorne, nursingtimes.net

Student life shouldn’t just be a hard slog

Lecturers would have you believe that you should eat, sleep and walk nursing.

I am a mature student nurse, married with four children aged between nine and 14, and I find that yes, you do have to work hard, but you also have to take time out and enjoy your family and life in general.

If you don’t do this, you will begin to resent the hard slog and blow a fuse.

It is all about balance. Get it right and the whole student experience will be a good one.

Andrea Tracey, nursingtimes.net

Are nurses less kind in today’s health service?

It may be that I’m just getting older but nursing seems to be less kind or humane these days. We can “talk the talk” but not necessarily “walk the walk”.

Susan, nursingtimes.net

Follow no confidence vote with strike action

I actually believe the listening exercise wasn’t a gimmick. It was evidence that the government is worried at the merest hint of action from our profession.

The vote of no confidence and the vote for industrial action if employers attacked the national pay deal was a shot across the bows that actually made them start back-pedalling and begin changing rhetoric faster.

Send your views to nt@emap.com or go online at nursingtimes.net
Sarah Stanley, nursingtimes.net

What are you scared of?

Don’t want to do it, say no – martyrs sometimes. If you anyway). I do get sick of the signed up to a lifetime of it guilt (I’m a parent so have out of guilt. I can live with no. I never agree to overtime be compulsory and we unpaid overtime can never refuse to do you can refuse to do unpaid overtime

Edwin Hamell, nursingtimes.net

Waiting targets help the flow of patients

When waiting-time targets were introduced by the last government they were widely derided as “distorting clinical priorities”. There was some truth in this and some trusts used creative accounting to collect data.

Against the clock: should the A&E target be brought back?

However, the four-hour target in A&E did concentrate people’s minds and help to maintain the flow of patients through the department. Edwin Hamell, nursingtimes.net

Mike, nursingtimes.net

You can refuse to do unpaid overtime

Unpaid overtime can never be compulsory and we always have the option to say no. I never agree to overtime out of guilt. I can live with guilt (I’m a parent so have signed up to a lifetime of it anyway). I do get sick of the martyrs sometimes. If you don’t want to do it, say no – what are you scared of?

Sarah Stanley, nursingtimes.net

Mark Radcliffe

“When I grow up I want to make everyone agree with me”

I remember being asked when I was about 11 what I wanted to do when I grew up. Of course I should have said: “I’m a boy I won’t ever grow up,” but I was 11 and awkward. So, instead I shrugged, mumbled something about being the first footballer who was also a spaceman and ran for the garden.

In truth, like many people who went into mental health nursing I had no idea what I wanted to do. I never really even had a clue about what I was doing. In fact I still don’t know what I want to do when I grow up – although I concede, reluctantly, that dodgy knees and middle age have drastically reduced, if not wholly eliminated, my chances of being a footballer. But not a spaceman.

I do enjoy other people’s expertise. I listened to a lecture on ancient Greece recently and was struck not only by the lecturer’s depth of knowledge but also by his overwhelming love of the subject. I think if you are going to be expert in something, you have to love it don’t you?

And have deeply held convictions about it? Because, surely, when it comes down to it, if you and ask them what they think. Quite unsurprisingly this is the route Mr Lansley has chosen, offering as it does both expertise and collaboration.

The government has announced a listening exercise and there will be 50 experts agreeing with it shortly. Somewhat telling is the fact that there is only one practising nurse on the panel, and five GPs – all of whom, according to last week’s Sunday Mirror, are in agreement with Mr Lansley before they have even done any listening. I’m not sure it really matters who the other 44 people are – managers, bureaucrats, members of Mr Lansley’s family... I’m hoping Lady Gaga is in there... I’m hoping Lady Gaga is in there just to make it look less like a futile and manipulative exercise from the off but, unfortunately, I think I’m likely to be disappointed on that front.

I can’t say I am surprised but it seems a waste of time and money to pretend to engage expertise when really it is a dinner party, Why bother?

Maybe I am just being cynical but these proposals were not in any pre-election manifesto and they have been seemingly cobbled together with indecent haste and little thought. Will a listening exercise help it gather credibility? Perhaps. But for that to happen the panel will surely need more than just expertise – it will also need some political balance and then just a little bit of power.

Mark Radcliffe is senior lecturer and author of Gabriel’s Angel

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regrets of the dying should influence end of life care

You may be familiar with the online article “Top five regrets of the dying”. Written by Australian palliative care worker Bronnie Ware, it documents the most commonly expressed regrets of the dying (tinyurl.com/dying-regrets). It has a simple but powerful message, like all great writing. It has captivated some and irritated others but, either way, spread worldwide ripples of reflection and debate.

The article summarises many conversations Ms Ware has had with dying patients into five common areas of regret, namely:

» “I wish I’d had the courage to live a life true to myself, not the life others expected of me,”

» “I wish I hadn’t worked so hard,”

» “I wish I’d had the courage to express my feelings,”

» “I wish I had stayed in touch with my friends,”

» “I wish that I had let myself be happier.”

Ostensibly, the article could be viewed as a rather sad piece about death and regret. But there is a subtext that is inspiring and potentially life-changing. As Ms Ware summarises: “Life is a choice. It is your life. Choose consciously, choose wisely, and choose honestly. Choose to be happy.”

Certainly, it made me think twice. It reminded me that, contrary to popular wisdom, time is not money but a precious and finite resource. It also prompted me to remember that health is not to be taken for granted for without it we lose our freedom. But that’s just my take on it. Read the article for yourself – you’ll find an enormous amount of comment and discussion around it. Curiously, considering its source, there is not much from a nursing point of view. This has led me to reflect that perhaps more attention to the regrets of the dying could affect our approach to palliative care.

Compassion is often behind decisions to pursue a career in nursing. It’s considered to be one of nursing’s basic tenets. Despite recent publicity, my experience is that nurses do care. Not in a doe-eyed, angelic sister of mercy caricature, but by providing practical solutions to suffering, in an organised, efficient and professional way.

But compassion has an ugly sister – pity. The circumstances and dire needs of palliative patients can turn compassion into pity – not a helpful approach.

At its heart, compassion involves respect for another human being. It views every person as an equal. But pity – however well meant – is an emotion lacking respect and it deems its recipient. The loss of dignity associated with receiving it only adds to a patient’s emotional load.

Learning from the wisdom imparted by the dying alters that dynamic: the nurse-patient relationship becomes more equal. There is give and take on both sides and pity can be banished.

Growth doesn’t stop at puberty. Life can begin at 40, 50 or whenever you decide. A final emotional growth spurt happens when people are faced with their own mortality. By attending to the words that often accompany this concluding chapter in a patient’s life, nurses can learn lessons for our own lives, as well as honouring the wisdom of those we care for.

As the profession with probably the greatest impact on people’s experience of healthcare, nurses need ways of finding out how their work truly affects patients. This is one reason why qualitative methods are frequently used by nurse researchers.

However, while these can yield rich data on participants’ perceptions, feelings and perspectives, data analysis can be time-consuming.

Our article on page 20 looks at mind mapping as a method of analysis in qualitative research. The authors compared mind mapping with transcription of recorded interviews; it raised comparable themes and took far less time. While these are early findings, they suggest the time needed for such studies could be reduced.

Given the focus on patient experience as a measure of quality, mind mapping could enable more nurses to gain an insight into their patients’ needs.

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Ann Shuttleworth is practice and learning editor of Nursing Times.

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A communication aid helped initiate discussions around care at the end of life.

Think about it: a prompt to discuss end of life choices

In this article...

- Why effective communication skills are crucial in end-of-life care
- How a tool to improve communication was developed and implemented
- An evaluation of the tool and how it can help improve end-of-life care

In line with national developments and the Department of Health’s (2008) end-of-life care strategy, a number of end-of-life projects have been implemented across Blackburn with Darwen. Tools such as the Gold Standards Framework (www.goldstandardsframework.nhs.uk), the Liverpool Care Pathway for the Dying Patient (Marie Curie Palliative Care Institute, 2009) and preferred priorities for care (www.endoflifeicareforadults.nhs.uk) are accepted best practice, and their use is supported by service providers and commissioners.

Research from the King’s Fund identifies two broad challenges in end-of-life communication: difficulty predicting prognosis; and communicating with patients to plan care. Conversations at the end of life may be avoided because they are difficult, and health professionals may have concerns that they will not be able to meet patients’ preferences (Addicott, 2010).

Health professionals across Blackburn and Darwen were developing end-of-life communication skills by accessing communication training. However, it became clear that discussions around end of life to support advanced care planning were at times avoided or delayed. The main reason for this was staff had limited confidence in their communication skills and concerns about discussing perceived negative topics such as late-stage management and practical elements at the end of life.

Preferred priorities for care

PPC is a patient-held document designed to facilitate patient choice. Monitoring of the numbers of PPC documents completed locally identified they were not being routinely used. The PPC document should be patient-led, reflecting conversations around the patient’s end-of-life care agenda. However, most of those audited recorded discussions about where the patient wanted to be cared for at the end of life. This could be because the PPC was initially implemented in its original version – preferred place of care – or because of outcome measures to monitor where someone dies. This is one of the end-of-life care quality markers that measures numbers of patients who died in their preferred place (DH, 2009).

During training sessions groups of professionals were asked the question: “If you were given a two-year prognosis, what would be your priority?” Those with clinical experience of palliative care gave answers relating to symptom management and where they would want to be cared for, but those with little palliative care experience talked about goals and ambitions. This emphasises the broad range of subjects patients may prioritise, highlighting the need for discussions to be patient-led.
Project development
Following a successful bid from North West NHS Regional Innovations Fund, the “Think about it” tool was developed to prompt patient-led communication (Fig 1). The tool was developed to initiate earlier discussions about advance care planning and determine patients’ priorities for care. It was developed, implemented and evaluated by professionals from East Lancashire Hospice and NHS Blackburn with Darwen community nursing services. The project was led by the end-of-life care lead and clinical practice lead for community nursing.

After feedback from hospice professionals, community nurses, primary healthcare teams and allied health professionals, we showed the tool to East Lancashire Hospice day therapy patients, and presented at a GP patient forum meeting. Around 20% of the 145,000 people living in Blackburn with Darwen are Asian, so the tool was also shown to Asian carers. It was then translated into Urdu and a design company was recruited to improve its appearance. The final “Think about it” prompt incorporated 12 topics.

Implementation
Principles for implementation were agreed (Box 1), and the tool was piloted across Blackburn with Darwen between March and August 2010. We also provided copies of the tool to mental health and motor neuron disease services, and care homes.

The communication prompt was displayed at a palliative care conference and promoted at local events for the National Dying Matters coalition (www.dyingmatters.org). We also sent information to the Lancashire and Cumbria end-of-life network team and PPC development team to inform them of the pilot.

Evaluation
A questionnaire was sent to all health workers who used the prompt over the five-month pilot. Of the 50 questionnaires sent out, just under half (22) were returned. The evaluation included questions about the number of times the prompt had been used, and whether it increased the professionals’ awareness and confidence to support discussions with patients.

The completed evaluations showed the topics discussed by patients included family, friends and pets, medical care and support, and legal issues (see Fig 1). Feedback from hospice day therapy professionals suggested the tool triggered discussions with patients. One patient said the tool’s subtle and indirect approach meant he felt more able to consider topics that concerned him. Discussions at the GP patient forum meeting also suggested people wanted to discuss important issues and the prompt helped them to do this.

The number of completed PPC documents and advance care planning discussions increased during the pilot phase, although this cannot be attributed solely to the prompt as “quality in healthcare is a multifaceted concept” (Sutherland and Coyle 2009). We also identified ways to improve implementation, such as leaving a paper copy with patients after discussion. The tool also received positive feedback from NHS Blackburn with Darwen Patient Advice and Liaison Service Readers Group.

Conclusion
Effective communication is vital to delivering high-quality care at the end of life, but professionals need training and support to maintain confidence and develop their skills. A team approach was vital to the success of the communication prompt, and partnership working across the region has improved the overall implementation of end-of-life care initiatives, improving outcomes for patients and their families. NT

References
Marie Curie Palliative Care Institute (2009) Liverpool Care Pathway for the Dying Patient. Liverpool: MCPCI. tinyurl.com/Marie-Curie-LCP
How effective is the preferred priorities of care document?

In this article...

- An overview of the preferred priorities for care (PPC) document
- District nurses' experiences of using the PPC in practice
- Developing a PPC protocol and guidelines for successful implementation of the document

This study explored district nurses' experiences of using the PPC document. The study was carried out to assess district nurses' experiences of using the PPC document, and how it can be used to help improve end-of-life care.

Research from the past 15 years was reviewed, based on six key phrases: preferred priorities for care; end-of-life care; district nurse experiences; care of the dying at home; district nurses; and palliative care in the community. Data sources included the Anglia Ruskin University and Royal College of Nursing libraries, Medline, Cinahl, Cochrane and the British Nursing Index.

District nurses are the main implementers of the PPC, yet a lot of the research focuses on the availability of palliative care in the community rather than the experiences of district nurses. Several studies have shown that patients with a PPC are more likely to receive the end-of-life care they want in the place they want (Henry and Fenner, 2007; Storey, 2007; Jones and Pooler, 2005; Pemberton et al, 2003).

Storey (2007) highlighted the challenges district nurses face in using PPC documents. A pilot study suggested some felt “vulnerable at being faced with something in print they do automatically as part of their routine care”. The study also suggested some district nurses avoided exploring the issues raised by the PPC.
document and chose not to complete it (Storey, 2007).

The literature review also identified a lack of nurse training in communication skills and palliative care.

Caring for patients at the end of life can be extremely stressful for nurses (Wilkinson et al., 2008), yet end-of-life care is not a mandatory part of pre-registration nurse training or post-registration district nurse training programmes. This can leave some nurses ill-equipped to initiate and manage complex conversations about end-of-life care with patients and their families (Henry and Fenner, 2007; Lowson, 2007; Chapple et al., 2005).

Taylor (2007) argued a lack of training in communication affected how nurses worked: “Communication appears to have low priority within training, so why would it have high priority within care?”

Some nurses’ lack of experience and knowledge made them reluctant to use the PPC tool (Henry and Fenner, 2007; McKenzie et al., 2007; Storey, 2007; Newton, 2006).

**Method**

This study took a descriptive, phenomenological approach.

After ethical approval was secured, district nurses at West Essex Primary Care Trust were invited to participate. They had to have completed two PPC documents in the community and agree to be interviewed to take part. Eleven district nurses were included in the study (Table 1).

In-depth interviews were carried out with all the nurses to determine their experiences of using the PPC document. The interviews were transcribed, and the data broken down into categories and themes.

Although the sample size was small, limiting the study participants to district nurses who had experience of using the PPC document produced in-depth data.

**Results**

Five major themes emerged from the interviews (Fig 1). These were: communication skills; hopelessness; empowerment; admission avoidance; and multiprofessional working.

**Communication skills**

Study participants said the PPC document enabled in-depth conversations. The more they used the document, the more confident district nurses felt in starting difficult conversations:

“...The document is quite straightforward and is a good tool for opening up discussions with families” (P6).

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“I have 30 years’ experience but these subjects can be quite difficult to raise for junior staff. The PPC is helpful as it gives them something to work with” (P9).

The nurses acknowledged that using the PPC document was initially challenging, but said that experience gave them confidence. Personal experiences and reflection through peer support also helped them to achieve the confidence required to start and maintain conversations around end-of-life care:

“It’s difficult for nurses with not as much experience. I think that, as you form your own personal experiences, you know how to deal with situations” (P3).

“Get a good relationship going with your patient, then gently introduce the document. Showing empathy will help” (P4).

**Challenges associated with end-of-life care**

- Health and social care staff often find it difficult to initiate discussions about end-of-life care. This makes it difficult to determine people’s needs and preferences for care and to plan accordingly
- People frequently need care from several services, yet care is often poorly coordinated
- People approaching the end of life need around-the-clock access to care and support. Even when services are available, they do not always meet people’s needs. This may be because health and social care professionals have not received adequate training
- When people enter the dying phase, health and social care professionals may not know what to do or have the resources to ensure maximum comfort for the patient and support for carers

Source: Department of Health (2008)

“Active listening was a key skill required to use the PPC effectively. The nurses felt they needed time to get to know patients so they could listen to them and build a rapport.

Some participants felt they would like to take part in advanced communication skills training. Others expressed dissatisfaction at nurse training, saying it did not prepare them for the types of conversations they were experiencing. With no formal guidelines to consult for clarification, they relied on peer support.

**Hopelessness**

Participants recognised that lack of confidence in using the PPC prevented some members of the team from using it.

Some staff felt the PPC document was seen as a “death” document for patients, and that talking to families about their preferred priorities for end-of-life care could take away any hope and goals they had left. To prevent feelings of hopelessness, participants used empathy to build a rapport with patients and their relatives so they felt able to discuss priorities for care with the nurse:

“It is taking away hope for some people. Different people accept things in different ways, and when you start discussing the PPC you can still feel you’re taking away hope” (P3).

“I find it quite difficult to introduce [the PPC] because sometimes it feels like you are taking away people’s hopes when they are striving to survive. We shy away from using it as it feel it may upset people” (P4).
Research

"I think you have to be very empathetic using the PPC because a lot of people with a cancer diagnosis are not well and you get a lot of people in denial. In our team, we tend to find it is nurses who get asked to take the PPC as they are more able to relate on an empathetic level. If you home in on empathetic skills you won’t have a problem" (P2).

Empowerment

Study participants said the PPC empowered both patients and professionals by providing the opportunity to make informed choices and ask questions. They highlighted enabling people to die in their preferred place as their primary concern, and said the PPC could reduce unnecessary hospital admissions and treatments:

“She [the patient] was not being moved from her home as she did not, under any circumstances, want to go to hospital. She taped the PPC on the wall above her bed and, when anyone came in, she said ‘I am staying here’. That gave her a sense of security and inner peace, and helped her as we all listened and kept her at home” (P7).

“I do think that it definitely stops them [patients] going into hospital” (P10).

Admission avoidance

People in care homes with a PPC document are more likely to avoid unnecessary hospital admission as professionals, care home staff and families are less likely to panic if a PPC had been completed. The participants said family members and care staff felt empowered to challenge decisions about transferring residents to hospital:

“A lot of the homes around here want all the patients to have a PPC as it empowers them” (P2).

“Because he [the patient] had filled out the document, he felt they took notice of him. Nobody panicked and called an ambulance, and he didn’t end up in A&E. That gave him and the care staff peace of mind. People do not want to die in hospital” (P2).

Multidisciplinary working

The interviews also revealed the nurses saw PPCs as an important boost to multidisciplinary working. Patient care in the community often involves many different services, with various professionals involved. The PPC helps promote discussion in team meetings and improve communication, often as a result of knowing what patients want:

“IT makes things so much easier for healthcare professionals to know what patients want. I think the document can be used to promote collaborative working, not only with the patient themselves and the nurses but also with other teams. This document is here to stay” (P7).

The district nurses liked the fact the document stored contact details for every member of the multidisciplinary team, including hospice staff, chaplain, neighbours and volunteers.

However, the interviews also identified disappointment and concern that other healthcare professionals saw completing the document solely as the district nurse’s job. Several participants suggested health professionals who already had relationships with patients may be better placed to introduce the PPC. The district nurses felt the PPC should be introduced by the professional most involved in providing care, which would be promoted by guidelines on using the document:

“If somebody has a good relationship with a patient, such as a patient with multiple sclerosis having a long-term relationship with a physiotherapist, I don’t know why the document can’t be used by that discipline to elicit the patient’s wishes. It does not have to be us [district nurses], although, in my experience, it is us they ask to complete it. Perhaps we need guidelines” (P7).

One participant felt introducing the PPC was a way to involve the district nurse early in a patient’s progression along the end-of-life care pathway.

As the health professionals who introduce the PPC document and help patients complete it, district nurses felt under pressure to deliver its contents. The need to explain that some choices may not be possible was identified as an issue.

Discussion

The study results showed the PPC document was largely used as a communication tool. Communication is essential in end-of-life care to understand patients’ beliefs and choices, and the study showed a firm belief that, if a patient makes a choice, professionals have a duty to take notice.
Effective communication requires a balance of listening, speaking and understanding (Osbourne, 2008). The study findings echoed the literature, suggesting nurse training in communication skills did not adequately prepare nurses for practice. A second important issue identified by the study is who should take responsibility for introducing the PPC document. District nurses said other professionals who had been involved in a patient’s care for longer, such as the GP, may be better placed to raise the issue and complete it.

Both the study and the literature suggested the PPC was sometimes introduced too late, or when individuals were too vulnerable to discuss their choices (Storey, 2007). This could be attributed to the document’s former title and role – preferred place of care rather than priorities for care.

The district nurses felt the document enabled them to give something back to patients and their relatives. Although completing a PPC can be time consuming, the district nurses were positive about the time spent with patients doing this which was seen as empowering for both professionals and patients. Participants also said the PPC could be used as a tool to focus discussion between themselves and the multidisciplinary team.

The PPC is about more than just completing a document – it is about mutual trust, dignity and respect. It provides a “wish list” for patients and lays the groundwork for advance care planning. The district nurses saw this as a major benefit as it gave patients and relatives an insight into what to expect.

However, the findings suggested that, without reflection, peer support and clear guidelines, the tool would not be embedded into practice. The study highlighted that some nurses shied away from using the document through lack of experience and knowledge. However, they said effective use of the tool improved with experience, and the PPC process improved their communication skills.

Developing a PPC protocol
Clear guidelines and protocols on how and when to introduce a PPC document, and how to complete it, are needed. This would also help health professionals to understand the document and provide guidance on where to obtain advice, support, and training.

All members of the multidisciplinary team need to be educated in how to use the document and identify their needs, especially around communication skills. A multiprofessional group formed locally to support staff and develop the PPC protocol is essential.

The protocol should show when and how a PPC document should be implemented, who by and who to contact if there are problems or further support and guidance is required. Implementing the protocol would require all members of the team to look at changing practice, and improving communication skills.

The protocol should also take account of patients who prefer not to have their wishes and preferences formally recorded on a PPC; nurses can still engage in advance care planning with patients through less structured conversations.

This change in practice is in line with the aims of the National End of Life Care Programme (www.endoflifearefordults.nhs.uk) and quality markers set out by the Department of Health (2009). It will ensure everyone can access and receive high-quality end-of-life care from confident and skilled professionals in all settings.

Conclusion
The district nurses who took part in this study found the PPC to be an effective communication tool. While it could lead to difficult conversations, it provided an opportunity to build relationships and allowed patients to voice their expectations and choices for care. District nurses saw PPC as a tool to empower patients, families and professionals in improving end-of-life care.

However, the study does raise questions about whether other professionals should introduce the document, especially as district nurses typically begin working with patients at a relatively late stage in their journey along the end-of-life care pathway. Patients are often treated in the community from diagnosis and by a range of professionals, yet completing a PPC is often seen as the sole responsibility of district nurses.

A strong relationship with the patient is vital when introducing a PPC, and this must be governed by guidance and reflective support to ensure successful implementation across the board. NT

References

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A new NICE guideline offers advice on when infants, children and young people need sedation and how to carry this out safely.

Sedation for infants and children

Every year, around two million children and young people who visit hospital emergency departments due to accidental injuries may undergo procedures where sedation is required (Audit Commission/Healthcare Commission, 2007). Children may also need sedation for radiological or dental procedures, during inpatient investigations and interventions, or when they present at GP surgeries and walk-in centres.

While sedating children is part of health professionals’ practice, there has been little guidance on which techniques are most effective and what resources, including staff training, are needed to administer sedatives safely. Evidence and research increasingly highlights the impact on children of procedures that are poorly planned and managed. These effects, which can be long-lasting, include anxiety, pain and avoidance behaviours.

The National Institute for Health and Clinical Excellence developed a guideline to improve care and safety standards in England and Wales for sedating infants, children and young people by providing clear recommendations for health professionals. It classifies sedation based on the American Society of Anesthesiologists (ASA) definitions. They are:

- **Minimal sedation** Where patients are awake and calm and respond normally to verbal commands;
- **Moderate sedation** Where patients are sleepy, but respond purposefully to verbal commands or light tactile stimulation;
- **Conscious sedation** Similar to moderate sedation, except verbal contact is always maintained with the patient. This is commonly used in dentistry;
- **Deep sedation** Patients are asleep and cannot be easily roused but do respond purposefully to repeated or painful stimulation. They may need assistance to maintain a patent airway.

Children must be assessed medically and psychologically before they are sedated.

Health professionals preparing for the procedure and assessment of a sedative agent must consider young patients’ medical condition, problems with sedatives, physical status including the condition of the airway and psychological and developmental status. It is also important to consider whether the procedure is defined as painless or painful. This enables health professionals to include suitable analgesics to avoid unnecessary pain.

There is also guidance on fasting before sedatives are administered.

The guidance advocates routine monitoring for moderate to deep sedation. Parameters include behavioural and psychological criteria, such as depth of sedation, oxygen saturation, pain and anxiety. Electrocardiography, capnography and blood pressure monitoring should also be used if deep sedation is administered.

NICE makes recommendations for education and training to ensure health professionals keep their knowledge up to date. The guideline outlines areas where education and training should be targeted. These include:

- Knowledge, understanding and competency in sedation drug pharmacology and applied physiology;
- Assessment of children, monitoring and managing complications;
- Practical experience of effective delivery of sedation techniques and managing complications, which include observing, interpreting and managing clinical signs, and how to use equipment;
- Documented up-to-date evidence of competency, including satisfactory completion of theoretical training covering the principles, and a comprehensive record of practical experience of sedations carried out.

The guideline recommends that trained health professionals should carry out the assessment of technique which is suitable before a young patient is given sedation. If this assessment identifies problems, specialist advice must be sought before proceeding.

Two trained members of staff should be available during the period of sedation to monitor the child or young person. Immediate access to resuscitation and monitoring should be at hand during sedation.

The guideline includes evidence for the use of chloral hydrate, fentanyl, ketamine, midazolam, nitrous oxide, opioids, propofol and sevoflurane in sedation. Recommendations on using these drugs to achieve a desired level of sedation should ensure they are delivered by safe, competent health professionals.

In producing the guideline NICE aims to ensure that the assessment of children before a procedure – taking into account their history, levels of anxiety and coping mechanisms – will be planned and managed in a structured way and result in a positive and safe outcome.

Offering children and young people (and their parents or carers) verbal and written information about proposed sedation techniques, alternatives to sedation and associated risks and benefits may encourage them to become more engaged in the process, resulting in better outcomes. NT

The guideline Sedation in Children and Young People is available for download at www.nice.org.uk/guidance/CG112

Author Liz McArthur is clinical nurse specialist, pain and sedation service, Alder Hey Children’s Foundation Trust, Liverpool and a member of the NICE guideline development group.

Reference
Community midwives have more time to spend on care and carry out more home visits thanks to digital pens linked to BlackBerry mobile phones

Digital pens developed by Paper IQ for BlackBerry smartphones allow midwives to record patient notes during home visits, so they don’t have to type them up again back at the office. With a much lighter administrative load, they now spend more time with patients and carry out more visits – plus they can call for help discreetly if required.

**DIGITAL PENS RELEASE STAFF FROM ADMINISTRATIVE TASKS**

Portsmouth Hospitals trust has dramatically improved the efficiency of its community midwifery team with innovative digital pens developed by Paper IQ used with the BlackBerry smartphone. The pens free staff from administrative tasks by capturing data electronically so that they can spend more time on patient care.

**THE CHALLENGE**

Community workers, particularly midwives, spend a lot of time visiting mothers at home collecting information about their health and their personal and social history, and developing birth plans. Writing up the notes in the office is a lot of work, and often the same information is collected several times.

**THE SOLUTION**

The trust’s IT department was asked to look for a data collection system that allowed staff to work in familiar while collecting data electronically. The solution needed to be light and easy to use because community midwives spend much time travelling.

A digital pen solution through Paper IQ on BlackBerry devices was selected. Midwives and nurses use the pen to write down patient information on a form which is automatically captured digitally.

Richard Sargent, ICT change manager, says: “The BlackBerry is something we have been using previously. It is easy to use – it is easy to train people to use. The BlackBerry came across best with the functionality of the device and of the pen as well.”

He adds: “We are not changing any working practices; all we have done is take normal midwifery booking forms that they would use and put them on digital paper.”

**THE BENEFITS**

The major benefit for community midwives is that, because they do not have to input information again or travel back to the office so frequently, they can spend more time with patients and see more patients per day. Initially the trust has projected that use of the pen will free up the time of seven midwives.

Community midwife Paula Wilson says: “The benefits for patients are that it frees time for us to care, for us to be with the woman. That is what midwives wish – to be with the woman supporting her, her birthing partner and her baby through all aspects of care. The digital pen gives us back that time. It takes away some of the administrative time which is absolutely fantastic.

“As far as making more visits in a day is concerned, I think it will help. Travelling often takes up as much time as seeing the clients. We’re probably saving at least half the time it used to take us to do a booking.”

Each digital pen has a serial number and is allocated to a specific person. This means that there is a chronological trail of interactions with patients, which midwife saw them, and when and what happened. This is essential from a litigation perspective; in addition, the pen gives the management team access to real-time activity on the team, whereas previously that information was only available at the end of each month.

The pen also enables staff to call for help discreetly. Lead midwife Sharon Hackett says: “If they do one action, like scroll through something, it alerts not only myself as the manager but potentially the police.”

Director of ICT Bill Flatman concludes: “I see the digital pen delivering future benefits to the hospital because it is applicable in many areas. It allows staff to work closely with patients and collect data in a way that is unobtrusive and doesn’t interfere with the delivery of care.”

**A GREAT RANGE OF APPS TO COMPLEMENT SOLUTIONS**

A wide range of apps have been developed for the BlackBerry platform to help nurses provide better quality and more efficient care. These can help nurses organise their work and improve communication. Most importantly, some apps specifically help nurses by alerting them when a patient needs attention, and enabling them to access patients’ notes on the move. Some track lone community workers and enable them to summon help discreetly if required.

For more information email healthcare@rim.com or visit www.BlackBerry.co.uk/healthcare
Mind mapping in qualitative research

In this article...
- Comparing mind mapping with traditional qualitative research
- How mind mapping works
- Benefits of mind mapping and implications for future research

Mind mapping is a technique used to capture such things as ideas, themes, concepts and tasks in an illustrative format. The mind map begins with a central concept such as a word or image being placed in the centre of a sheet of paper, with subheadings or related themes branching off. These branches can be subdivided or related to other branches (Fig 1).

Individual users develop their own way of using shapes, colours, lines or symbols in their mind maps. They convert the information into a combination of written, diagrammatic and graphical representations allowing related themes to be linked on both paper and in their mind (Buzan, 2003).

Mind mapping in phenomenology

Phenomenological enquiry is a commonly used qualitative research method, in which researchers try to interpret participants’ perceptions of reality. In discovering the essence of a “phenomenon”, researchers often try to “Bracket” preconceived notions, or at least be aware of any preconceived ideas they may have.

Miles and Huberman (1994) stated that qualitative analysts decide what things mean from the time they begin collecting data, even when they claim to work inductively. It may be a naïve for researchers to try and consider information with a clear and non-judgemental mind during the data collection phase of qualitative research. However, to accept this subjectivity and embrace it by using mind mapping may be more realistic. Mind mapping also allows free thinking, and has an aim to: “clear the mind of previous assumptions about the subject” (Buzan, 2003).

Traditionally, transcribed data is broken down into themes from which findings are taken. A more suitable way of analysing data may be to accept analysis begins at the interview stage and that formal analysis should begin soon after – or even during – the interaction, without waiting to produce transcribed text. Mind mapping could help with this.

With mind mapping the boundary between transcribing and analysing data may become blurred because the process of transcribing using a mind map will allow researchers to think creatively, making links between themes, or statements while the transcribing is underway.

Tattersall et al (2007) concluded that mind mapping should allow researchers to make rapid and valid transcriptions and to analyse qualitative interviews.

Aim

In theory, mind mapping could be used in phenomenological research to transcribe and analyse interactions between people as they are listened to (Tattersall et al, 2007). This study applied this theory to a qualitative study, comparing the results obtained by mind mapping with those obtained by a traditional qualitative analysis.

Method

A research project conducted by a chronic condition nurse practitioner (CCNP) was used as the vehicle for assessing the difference between mind mapping and traditional analysis. The research was an examination of patient and carer perceptions of a new CCNP service within the community setting. Ethical approval was obtained.

The interviews were semi-structured and designed to elicit patient and carer perceptions of the CCNP service. Eight subjects (a mix of patients and carers) were recruited using a purposive sampling method; the CCNP who conducted the interviews was not known to participants.
Interviews were recorded and the
recordings were analysed by different
types of researchers using the following
methods:

Method 1: A novice researcher (the CCNP
who conducted the interviews) who was
inexperienced in qualitative research and
mind mapping but had a basic
knowledge of both used mind mapping to
produce transcription and analysis.

Method 2: A research manager who was
experienced in quantitative research and
mind mapping but had little
experience of traditional qualitative
research also used mind mapping to
produce transcription and analysis.

Method 3: A clinical psychologist who
was experienced in qualitative research
methods transcribed interviews into
text and analysed using interpretive
phenomenological analysis (IPA). This
method focuses on an individual's
personal perspective (phenomenology)
with researchers acknowledging that
this cannot be done directly or com-
pletely due to their own conceptions
(Murray and Chamberlain, 1999).

The researchers’ findings were confi-
dential until the analysis was complete.

Results
The themes, along with a synopsis of
researchers' comments are reported below:

Method 1
Theme 1 Psychosocial support
Participants felt the CCNPs provided sup-
port. They also valued the proactive aspect
of the service, such as the CCNPs helping
patients and carers with the stress of coping
with long-term illness. They felt the CCNPs
treated them as individuals, and were
approachable and accessible.

Theme 2 Advocacy and accessing services and
equipment
All participants said the CCNPs helped
them to access other services and equip-
ment, and advocated on their behalf. The
data suggests the nurses in particular nego-
tiate with GPs for changes in medication
and to access different treatment options.

Theme 3 Education and advice
The study data suggested that advice and
education were important aspects of the
care provided by the CCNPs.

Theme 4 Clinical skills
Patients and carers appreciated the CCNPs' clinical skills and recog-
nised without these nurses' interventions they would have to see
their GP much more often. Patients also
said how the CCNPs initiated investigations
and instigated changes to treatment.

Theme 5 Patient dependence
Patients and carers were invited to discuss
any areas of the service they disliked or felt
could be improved. All responses were
positive, although one patient felt more
visits from the CCNP were needed.

Theme 6 Confusion over role definition
The data suggested some patients were
confused about the inclusion criteria for
the CCNP service.

Method 2
Theme 1 Support
Many of the positive aspects of the CCNP
service perceived by participants focused
on the individualised care or advice given
by the nurses. This focused on aspects of
life not directly concerned with patients'
physical conditions, but which affected
their daily lives. Patients talked about how
their main carer had received advice about
health, social services and transport.

Theme 2 Liaison
One part of the CCNP service mentioned by
all participants was the benefit of having a
link between the patient and other health or
social service professionals. They saw
having a good relationship with a health
professional who can liaise with other agen-
cies as a significant benefit. Some examples
given were that the CCNPs could “chivvy
things along” with regard to social care.

Theme 3 Contact
Patients saw having an easily contactable
CCNP as a benefit. One suggested there was
insufficient contact but these comments
were due to social rather than health needs.
Comments such as “you know someone's
there”, “feel individual” and describing the
nurse as “my rock” were mentioned when
discussing the patient and nurse relation-
ship. In addition to these social aspects of
the relationship, the physical care provided
by the CCNPs was appreciated because it
reduced the need to visit the surgery.

Method 3
Theme 1 Positive practical aspects of the service
Participants appreciated a number of prac-
tical aspects of the service. They valued the
education and advice they received from
the nurses.

Patients saw the CCNPs as having a
broad knowledge and remit and the ability
to help patients access other services. The
nurses were seen as being in a powerful
position to offer patients practical support,
including suitable aids.

Theme 2 “Human” side to the service
Some patients compared their current
treatment with previous treatment, which

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they viewed as being less “humanising”. They felt the current service was important, because it treated them “like a human”. Patients believed there was a human side to the service for a number of reasons: all said they had a close relationship with the CCNPs, and saw them as accessible and flexible. The nurses were regarded as being never too busy to meet patients’ needs, and patients also felt the nurses communicated well with them.

Theme 3 Interaction between “practical” and “human” aspects of services

One of the most striking themes was the interaction between the “human” and “practical” aspects of the service. Participants believed they were treated as humans and that the CCNPs were knowledgeable, providing practical support. They saw this combination as a vital safety net for them.

Not only did participants have someone to confide in, but they also had someone who they could trust to give them appropriate practical support where necessary. The CCNPs treated their patients with dignity and respect, and were knowledgeable about service issues. This meant patients often felt the CCNPs were aligned with them, and would fight for their needs.

Theme 4 Emotional impact on the patient

Participants believed the service had a positive impact on them, both on an emotional and practical level. The interaction between the practical and human sides of the service reduced pressure on patients. There was also a sense that the service empowered patients and gave them a sense of control.

Analysis

When we looked at the results, the theme descriptions varied widely, but this was to be expected given the researchers’ varied backgrounds and the subjective nature of the research methodology. However, the majority of themes revealed by the traditional research method were comparable with those derived from mind mapping.

If the research from the individual methodologies were taken to their conclusion, the service improvements and recommendations would be very similar. For example, if we take method 2 – the most simplistic of methodologies – the CCNP service within the community setting with those derived from mind mapping.

The themes emerging from this study initially appeared to be rather disparate. However, given that the ultimate goal for any research is to improve services, all methodologies seemed to bring out useful information in terms of understanding this patient group’s perspective, but in a shorter time when mind mapping was used.

The implications for future research on the use of mind mapping are about identifying how it can best serve qualitative researchers by answering such questions as:

- Is there a type of study best suited to the use of mind mapping?
- Is mind mapping ideal as an adjunct to traditional analysis, ensuring all themes are identified?
- Is it methodologically sound for researchers who have conducted study interviews to use mind mapping and/or those with a purely analytical role?

Qualitative research is a subjective process so it is crucial that the process followed by researchers can be described for others to follow and learn from (Cormac, 2000; Parahoo, 1997). However, mind mapping may reduce the availability of the “audit trail” in qualitative research, not only because of the subjective nature of the data, but also of the methodology.

Conclusion

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We talk to Michele Hiscock, deputy director of nursing at Royal Brompton and Harefield Foundation Trust, who has been a nurse for 34 years

What did you decide to become a nurse?
I discovered my grandmother was a nurse when I was 10 years old. She convinced me that nursing was for me. I never wanted to do anything else. Sounds corny, but it’s the truth.

Where did you train?
On a gynaecology ward at Southmead Hospital, Bristol.

Who is your first job in nursing?
I was working on a surgical ward with a fellow student. We went to give a patient a suppository. I was at the top end talking to and supporting the patient while she was down the other doing the insertion. Success – the procedure went well and we were proud of our achievement. But as we walked back to the treatment room, she turned to me with a look of horror and said: “Oh no. I forgot to put on the glove!”

What keeps you awake?
I have learnt from people at different stages. I have learnt from patients – when I worked in a renal unit, they taught me about the dependency and trust that patients have in nurses.

What advice would you give someone starting out?
Be open to listening and learning from colleagues and patients your entire career. You can make a huge difference to people at vulnerable times – make it a safe and good experience. Nurses multitask brilliantly to the extent that it can be to their detriment as others in healthcare say “nurses can do that”. Always stand up over what nursing is and what it is not.

What keeps you awake?
If I have not made myself clear in advice I have given or a major incident involving nursing.

What’s the most satisfying part of your job?
Introducing something new that benefits patients. Seeing a nurse develop and demonstrate leadership skills. Working with a good team of people who support each other and are open to new opportunities. Hearing that patients have had a good experience in our trust.

What’s your proudest achievement?
One was when I sold the idea of pain control sister at a senior staff nurse interview and was given the opportunity to trial the role three days a week. Within six weeks, the job went full time, and within four months, I had introduced patient controlled analgesia (PCA) after cardiac surgery. This was in 1991, which made Royal Brompton Hospital one of, if not the first, hospital to have PCA by proxy in the intensive care unit as it was attached to patients immediately following cardiac surgery.

What do you think will change nursing in the next decade?
Expansion of nursing roles. The move to a degree-entry profession and its impact on the current workforce wanting to study for degrees themselves.

What would you have done if you hadn’t become a nurse?
Public relations.

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Marian Coliof’s research work involves direct patient care

spinal injury. I was familiar with this because I worked on ski championships as well as in the military, and had been trained to do helicopter evacuations for neck and spinal injuries.”

Inspired to work at the “biggest and best hospital in my opinion,” Mr Coliof joined Addenbrooke’s in 2008. Starting in gastroenterology, he quickly became interested in haematology and bone marrow transplants, becoming chemo competent.

“Here the high standard of care is not just about the patient, but their families. It’s really intense looking after patients with cancer because they can become very ill in under three hours – the nurse is responsible for doing the right observations at the right time to maintain their safety,” he says. This professional interest in chemotherapy and cancer led him to apply for his current role as a clinical trials nurse in January 2011.

“My background in cancer research and haematology definitely helped, but this is a varied role and still requires you to put the patient at the centre of the work.”

Trials can relate to medical products, radiotherapy, drugs or other treatments, and any number can be running at the same time. “My specialism is lung and oesophageal cancers, but I can cover colleagues’ trials in breast or prostate cancers – our knowledge has to be that wide,” says Mr Coliof.

The job involves telling patients and families about the trial and side-effects; answering their questions; giving them information so they can make an informed choice about participating; organising the tests that take baseline readings and provide progress outcomes, such as CT, MRI, ultrasound and bone scans; giving treatment; processing blood samples; getting results; and observing patients to ensure their safety. As trials usually involve 50-500 participants, keeping track of the in and outpatients is vital for their safety, quality of life and trial success. That usually means seeing a patient at least every three weeks but it can be more often. With trials lasting 16-18 months, a commitment from nurses and patients is significant.

Mr Coliof adores his job: some 75-80% of his role is direct patient care, but he still does general shifts at the hospital to maintain his hands-on skills and dedicates extra hours to reading about the latest cancer research and clinical trials.

“Many of the trials are worldwide, so we get together with colleagues from around the world to see how the multiple trial centres’ work is panning out. That’s rewarding and educational. “It’s been proven that clinical trials have increased the life expectancy of some patients with certain conditions by up to two years. It’s not as immediate as saving a life on the battlefield, but my reward is knowing that I am helping to save many more lives in the next generation and to give a better quality of life.”

Jenni Middleton
Seaford, East Sussex

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- Treating minor illnesses
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- Pre-Placement Assessments
- Health promotion activities
- Supporting a GP clinic – twice monthly

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Providing a service to include:

- Treating minor illnesses
- Triage and referring onto local A&E/minor injury units as appropriate
- Responding to emergency incidents on site
- Drug and alcohol screening
- Pre-Placement Assessments
- Health promotion activities
- Supporting a GP clinic – twice monthly

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**Trident Medical Services, The Occupational Health Centre, Building F7.1, AWE Plc, Aldermaston, Berkshire RG7 4PR**

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[content about job positions and requirements]

For full details please contact the medical team on: 01227 780888 or email your CV to: medical@careerline.co.uk  Ref: MH 60631

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For an informal discussion, please contact Lindsay Ratapana on 0161 446 8007 Bleep 12812.

A job description and information pack are available online at www.jobs.nhs.uk. Search for job reference 413-1194. Applications should also be made online. The recruitment team can be contacted by email: recruitment@christie.nhs.uk

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MSc Health Care Management

The programme is specifically designed to develop the management skills and knowledge of health care clinicians and managers with a view to improving patient care. It is based in the Faculty of Management and Law.

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Have you signed up for Nursing Times Job Alerts?
When a patient or carer complains about their care experience, this is a monumental effort for them. To make contact by letter or speak to you takes time and effort and any member of staff who receives such communication should recognise this.

Prevention is better than cure, and it’s vital to teach staff to be alert to the patients in their care and spend time listening to their worries and fears. This is increasingly important to patients.

Within University Hospitals Birmingham, a local patient experience survey reviews patients’ views of their particular experience. It has been recognised that active patient communication is the only way to support this. Hourly care rounds by members of staff have been adopted, which give patients an opportunity to raise any questions or queries in a timely manner.

This aims to reduce or eliminate the number of times the patient, relative or carer has to raise complaints after discharge, which can be both distressing and tortuous for a patient.

The hospital staff may believe they have done nothing wrong, but personal perception is powerful and influences experience of care at the time and in the future.

When receiving complaints, you need to respond to them in an accurate and timely way, and demonstrate remorse where failings are identified and learning where possible.

You will only do this if you can accurately identify the issues the complainant is raising, so clarify the situation by telephone, meetings and written responses to ensure the means of resolution is suitable to the complainant, involving staff who delivered the care where possible.

Identify those who delivered the care to obtain an accurate reflection of the circumstances so you can use any contemporaneous notes of events. Involve the staff to get an accurate view of the situation from their perspective so you can understand and acknowledge the impact of their actions on the patients in their care.

It may seem harsh, but being involved in such responses encourages staff to deal with issues when they occur and makes them more aware of the effects of their communication and actions at the point of care. You can also involve them in meetings to discuss what happened and offer learning opportunities.

Most complainants are hoping that their concerns are acknowledged quickly, their fears allayed, apologies provided and that learning has been achieved.
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