Long term conditions principles of care nursing essay

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'When you leave the clinic, you still have a long term condition. When the visiting nurse leaves your home, you still have a long term condition. In the middle of the night, you fight the pain alone. At the weekend, you manage without your home help. Living with a long term condition is a great deal more than medical or professional assistance.'Harry Cayton, (DH, 2005a)This essay will provide a critical account of the health requirements of a patient suffering from a long term condition. It will concentrate on the experience of caring for a patient with type 2 diabetes, within the community. It will consider government policies and guidelines which relate to the management of diabetes, and the role of the district nurse. The Nursing and Midwifery Council (NMC, 2008) Code of Professional Conduct Guidance has been maintained throughout this essay and therefore, all names have been altered for the purpose of confidentiality and anonymity. Currently in the UK there are over fifteen million people in England reported to beliving with a long term condition. (DH 2009), of these it is reported that 2. 6 million people are diagnosed with diabetes. This has increased since 1996 from 1. 4 million (Diabetes UK 2010), and over 500, 000 more whom are unaware that they have it. It is also predicted that by 2025 over four million people will have diabetes, with the majority having type 2 diabetes. According to Clinical Knowledge Summaries (CKS) (2009) the risk of developing type 2 diabetes increases with age, possibly because as people age they become less active, gain weight, and this affects their mobility and weakening their circulatory system. However this notion is relatively weak as whilst white people over the age of 40 are prone to developing the illness, ethnic minority groups are affected from age 25 years upwards (Diabetes UK 2006). This distinction suggests that diabetes may relate to dietary choices. Another possible

explanation for the development of type 2 diabetes is a genetic link, where people are more likely to develop diabetes when a close relative already has it. Mary is a 61 year old afro-Caribbean lady whom had recently been diagnosed with type 2 diabetes. She lives alone since her husband died 10 years ago. She has no family in this country, and does not have many friends, more 'acquaintances'. Mary had recently sustained a fall, fortunately nothing was broken, but she had suffered with severe bruising and loss of confidence. Her G. P. had been concerned about her and had asked the district nurses to monitor her blood sugars and blood pressure due to already diagnosed hypertension which she takes medication for. On assessment it was identified that Mary has been finding it hard to accept her diagnosis; she was hoping that her G. P had made an error. Hicks (2007) explains that it is not unusual to see denial in a hearing a diagnosis. Dunning (2009) goes on to say it can be appropriate in the early stages so that it enables people to keep a positive attitude and as a coping mechanism. However prolonged denial can cause future problems and possible neglect of warning signs that the condition is worsening. Mary's knowledge of diabetes is very poor and her perception is that eventually everyone that has it will have to have injections, go blind, have something amputated and then die. She also stated that the only dietary advice she had been given was to stop eating sweets and food with sugar in. She had been finding it difficult to stick this as she found that most of the food she enjoyed had sugar in, she had also been told to eliminate fruit from her diet as someone told her that it was also high in sugar. Mary reported that she has started to feel 'low in mood' and that she was feeling 'anxious' about her 'bleak' future. Lloyd (2008) states people with diabetes are twice as likely to have depression as those who don't. She

goes on to say recent research has shown that this can have a detrimental effect on glycemic control, on self-management of diabetes and on overall quality of life. Evidently Mary has very limited knowledge of her diabetes this in turn has had a negative impact on her psychological well being. The integral place of psychological care, within a holistic approach to diabetes care, is recognised in the National Service Framework (NSF) for Diabetes (2001) where it states that 'The provision of information, education and psychological support that facilitates self-management is therefore the cornerstone of diabetes care'(p22). Similarly the National Institute of Health and Clinical Excellence (NICE) (2003) reports that diabetes professionals should have appropriate management and detection skills of non-severe psychological disorders, whilst being able to identify and arrange prompt referrals of people with significant psychological difficulties that can interfere with their well-being or diabetes self-management. From Mary's assessment it was established that she was not in need of an urgent psychological referral, and that possibly an appropriate education programme would facilitate Mary with the information to be able to understand and manage her diabetes. As acknowledged by the DH (2005b) patient education is designed to improve knowledge, skills and confidence, enabling people to take more control of their condition and assimilate self-management. Siminerio (2008) continues to say that due to the complexity of managing diabetes the patient will require health professionals to support with the appropriate amount of time and long term support to ensure self-management is achieved. Due to the interpersonal nature of their duty, district nurses play a crucial role in the primary care of those suffering from long term illnesses. Cook cited by DH (2005b) states 'Caring for people with long term conditions is a key part of

community nurses' (p5). Their home visits and interaction with patients, provides emotional support by developing close trusting relationships, and quickly identify health problems. Nevertheless, recent government policies implemented aim to improve the quality of patient care, reduce the number of hospital patients and deliver more health care to patients at home. However, due to the aging population and the demand for community care is increasing thus putting extra strain on the already full caseloads, resulting in a breakdown of strong patient-nurse relationships. Instead continuity of care may operate primarily through partnerships, shared nursing roles and the involvement of social services, voluntary agencies and NHS organisations. Even before we can really consideration of how Mary receives health promotion advice, there should be consideration for her receptiveness and readiness to receive that advice. Prochaska and DiClemente's model of change (1984) (Budd and Rollnick 1996) (appendix 1) is a good example of this. Mary is in denial. It is hard to imagine that she could ignore the severity of diabetes along with the associated risks. However, this could have been to do with possible poor advice from the onset of her diagnosis or through fear (or possibly other reasons) but she has been in denial. This particular episode care following her fall and meeting with the district nurse may well be the catalyst that Prochaska and DiClemente refer to in generating a perceived need to change. Realisation of this fact should be a useful tool for any healthcare professional to capitalise on when endeavouring to manage the change process (Nickols 2004). Colin- Thome (2010) states 'Delivering improvements for people with long term conditions isn't just about treating illness, it's about delivering personalised, responsive, holistic care in the full context of how people live their lives'. In 2000 the Labour government

introduced a strategy to reform the NHS. 'The National Health Service Improvement Plan', aimed to modernise services, raise standards, tackle under funding and make a shift towards patient centred care (DH, 2000). A key strategy to emerge was the introduction of the National Service Frameworks in 2001. The NSF's were designed to bring health care in all areas to an acceptable national standard (NSF 2001). They aimed and put a stop to discrimination, offer provide person centred care, and access to fair and prompt services appropriate to people's needs (Dimond 2008). They also intend to respond to the experience and concerns of service users, use resources efficiently to achieve the greatest possible benefits and promote people's health and independence. Standard One of 'The NSF for Long Term Conditions' (2005c) requires healthcare professionals to deliver person centred care. Person centred care is seen as a key objective in healthcare. It lies at the heart of a number of policies and government strategies aimed at providing and improving personalised care, such as 'High Quality Care for All' (DH, 2008) and 'Our Health, Our Care, Our Say', (DH, 2006). The Royal College of Nursing (RCN) (2007) describes person centred care as care which is safe, effective, promotes health and wellbeing and helps to integrate patient's into today's society and community. Person centred care also informs, empowers, is timely and convenient (McCabe and Timmins, 2006). It is an approach which integrates patient ideas, expectations, beliefs, values, culture, emotional needs and social perspectives whilst ensuring mutual participation in a shared decision making partnership (Antai-Otong, 2006). The strategy of empowering and educating the patient is thought to be amongst the most useful (Peile 2004). Mary is far more likely to comply with a treatment regime if she understands the regime, the reasoning behind it

and is given the tools to achieve it. (McDonald et al 1999). Empowerment and education is an important concept in patient management and has been widely used over a huge range of clinical issues (Kelly 2002). It will be particularly useful for Mary, not only with regard of accepting she has diabetes, but with the whole question of her diabetic control as well (Gadsby 2005). Mary will almost certainly have a large number of questions and concerns that she should be encouraged to raise, as understanding is a vital ingredient of compliance (Marinker 1997). District Nurses must act as teachers and counsellors, helping patients regain independence by showing patients or carers how to confidently perform care-giving duties in the absence of the nurse. Therefore play an indirect but crucial role in keeping hospital admissions and readmissions to a minimum. When educating a patient with diabetes, care must be taken to ensure that they recognise that diabetes is a progressive condition, and that their requirements will probably change during their life. Expert Patient Programmes (EPP) (DH 2007) are a valuable opportunity for individuals living with diabetes to learn more about how they can manage their condition, better themselves and not rely so heavily on healthcare services. They have been proven to be beneficial and involve lay members who nurse patients. Reports suggest they have been considerably successful at regaining patients' independence (DH, 2007). It has been suggested that accident and emergency attendances could be reduced through the use of expert patient programmes, along with individuals accessing out of hours general practitioner services (EPP 2009). However, The Healthcare Commission found, following a study that in two thirds of Primary Care Trusts (PCT) 20% of people or less had been offered courses, even though there were structures of education and training in

place. In half of the trusts, 10% of people reported to going to a course. Overall the reporting of attendance varied from 1% to 53%. There was also no consistency of the length, content and style of educational. Some were unstructured, not evaluated and were delivered by insufficiently trained staff. If the correct education programme is enforced then Mary would be able to manage her own care with support from the community team. Self management is seen as an integral, even central part of the system of care provided to people with long term conditions and can be instigated through the implementation of expert patient programmes (Davidhizar, 1998). The British Diabetic Association (BDA) (2005) also suggests that 'the overall aim of diabetes management is to enable people with diabetes to achieve a quality of life and life expectancy similar to that of the general population' (p5), ensuring high quality equal care to ensure the provision of appropriate information and education to enable people with this condition to maximise their wellbeing. Kozier et al continue to explain that supported self care management refers to the individual's ability to manage their symptoms, treatment, physical and psychological consequences and lifestyle changes inherent in living with a long term condition (2008). Also through working in a multidisciplinary approach, different professionals can collaborate with each other in order to benefit the patient and deliver person centred care (Lethard, 1994). Nevertheless, education alone is frequently not enough. Merely providing information often does not lead to a change in behaviour. If there is a continuation of motivational struggles and unwillingness to change Prochaska and DiClemente suggest using motivational interviewing to try and over overcome this (Nickols 2004). This looks at encouraging and supporting people in adopting new behaviours. The district nurse would

support the Mary whom is struggling with ambivalence about change. Encouragement is used so that there is recognition and action to move to the action stage, this where they can start to understand and feel able to change (Gallagher and Scott 2006). However, Bundy (2004) does go on to say this can be seen as quite challenging and can have elements of being confrontational. This process needs to be executed wisely, and there needs to be a relationship with trust for it to be beneficial. This can take time and as recognised previously there may not be continuity of care with the same nurse. Furthermore, care planning is also a key part of managing long-term conditions, and its importance has been stated in a number of major policy documents. The final report of Lord Darzi's, High Quality Care for All, NHS Next Stage Review, (2008), stressed that over the following two years, everyone with a long-term condition should be offered a personalised care plan. In February 2008 the National Diabetes Support Team (2008) produced its guide to implementing care planning in diabetes Partners in Care and is also working with Diabetes UK and other key partners to determine ways to support the NHS in embedding the principles of care planning into the delivery of diabetes services (NSF 2008). It has been reported that Primary care is getting better at managing diabetes and one of the outstanding achievements of the Quality and Outcomes Framework is the rising numbers of diabetics receiving essential tests and measurements (for example, blood pressure and cholesterol). The results of those tests have also indicated health improvements, however an important fact is the 2005/6 National Diabetes Audit (Healthcare Commission 2007) found that not everyone is receiving every care process that they need thus indicating that there is still gaps in care. The theme of the final report of the NHS Next Stage Review

acknowledged that too few people have access to information about their own care (NSF 2008). It is imperative that the person with diabetes has as much information as possible to allow for maximum utilisation of their time with the healthcare professional. The Department of Health recommend that measures can be taken to improve the lives of diabetics. Although diabetes currently cannot be immediately cured, by using medication and other therapies it can be controlled (2005a). Mary will have to be closely monitored to ensure that she is compliant with her management of diabetes. As has been demonstrated there are many interventions which district nurses can undertake. However, for Mary to have the best possible care a collaboration of multi disciplined professionals need to par-take in a proactive role in the holistic treatment of diabetes. The government's aims are to support people with long-term conditions by delivering recommend changes that will help people. This is particularly vital as the long term compliance of the person with diabetes is essential to prevent and delay complications, as diabetes is estimated to account for at least 5% of UK healthcare expenditure (DH 2008). In conclusion, it is clear that the key role of all health professionals requires knowledge and understanding of issues and policies to support patients. Furthermore, this role requires a detailed knowledge of inter-professional and multidisciplinary working. It requires high levels of communication skills, diplomacy and assertiveness. Health professionals also need to have knowledge of service delivery systems to enable them to carry out their role and to provide their patients with an efficient and seamless service