Celebrating International Nurses’ Day

Argyll and Bute’s Nurses

Known across the globe as International Nurses’ Day, it falls every year on 12 May (Florence Nightingale’s birthday), and is a chance for everyone to come together and recognise those working in nursing.

Over the past decades, we have seen changes in disease burdens as well as in demography. The heavy and increasing burden of non-communicable diseases including mental disorders and an ageing society has forced governments and the health professions to think differently.

This has led to an increasing focus on disease prevention and health promotion and to a shift in the locus of care provision from institutions to community-based primary health care. New infectious, environmental and lifestyle risks at a time of rapid demographic changes threaten health security for all (Frenk et al 2010).

This has also brought forward a need to refocus on holistic care namely person centred care and a life-course approach.

As the largest group of health professionals, who are the closest and sometimes the only available health workers to the population, nurses have a great responsibility to improve the health of the population.

Over the past few years there have been many sad and distressing stories in the media which have illustrated the frightening consequences that there can be for people when the care delivered by nurses does not meet the high standards which we all duly expect.

This year, on International Nurses Day, we want to celebrate some of the excellent work that nurses are doing in Argyll and Bute.

Nurses at the Forefront– Leading the Changes

Pat Tyrrell, Lead Nurse for Argyll and Bute CHP, is asking all nurses on May 12th to take some time to reflect on the ways that they are improving the lives of the people with whom they work on a daily basis.

She is also reminding nurses of their critical role in ensuring that we do the best for everyone in our care at all times. When things are not right she reminds nurses that they must speak out. Keeping the person at the centre of our care and at the centre of our concern means that we find the confidence and the voice to challenge others and to positively rebel against an unacceptable status quo.

For further information, or queries related to Nursing Services in Argyll and Bute please contact:
Pat Tyrrell on p.tyrrell@nhs.net or telephone 01546 605645
**Caring for the Family in Helensburgh**

John is a 48 year old married man with two young children. He has Multiple Sclerosis. Last year John fell in the bathroom and developed a significant pressure sore as a result of lying on the floor for some time. Carol Anne McDade, Team Leader and her District Nursing team in Helensburgh worked with the family who were struggling with a number of different issues apart from just the wound which had developed. John’s mood was low and both he and his wife were struggling to come to terms with his diagnosis and the changes in their lives. After eight long months the wound has now healed, John and his wife are in regular contact with the Carers Centre in Helensburgh and with the MS Therapy Centre. John has a range of specialist equipment now in place to improve his independence and the family have become both more realistic and positive about the future.

For more information please contact carol-anne.mcdade@nhs.net

**How One Nurse using a nurse led service delivering a cognitive behaviour therapy approach in Oban helped her patients**

“I feel I now have a much better insight into how to move forward. I can use some of the skill that I’ve learned to cope with situations that arise”

“Being able to talk things out and normalise my feeling has helped me turn the corner and speeded up my recovery”

**Patient Experience in Cowal Community Hospital**

Kathy Graham, Senior Charge Nurse at Cowal Community Hospital considers Patient Experience a fundamental aspect of quality care.

Kathy says that “while recognising that spending quality time with patients in a busy ward environment is challenging, we as a team have endeavoured to work together to create a calm, patient-centred environment for patients, relatives and those delivering care.

The implementation of Care Rounding where nurses carry out regular checks with individual patients at set intervals at a frequency dependant on the patient’s clinical condition is now embedded in practice. In addition all patients in single rooms have half hourly checks to avoid feelings of loneliness and lessen the anxiety of feeling isolated.

To improve care for people with dementia we have introduced an Orientation Board, Picture Menu Board and appropriate signage for toilets and bathrooms. Keen to promote Person and Family Centred Care we have implemented ‘Getting to Know Me’ documentation which has allowed us to improve the quality of information shared between patient, family and staff. Ongoing work includes developing Reminiscence Books with both local and general themes and the use of aromatherapy in dementia.”

For more information please contact kgraham@nhs.net

**Nurses Improving Care for Children in Emergencies**

In Campbeltown Hospital the nurses have been testing the Paediatric Unscheduled Care Service. When a sick child attends A&E the nurses dial a dedicated telephone number and are connected to PICU in Glasgow where they can select between a telephone conversation or a video link with a paediatric consultant. They have used the video link when they have had very sick babies/children. The video screen is quite large and is on wheels so that it can be moved around the room and the consultant can get a very good view of the patient, this is also very reassuring for the parents as they can also speak with the consultant. It takes a lot of stress and worry away from medical and nursing staff. Where required the Paediatric Retrieval Team will fly to Campbeltown to escort the child to Glasgow.

For more information please contact hilary.rankin@nhs.net

“I felt privileged to be treated as well as I was. This is my second time in two years and the hospital and staff can only come highly commended May your good work continue.”

“Cannot think of anything I would change. I would like to thank each member of staff for their great kindness and care of me which I have greatly appreciated. Thank you for restoring me to health”

“This is an excellent service that reassures parents and local nurses that the best care and decisions are being made for each child” Hilary Rankin, Senior Charge Nurse
New Skills for Nurses in Islay Hospital reduce Travelling for Patients

Nurses working in Islay Hospital have developed the skills to enable them to administer continuous infusions of IV medications for a small number of patients with rare chronic conditions involving the immune system. These patients previously travelled to the mainland on a regular basis – three or 6 weekly. Admission to the ward as day or short stay cases has replaced the need for travelling to and overnight stays in mainland hospitals, thereby making a huge difference to the quality of life of the individuals.

For more information please contact Alison.guest@nhs.net

Improving Services for Those Affected by Substance Misuse

Argyll and Bute Addictions Nurses are not many in number but their work with, often marginalised, groups can make significant improvements. One of the nurses, Mike from Helensburgh says We aim to maximise the patient’s safety and minimise their discomfort by providing a supported/medicated detox involving daily home visits, monitoring of symptoms and medication, while at the same time giving encouragement and practical advice and fostering family involvement. Within the week the change can be striking --- “I feel brand new”, --- “best since I can remember”

I have been a health care support worker for the Argyll and Bute Addiction Team for over five years now. In 2011 I was offered the opportunity to train as a mental health nurse through the Open University whilst being supported by the Addiction Team. By being offered this chance to further my career I will also be able to provide a more in-depth knowledge towards my patient care which will provide a better outcome for my patients.

For more information please contact david.greenwell@nhs.net

Four A&B Health Family Support Workers trained in Roots of Empathy - an evidence-based classroom program effective in reducing levels of aggression among school children while raising social/emotional competence and increasing empathy.

The FSWs identify mothers of 2 -4 month old baby - the baby becomes the teacher and the children learn from the baby based on observation and interaction with their classmates and the “baby teacher.”

The baby visits the school children’s classroom with Roots of Empathy facilitator and the mother.

The children see the baby grow and change and this helps the children question how they feel about themselves and how they should relate to other people. Children learn things like not to raise their voice and to be more caring.

One story relating to a Primary 4 boy with poor social and language skills and he came across as very gruff and labelled a ‘difficult child.’

After the third baby visit just as the mother and baby were leaving he went over and said, 'I've brought this teddy bear for the baby.'

The boy lives with his mother (a single parent) and they don't have much money. The boy had saved all of his pocket money and bought the teddy for the baby. Previously the boy had been labelled as a troublemaker. With the input from the FSW and the RoE programme this was a chance for him to show that he is empathetic and you could see how the emotions of the baby made a difference to him.

For more information please contact patricia.renfrew@nhs.net
Person Centred Care in Isle of Bute

An 86 year old man had been an in patient on the ward for a period of five months. The long length of stay was the result of the guardianship process being completed. While in hospital he had experienced a bereavement when his wife, his main carer, died. She had cared for him as he had a number of long term conditions as well as advanced dementia. He had had no other close family.

The ward staff built a close relationship with him whilst supporting him through his bereavement and wife’s funeral. Following assessment it was felt that he required nursing home care at discharge. An appropriate nursing home was found and following assessment he was accepted.

Near the time of transfer to the nursing home the Senior Charge Nurse decided to explore alternative options for his discharge. The historical process for discharge would have been to organise an ambulance to transfer the gentleman to the nursing home. Although this would support an efficient discharge she felt it was very clinical process and would only exacerbate his anxiety. The ward staff had also expressed their apprehension at this man being transferred by ambulance to a new home with people he did not know.

With the support of the community team she arranged for him to be escorted by a ward support worker whom he trusted and a community support worker in one of the hospital cars. This allowed for a much more relaxed and supported discharge. Following his discharge the staff who escorted him fed back that he had enjoyed his afternoon tea and settled at the home well.

As a result of this process we have supported another transfer similarly with excellent feedback. Ward staff report they found the process a meaningful one and felt it truly supported a person centred approach to care. It has also supported a closer working partnership between the Hospital and Community Care Team.

Nurses collaborating with Carers

An elderly female patient developed post operative abdominal wound complications which required a negative pressure therapy dressing for a number of weeks. Initially this woman found the whole process and especially the machine quite intimidating and embarrassing. The nurses discussed this with her husband (a former upholsterer) and he designed and made a bag to carry the machine in.

This became known amongst the team as her “Gucci handbag”. The bag allowed her to personalise something that had originally scared her, improved her confidence - enabling her to go out in public, and also got her husband involved.

For more information contact kate.smeaton@nhs.net

Improving Care for People After a Stroke

In Ward I in Lorn and Islands Hospital if a patient has a stroke and they are not being thrombolised they are admitted directly to the ward and treated by the multidisciplinary stroke team who then follow them from the point of admission to discharge and in many cases into the community. Kate Smeaton, Senior Charge Nurse, feel this benefits the patient and their families as they now have one team throughout their hospital admission that can also oversee their discharge and their rehabilitation.

For more information contact kate.smeaton@nhs.net

New Nurse Led Service

In March Cheryl Howe started a new role as Advanced Nurse in Multiple Sclerosis and Parkinson’s Disease. This is incredibly exciting because Argyll & Bute has never had a Multiple Sclerosis and Parkinson’s Disease specialist nurse service before.

Cheryl is currently speaking with people and their families affected by these conditions across Argyll and Bute and finding out what the patient’s journey, in this rural area, is like for both conditions. It is really important that people have good access to health and social care no matter where they live. Cheryl will work to make the journey seamless from the perspective of the patient.
Band 6 Nurses and AHPs Developing New Leadership Skills

The first Band 6 Leadership Development Programme, led by our Practice Educator, Catrin Evans, ran in Argyll and Bute between September and December 2013. Participants came from a variety of roles and backgrounds from across the CHP. The programme is aimed at the senior band 6 practitioners that have management responsibility. It is designed to be practice led, flexible and relevant to today’s working environment. The programme is intended to have a blended learning approach where there will be face to face contact, online learning via a community of practice and workplace learning. Each of the participants undertook a Quality Improvement Project as part of the programme. Initial evaluation has been very positive and the second cohort of nurses, midwives and AHPs are now underway. For more information please contact Catrin Evans at catrin.evans@nhs.net

What Recovery Means to Me? By Gillian Davies, Mental Health Nurse

I have worked within mental health care as a registered mental health nurse for 23 years. During this period there have been many changes however fundamental to the cornerstone of mental health care is the person and their families. We know that people can and do recover from episodes of serious mental ill health. However I often ask myself what must it be like to experience such illnesses or disruption to your life and what affect does this have on your family?

The thought of having no hope or optimism to enjoy or be supported in your life feels empty and sad. Feeling isolated in your community, having no hope or outlook, losing your identity to illness and diagnosis and feeling powerless in this situation. Leads to confusion, frustration and loneliness and inhibits recovery from mental ill health.

Winning an Award for Their Work on Recovery at the national Mental Health Nursing Awards

I have always enjoyed talking to and helping people to find out about them as the person what makes them the person as opposed to an illness/diagnosis. Finding out what makes someone smile, who supports them, what are their interests and achievements, who they are as a person and what needs they have is integral to developing a therapeutic relationship with someone and essential to support recovery from mental ill health!

Recovery orientated principles and the recovery approach to care is not new. The recovery approach to practice has been embedded in mental health for years but the change to legislation and the enactment of the mental health care and treatment act of 2003 supported the Milan principles to care in which participation, reciprocity, non-discrimination and the least restrictive alternative to care were introduced as four of the core ten principles to mental health care and treatment. This change started to encourage us as mental health practitioners to engage in these principles more and when working with person form a relationship that supported collaboration.

However we realise that it is essential to support the person to be their own expert in their recovery. Our role you may ask, to support, help and empower the person on their journey but more importantly forming a partnership with the person to build on their strengths and for the person to lead a fulfilling and meaningful life!
Approximately two thirds of people with dementia in the UK are cared for in the community by family members. Many of these carers report experiencing much stress and have a high incidence of depression, finding it challenging to leave the home and their loved one leading to social isolation, physical and mental health problems. Many studies highlight the need to support carers in caring for themselves physically, emotionally, mentally and spiritually.

Mindfulness practice was originally developed in the East Asia and has strong correlations to meditation practices. The most recent and frequently cited method of mindfulness training was developed by Jon Kabat Zinn in the late 1970’s and encourages the user to focus upon the present moment without judgement, and showing kindness to themselves with "more balance and resilience at work and home". (Mindfulnet, 2013).

**Aim of project**

This project sought to determine whether Mindfulness Based Cognitive Therapy (MBCT (Segal, Williams and Teasdale, 2013) is an appropriate and beneficial support tool to improve the health and wellbeing, personal respect and dignity of carers of persons with dementia by enabling them to employ coping strategies in response to the challenges of the caring role.

**Methodology**

A self-selecting sample of eight participants were interviewed at the beginning of the project in order to determine their views on how caring affects their health and wellbeing. (MBCT) was delivered in a closed group setting over a six month period, to carers of those living with a person with dementia. The project will conclude in June 2014 thereafter the participants will be interviewed at completion of the programme in order to determine their views on the usefulness of (MBCT) on their health and well-being and carer role.

**Initial Thoughts from the Carers on the Caring Role**

From the initial interviews we were able to ascertain some of the thoughts and feelings from the carers on their role: 

It was reported that there was a sense of responsibility and some difficulty in accessing free time to enjoy pastimes/spend time with relatives/go on holiday etc. 
There was always a requirement to be patient and this led to a sense of frustration/difficulty in the relationship. 
There is a sense of loss around the relationship and the sense of losing the person. 
Emotionally and physically there is also some degree of loss between the carer and the cared for person. 
A sense of neglect of themselves is also evident, the focus each day is on the cared for person. 
Additional stress is added to the family unit bringing the person with dementia into the family home.

**Results**

Preliminary results show that the participants have evolved and formed a sense of community but also feel that mindfulness helps them to cope with feelings of isolation, frustration and loss evident from the responsibility of their carer role. 
For more information please contact Wendy O’Ryan at wendy.oryan@nhs.net
Nurses Working as part of the Extended Community Care Team
Working Together to Achieve Person Centred Outcomes

A recent piece of work with independent nursing home colleagues has resulted in the successful return home of a lady and fulfilment of her wish to do so. A long period in hospitals in Glasgow and the local Community Hospital following a fractured neck of femur with subsequent pneumonia and acute renal failure had left Maisie weakened and lacking in confidence.

Throughout her stay in Campbeltown Hospital the MDT team had worked with her to achieve a level of independence to allow her to return home with support of a care package. The progress was slow and there were doubts about the likelihood of achieving this. Throughout Maisie maintained she wished to go home.

Discharge date was planned and the Extended Community Team in conjunction with the Delayed Discharge Manager discussed the discharge with Maisie and her niece. She was discharged home and admitted to the Virtual Community Ward where we could monitor her progress and set clear and achievable goals.

It became very clear in the first 24hrs that transition to home had been extremely stressful and Maisie’s level of functioning had reduced. A number of factors came together at that time that meant a quick decision had to be made. Keeping Maisie’s wish to be at home at the centre of this process a decision was taken with Maisie and her family to transfer her to the local nursing home for three weeks with a view to building stamina, setting goals and working with nursing home colleagues to ensure that these were achieved.

The Virtual Ward meetings were the focus for discussion, goal setting and review of weekly goals. At each step this was communicated in person to Maisie’s key worker within the home. Members of the MDT worked alongside the nursing home staff to carry out the work with Maisie and as she progressed, plans for home progressed with the input of the Delayed Discharge Manager.

At the end of the three weeks Maisie had achieved all the goals set and was very clear that she wished to try home again. In order to reduce risk on return home telecare alarm and bed sensor were in place, with agreement that urgent response from the Community Team during the day and CarrGomm at night would be made. It was also agreed that the use of Shopper Aide would supplement private help that Maisie had alleviating some of her anxiety and reintroduction of chaplain visits would also support her.

On return home Maisie remained on the Virtual Ward and visits were set to support her at frequent intervals over the first 6 days, 2hrly for 2 days, 3 hrly for 2 days then 4 hrly with 2 scheduled visits at night from CarrGomm. Although a little anxious and uncertain at first Maisie has settled back into her home. This period of reablement has fed into the assessment and care plan for permanent care package to support her. It is the joint work between statutory and independent sector that has made this achievement possible.

For more information please contact louise.burke@nhs.net