

Nurse practitioner consultation essay sample



**ASSIGN
BUSTER**

For the purpose of this essay, I will discuss the case of a five years old patient presenting to my place of work with the symptom of shortness of breath (SOB). To maintain confidentiality the pseudonym “ Ryan” will be used to refer to the child and Ryan’s mother will be frequently referred to as “ mum”. As this assignment is a critical evaluation of my own practice, elements of it will be written in the first person. Webb (1992) considers writing in the first person acceptable when personal experiences and opinions have played a significant role in shaping the ideas presented.

My current role is that of unscheduled care practitioner (paediatric specialist) within a health centre, which aims to compliment the services of local GP surgeries. I am employed to carry out same day consultation, assessing and managing patients presenting with a vast variety of illnesses and injuries.

The first part of this work will be pertinent with the history taking process within a consultation; the second part will focus on assessment and physical examination. This essay aims to demonstrate comprehensive history taking and a structured approach to the consultation. A thorough assessment and examination of the respiratory system will follow, together with a rationale for examination skills used and a critical analysis of the clinical findings.

On searching the literature, many models of consultation were found. However, one that follows a logical approach, which is applicable to most clinical settings is the Calgary-Cambridge guide developed by Silverman, Kurtz and Draper (2004). As observed by Munson (2007) this model provides an easy-to-use structure that complements the traditional nursing holistic assessment. I choose this guide as it encourages a patient-centred, active

partnership between the nurse practitioners and the patient, based on therapeutic communication, whilst it advocates the value of reflective practice to aid personal and professional development (Gibbs, 1988, Benner, 1984). The model is concise, clear and evidence based, fostering the ability to gather patient information through a structured history and physical examination.

It consists of five main sections: initiating the session, gathering information, explanation and planning, and closing the session. Physical examination of the patient is situated between the second and third section.

INITIATING THE SESSION

This stage involves preparing for the encounter, establishing a rapport with the patient and identifying the reason/s for the patient attendance. Chafer (2003) observed that a lack of attention to the pre-consultation stage can have adverse effects on the clinical reasoning and the ability to perform effectively during the consultation. I began by reading the triage notes to ascertain the patient presenting complaint, his age and any previous medical history noted. The triage note read: ' 5 years old with shortness of breath'. I previewed the computer records to check for previous attendances. Chafer (2003) agrees that the patient's notes and records should be checked to raise awareness of previous problems or any regular treatment/medication the patient is taking. In my place of work, we do not have access to patient's medical records, other than the details of any previous attendances in the out- of-hours providers. Computer records showed that my patient had been seen twice before in primary care with episodes of shortness of breath/

exacerbations of asthma. The medication records also showed that Ryan used a short acting beta 2 agonist.

With this information in mind and the presentation of shortness of breath, I began formulating a hypothesis that the reason for my patient's attendance could be a further episode of exacerbation of asthma. However, I strived to keep an open mind and refrain from making a premature diagnosis. As observed by Walsh, Crumbie and Reveley (2004) the nurse practitioner should start the consultation with a fresh mind and avoid formulating diagnosis too quickly, as this may weaken the assessment and derail the practitioner.

Self-awareness is another important aspect to consider during this stage. I try to prepare myself for the encounter with a patient by clearing my mind from any distractions/stresses caused by previous consultations, so that I can focus entirely on the new patient. Walsh, Crumbie and Reveley (2004) explain that consultations can be stressful and emotionally draining and, in a busy clinical environment, it is easy to hang on to charged emotions from a previous encounter. Kaufman (2008) agrees that before the patient arrives in the room the practitioner should deal with, or at least acknowledge any negative feelings or stress.

It is my belief that every patient, regardless of the severity of their condition/presenting complaint deserves my undivided attention and I am also aware of the importance of 'getting right' those first crucial moments of a consultation. How the patient is greeted, patient comfort and environment

all shape the patients first impression and help to develop communication and rapport (Egan, 1998).

Once I dealt with the above issues, I was ready to call my patient. I introduced myself to Ryan and his mum and welcome them both to the consultation room. To build rapport, practitioners should begin the consultation with a greeting, introduce themselves and state their role (Kaufman, 2008). With paediatric patients it is also important to establish who the accompanying adult is, to make sure that the person present has parental responsibility for the child. I explained my role as trainee nurse practitioner and I explained to Ryan what I was going to do. Children cope better when they are fully informed of what to expect. With regards to this, Howells and Lopez (2008) states that informing children and parents of what will happen reduces anxiety and uncertainty.

The initial moments during a consultation are crucial in establishing a trusting rapport and evidence links the quality of communication to clinical outcomes (Gask and Usherwood, 2002). The success of a consultation depends on how well the patient and clinician communicate with each other (Kaufman, 2008). When dealing with paediatric patients, enhanced communication skills are required, as the practitioner needs to communicate effectively with both the parent/guardian who is often the historian, and the child. This requires the practitioner to continuously 'switch' language from a level which is suitable to the parents, to a level appropriate to the age and level of understanding of the child (Cahill and Papergeorgiou, 2007).

I felt that the initial encounter went well. Ryan was calm and cooperative. Mum appeared open and relaxed, responded well to my opening statements and was forthcoming with information. I felt that I built up a good rapport with both child and mother.

GATHERING INFORMATION.

‘ Taking a patient history is like playing detective searching for clues, collecting information without bias, yet staying on track to solve the puzzle’ (Walsh, Crumbie and Reveley, 2001). The history is regarded as the most important part of the assessment process. Epsein, Perkin and Cookson (2008) confirmed that an accurate history can provide 80% or more of the data required for diagnosis.

In this scenario, the patient’s mother was taking on the role of historian. I asked mum to tell me about Ryan’s problem. Whilst reading the literature surrounding this topic, I discovered that it is preferable to use open questioning at the beginning of a consultation. With this in mind, I began the consultation with an open question to allow the historian the freedom to express the problem in their own words and to get a clear picture of their perception of the problem. Lewis, Pantell and Sharp (1991) found that parents are most satisfied when they are allowed to express their concern and expectations early in the consultation.

Active listening is possibly the most fundamental communication skill required during the history taking (Walsh, Crumbie and Reveley, 2004). I used active listening skills and I allowed the mother to talk without interruptions. According to Wisson, Roter and Wilson (1994) a practitioner is

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more likely to uncover psychosocial problems if the parent is allowed to have their say without any interruption. Gask and Usherwood (2002) found that once a practitioner has interrupted the patient will rarely introduce new issues and this can result in failure to disclose significant concerns.

Interestingly, the longer patients are given early in the consultation to speak, the shorter the overall consultation will be (Langewitz et. al, 2002).

Ryan's mother explained that he had started with cold symptoms (cough, runny nose and low grade fever) three days before and he then developed wheeze and SOB 24 hours ago. Mum also informed that she had been giving Ryan his Salbutamol inhaler (4 puffs at a time) through a spacer every 3-4 hours in the last 24 hours, with little effect. When asked, mum expressed her main concern was Ryan's cough, which prevented sleep and was distressing.

I used the mnemonic PQRS (Zator Estes, 2002) to gather more specific information regarding Ryan's symptoms. PROVOCATION/PALLIATION: Mum described the cough to be worst at night; the cough was temporarily relieved by the use of the salbutamol inhaler. QUALITY: Mum described the cough as dry and producing intermittent wheeze sounds. REGION and RADIATION: During coughing episodes mum noted that Ryan appeared to be using the muscles in his chest to breathe. SEVERITY: Mum reported that the cough and wheeze kept Ryan awake for most of the night. TIMING: Symptoms started 3 days ago, with worsening wheeze and SOB in the last 24 hours.

The details of these symptoms provided important clues to assist me with diagnostic decision making.

I then asked about Ryan's past medical history: he had suffered from previous episodes of wheeze and SOB in the past. These episodes were usually concomitant with Ryan suffering from a viral illness. The last time Ryan was seen by a doctor with the same symptoms was six months prior, when he was suffering from an upper respiratory tract infection (URTI). His general practitioner (GP) first prescribed Ryan an inhaler when he was three. Mum also reported that Ryan was free from respiratory symptoms between viral illnesses. Although asthma had been mentioned by health care professionals in the past, Ryan had not been given a formal diagnosis of asthma as yet. Diagnosing asthma in children requires excluding first other causes of recurrent respiratory symptoms (NICE, 2007).

According to Bush (2007) since so many causes of childhood symptoms are transient and reversible (post-viral and post-mycoplasma) a diagnosis of asthma should be sought only if symptoms recur and when the child is old enough to perform a lung function test. Ryan suffered from bronchiolitis as a baby and that, after birth, was the only event of hospitalisation in his life. Apart from the inhaler Ryan did not take any other regular medication. Mum administered Paracetamol as required to manage the fever and cold symptoms. Asked about any allergies, mum informed me Ryan had no known allergies.

I then explored information specifically relevant to a paediatric history (Barnes, 2003). Ryan was born full term, normal vaginal delivery. He did not require admission to special care after the birth. There had been no concerns with regards to his development or any behavioural issues. Ryan was a happy, active 5 years old attending school and reaching milestones

appropriate for his age and stage of development. All his immunisations were up to date. This information enabled me to exclude premature delivery factors.

Details of family history were then noted: Ryan lived at home with his mum and mum's partner, and a younger sibling, aged 18 months. Mum suffered from atopic asthma from a young age, her asthma was well controlled on medication. Details of family history are particularly relevant in this case, as a family history of asthma or atopic disorder is one of the features which increase the probability of a diagnosis of asthma (Scottish Intercollegiate Guidelines Network, 2008). Other than this, she was generally well, and apart from oral contraception, she did not take any other regular medication. Ryan's father did not suffer from any chronic illness and his past medical history was unremarkable.

Although I felt satisfied that I got a comprehensive history from mum, I find it is frequently difficult to explore full patient's and family's past-medical history during a 15 minutes consultation. However, in evaluating and reflecting upon my own practice, I have realized that there is a balance between some shorter consultations and those more complex cases which require more time, and these often balance out. Hence, I am comfortable and do not feel anxious or pressurised in committing the extra time needed.

RESPIRATORY ASSESSMENT AND EXAMINATION.

A rapid but thorough assessment is undertaken to determine the nature and severity of the presenting problem and whether immediate interventions

such as oxygen therapy are required (Aylott, 2006 a). I therefore began my assessment by checking the A, B, C (airway, breathing and circulation).

The child was fully alert and responsive and his airway was patent. I followed Bickley's (2009) cardinal techniques of examination, comprising of:

inspection, palpation, percussion and auscultation. My assessment began with my first impression of Ryan's general appearance. Within seconds of meeting Ryan, I noticed that the work of his breathing was increased: he was using his accessory (shoulder) muscles to breathe and I also noticed he had a mild tracheal tug. His colour however was good, there was no suggestion for peripheral cyanosis, he was well perfused, his extremities pink and warm and his capillary refill time was less than two seconds. No clubbing or splinter haemorrhages of the nail were noted, suggestive of lung disease and endocarditis respectively. Bush (2007) described that digital clubbing in children is likely to indicate cystic fibrosis. On checking his mouth there was no evidence of central cyanosis. His mucous membranes were pink and moist and no signs of anaemia were identified.

I then moved on to further assess respiratory effort, efficacy and effects on other physiology. In order to do this I asked mum to remove the child's clothing and fully expose his chest, allowing thorough inspection. The thoracic cage of young children is much more compliant than that of adults. When there is increased inspiratory effort, this results in chest wall recession and a reduction in the efficacy of breathing (Advanced Paediatric Life Support Group, 2005).

His respiratory rate was 40 (counted for a full minute). An accurate measurement of respiratory rate is vital in identifying respiratory distress in children (Aylott, 2006 a). Tachypnea or a rapid respiratory rate is a sign of airway or lung disease, or a response to a metabolic acid load (Knowles, 2004). The normal rate of respiration in a child is inversely related to age, with rates greater than 50 being abnormal in the infant and, and greater than 30 abnormal in the child (Candy, Davies and Ross, 2001). I noted mild intercostal recessions with each inspiration. No sub costal or sternal recessions were identified. As explained by Aylott, (2006 a, p. 42) ' any process that stiffens the lungs or increases airway resistance will be reflected in recession'. No flaring of alae nasi or grunting was noted, both suggestive of acute respiratory distress (Advanced Paediatric Life Support Group, 2005). Ryan was talking, but in broken sentences. His oxygen saturation levels were recorded using pulse oximetry at 92% on air.

On checking the rhythm, amplitude and contour of his pulses, I counted his heart rate to be 110 regular. I decided against checking his peak flow measurement. I thought about this and reviewed the evidence, my rationale for omitting peak flow was that Ryan had never performed this test previously and therefore needed to master this skill and, as the evidence refers to accurate measurements (NICE, 2007), it was unlikely that I would obtain a true reading. He had a low grade pyrexia of 37. 4. Blood pressure measurements were also omitted in this instance. Measuring blood pressure is an invasive, often unnecessary procedure in children. Blood pressure is a poor indicator of cardiovascular homeostasis in paediatrics (McKierman and

Lieberman, 2005) and hypotension is known as a late and 'pre-terminal' sign of circulatory failure (Advanced Paediatric Life Support Group, 2005).

These observations alone provided me with sufficient information to conclude that my patient was suffering from a degree of respiratory distress. However to further enhance my assessment, I moved on to palpate, percuss and auscultate the child's chest.

Palpation is a method of examination whereby the practitioner feels the shape, size, texture, location or movement of body parts-in this instance the thorax (Candy, Davies and Ross, 2001). This allowed me to determine the degree of chest movement during inspiration and expiration, a strong indicator of respiratory function and dysfunction.

I began with observing the shape of Ryan's chest. No barrel-shaped chest was noted or pigeon chest, which consists of a prominence of the sternum and costal cartilages, a common sequel to chronic respiratory disease in childhood. (Monaghan, 2005). There was no sign of previous surgery or injury.

On palpation of the chest wall (front and back), chest expansion was recorded as symmetrical (chest rising and falling at the same time and to the same degree). Processes that lead to asymmetrical lung expansion are, for instance, when fluid or air fills the pleural space (Gill and O'Brien, 2002).

After palpating chest movement, I palpate the position of the trachea which should be central within the suprasternal notch between the sternomastoid

tendons (McChance and Heuther, 2006). Tactile fremitus was then assessed and no abnormalities detected.

Percussion on all lung fields was unremarkable: resonance is heard in a normal lung function. No dullness, normally heard when lung tissue is rendered airless by consolidation, collapse or fibrosis or hyper resonance found over a large thick walled pulmonary cavity (Bickley, 2009) were noted.

Auscultation of Ryan's chest, however, was significant. Panitch (2005) referred to auscultation as perhaps the most sensitive method for identifying infants and children with respiratory distress. Auscultation assists the practitioner with identification of normal and adequate breath sounds, the characteristics of the breath sound; location and phase of the sound heard and adventitious breath sounds. (Aylott, 2006 b). Ryan was asked to breathe evenly through an open mouth at a comfortable rate. I auscultated anterior and posterior chest wall, in all areas of lung fields for full inspiration and expiration cycle, comparing both sides. A widespread marked expiratory wheeze was identified. Wheezes are caused by airway narrowing which can be caused by broncho-constriction of smooth muscle or the presence of mucus. They are a feature of asthma and airway obstruction in bronchitis and bronchiolitis. (Aylott, 2006 b).

Air entry however was good and equal on both sides. There were no other abnormal sounds such as crackles, rhonchi or stridor. Vocal resonance was carried out, the auscultatory equivalent of vocal fremitus with no significant findings.

As part of my assessment I also carried out a full ear, nose and throat examination of the child, which was unremarkable, other than showing that the child's throat was a little red but clean, with no suggestions of infection.

On reflection, the examination phase with Ryan went well. I felt the time spent during the initial stage building up a relationships and gaining the child's trust was beneficial in enabling me to complete the examination without any resistance or distress. As noted by Howell and Lopez (2008) to enable children and their parents to quickly feel comfortable and able to trust will increase the chance of willing participation during examination and information sharing. I was aware that Ryan's condition called for prompt management and I felt the urgency to initiate treatment immediately. However I now appreciate the importance of comprehensive history taking and thorough examination in aiding clinical decision-making, thereby making treatment plans more effective.

MANAGEMENT

Having discussed all details of the history and my clinical findings with the GP on duty, we agreed that Ryan was suffering from a viral induced exacerbation of asthma (diagnosis) and that he would benefit from nebulised beta2 agonist. Ryan had been treated with a nebuliser in the past, remembered what the treatment entailed and he and mum happily consented to the procedure.

Ryan responded well to the nebuliser: his colour remained good but he was now able to talk in full sentences. He appeared more bright and joyful, playing and laughing with mum. His respiratory rate came down to 30,

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oxygen saturation 95% on air and his heart rate 92 regular. Intercostal recessions and tracheal tug were no longer visible.

I auscultate Ryan's chest again and asked the doctor to also review him. Prolonged expirations with wheeze were still audible, however these were much improved and not as pronounced as before the treatment.

EXPLANATION AND PLANNING.

A management plan was agreed in partnership with both the GP and Ryan's mother: Ryan would be discharged home with a short course of prednisolone (20 mg once a day for 3 days), the use of his short-acting beta2-agonist via the spacer and a review with his GP post-treatment (NHS Clinical Knowledge Summaries, <http://www.cks.nhs.uk/asthma/management#-310761>, no date).

I assessed Ryan's technique in using his inhaler prior to discharge. Patient education is paramount as successful treatment depends on effective self-care by the patient. As observed by Walsh, Crumbie and Reveley (2005) using inhalers requires some mastery and inadequate technique is often implicated in exacerbations of the disease. No problems were identified with Ryan's technique and mum was confident and capable in assisting Ryan in administering the medication. Providing the correct type and amount of education requires actively finding out what the patient already knows and has experience of (Kaufman, 2008). Being asthmatic herself and hence having a good insight into the symptoms and management of asthma, Ryan's mother appeared knowledgeable and at ease in caring for her child from the onset.

Despite this, part of my discharge management included comprehensive advice on how to care for Ryan at home and clear worsening symptoms to closely monitor for. I re-inforced to mum all symptoms of increased respiratory effort to be aware of: increased respiratory rate, inability to speak in full sentences, any changes of colour, audible wheeze. I specifically instructed her to expose the child's chest and look for any intercostal recessions, the use of accessory muscles or a tracheal tug. Mum was advised that if any of the above were noted (in spite of the medication), to not hesitate and must promptly re-attend or ring for an ambulance.

A review of the literature has reminded me that parental education is critical in ensuring compliance with treatment and successful management. Maltby, Kristjanson and Coleman (2003) observed that every parent who faces an illness in their child's life might doubt their ability to care for the child. Burns, Gray and Henry (2008) added that helping parents of children with asthma to achieve adequate self-management requires information, assessment of symptoms management and a regular medical review.

On reflection, my management plan was influenced by Ryan's positive response post-nebuliser and mum's knowledge and ability to safely care for Ryan. This, coupled with explicit safety-netting instructions influenced our decision not to refer to secondary care at this time, confident that mum would seek medical help should Ryan deteriorate. CLOSING THE SESSION

The final part of the consultation is concerned with closing the session and includes important functions such as final checking and 'safety netting'. As explained by Chafer (2003) safety netting sets out contingency plans in the

event that something goes wrong. This protects practitioners, whilst it empowers patients. Kaufman (2008) observed that while safety netting is a key tool in all consultation, it is paramount in in any encounter where the practitioner has limited information, such as out-of-hours consultation where one has no previous knowledge of the patient.

As the consultation was drawing to a close, I asked mum and Ryan if there was anything else they needed clarifying or that they would like to discuss. Both assured me that they were happy with all the advice and information provided and mum expressed her gratitude to me with the overall consultation and management of Ryan's illness. I clearly documented all details of the consultation and I sent an electronic copy of this to both Ryan's GP, requesting a review post-treatment and to the respiratory nurse suggesting a full respiratory assessment.

On reflection of the overall encounter, I conclude that effective communication is the key to a successful consultation. From building the initial rapport with the patient and his mother and gaining their trust and cooperation during the history taking through to working in partnership to negotiate care and finally providing education and discharge advice, communication skills are essential at every stage of the consultation.

The Calgary-Cambridge model addresses the skills required for an effective consultation. Using this, I feel I have developed a more structured approach in the clinical decision making process. I now fully appreciate that an accurate and complete biomedical history is the single most important part

in the whole process and that a thorough examination is crucial in developing sound diagnosis and appropriate management plans.

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