Health promotion in relation to holistic care

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This essay will attempt to discuss the significance of the link between health promotion and holistic care for the patient. Firstly, the patient will be introduced and a definition of holistic care and assessment will be given. Secondly, the health promotion model and nursing interventions will be described and discussed. Finally this essay will reflect on the effectiveness utilising of health promotion models care; rounded up by a conclusion of the findings. Names in this essay have been changed to protect the patient's identity and maintain confidentiality in accordance with the nursing and midwifery council's guidelines (NMC, 2008). Verbal consent was obtained by the client and her family, to use their basic anonymised details.

The patient, who for the purpose of this essay shall be known as Jane, is 21 years old and has an acquired brain injury (ABI) following a road traffic accident. An ABI is defined by Headway (2010), the brain injury association, as ' an injury caused to the brain since birth'. Jane has problems remembering information and continually repeats what she says, and also repetition of speech, known as ' perseveration'. Jane was originally admitted onto the neuro rehabilitation ward to address challenging behaviours at home and following successful interventions was due to be discharged when an appropriate care package could be put into place. Due to the complexity of Jane's condition her care package was taking longer than planned. While waiting for discharge, Jane, who usually lives at home with her mother, has undertaken many home visits. It then became apparent that Jane was losing weight to the extent that she had become underweight and it became necessary for this to be addressed before Jane could be discharged.

It was important that Jane’s weight was addressed as after a Malnutrition Universal Screening Tool (MUST) assessment was carried out it was concluded that Jane was at high risk from malnutrition. ‘ MUST’ is a screening tool that recognizes malnutrition and those at risk of malnutrition. It encourages multidisciplinary working which improve clinical outcome (BAPEN 2003). At 5 foot 7 inches and weighing 53 kilograms Jane’s body mass index (BMI) was 19. She also had lost approximately 0. 5 kilograms a week for the prior four weeks meaning she had lost nearly 5 percent of her body weight. Best (p. 23, 2008) states that ‘ malnutrition is caused by an inadequate availability of nutrients, because of either poor intake or deficiency as a result of disease. It is widely accepted that adequate nutrition plays an important role in maintaining optimal health’. Following a healthy diet has lots of benefits, not only physically but mentally too. According to the World Health Organization (1948) health is ‘ a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.

Following this a complete holistic assessment was carried out. The world health organisation (WHO, 2004), states that holism is a concept which takes into account a patients mind, body and spirit. It includes all aspects of the client and carers life, for example, account of problems from both person and carer, psychiatric and physical health history, medication and compliance, social history, past and current hobbies and interests, daily living skills, driving and faith/religion. Each of these elements is seen as inter-related and as equally important so when any of the elements are compromised there will be an inevitable effect on the others (Ellis 1999, Brooker & Waugh 2007).

The assessment used for the patient is a trust based holistic assessment founded on the Roper-Logan-Tierney Activities of Daily Living Model. Although published in 1980 this first model of nursing is just as relevant today. The model identifies the 12 activities of daily living as: communication; breathing; eating and drinking; eliminating; sleeping; dying; mobilisation; managing a safe environment; personal cleansing and dressing; work and play; expressing sexuality. These activities identify the basic health needs with the emphasis on assessing the effect of the mind, body and soul of each activity in relation to the person's health. They note how the activities are inter-related and not mutually exclusive (Roper et al 2000). They expanded on the inter-linked relationship between the patient, activities of daily living, factors which influence these activities (for example environmental factors), the lifespan and our level of dependence. It is because of these views that this model has been utilised as a true holistic assessment. Hinchcliff et al (2008), Brooker & Waugh (2007) and Dougherty & Lister (2008) substantiate that assessment is an ongoing, complex, systematic and interactive process. It involves gathering a range of information from and about the client and then using that information to decide the care, support and intervention that is required. The information is then clearly documented as in line with the Nursing and Midwifery Councils guidelines (NMC 2005).

Subsequent to the assessment, Jane was discussed at the weekly multi-disciplinary team (MDT) meeting, as in accordance with the NMC code which states that nurses must work together with other professionals as a team whilst sharing and valuing each others' skills and knowledge (NMC, 2008).

The nurse is at the core of the clients care and can therefore communicate and negotiate the client's needs and preferences to other members of the interprofessional team (Day, 2006).

Following the meeting various interventions were put in place: Blood tests were ordered to check for any underlying medical causes (test results were negative). Jane's weight was to be monitored on a weekly basis, food and drink charts as well as nutritional supplement charts were to be completed by nursing staff and Jane's relatives who often took her out for meals. The Royal College of Nursing's campaign ' Nutrition Now' (RCN 2007) suggests that patients are also monitored to make sure that they are eating the food they are offered. Protected mealtimes on the ward would be observed by all members of the multidisciplinary team as sometimes this was not adhered to. ' Nutrition Now' (2007) also highlights the need for protected mealtimes so that there is a more relaxed atmosphere for patients to eat their meals' and that they are assisted by nurses as well as healthcare staff to eat their meals. The dietician would review Jane's nutritional intake: Speech and language would assess Jane for any swallowing difficulties: Occupational therapy would observe Jane eating and drinking before making any recommendations: Jane's weight would be monitored and reviewed at following MDT meetings. Auty & Rennie (2007) suggest that professionals working in isolation with a client rather than in a team struggle to achieve the optimum outcome for the client as any treatment provided could be ineffective.

Jane's named nurse explained to Jane issues that had been discussed at the MDT meeting and that Jane's weight would need to be stabilised before she

could be discharged. Also a care plan would be put in place to address this issue. Nursing staff had already identified that Jane would be worried about becoming overweight as this was something she relayed often during conversations with them. Rosenstocks's health belief model (1952) cited in Glanz (2005) works by exploring peoples' perception and ways to inform, encourage and motivate change. There are six steps contained in this model: Perceived susceptibility; perceived severity; perceived benefits; perceived barriers; cues to action; self-efficacy. These steps were applied to the issue of Jane's weight.

Jane was worried about becoming overweight (perceived susceptibility) and she was informed of the risk to her health because of not eating enough. Jane's understanding and judgement of the severity of the situation were difficult. Short-term memory problems and the inability to process information and make informed decisions are common problems associated with ABI (Headway 2009). Because of this the nurse clarified to Jane how her health would be affected and that she would not be well enough to be discharged (perceived severity). Jane appeared to understand that she needed to put on weight before she could return home, it was explained that her food intake would be monitored and that the dietician had revised her diet to include high calorie foods and supplements. Jane was happy to comply with the interventions as she knew she would be discharged but she was worried that she would not be able to eat and drink enough even if she wanted to (perceived benefits). Jane was reassured that she would be given support and guidance to ensure the best possible outcome (perceived barriers). Although ' cue's to action' are directed more towards people living

in the community it was adapted to meet Jane’s needs, she was given information in a format she could understand and also took part in ‘ Health Eating Sessions’ with patients from other wards. Jane was supported and encouraged to eat snacks as well as her regular meal, food she enjoyed was made available to her at anytime. She also had regular motivational chats with her named nurse (self-efficacy).

The Tannahill model (1985) cited by Downie et al (2002) was also utilised. This model defines health promotion as an approach to improving health and diminishing the risk of ill health through incorporating three processes; health education; prevention; protection. Health education: influencing people’s behaviour and attitudes; encouraging positive well being and diminishing ill health. Prevention and protection: to diminish the risk of disease developing by interventions, that is, primary: Giving people the knowledge to make better choices with regard to their health, for example, risks related to smoking; immunization. Secondary intervention: Health screening for early detection, for example, smear tests, smoking cessation. Tertiary: Managing established disease and preventing complications, for example, rehabilitation advice after stroke or serious injury. Protection: through government policies: public health and health promotion programmes can improve health, reduce disease risks, manage chronic illness, improve wellbeing, promoting self-sufficiency of individuals.

In conclusion the holistic assessment and health promotion and belief models have worked well for the patient. It allowed the multidisciplinary team to put together an effective care plan. The nurses involved with Jane’s care gave lots of encouragement and advice to Jane and because nursing

staff followed the care plan Jane began putting weight on. Although the reason why she needed to do so and the reassurance that she would not become overweight had to be explained to Jane continually because of her short term memory problems. The effectiveness of the care plan is apparent as despite NICE bringing in ‘ Providing nutritional support for adults’ guidelines and the introduction of specialist nutrition teams, being brought in over the last twenty years there are still patients who are somehow being missed and are under-nourished (Holder 2009). Additionally NICE guidelines (2006) state that ‘ knowledge of causes, effects and treatment of malnutrition among healthcare professional in the UK is poor’. It goes on to say that all health professionals linked with patient care should be trained in knowing how to provide ample nutrition for peoples’ needs’. This can be seen to still be a major factor in the improvement of nutrition for health. Holder (2009) asserts that nurses need to be aware of all initiatives nationally, regionally and within their own trust so they are able to provide better nutrition for their patients.

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