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Editorial

Writing for the century: New scholars making an imprint on the next generation

Elizabeth Mason-Whitehead & Annette McIntosh-Scott

New Scholar follows a long tradition of journals in health and social care that inform, stimulate and sometimes provoke. The originality of New Scholar is that its writers are you – the new generation of nurses, midwives, health visitors and social workers. It will soon be your turn to educate students, write books and papers, create new evidence and formulate new policy. The challenges in delivering your carefully crafted pieces to journals, publishing houses and conference organisers can be both frightening and exciting. They may even seem daunting – but not a bit of it! At its best publishing is a collegiate endeavour which brings together each generation to produce work of quality and influence.

The purpose of New Scholar is to introduce students to the process of publication, to showcase the best of their work and to inspire other students to aim high in their own endeavours. It also demonstrates that all of us in the health and social care professions have more commonalities than differences, while still retaining our specialist expertise.

In this first edition of New Scholar we have published a range of papers demonstrating the breadth of undergraduate scholarly activities. For example, the article describing a washing and dressing care plan (Hansell and Chapman) gets to the heart of nursing practice. The literature reviews addressing breastfeeding (Llewellyn and Greenwood), breast reconstruction following surgery (Perry and Ridgway) and nurses’ attitudes to inpatient mobilisation (Merreywether and Chapman) illustrate our authors’ engagement with specific subject matter and the relevance of this to practice. The reflection papers on blood pressure (Lockett and Clarke) and child protection (Bisson and Bywater) are testament that the health and social care professions are leaders in reflective practice. Improving equality for women and men in professional practice (Martin and Ebrahimi) reminds us that there are plenty of ‘old chestnuts’ requiring new deliberations.

In this first edition we also have three book reviews. The book authors or editors are from our own academic staff and it is important that students review our writing as we do theirs, ensuring a two way process of mutual respect and learning. The theme of learning together is continued in the rest of the journal where staff and students write joint papers, working and progressing together.

Writing is important because it develops the understanding of the writer, stimulates readers to reflect on practice and adopt new perspectives, and ultimately benefits service users through advancing professional knowledge and expertise. Throughout the century, your written word will find its way to readers in forms we have yet to discover, as each decade will surely bring a new form of iPad or Kindle. What will remain constant will be the importance of good writing and its significant contribution to the development of our professions. Publishing is not without power and empowering the next generation through writing is one of life’s greatest privileges – one which will soon be yours.
An example of a child protection case: A reflection on the social work assessment process and adoption proceedings

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Abstract
This article outlines a hypothetical, holistic initial assessment of an anonymous case study (appendix one) relating to social work practice with children, young people and families. In doing so it demonstrates the preparation involved in working as the allocated social worker undertaking an initial social work assessment followed by an initial plan for further intervention. An holistic overview of the historical, cultural, psycho-sociological, ecological and legal perspectives relating to the context of the case is presented, and is concluded by outlining the most appropriate model of social work intervention. Critical attention to demonstrating the nature of social work assessments with children and families, within the context of anti-oppressive and anti-discriminatory practice, is presented throughout. An overview of the social worker’s role and responsibilities when working within a multi-disciplinary environment to safeguard children when signs, symptoms and consequences of child abuse and neglect are identified is demonstrated. Finally, a critical reflection is presented which served to contribute to the author’s ongoing professional development.

Key words
Social work; children and families; safeguarding children; assessment; intervention; adoption

Introduction
The case study, in which the characters are fictitious, provides a detailed insight into the life of a young mother named Helen and her two daughters, Mollie aged six and of dual heritage, and Chantel, aged three. The purpose of the case study is to provide details of Helen’s chaotic lifestyle and how this has impacted on the children, therefore leading to a social work assessment. The case tells us that Helen was sexually abused as a child by her father, who was violent to her mother and had a serious alcohol problem. Helen was known to social services during her teenage years and began using heroin at the age of thirteen. Today Helen is a dependent drug user who has struggled to care for her children, and a number of issues have raised concern for child protection agencies. Here, I (CB) write how I would have responded to the case as a social worker, if this were a real life scenario.

After reading the case notes, I acted with a child-centred approach by attending one of the children’s contact sessions held at Chantel’s foster placement, Debra and her civil partner Fiona’s home. To do this I contacted them and Mollie’s foster carers, Jim and Mary, to find they were more than happy for me to attend. I believed this to be the best course of action due to the urgency of the case and because the welfare of the children is paramount, as stated in section one of the Children Act 1989. This section states the ‘no delay’ principle and as Mollie had been in the care of Jim and Mary for eight months I felt permanency needed to be considered at that point.

To achieve best practice it was vital to consider the psychosocial factors. In this case, Mollie and Chantel’s development needed to be looked at, as the neglect and significant harm both children had suffered may have had an impact on their lives. Attachment theory helped me to understand the quality of the relationships each child had and by using a developmental framework I was able to observe, assess and evaluate risk while analysing social behaviours (Howe, as cited in Adams, Dominelli & Payne, 2009a).

Assessment
The Framework for the Assessment of Children in Need and their Families (Department of Health, 2000) uses a systematic approach to allow for the analysis of gathered information (Parton, 2006). The assessment framework looks at parenting capacity, the child’s developmental needs, and family and environmental factors, rather than being solely based on risk. There is emphasis on both a strengths perspective and the underpinning ecological concepts; however Calder and Hackett (2003) have critiqued the framework for omitting the concept of risk. Risk assessments are vital when involved with safeguarding children and there is a worry that professionals will take an overly positive outlook (Calder & Hackett, 2003). In this case, the framework had been used to structure the core assessment and I continued to use this to re-assess the situation. The framework has been integrated into Working Together to Safeguard Children (Department for Children, Schools and Families, 2010), which states that the evidence found during the assessment should underpin judgements about the welfare and safety of the child, and the form of intervention.

An ecological approach to assessment ensures that attention is paid to the interaction between the child, their family and their environment (Ward & Rose, 2002). Systems theory considers the interdependency of individuals and sub-groups within the family, and the effects of environment on its functioning, focusing on how different roles and relationships combine to influence child development and wellbeing.
However, Parrish (2010) critiqued it as being descriptive rather than prescriptive in regards to overlooking the individual child’s circumstances. Feminists, for example, have critiqued systems theory as being too traditional in respect of not considering one-parent families (Parrish, 2010).

The Victoria Climbié Inquiry Report by Lord Laming (Department of Health, 2003b) recommended that improvements were made to how information is shared within and between agencies, and led to a Government response and the Every Child Matters Green Paper of 2003 (Department of Health, 2003a). The death of Baby Peter in 2008 and the Lord Laming progress report of 2009 led to the strengthened Working Together to Safeguard Children (Department for Children, Schools and Families, 2010) guidance which addressed many of Lord Laming’s recommendations. It is it vital that, as practitioners, we learn from tragic cases to ensure the same mistakes are not repeated. With regards to Mollie and Chantel, I contacted other professionals involved in both children’s lives. To carry out a full holistic assessment, inter-agency working was required in order to gather and share large amounts of information to help understand how service users psychologically relate to their social and material environments (Adams et al., 2009a). A multi-disciplinary assessment involves working in conjunction with other professionals and agencies, in this case the children’s GPs, social workers involved in the initial core assessment, teachers and Helen’s substance misuse worker. If workers do not communicate with each other and trust each other’s judgements, then a multi-disciplinary assessment will not be successful (Coulshed & Orme, 2006).

My main concern with Mollie was that she did not want to see her mother at contact sessions and frequently pretended to be unwell. Mollie could have been protecting herself from further rejection. Baumeister (as cited in Cameron & Maginn, 2009) concluded that humans respond to parental rejection as they do to physical injury. Rejection can lead to a loss of motivation and willingness to make efforts and sacrifices to change their behaviour in order to meet the needs of others. Ainsworth et al. (as cited in M. Payne, 2005b) identified five types of attachment when studying the infant’s responses to separation and reunion with a parent: non-attachment, secure attachment, avoidant attachment, resistant/ambivalent attachment and disorganised/disorientated attachment. Mollie’s behaviour could have suggested an insecure or avoidant attachment, as she was avoiding Helen and not seeking physical contact.

As stated in the case notes, Mollie’s past experiences of neglect and significant harm by her mother could have activated attachment mechanisms. The lack of warmth, responsiveness and consistency of interaction between parent and child can be detrimental to the child’s development (M. Payne, 2005).

After initial introductions with both foster parents I decided to engage with Mollie through play. It was clear that Mollie felt comfortable in Debra and Fiona’s home as she had her own play space and was free to explore. She was happy for me to join her to do some drawing, which led me to believe that a secure base had been provided (Beek & Schofield, 2006). I used this technique as children frequently express themselves through drawing, providing observers with insight into their inner world and feelings (Malchiodi 1998, as cited in Hamama & Ronen, 2008). I was aware, however, that Thomas and Jolley (1998, as cited in Hamama and Ronen, 2008) claimed drawing on its own is unreliable and inaccurate in assessing personality and should not be solely relied upon, but can be useful when combined with other sources.

Mollie started to colour pictures in her colouring book and I used this time to talk about school, her friends and things she liked to do. I asked Mollie about her sister, suggesting that she drew a picture of her and Chantel and the people she was close to and felt safe with. Mollie drew Jim and Mary, Debra and Fiona, her school teacher but not her mother. I asked Mollie about her mother and if she liked spending time with her and Chantel at the family centre. She said she didn’t see her very much and didn’t like going. This assisted me in my duty with regards to Section 22 of the Children Act 1989, which sets out a duty for local authorities to ascertain the wishes and feelings of the child before making any decision, giving consideration to the child’s age and understanding (Brammer, 2007).

There are many different ways to develop communication with a child including the use of games and story telling, however for this visit I used ‘triggers’ for Mollie to use to help her communicate her feelings. I drew a range of faces displaying different emotions onto circles and placed them on sticks; when thinking about a certain person or event, Mollie could use the sticks to allow me to identify how she felt (Triseliotis, Shireman & Hundleby, 1997). I asked Mollie how she felt about going to live with her mother again and she held the angry face and sad face. With regards to living with Jim and Mary she showed me a smiley face, and as for living with Debra and Fiona she showed me a very smiley face. This demonstration was verbally supported by Jim and Mary, who told me how much Mollie had changed in the last eight months. They told me that Mollie became very anxious when she had contact with Helen; however when she went to Debra and Fiona’s for respite she became very excited and looked forward to seeing them and Chantel.

When looking at the stages of development, Mollie’s health, education, identity, family and social relationships, social presentation, emotional and behavioural development, and self-care skills are all considered and form part of the core assessment document for her age category. Parental problems can have an adverse effect on a child’s development and therefore the neglect Mollie had suffered, as a result of Helen’s drug use and violent relationships, could have led to Mollie experiencing emotional distress and uncontrolled behaviour (Cleaver, Unell & Aldgate, 1999).

With Mollie happily playing I used this opportunity to focus on Chantel with the use of the core assessment document for children aged up to two years old. The effects of heroin on a new-born baby can cause withdrawal symptoms that include high pitched crying; rapid breathing and heart rate; disturbed sleep patterns; sweating and fever; vomiting and diarrhoea; and feeding difficulties (Cleaver et al., 1999). Crucially, the first year of life is the start of emotional and social development.
Infants of Chantel’s age would, for example, be startled at loud noises, respond to voices and begin to respond to the sound of their name. Parental rejection is problematic for an infant’s emotional development (Parrish, 2010), so when considering Bowlby’s (as cited in M. Payne, 2005) early attachment theory with regards to both Chantel and Mollie, I was concerned that children who suffer maternal deprivation will experience separation anxiety, feelings of loss and disturbances in behaviour in later life. With regards to Chantel, I was able to establish that she would not have developed a secure attachment with Helen due to the lack of opportunity to form one, but that she displayed secure attachment behaviours with her primary care givers, Debra and Fiona (Ainsworth et al., as cited in M. Payne, 2005).

I informed the foster parents that adoption was being considered for the two girls, and that I would keep them updated accordingly, advising them to be honest with Mollie if she had any questions. I also explored their wishes and feelings as they are important people in the children’s lives (Allen, 2005). Jim and Mary voiced concerns about their personal situation, and stated that they felt Mollie should be placed with Debra and Fiona so she can be with Chantel. Both couples felt the children should be adopted, and Debra and Fiona reiterated their hopes of being considered as adoptive parents for both girls.

Following my initial assessment with Mollie, Chantel and their foster carers, I prepared myself to meet with Helen in order to assess how she was coping. My aims for this initial introductory meeting were to ascertain her understanding of the children’s situation, explore her understanding of the impact that her drug use during pregnancy had upon Chantel’s health, and generally identify how committed she was to to both children. To do this I used the Guidelines for Professionals for Assessing Risk when Working with Drug Using Parents (SCODA, 2003) which help to identify the type of drug use, how it is being managed, the impact it is having on the children and the effects it is having on the parents’ capacity to respond to their children’s needs. It has been stated that a parent using drugs does not necessarily result in an inability to parent, so to claim that a parental drug problem is bad for a child’s welfare is quite bold (Kroll & Taylor, 2003). The Lord Laming Report following the death of Victoria Climbie (Department of Health, 2003b) stated that professionals often take things at face value and recommended that things be questioned and alternatives considered. Therefore a full holistic assessment is required (Barnard, 2007).

While assessing Helen, I needed to be mindful of her background and her past childhood experiences. The sexual abuse from her father that Helen experienced could have negatively impacted on her own development throughout her life and subsequently affected her parenting ability. Women who have suffered sexual abuse during their childhoods are more likely to suffer from mental health and behavioural problems such as alcohol and substance abuse, depression and being a victim of domestic violence (Howe, 2005). As a reflective social worker, exploring research and theoretical frameworks enabled me to develop an evidence-based approach, rather than only relying on past professional and personal experiences (Smith, 2004).

I rang Helen to introduce myself and she agreed that I could visit her at her home. This allowed me to assess her home conditions and was a location where Helen might feel more comfortable. I informed her that my role was to re-assess the current situation. I used a questioning model of assessment as it was important for me to consider the nature of the questions and the way the answers were used. I was mindful, however, that the model can seem like an interrogation and has been viewed as disempowering (Coulshed & Orme, 2006). I thought this model was appropriate for assessing Helen at this stage because her answers would impinge on my decisions and judgements as to what course of intervention and action to take. From the visit I ascertained that Helen’s drug use is dependent. I explained to Helen how concerned we were about the need to provide permanancy and consistency for both Mollie and Chantel, and that as a consequence of her inability to improve her current context, permanency planning with regards to adoption had to be considered. I explained that I wished to carry out a re-assessment of her parenting capacity, while also exploring how she felt about the girls being placed for adoption. I gave Helen information about her rights and entitlements to legal advice adhering to National Occupational Standard 1 (Topps, 2002). Helen stated that she had tried to provide for Mollie and Chantel but couldn’t cope due to her drug addiction, and that it wasn’t her fault. Helen explained that she was struggling to pay her bills. When I asked her if she was prioritising her income to buy drugs before taking care of herself, she said ‘Yes’. I asked if this would change if the girls were to be returned to her care and she just looked at me. I explained that if she wanted the girls returned to her care she would need to demonstrate changes to her priorities in order to take care of them. I suggested that she could make a start to this by attending the substance abuse clinic and showing her commitment to the girls during her contact sessions. I shared my knowledge regarding the effects and impacts that drug misusing parents can have upon children, particularly when using during pregnancy. Helen did not appear to be aware of the severity of the effects her drug use had on Chantel at her birth, and stated that she thought she was just a ‘whiny baby’. The social construct of motherhood and the role of being a mother, which expects mothers to develop maternal protective feelings towards their offspring, places extra stress upon mothers for whom there are barriers to this emotional state (Medina & Magnuson, 2009).

When I enquired about Mollie’s father, Helen said she had not had any contact from him and that he was not registered as the father on Mollie’s birth certificate. However, she informed me of the prison where he was serving his sentence and gave me her consent to keep him informed of the situation if necessary. Due to the amendment of section 4 of the Children Act 1989, under section 111 of the Adoption and Children Act 2002, if parents are not married but the father’s name appears on the birth certificate, then the father will have parental responsibility. In this circumstance, Mollie’s father did not have parental responsibility; however, if Mollie was adopted I would consider writing to inform him of this with the consent of Helen. In adherence to the General Social Care Council (GSCC) Code of Practice 5.5, it was important that I had a non-judgemental attitude towards Helen and although I may on a personal level disapprove of her actions, I should not disapprove of Helen herself, nor convey this as a practitioner. I uphold the professional value that help should be offered in accordance with need and not according to if that person deserves help. This is an important part of social work as it is our values and adherence to anti-oppressive practice which guide us in our decision-making (Thompson, 2009).
Part 3 of the Children Act 1989 sets out the duties the local authority has towards all looked after children. The Quality Protects initiative was launched in 1998 to improve outcomes for looked after children, objective 1.4 being to minimise the time children remain in care before being adopted. The National Standards principles also include the avoidance of delay in adoption (Brammer, 2007). The concerns for looked after children identified by Quality Protects are reiterated in the Care Matters Agenda, which reinforces the determination to improve their quality of life (Cameron & Maginn, 2009).

Research highlights that looked after children are more likely to display oppositional and anti-social behaviour, show disturbances in their emotions, suffer from high levels of anxiety and misery, and show high levels of hyperactive behaviour. Emotional and behavioural problems in childhood can lead to a range of difficulties in psychosocial functioning in adulthood (Ward & Rose, 2002). In addition, frequent changes in environments, carers and relationships can affect the development of self-esteem and self-efficacy during childhood (Parrish, 2010). The Government’s targets to improve the outcomes for looked after children should be seen in the same light as the Every Child Matters agenda, which aims to improve the outcomes for all children (Brammer, 2007). I was careful, therefore, to retain a child-centred perspective and ensure that any decision-making would be in the best interests of each child.

Recommendation

After my initial visits I conveyed my findings to my manager and, tentatively at this stage, recommended that adoption would be in the best interests of Mollie and Chantel. The Local Authority Social Services Act 1970 section 7 sets current guidance on the preparation of care plans, and states that where adoption is an option the authority should adopt a twin-track approach (Brammer, 2007). I felt this option could have been considered at an earlier stage, but after eight months and with the consistent lack of engagement from Helen I didn’t think this approach was suitable. I considered that Helen has not demonstrated any capacity or motivation to change, and that she had conveyed very poor commitment to drug rehabilitation and to the outcomes for looked after children identified by Quality Protects are reiterated in the Care Matters Agenda, which addresses the need to explore whether to place Mollie with people of the same race. This is a controversial issue as all children need help in making sense of their own identity and culture (Thomas, 2005). I considered that by being a same sex couple, Debra and Fiona would have an awareness of the stigma and oppression that comes with being part of a perceived minority group within society; and that as a result of their experiences, they would be able to empathise with Mollie and guide her to find her own identity in society (G. Payne, 2006). Recognising Mollie’s ethnicity and responding to difference and diversity reflects ethical social work practice. When working with people from social divisions who may have suffered from disadvantage or oppression, whether caused by race or sexuality, it is important not to repeat this in practice and where possible to help them to overcome the effects of oppression (G. Payne, 2006).

Adoption terminates parental responsibility as it is permanent and irrevocable. History suggests that some form of informal adoption has always taken place. The Adoption Act 1926 gave legal recognition to the process. Over time the Act has developed, providing a legal framework to regulate practice. The number of adoptions peaked in 1968 with 27,000 adoptions. Changes such as the increased availability of contraception and abortion, and the reduced stigma around single parents in society, have affected the number of children available for adoption (Brammer, 2007). Section 144 of the Adoption and Children Act 1995 states that when finding a placement for Mollie: as she is of dual heritage, I would need to explore whether to place Mollie with people of the same race. This is a controversial issue as all children need help in making sense of their own identity and culture (Thomas, 2005). I considered that by being a same sex couple, Debra and Fiona would have an awareness of the stigma and oppression that comes with being part of a perceived minority group within society; and that as a result of their experiences, they would be able to empathise with Mollie and guide her to find her own identity in society (G. Payne, 2006). Recognising Mollie’s ethnicity and responding to difference and diversity reflects ethical social work practice. When working with people from social divisions who may have suffered from disadvantage or oppression, whether caused by race or sexuality, it is important not to repeat this in practice and where possible to help them to overcome the effects of oppression (G. Payne, 2006).

As Section 23 of the Children Act 1989 states that where possible accommodation for siblings to be placed together should be provided, I requested that as Chantel was over the worst of the Neonatal Abstinence Syndrome, Mollie should be moved to the foster care of Debra and Fiona, and that they should be assessed as adoptive parents for both children. This would save time in the future if permanency via adoption is sought, as both girls must have lived with Debra and Fiona for twelve months before a placement order can be applied for. This length of time provides each child with the opportunity to develop their relationship with the carer(s), and for the supervising social worker to assess and monitor the children in their potentially new home environment (Brammer, 2007). This time would also allow Helen to become prepared for the separation from and loss of her daughters, and for a final contact session with the girls in order to provide closure for them and her.

As my identified plan involved assessing civil partners Debra and Fiona as prospective adopters, it was important for me to have an understanding of structural oppression in relation to heterosexism. In addition I explored my values utilising a range of models, such as Thompson’s Personal Cultural Social (PCS) model (Cocker & Brown, 2010). In addition, consideration of race and ethnicity would be required when finding a placement for Mollie: as she is of dual heritage, I would need to explore whether to place Mollie with people of the same race. This is a controversial issue as all children need help in making sense of their own identity and culture (Thomas, 2005). I considered that by being a same sex couple, Debra and Fiona would have an awareness of the stigma and oppression that comes with being part of a perceived minority group within society; and that as a result of their experiences, they would be able to empathise with Mollie and guide her to find her own identity in society (G. Payne, 2006). Recognising Mollie’s ethnicity and responding to difference and diversity reflects ethical social work practice. When working with people from social divisions who may have suffered from disadvantage or oppression, whether caused by race or sexuality, it is important not to repeat this in practice and where possible to help them to overcome the effects of oppression (G. Payne, 2006).

Adoption terminates parental responsibility as it is permanent and irrevocable. History suggests that some form of informal adoption has always taken place. The Adoption Act 1926 gave legal recognition to the process. Over time the Act has developed, providing a legal framework to regulate practice. The number of adoptions peaked in 1968 with 27,000 adoptions. Changes such as the increased availability of contraception and abortion, and the reduced stigma around single parents in society, have affected the number of children available for adoption (Brammer, 2007). Section 144 of the Adoption and Children Act 2002 states that two people of the same sex living as partners can adopt; however, Tony and Barrie Drewitt-Barlow were turned down for adoption after 18 months of meetings and it was suggested by the panel for them to adopt a child with special needs. They were happy to do so, but after six months of visits to a five year old with Down’s Syndrome they were again turned down by the panel, which deemed them unsuitable to adopt (Watson-Smyth, 2002). When adoptive parents are assessed, regardless of sexuality, there should be good communication, the capacity to adapt to change, realistic expectations, and the capacity to tolerate a vast array of different emotions, sleep
deprivation and diminished privacy (Parrish, 2010). Debra and Fiona were in a stable relationship for seven years and had attachments with both children. They demonstrated their ability to parent and provide a stable environment for the girls to flourish, grow and develop, therefore preventing further developmental delay.

In 2001, the National Health Service National Treatment Agency for Substance Misuse (2001) was established to provide a range of treatment and services for drug users. I recommended that Helen received an intensive level of rehabilitation that included talking therapy to address her traumatic childhood and to deal with the loss of her children. I would also like to see Mollie receive some counselling or family therapy to build resilience and coping mechanisms. The interests of the children are the key standard by which interventions should be measured in order to make the best decisions for their future.

Critical reflection

Being accountable for my work it is important to give an account of what has been done or not done. It is also important to be able to self-critique and take criticism from others. Another useful way to give an account is through supervision and critical reflection. I found reflecting with colleagues useful to share ideas and accounts (Adams et al., 2009a). I found reflecting on my practice very useful for moving forward with a decision. The case enabled me to put theory into practice, which developed my confidence in doing so. Traditional ideas have been critiqued as theory does not provide a ready-made solution to the problem; however, the model of professional practice allowed me to apply my ‘formal knowledge’ of research and theory as well as ‘informal knowledge’ of professional and personal experiences (Thompson, 2009).

I picked this case study because, being close to someone in a similar situation to Helen, I felt I could relate to the case and the people involved. The complex issues in this case caused many dilemmas when deciding on the best way forward. One ongoing dilemma was working with the ideology of social work practice and ethics yet following social work law. As much as I have carried out the role of protecting and safeguarding, when working with people you can only empower so much. With Helen, as much as I recognised her need for empowerment, support and intervention in her own right, time was against me; and at the end of the day, as the law states, the welfare of the children was paramount (Adams, Dominelli and Payne, 2009b).

In order to overcome these dilemmas, reading previous cases and reports gave me a lot to learn from and I believe this to be an ongoing process. To demonstrate anti-discriminatory and anti-oppressive practice a sound social work ethic and value base is needed. The GSCC Code of Practice provides us with a set of standards and I believe I worked to them throughout the assessment process of this case.

References


**Appendix one**

**Case study**

Mother: Helen Ross, aged 24 years, White British.
Children: Mollie Ross, aged six years, Dual Heritage; and Chantel Ross, aged three months, White British.
Father of Mollie: Joshua MacDonald, aged 22 years, Black British.
(Joshua had intermittent contact with Mollie during the first six months of her life, but has since left the area and is now serving a five year jail sentence.)

There is no information about the father of Chantel. Helen says that Chantel was conceived during a ‘one night stand’.

Helen comes from a family in which her father, Brian Ross, sexually abused her from the age of 4 years to 7 years. He had a serious alcohol problem and was also regularly violent towards her mother, Sylvia Ross. Helen was accommodated by social services several times during her teenage years.

She is currently using heroin, having first used heroin at the age of 13. Helen’s main support in her extended family has been her maternal aunt, Sheila Redgrave, her mother’s younger sister. Sheila’s own children, Stephanie aged 16 yrs and Michael aged 20 yrs, both still live at home in a three bedroom council house with Sheila and their father, Mike Redgrave, who works as a bus driver.

Helen’s chaotic lifestyle and her dependency on heroin have been of ongoing concern for child protection agencies since before the birth of Mollie. Concerns included:

a. Mollie often being left as a baby with many different carers, including young non-school attendees who congregated at Helen’s flat.

b. Neighbours reporting loud noises, fights, and comings and goings at Helen’s flat late into the night.

c. Helen regularly coming to social services to say she had no money to buy nappies or feed Mollie.

d. Reports from police of violent incidents in which Helen had apparently been assaulted by boyfriends/male visitors to the flat (she never pressed charges).

e. Mollie being inappropriately dressed for cold weather, as if Helen was not able to notice that she was cold.

f. Some concerns from the health visitor about Mollie’s small stature and slow growth.

g. Once Mollie started at nursery school, there were frequent issues about her being late, inappropriately dressed, hungry and tired – and about Helen failing to turn up to collect her, or turning up over an hour late.

h. At nursery school, Mollie also had difficulty relating to her peers. There were problems with her stealing food from other children and hurting them by kicking, pulling hair and hitting.

Mollie’s great-aunt Sheila was a major support to Helen and Mollie during this period. She would sometimes take Mollie in for weekends or longer periods to give Helen a break. She would collect Mollie from school when Helen was unwell. She also provided money and practical help. It was primarily the involvement of Sheila that led to the professional agencies feeling that the situation, though worrying, was just about ‘good enough’.

However, Sheila’s relationship with Helen was ambivalent. At times she was fiercely protective and supportive of her. At other times she herself reported concerns to social services. There were also times when Sheila fell out with Helen, feeling used and put upon, and during these times she refused to help out with Mollie. During one of these times, Helen once requested social services to take Mollie ‘into care’ as she could not cope. However, Sheila did again reluctantly step in and offer to give Helen some respite.

**Admission into ‘Looked After Care’ of Mollie and Chantel**

A duty social worker was called to the scene one evening, when the
police had arrived at Helen’s flat to break up a fight between two men. Helen was unable to be aroused from a heavy intake of drink and drugs. Mollie was taken into local authority foster care via an Emergency Protection Order and a subsequent Interim Care Order was obtained. It was established that Helen’s aunt Sheila had left for a five week holiday abroad that morning and as Helen’s father was now living with her mother again, it was not safe to place Mollie there due to the previous sexual abuse allegations made by Helen. During the following weeks, Helen did not answer the door or was not home when the social worker called, and she did not respond to letters requesting that she make contact with the social worker. Mollie was subsequently registered on the Child Protection Register in the category of neglect and a core assessment was instigated.

When Sheila arrived back home, she made immediate contact with the social worker and in an angry outburst accused the social worker of over-reacting. She stated that she had seen Helen that morning and Helen was distraught at not being able to see Mollie. She also explained that Helen had just found out she was two months’ pregnant, which was why she was in a ‘bad way’. Sheila did not believe that Helen had not wanted to attend meetings or make contact, and accused the neighbours of being nosey and interfering; she demanded that Mollie be returned to Helen’s care.

Sheila stressed that she did not feel she could take up full time care of Mollie as she had just started a new job and needed the money, but she explained that she would continue to offer support, and might be willing to offer more care in the future. Although Helen was at that point saying that she was willing to meet with and work with the professional agencies, the decision was reached that Mollie should remain in her current short term foster home while the core assessment was underway.

In fact, Helen’s co-operation with the professional agencies was sporadic; for example, after Mollie had been in care for two months, Helen actually disappeared completely for a fortnight.

Mollie, on the other hand, seemed to thrive in foster care. School reported fewer behaviour problems and she began to gain weight. The social worker and foster carer also noted that Mollie presented to be quite apprehensive in advance of contact with Helen and they suspected that Mollie frequently pretended to be unwell with tummy aches etc., as she then made a dramatic recovery when contact was cancelled.

Increasing concerns about Helen’s lifestyle and heavy drug use followed and a pre-birth assessment led to a decision that the new baby (Chantel) should go into local authority care at birth; an Interim Care Order was obtained. When Chantel was born, she was suffering from Neonatal Abstinence Syndrome (effects of withdrawal from heroin) and was distressed, agitated and prone to prolonged screaming. (She is now over the worst of this.)

Mollie’s foster parents did not feel able to cope with Chantel and she is now with a foster parent who specialises in work with small babies. Some contact has been arranged for Mollie to see her sister at her foster home, over and above the contact they both now have with Helen at the Family Centre.

Current issue

Mollie was removed from Helen’s care eight months ago initially via an Emergency Protection Order. An Interim Care Order is currently in place for both Mollie and Chantel. Mollie has been placed for the past eight months with local authority foster carers Jim and Mary, who are both White/British, in their late 50s; they have been foster carers for over 20 years. Chantel has been with her foster carer, Debra Lewis and Debra’s civil partner, Fiona Hayes, since her birth. Debra and Fiona are both White/British and have been together for the past seven years. Debra and Fiona have stated that they wish to adopt both Chantel and Mollie, and often have Mollie for weekends and holidays when Jim and Mary have requested some respite as they find the full time care of Mollie to be quite tiring.

Attempts are currently being made to work towards the rehabilitation of both children with Helen. This includes monitoring Helen’s drug dependency and the two hour daily sessions at a family centre in which she has contact with both children. However progress to date is poor: Helen is still using heroin, she has not been keeping appointments with the substance abuse clinic and she is regularly missing contact sessions with the children. It has now been decided to re-assess and review the current situation with a view to applying for Mollie and Chantel to be adopted, and you have been allocated as the social worker to undertake this.
Washing and dressing: A care plan

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Abstract
Care planning is an essential skill for nursing care. The model of nursing offered by Roper, Logan and Tierney (2000) can provide a structure to assess, plan and evaluate nursing care with regards to the basic activities of living. Being independent in maintaining personal hygiene and getting dressed is seen as the norm in society. Following a stroke, the ability to perform physical activities is often compromised, resulting in the need for help with intimate physical care. This can affect the person’s biological, psychological and social wellbeing. Nursing care to support this activity of living must be sensitive to social mores and the vulnerability of an individual who has experienced a sudden loss of physical function. When Michael experienced a right-sided hemiplegia following a stroke, his self-esteem and self-efficacy were diminished. This nursing care plan was written to identify and address Michael’s washing and dressing needs, both physical and psychological. Key nursing interventions including liaison with the multi-disciplinary team are discussed. The use of therapeutic communication skills, possible alternative washing and dressing approaches, and environmental adaptations are identified, and a clear rationale is given for their use in supporting Michael to achieve the goal of being able to wash and dress his upper body independently. The paper concludes by emphasising the importance of person-centred care throughout the care planning process.

Key words
Care plan; stroke; evidence-based care; self-efficacy; person-centred care; reablement

Introduction
Assessment of the individual’s care needs, in order to plan appropriate, evidence-based nursing interventions and evaluate care outcomes, is an expectation of professional nursing (Dougherty & Lister, 2008). In a recent report by the British Broadcasting Corporation (BBC) (2011), it is stated that ‘too many hospitals in England are falling short in the most basic care they are giving elderly patients’. This paper addresses one aspect of essential care that fits within that category, in order to emphasise its importance for the person’s health and wellbeing, and centrality to nursing practice. Roper, Logan and Tierney’s activities of living (ALs) model of nursing (Mooney & O’Brien, 2006) was the basis for an holistic assessment and approach to planning care for Michael (a pseudonym to maintain confidentiality [Nursing & Midwifery Council, 2008]). Michael was 72 years old and had a stroke seven days prior to this care plan assessment. A stroke is a sudden neurological deficit, caused by an acute interruption of blood supply to a specific part of the brain. It therefore impairs the reception and transmission of nerve impulses to a specific part of the body (Marie & Whittaker, 2004). ‘Stroke is the second leading cause of death in the world and the leading cause of serious long term disability in adults; about half of those who survive are dependent on others for assistance with personal activities of daily living six months after a stroke’ (Legg et al, 2007, p. 922). Michael had a right-sided hemiplegia and was struggling more with dressing than washing, but found it difficult to wash the left side of his body. Hemiplegia is the term used to describe ‘paralysis of one side of the body’ (Cohen, 2005, p. 191). Following acute care to stabilise his condition, he was admitted to the rehabilitation unit to promote his independence so that he could return home to live with his 76 year old wife, who has frail health. The stroke affected many of his ALs, including washing and dressing. This article provides an evidence-based care plan to address Michael’s need to regain full independence in this essential area of his life.

Assistance with personal hygiene may be seen as straightforward and lacking in complexity, but the promotion of independence in this area can have wide-ranging effects (Jones, 2011). Improving Michael’s ability to wash and dress independently will improve his fine motor skills, self-esteem, confidence and overall independence, and help to reduce anxiety related to feelings of helplessness. Carrying out the care ‘for’ the individual can result in the development of learned helplessness (Abramson, Seligman & Teasdale, 1978) and sub-optimal neuromuscular recovery (Purton & Golledge, 2007). The problem of being unable to wash and dress independently due to reduced mobility and energy following a stroke will be addressed by planning nursing interventions to promote independence and achieve identified care goals related to washing and dressing. These goals will be agreed by Michael, the nurse and other therapists. Involving Michael in the planning of these interventions increases the chance of success. Person-centred nursing (PCN) involves planning and delivering care centred around the service user, considering their biological, psychological, social (biopsychosocial) and spiritual needs, in order to develop a therapeutic relationship and ensure that care given is appropriate to the needs and wishes of the person (McCormack & McCance, 2010). It requires sensitive, genuine and honest communication between the nurse and the service user to promote good communication and trust. This means the care environment is one where care includes opportunities to respond sensitively to the needs of the individual,
rather than using a task-orientated approach. It places an emphasis on the process of negotiation between nurse and service user, where Michael would be able to express his priorities in care, but also be given full explanations of what interventions are recommended and why, so that care can be adapted for his individual needs. Health outcomes can then be assessed in terms of Michael’s satisfaction in his care and experience of a therapeutic relationship, rather than as a passive recipient of the care of someone who has had a stroke (McCormack & McCance, 2010).

Physiotherapy and occupational therapy play a very important role in the rehabilitation of a stroke patient, especially regarding washing and dressing. Michael requires a weekly assessment from a physiotherapist, to monitor the alignment and activity of his affected areas, to suggest exercises and movement to promote the development of neural pathways, and to prevent poor posture (Purton & Golloid, 2007). Weekly assessment by the occupational therapist is needed to monitor his progress and identify areas for future improvement in purposeful activity and development of independent, self-caring skills (The Stroke Association, 2012b). Once Michael has had these assessments, which include physical assistance and observations from both teams, the nurse will liaise and discuss his progress with the therapists, liaise with nurse colleagues regarding the outcome of the assessments, implement any techniques chosen and encourage Michael’s progress in targeted areas.

Specific needs of the service user/client
In order to meet Michael’s needs and to enable him to wash and dress independently, appropriate assessment tools are required to ensure care delivered meets identified needs, enabling its effectiveness to be measured against a baseline. Washing and dressing are basic activities of living, so it is important to promote improvement in this area. By improving and developing body functions and movement through washing and dressing, it will also enhance Michael’s mobility, which will in turn help him with different aspects of washing and dressing.

Assessment of washing and dressing skills
The first intervention would be to use appropriate methods to assess Michael’s level of independence with washing and dressing activities. A falls assessment would be made to assess risk factors in falling, and repeated every seven days. Although Michael is experiencing difficulty specifically with washing and dressing, it is important to conduct this assessment to ensure washing and dressing are carried out safely. If Michael’s assessment does indicate a risk of fall, further interventions such as grab rails in the bathroom and a shower chair will have to be put in place and used accordingly. It is the nurse who will be the first person to identify Michael’s limitations with washing and dressing, assessing where he is experiencing difficulties and in relation to which specific tasks, so that the level of assistance and support can be adapted as required. Although there to help Michael with areas of washing and dressing that he may be struggling with, the nurse is also there to assist and motivate him and provide guidance on techniques, rather than just washing and dressing him. Taking over Michael’s washing and dressing will not promote his independence and will eventually cause his current condition to deteriorate as he would not be using his affected limbs. It could also create learned helplessness through a repeated sense of failing to achieve goals (Abramson, Seligman & Teasdale, 1978).

The nurse will have full involvement with physiotherapy and occupational health assessments, and liaise with colleagues to ensure consistent care is delivered. Michael will usually be seen weekly by a physiotherapist, while nursing care throughout Michael’s day can promote regular movement and function, which is necessary and beneficial in terms of muscle strength and developing neural pathways. Task-orientated rehabilitation, which aims to improve function through setting achievement aims related to ordinary activities of living, is the most effective form of rehabilitation following a stroke, so the nurse’s role is highly influential in Michael’s ability to achieve his full potential (Rensink, Schuurmans, Lindeman & Hafsteinsdottir, 2009). The aim of physiotherapy treatment is to encourage and improve movement and flexibility of his weak right side, help him to regain use of both sides of his body again, and to reduce joint and muscle stiffness (The Stroke Association, 2012a). Michael will also be seen once a week by an occupational therapist: occupational therapy ‘involves finding new ways of carrying out tasks that may have become more difficult since the stroke’ (The Stroke Association, 2012b). It is important that nursing staff are fully aware of Michael’s ability so that they know what he can and can’t do on his own, and where he needs assistance. In this way, they can provide supportive care that promotes his independence, to ensure that progress continues and he does not deteriorate. Once both assessments have been completed, the nurse will then work with Michael in the wash room, assessing his ability to wash himself unaided. By helping him to use new equipment to aid his progress, and encouraging him to overcome difficulties, the nurse will support Michael to become more independent in washing and dressing activities. The nurse will also take into account Michael’s cultural expectations of his personal hygiene and appearance, rather than imposing his or her expectations on him. Michael is concerned to appear as ‘normal’ as possible for his family and visitors, so regards personal cleansing and dressing as being important in regaining his social role. An initial goal has been set for Michael to be able to wash and dress the top half of his body without assistance within ten days. Michael will attempt the constituent parts of this with nursing support, including verbal and physical prompts or assistance as required. His progress will be re-assessed weekly to ensure he is progressing. Once this goal is achieved, further goals, such as washing and dressing the lower half of his body independently, can be agreed. Daily rehabilitation support will help Michael to work towards achieving his goal of being able to wash and dress his upper body independently.

Interventions to promote physical independence
The second intervention would be to implement physical nursing care appropriate to his assessed needs and abilities. Michael is at risk of falls due to unsteadiness caused by his right-sided weakness. To aid Michael with washing and dressing, a perching stool will be required. A perching stool is a seat which allows the patient to use the wash basin from a better angle. It has a slanted seat and adjustable legs, which allows users to sit upright bearing minimal weight on their legs (Disabled Living Foundation, 2011). This will help Michael to access the sink from a better position and, as he will be sitting upright, he will be able to get to all areas of his body more easily. Michael is right-handed and is finding it difficult to adapt to his left hand being in control. Michael likes to shave daily and he is not finding this activity too difficult with his left hand, but he needs assistance from the nurse when removing the lid of the shaving foam and applying foam to his
face. The nurse will assist Michael in doing this, but to promote his independence will not do it for him. The nurse will encourage him to use his right hand to apply foam to his face by squirting it on to his affected hand, and using the unaffected hand to direct it towards his face and distribute it evenly (Chin, Finocchiaro & Rosebrough, 1998). When showering it is not safe for Michael to stand unassisted, therefore he will need to use a shower chair. He is capable of washing his body independently, but needs reminding to focus on using his affected side more. Once Michael has finished showering, he will need assistance with drying. He is finding it difficult to dry hard-to-reach areas such as his armpits, back and hair. The nurse will have to encourage Michael to push himself to lift his affected arm to be able to dry underneath it properly, and demonstrate effective techniques of drying his back and hair.

When dressing his upper body, there is a technique to accommodate a hemiplegia. First Michael should lay the shirt out flat so it is easily accessible. Then, with his good arm, insert the affected (right) upper limb into the correct sleeve and pull the shirt down over the elbow. He should then repeat this step with the unaffected (left) arm and finally pull the shirt over the head (Chin et al., 1998). This can be difficult if there is limited space to lay out the shirt and if he is finding it difficult to flex his affected arm. Physiotherapy will help with this, and the regular effort, with the motivation to become independent in this everyday self-caring activity, will promote Michael's ability to flex his right arm. By increasing physical activities and movement, and pushing himself to do more without the physical assistance of the nurse, Michael will gain confidence in his eventual ability to wash himself independently.

Interventions to promote psychological wellbeing and self-efficacy

The third intervention would be to give Michael psychological support and use effective communication to boost his sense of self-efficacy and encourage progress. Self-efficacy is a person’s belief in his or her ability to succeed in a particular situation (Gross, 2010). It is an important variable associated with quality of life, depression, ALs and physical functioning following a stroke (Jones, 2011). Good communication between the nurse and Michael is vital for him to maintain a positive outlook on things, remain focused on his goals and improve his self-esteem. ‘A person’s adherence to medical advice depends on the practitioners communicating information’ (Sarafino & Smith, 2012, p. 217). This is important in relation to Michael’s understanding of what the nurse is trying to explain or ask him to do. Effective and supportive communication can be achieved by clear, simple guidance, delivered with patience, gentle humour and sensitivity to Michael’s responses. However, even if there is clear understanding, Michael needs to want to work with the nurse and have the same goals before any interventions will be beneficial.

The process of developing a good working relationship between Michael and the nurse may take time, and is more likely to be successful if the approach of the nurse is centred on him (Sarafino & Smith, 2012). This requires the nurse to listen to his opinions and feelings and respond to them sensitively, and with some flexibility. Michael needs to be able to identify his own limitations, which will then focus his mind on overcoming them, so that he wants to work with the nurse in setting goals that he wants to achieve, and realistically believes he can attain. High self-efficacy and confidence are key factors in Michael’s progress. There might be times when he struggles to achieve what he sees as simple everyday tasks and becomes disheartened. This is a key moment in which effective use of communication skills by the nurse is vital in ensuring Michael does not become anxious or lose confidence. The nurse must encourage Michael to keep trying and highlight areas in which he is progressing well. The nurse should explain to Michael that some tasks will take time to achieve regardless of how small they appear to be, but that, with practice, neural pathways will be reconfigured and strengthened to allow greater dexterity. Working with Michael to set small and realistic steps towards achieving his goals, then demonstrating his progress in achieving those steps, will reinforce his sense of self-efficacy and provide continued motivation to regain independence in washing and dressing.

With the verbal communication being supportive and responsive to Michael’s individual needs, the nurse’s non-verbal communication, including body language, should be congruent with that message. Any difference between the two will make it more difficult for Michael to trust the genuineness of the nurse (McCabe & Timmins, 2006). This could hinder the development of a trusting professional relationship. Body language expresses feelings that could make Michael feel rushed or ineffective, particularly if the nurse is feeling rushed or lacking in optimism. Therefore, for the nurse to present positive body language and appear engaged in Michael’s efforts, the nurse must genuinely share in his goals, empathise with his feelings, and use professional knowledge and experience to feel encouraged even when Michael may be disheartened by temporary setbacks. If Michael feels the nurse isn’t interested in helping him or feels it is a waste of time or shows frustration, then he will not feel confident in achieving his goal. People are often not conscious of the non-verbal and para-verbal signals they communicate, so a genuine feeling of empathy and a non-judgemental approach are essential to enable Michael to feel emotionally secure and able to try, even if his efforts are not always successful (McCabe & Timmins, 2006). Good nurse-patient communication is essential in promoting Michael’s independence and plays just as important a role in his success as any physical help and assistance.

Conclusion

These interventions should be evaluated within the stated time, to assess achievement of outcomes. If Michael does not progress as expected, then the interventions may need to be altered or the goal slightly modified to meet his current situation. Whatever care assessment and care planning tools are used, a person-centred approach will enhance the care experience for both Michael and other service users, and will optimise health outcomes. A planned approach to care is essential to ensure that individual differences are identified, and that care is appropriate for the needs of each person and evidence-based. In this way, Michael can be supported to achieve optimum independence in washing and dressing following his stroke, which will improve his quality of life and independence in other ALs. Carrying out essential care with compassion, knowledge and competence is a defining aspect of the nurse’s role.
References


Breastfeeding benefits for mother and infant: A literature review

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Rationale for choice of topic
Although studies indicate breastfeeding is the most natural source of nutrition that a mother can provide for her child, for many reasons mothers are not choosing to breastfeed their babies or are not breastfeeding for an adequate length of time (Stanway, 2005). It is the role of the nurse to promote the benefits of breastfeeding; however, Dobson and Murtaugh (2001) found that while mothers seek the advice of nurses, many are not adequately trained to promote the benefits. As a student nurse, the author set out to determine the benefits of breastfeeding through a literature review, with the aim of promoting accurate advice.

Background
According to the World Health Organization (WHO) (2009), breastfeeding provides short and long term benefits for mother and child. For the child, studies show breast milk can reduce chronic and acute infections, obesity and Sudden Infant Death Syndrome (SIDS). Breast milk gives the infant the best nutritional start in life. It provides protein, fat, carbohydrates, nutrients and liquids (Blincoe, 2007). It is equally beneficial for the mother. Stanway (2005) cites that, among an array of benefits, it is known to accelerate the loss of pregnancy weight, and encourage the womb to shrink back to normal and therefore stop bleeding sooner than in formula-feeding mothers, in addition to helping to guard against pre-menopausal breast and ovarian cancer.

Breastfeeding rates are varied across the world. The research of Stanway (2005) illustrates that only 71% of new-born babies are breastfed in the United Kingdom. Throughout the last century, there has been a clear decline in the rates of breastfeeding mothers. Renfrew, Dyson, Wallace, D’Souza, McCormick and Spiby (2005) believe that this is due to the advice given to breastfeeding mothers by health professionals and the routine care of women in hospital.

Review of chosen literature
The main database used to identify studies was CINAHL. When searching from 2005-2010 and in UK and Ireland text, the term ‘breastfeeding’ showed 669 results. The terms ‘breastfeeding’ and ‘benefits’ then narrowed the search, retrieving 62 forms of publication. 22 of these were available as PDF full text articles. The author read through the publications, retrieving any other forms of cited literature relevant to this study using the search engine Google Scholar to find those not available within CINAHL.

The University of Chester library was used for the loan of the book Breast is best (Stanway, 2005). The following websites were used to retrieve publications: UK Baby Friendly Initiative, UNICEF, World Health Organization, National Institute of Clinical Excellence (NICE), and the Department of Health (DH).

The major theme emerging from the literature search is the well addressed health benefits of breastfeeding for the mother and child. The WHO documents the vast majority of this evidence-based research in the form of statistical reports, surveys and press releases. Although recognised, evidence surrounding the total volume of knowledge passed from health care professionals to mother is limited. Much of the literature is quantitative evidence and refers to acute health problems, mainly in third world countries. Additionally, all evidence used refers to and supports the benefits of breastfeeding for both mother and infant.

Findings
‘Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants’ (WHO & UNICEF, 2003, p. 7). The correct nutritional intake is vital when establishing a healthy lifestyle. The WHO (2010) supports this and suggests mothers should exclusively breastfeed for the initial six months of life, and in conjunction with appropriate foods up to two years of age. This ensures the child continues to receive a complete source of nutrition throughout development (Renfrew et al., 2005). The WHO (2009) estimated that non-exclusive breastfeeding in the first six months of life resulted in 1.4 million deaths. Breastfeeding is also known to be the most cost-effective method of infant feeding. An estimation of a mother’s financial benefit when exclusively breastfeeding is on average £450 annually (Stanway, 2005). Overall, it is reported...
that 84% of mothers across the United Kingdom are aware of the health benefits of breastfeeding (Bolling, Grant, Hamlyn & Thornton, 2007), yet the actual breastfeeding rate is lower. Haddinott, Tappin and Wright (2008) demonstrate the prevalence of breastfeeding at four months old across developed and developing countries, and clearly identify the low rates in the United Kingdom between 1995 and 2000 in comparison with equally developed countries. According to Renfrew et al. (2005), the reasons for low breastfeeding rates in the United Kingdom are the organisation of health services and the lack of preparation from health professionals in supporting effective breastfeeding. Due to physical setbacks with little support from midwives and nurses, fewer than 35% of infants worldwide are still exclusively breastfed at four months old (Heird, 2007). This indicates a mother’s lack of confidence in relation to the benefits of breastfeeding; an appropriate time for midwives and nurses to provide extra support and encouragement would be upon observing this. With regular training, healthcare professionals can play a critical role in providing support, through influencing decisions about feeding practices. This would enable nurses to provide much needed skilled support to a mother in maintaining her milk supply when a child is unable to feed adequately (Lee, 2004). It is now well established that skilled support, voluntary or professional, proactively offered to women who wish to breastfeed can increase the initiation and/or duration of breastfeeding (Renfrew et al., 2005).

Conclusion
Public health authorities are promoting the numerous benefits of breastfeeding at national and international levels. However, the message still needs to be more influential with greater encouragement and perseverance. Many mothers wish to give the best nutritional start in life to their children, and rely on nurses for advice on doing so. Midwives, nurses and other health professionals should put themselves in a position of encouraging mothers to breastfeed, not only for the health of the child, but also the mother. There is little evidence supporting the depth of knowledge passed from health professional to mother surrounding breastfeeding. However, there is substantial evidence and documentation outlining and supporting the benefits of breastfeeding. Reader-friendly documentation from organisations such as UNICEF (1994) and the Baby Friendly Initiative programme is available to the public and health professionals. Breastfeeding offers opportunities for nurses to develop and extend competencies while enhancing a mother’s treatment and experience.

References
1. Introduction

This report will reflect upon my experience of performing the clinical skill of blood pressure measurement in a simulated practice environment. I have chosen this as I have a personal interest because my family has a history of hypertension. From this I recognise the importance of accurate blood pressure readings, and it has made me keen to improve my knowledge and perfect my practice. I also understand that monitoring of blood pressure is crucial as hypertension is a key risk factor for a stroke or developing coronary heart disease, the leading causes of the UK mortality rate (Department of Health [DH], 2005)

To share my reflection I used Gibbs’ model of reflection (Gibbs, 1988) which looks at description, feelings, evaluation, analysis, conclusion and action plan. This model has been used as a medium to facilitate my thoughts, feelings and behaviours in regards to my first practice within the skills laboratory. This report will include evidence-based information on the importance of accuracy of this procedure and how practice can be improved.

Confidentiality will be respected throughout this report with any names anonymised in accordance with Nursing & Midwifery Council (NMC) guidelines (NMC, 2008).

2. Description of what happened

After a tutorial and demonstration I was tasked with practising blood pressure using an aneroid sphygmomanometer on fellow students following instructions from a learning tool provided.

After gathering the equipment, applying standard precautions relating to infection control and seating my ‘patient’, I began by applying the cuff. However I had difficulty positioning it correctly in line with the brachial artery and struggled to get it high enough up the arm to place the stethoscope in what I thought was the right place. Checking the patient was comfortable, I asked them politely to adjust their arm so that I had better access to the brachial pulse. I then checked with the patient that the cuff was not too tight.

I found the radial pulse and pumped up the cuff until I could no longer feel the pulse. This registered at 110 millimetres of mercury (mmHg) which gave me my estimated systolic measurement. I felt for the brachial pulse to determine the correction position of the stethoscope, however on first attempt I was unable to find it. After several attempts, I eventually located a faint brachial pulse and placed the stethoscope in this area. However misunderstanding the procedure, I attempted to listen for the Korotkoff sounds without success. After re-reading the information provided I realised that the cuff had to be inflated to hear the sounds, and I pumped it up 30 mmHg above the estimated systolic measurement so that I would not miss the entry of the Korotkoff sounds. I then began to let the air out, but due to my awkwardness let this out very quickly. I found this part of the process difficult as one hand was holding the stethoscope in place and the pump/clip had to be operated using the other hand. The Korotkoff sounds were also very difficult to hear and despite re-positioning the earpieces and the stethoscope several times, it still took me some time before I could hear the initial sharp ‘thud’ and then the subsequent sound phases.

Once again I experienced confusion with the procedure, listening for the sounds to silence and logging this as the diastolic measurement but not logging the initial thud as the accurate systolic measurement. After further guidance from the session facilitator I was able to identify a blood pressure reading of 112/66 mmHg.

What were you thinking and feeling?

I had a real mix of feelings when beginning the procedure. I was keen to attempt the skill as it was one of the first clinical procedures that we had been given to practise in my programme and it is a fundamental skill in nursing. However alongside the excitement, I was nervous about doing it wrong. My thoughts also centred on the fact that it involved another person, and that I had to manage their feelings and impressions of me at the same time. I felt very self-conscious of my actions and clumsy in my approach. During the second half of the procedure when listening for the Korotkoff sounds I felt very frustrated as the environment was very noisy, making it difficult for me to concentrate and hear the sounds.
What was good or bad about the experience?

On the whole the experience was positive, with the best elements being able to practise the procedure in a controlled environment where there was plenty of support and we were all learning a new skill. I was also pleased that I managed to locate the radial pulse easily, as previous attempts in an earlier lesson had failed.

The negative part of the experience stemmed initially from my lack of knowledge and confidence in performing the procedure. This, in addition to panic and the noisy environment, led to several failed attempts at fitting the cuff, finding the brachial pulse and positioning the stethoscope. I also was unsure about what Korotkoff sounds were and this, combined with the position of the stethoscope and deflating the cuff very quickly, led to difficulties in me hearing them. Additionally, I realised after the event that I did not check the position of my patient, ensuring their arm was level with the heart and that their legs were not crossed, which can affect blood pressure readings.

3. What sense can you make of the situation?

From reflecting on my negative experiences of this procedure and based on the evidence I have found, I can see that a number of errors or difficulties in practice can artificially affect blood pressure readings (Baillie, 2005; Blows, 2000; British Hypertension Society (BHS), 2010; Dougherty & Lister, 2008). If a patient is moving about or difficulties with was the positioning of the stethoscope, as indicated in 2005 by Valler-Jones and Wedgbury, the correct positioning should be lightly over the brachial artery ensuring that it is not under the cuff as this can cause a delay in the occurrence of Korotkoff sounds. Similarly, it is important to ensure that the ear tips of the stethoscope are angled forward into the auditory canal to optimise hearing of the five phases of Korotkoff sounds (Alexis, 2009; BHS, 2010; Dougherty & Lister, 2008) as an initial clear tapping increasing in intensity, leading to a swishing sound, which is then followed by a third sharper sound that in the fourth phase muffles, moving to silence in the fifth phase. Following my issue with deflating the cuff too quickly, I have learnt that Blows (2000) and BHS (2010) give a recommended deflation rate of about 3 mmHg per second, which accommodates most heart rates.

To conclude, Campbell, Chockalingam, Fodor and McKay (1990), Jevon (2009) and BHS (2009) all found that errors in technique and equipment malfunctions accounted for differences in readings, and that such errors could be reduced by an improved technique and taking several readings.

4. Development of your application, knowledge and understanding of this skill

What else could you have done?

In summary, the main problems I had with the procedure were surrounding navigation of the equipment, understanding the procedure and hearing the Korotkoff sounds. In hindsight I could have familiarised myself with the procedure before the practice session using a clinical handbook. This would have given me more confidence and eliminated some of my initial errors surrounding locating the brachial artery and the correct placement of the cuff and stethoscope. It would also have made me more aware of the patient's correct positioning. Familiarising myself with the equipment might have helped me to deflate the cuff less quickly and I could also have moved to a quieter location to enable me to concentrate on listening for the Korotkoff sounds. Finally, understanding the factors influencing blood pressure within the clinical environment would also have helped me to validate the blood pressure reading.

Action plan

In the future, prior to practising the procedure, I will ensure I undertake a revision of the main key points using available learning materials, such as The Royal Marsden Hospital manual of clinical nursing procedures (Dougherty & Lister, 2008). If I experience difficulties in hearing the Korotkoff sounds, I will ensure that the stethoscope is positioned correctly and that the ear tips are correctly inserted facing forward. I will also try to ensure that the area is quiet to aid my ability to concentrate. Finally, where necessary, I will repeat the procedure taking two readings.

As practice is crucial in obtaining accurate readings, I bought a
sphygmomanometer to practise on family and friends, and during my following placement I arranged a visit to a heart support unit where I was able to observe and undertake a number of blood pressure checks on service users.

References


‘Closing the gap’: Improving equality for women and men in the nursing profession

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Abstract
This article investigates the assumptions and stereotypes associated with gender discrimination and their impact on the nursing profession, practitioners, services and patients.

Key words
Male nurses; gender discrimination; stereotypes; media influences

Introduction
The typical image of a nurse is one of a caring and nurturing individual who is female, in whom these traits are considered innate. This pertinent point is echoed by Thompson (2007) in his assertion that ‘care is most often seen as an extension of the traditional woman’s role’. In his discussion on gender inequalities Thompson adds that it is important to ‘go beyond stereotypical gender roles’ (p. 70). This is particularly the case for male nurses who often are perceived as either sexual predators or as homosexual given their professional orientation (Twigg, Walkowitz, Cohen & Nettleton, 2011; Harding, North & Perkins, 2008). This critical discussion challenges media representation of professional stereotypes, in this instance male nurses. In doing so it seeks to illustrate an issue that is overlooked within the nursing profession and in pre-registration education.

Stereotyping and prejudice are closely related and in some cases difficult to define. Webb and Tossell (1999) explain that prejudice is derived from stereotyping, and that it is an attitude that can be towards an individual or a group. These attitudes are not based on factual evidence. They are either expressed overtly in behaviour or remain ‘secret’ (p. 16) at subconscious level, but they nonetheless affect what a person thinks, feels and does. Stereotyping is described by Clements and Jones (2008) as a series of shared generalisations about characteristics of a group or class of people. Discrimination is often the product of stereotyping and the expression of prejudice which involves the unequal treatment of an individual or group of people on the basis of features such as race, age, sex, and disability (Clements and Jones, 2008). Thompson (2003) distinguishes between processes of discrimination (such as marginalisation, stigmatisation, invisibilisation), categories of discrimination (including class, race, gender) and forms of discrimination based upon the categories (for instance, classism, racism, sexism). In the case referred to later in the article, the process of discrimination involves stigmatisation resulting in marginalisation; the category of discrimination is gender, with sexism as the form of oppression.

The Sex Discrimination Act (SDA) (1985), amended recently and now known as the Equality Act (2010), makes it unlawful to discriminate against people on the grounds of their gender. There are two types of discrimination in employment, education and advertising: 1) direct and 2) indirect. The first is manifest when one person receives less favourable treatment than another, and the second involves a condition, rule, or policy which disadvantages people who share a protected characteristic (Brammer, 2007; Thompson, 2007). Sexism is a prejudice that is based on someone’s gender, and although sexism is discriminatory behaviour towards both sexes the term is almost universally used to describe unequal treatment of women (Clements & Jones, 2008). The case of Andrew Moyhing illustrates this well.

Andrew Moyhing was 29 and a qualified nurse working for the National Health Service (NHS). In 2006 Mr Moyhing left his job after being refused the opportunity to carry out ‘intimate tasks’ on female patients. Twigg et al. (2011) explain that generally upper arms and the back are neutral areas and can be touched by most people, but the knees and thighs are less so; breasts and genitals, however, are ‘off limits’ and these are classed as intimate areas. Mr Moyhing was told that if he was to perform these procedures he must have a chaperone present. Following this experience Mr Moyhing challenged the trust’s policy that only male trainees must be chaperoned and argued that his training was restricted, which prevented him from learning how to carry out intimate examinations. Four media articles have been critically examined in relation to his case. These include one from the British Broadcasting Corporation (BBC), and one from the Telegraph and two from the Guardian newspapers.

Andrew Moyhing did not object to the wishes of the patient requesting or choosing to have a chaperone, but the patients were not given that choice. Mr Moyhing stated that ‘This was offensive to me as a man, made me feel inferior’ (Carvel, 2006). The BBC (2006) state that initially Andrew’s claim against the NHS was rejected, but the ruling was overturned by the Employment Appeals Tribunal. The law which
assisted him to win his case was the SDA (1986). Mr Moyhing was supported by the Equal Opportunities Commission who stated that ‘the Employment Appeal Tribunal was right to find that it was not acceptable to have a chaperoning policy based on lazy stereotyping’ (Batty, 2006). The key issue in this case is that Andrew Moyhing and historically other male nurses are being indirectly discriminated against on the assumption that all men are ‘sexual predators’. Male nurses constitute only 10% of the workforce, making it arguable that they are in a vulnerable position because of their minority status (Prideaux, 2010).

Mr Moyhing felt degraded by the policies in place at the hospital. These stated that male trainees had to be chaperoned (Womack, 2006), although this did not apply to female students or staff treating a male patient. He also felt that this policy had affected his learning. Andrew made his case in the hope that it might improve equality between men and women in what is often classed as a woman’s career.

‘Nursing has historically been defined as a caring profession and caring is viewed as a feminine trait.’ (Prideaux, 2010, p. 42)

The media has played a big part in how nurses are characterised. Firstly they have been portrayed as young, seductive females, who are described as ‘air heads’. The second interpretation projects them as being the opposite of this – as rough, and threatening (Masters, 2005). There are many ways that the media influence the way we stereotype professionals such as through news, magazines, cards, films, and programmes. Harding et al. (2008) add to this by stating that:

‘Repeated nonsexual touch is often part of nursing care, but it has been imbued with sexual meaning through the dissemination of films, cards, novels, and jokes that sexualize the work of nurses. Young female nurses become objects of sexual desire; male nurses on the other hand, are constituted as objects of sexual threat.’ (Harding et al., 2008, p. 89)

Burton and Misener (2007) state that the media portray and maintain powerful stereotypes. One theme that has been portrayed is that male nurses must be gay, since they have chosen to take on ‘women’s work’. Another is that if a male nurse is not gay, then they are a ‘womaniser’. Burton and Misener (2007) further state:

‘The presumption is that heterosexual men choose nursing for sexual exploits and conquest or to advance professionally on the backs of less ambitious female nurses.’ (Burton & Misener, 2007, p. 258)

Twigg et al. (2011) add that some men dislike the idea of having a same sex care worker, perceiving it as a homosexual encounter; this is from the assumption that a man in a care worker role is not a ‘proper man’.

This type of stereotyping and associated assumptions can not only affect male nurses, making them feel vulnerable, but can also affect patients and colleagues. The enforcement of a chaperone policy may offend patients. As Prideaux (2010) comments, female patients may take offence at a male nurse requesting a chaperone being present. This is because the patient may think that staff are assuming that a false allegation may be made. Female patients are generally uncomfortable when more than one person is present during an examination and may feel embarrassed. As such, women should be asked if they would prefer a chaperone instead of staff assuming that there is a policy that indicates one is necessary (O’Lynn, 2007).

Harding et al. (2008) explored the experiences of male nurses in providing physical intimate care. The study included interviews with 18 male nurses. The findings concluded that male nurses felt vulnerable, paranoid, and worried about what allegations were going to be made against them.

Male nursing students may face discrimination from practising nurses, physicians and the public. For example male nurses often ask male colleagues for assistance in lifting and turning patients, emphasising physical strength rather than professional expertise (Chitty, 2005), skill or knowledge. The study conducted by Harding et al. (2008) looks at the segregation of male and female staff. They explain that there is a long history of men being segregated from female colleagues or monitored, and give an example of how bad things used to be. They also, in reference to their research, state that this continues today:

‘Several [participants] suggested that monitoring continues today in the form of other (female) staff asking a (female) patient’s permission for a male to provide care to her. This irked several participants, because they believe they should have the right to interact with the patient first.’ (Harding et al., 2008, p. 93).

There are many policies and laws that protect professionals and services users. In reviewing the statutory law on discrimination and equality, the government has recognised that individuals may need help and advice on understanding the law (Brayne & Cart, 2008). Over time three commissions have been created: the Equal Opportunities Commission (EOC), the Commission for Racial Equality, and the Disability Rights Commission. They have now been merged into the Equality and Human Rights Commission. Brammer (2007) states that a simple evaluation of the effectiveness of the legislation would suggest that, despite it, discrimination still continues as in the Moyhing case. The role of the EOC was to promote equality and diversity, enforce equality laws, work towards eliminating discrimination and harassment, and encourage public authorities to comply (Brammer, 2007); in this case its role was to help Mr Moyhing fight for his rights and promote equality. The EOC states in one of the articles reviewed that this ruling challenges assumptions that all men are sexual predators, and that it will help to open up nursing to men (Carvel, 2006).

Mr Moyhing believed that his training had been hampered because organisational policy was preventing him from learning how to carry out intimate examinations on female patients, while female nurses were taught to treat both male and female patients. Harding et al. (2008) comment that male nurses felt they had a lack of guidance on using intimate touch appropriately or developing strategies to protect themselves. They also stated that nurses felt that their education lacked instruction on assisting patients with intimate care. Their pertinent statement below relates to the nurses’ feelings:
‘The focus was essentially on the female genitalia, which he described as being “flashed over in a very short period of time”. He continued “it was presumed that young women knew and understood”. Allan, a young gay man, had to ask one of his peers for help to gain the knowledge he needed to adequately assist female patients meet their hygiene needs.’ (Harding et al, 2008, p. 96)

Mr Moyhing states that he believes that if male students are treated more equally, those such as himself who abandoned nursing careers will stay, and the numbers of male and female nurses will start to equalise (BBC, 2006).

Conclusion
From these media examples and critical discussion of the literature, the types of stereotyping and discrimination that male nurses face every day are apparent. It is also understandable why there are fewer male nurses than female ones. Sex discrimination is mostly seen as discrimination towards women in the working environment and often identified as the ‘glass ceiling’, but this article has shown that it applies as much to men as it does to women.

Health and social care service providers need to be cognisant of the issues and tensions relevant to intimate care provision by male nurses. This will facilitate more productive relationships between staff members and the patients served. The onus, however, is also on pre-registration education providers to enhance professional education in this area. Attention to these points may serve to equalise male/female nurse ratios, and enhance the value that the current minority bring to patient encounters and organisational practice.

References
Attitudes of nursing staff to inpatient mobilisation: A literature review

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Abstract
A literature review explored attitudes of nursing staff towards mobilising inpatients on an acute medical ward. Functional decline occurs in up to fifty per cent of hospitalised older adults, and with an ageing population (McKenna, 2008) assisting patients to perform their own activities of living rather than providing all physical care will help to prevent functional decline and is key to rehabilitation (Resnick, 2001). The review explores if nurses’ attitudes act as a barrier to changes in nursing practice aimed at promoting early ambulation as part of rehabilitation care (Jootun & MacInnes, 2005).

Key words
Early ambulation; mobilisation; nurse attitudes; rehabilitation

Introduction
This literature review was undertaken in order to identify the current state of evidence-based knowledge related to the theory and practice of early mobilisation in older adults, specifically applied to nursing care in acute medical care settings. A systematic approach has been used to allow for replication and ensure a complete picture of current evidence within the context of the question (Aveyard, 2010). The number of hospital admissions of the elderly is increasing and hospitalisation often leads to functional decline (Isaia et al., 2009). Twenty to thirty per cent of the population over seventy five years old are clinically frail and hospitalisation is recognised as a major cause of frailty (Topinková, 2008). With the number of people aged sixty five and over expected to increase by sixty five per cent in the next twenty five years, and an expected doubling of people aged eighty five and over, managing older people’s health and taking action to prevent functional decline becomes increasingly important (Hartree, 2011). The population shift will have dramatic effects on healthcare provision and it is essential that nurses have the skills to care for this age group (Lawson, 2006).

Functional decline is the reduced ability to perform tasks of everyday living due to a decrement in physical or cognitive functioning (Brand, Jones, Cox, Amatya & Staley, 2004). Reduced mobility levels and inactivity during hospitalisation leads to physiological changes such as reduced muscle strength and accelerated bone loss, resulting in functional decline (Kleinpell, Fletcher & Jennings, 2008). Early mobilisation following a stroke is a key component of reducing complications such as urinary tract infection, chest infection, mobility-related falls, shoulder pain and deep vein thrombosis (Smith & Arias, 2007). Older adults are more susceptible to experiencing functional decline and hospitalised adults over the age of seventy four have shown statistically significant deterioration in individual scores for mobility, transfer, feeding and personal hygiene within two days of admission (Brand et al., 2004). Functional decline occurs in up to fifty per cent of hospitalised older adults and in thirty per cent of cases is unrelated to the initial diagnosis (Mckenna, 2008). The rate of loss of muscle strength may be as high as five per cent a day with inactivity (Jones, Lowe, MacGregor, Brand, Tweddle, & Russell, 2006) and only half of those who experience functional decline will regain function after hospital discharge (Graf, 2006). Physical and cognitive functioning can often be overlooked as hospital care focuses on acute illness (Graf, 2006).

Multi-disciplinary intervention that includes exercise reduces the length and cost of hospital stay, and increases the number of patients discharged home from the acute medical inpatient setting (Morton, Keating & Jeffs, 2007). This approach also improves function on leaving hospital (Morton et al., 2006). The need for further rehabilitation, respite or residential care could be avoided by ensuring patients’ functional status does not decline (McKenna, 2008). Personal integrity and wellbeing may be threatened by the loss of mobility, reducing physical freedom, independence in daily activities and social interaction with others. Functional decline also increases the risk of illness and readmission (Kneafsey & Haigh, 2009). Assisting patients to perform their own activities of living rather than providing all physical care will help to prevent functional decline and is key to rehabilitation (Resnick, 2001).

The hospital environment plays a significant role in discouraging ambulation and commonly it is the hospitalisation, not the illness itself, which contributes to functional decline in older medical patients (King, 2006). Many adults become fearful of falling due to high beds, shiny floors, equipment clutter, and use of restricting devices such as intravenous lines and catheters (King, 2006). Older patients are one third as likely to experience a decline in functional status when nurses initiate interventions to ensure the patient remains as independent as possible during hospitalisation (King, 2006). These include mobilisation goals, self-care activities, routine walking schedules, activities to prevent sensory deprivation, fall prevention, restraint reduction, delirium detection, incontinence management, good nutrition and maintenance of skin integrity (Kleinpell et al., 2008).

In the care of older people, the nurse needs to ‘maintain quality of life and protect independence’ and meet physical and functional health
needs in order to provide individualised care (Nursing and Midwifery Council, 2009). Assessment of mobility levels and needs is necessary for preventing deterioration and maximising functional ability (Royal College of Nursing, 2004). Nurses are in a key position to reverse the trend of functional decline seen in hospitalised older adults, as nurses who promote mobility and independence will improve functional outcomes (King, 2006). Despite this, studies have reported that nurses have substantial gaps in their knowledge and theoretical understanding of preventing functional decline (Gillis, MacDonald & Maclisaac, 2008).

Literature Search: Method

The Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was searched. The most relevant and inclusive CINAHL headings were identified before carrying out the search, along with major concepts and subject headings. Limiters were used including English language only, full text only and articles published after the year 2000. Only literature published in the last ten years was used, as nursing practice changes in response to new knowledge and practice development, so findings before this would not be relevant (Gerrish & Lacey, 2010). The literature searches (see Figure 1) were carried out between October and December 2010.

When ‘mobilisation’ was used as a keyword for a search it did not generate any relevant literature. Using CINAHL headings it was identified that ‘rehabilitation’ and ‘early ambulation’ were more appropriate keywords. When ‘rehabilitation’ was used as a ‘word in subject heading’ and ‘nurse attitudes’ used in ‘all text’, one hundred and fifty five results were found. Using the limiters this volume was reduced to forty eight results and a further thirty six were discarded because they were concerned with the attitudes of other healthcare professionals, such as physiotherapists, or because they were related to mobilisation with specific medical conditions. The Boolean operator ‘AND’ was used to ensure results contained both keywords.

‘Early ambulation’ AND ‘nurse attitudes’ as a search did not produce any results, however ‘early ambulation’ alone found fifteen results when the limiters were applied. On reading, only two of these related to the research question as the others were either not concerned with nurses or were studies researching whether patients should be mobilised after certain health problems, mainly based on the intensive care unit. By using ‘rehabilitation’ as a ‘word in the abstract’ and ‘nurse attitudes’ as a ‘word in subject heading’, and with the limiters applied, one other article was found.

Findings

In a rehabilitation unit, nurses perceived the role of physiotherapists to be concerned with mobility and movement, and the role of the nurse to be more diverse within patient rehabilitation (Dalley & Sim, 2001). Nurses valued the physiotherapists’ knowledge and skills in mobility and movement, but felt they had insufficient understanding of the demands and pressures of nursing practice (Dalley & Sim, 2001). Physiotherapists’ autonomy over the structuring of their work pattern, due to its specific nature, made nurses feel physiotherapists have higher status than them, as the nurse’s role was perceived as being undefined with a lack of boundaries and insufficient control over working patterns (Dalley & Sim, 2001). Effectively, despite having common aims with physiotherapists, nurses may have a negative attitude to mobilising patients as they do not see it as being within their job role. Nurses may benefit from structured goals about patient mobilisation to ensure they feel they have equal status to physiotherapists in rehabilitation. The lack of communication and teamwork were perceived to be barriers to effective rehabilitation.

On a neurological rehabilitation unit, poor teamwork and the feeling of nurses being undervalued by patients and other health professionals were perceived to create a barrier to effective rehabilitation (Barreca & Wilkins, 2008). Interviews with nurses showed that they felt their role was pivotal in the rehabilitation process, but they identified barriers to a facilitative care approach, including difficulty in letting patients struggle with activities of living, and a lack of resources and time to practise facilitative care. Other professionals felt that nurses did not practise functional activities with patients, and patients seldom mentioned nurses when asked which team members helped them during the rehabilitation process (Barreca & Wilkins, 2008). This study shows how nurses are aware of the importance of patient mobilisation and activity, but do not feel they are able to carry out the role as effectively as they would like because they have the perception that they are limited by time and resources. In a study of student nurse experiences, they reported that patients’ mobilising needs were not assessed and documented on care plans properly, as this was seen to be a health and safety matter and not part of the patient care. They felt ward staff (their role was not stated) were ‘set in their ways’ and reluctant to change their methods of mobilising patients (Jootun & MacInnes, 2005). Student nurses also found that staff preferred to lift patients in order to make the task quicker, rather than to allow them to mobilise independently (Jootun & MacInnes, 2005).

Similarly, rehabilitation unit nurses felt hurried to have patients washed and prepared on time for rehabilitation sessions, so they often completed hygiene needs for the patient, which does not promote independence.
A lack of common language used by allied health professionals in their notes, including abbreviations, as well as an absence of care co-ordination, contributed to poor teamwork and a limited rehabilitation role for nurses. Nurses also felt their time was often taken up with the management of secondary health conditions, unrelated to the purpose of the patient’s admission (Pryor, 2008). Time poverty and poor teamwork were perceived to be the biggest obstacles in mobilising patients, so co-ordinated rehabilitation care and a recognition of the qualified nurse time needed for quality care when planning skills mix and staffing levels could improve nurses’ approach. It was also identified that what nurses understand and expect of patient rehabilitation was different from what they perceived patients to understand and expect. This incongruence was thought to be because although nurses knew that successful rehabilitation required patients to be active participants in their own care, patients did not share this view. Patients expected nurses to actively care for them at the bedside and did not realise that rehabilitation was a continuous process, instead thinking it comprised intermittent activities carried out by other members of the multi-disciplinary team (Pryor & O’Connell, 2009).

Similar themes were identified in Smith and Arias’ (2007) questionnaire study of nurses, doctors and physiotherapists which aimed to identify their knowledge of early mobilisation and complications of immobility, and their understanding of different terminology and concepts in the care of patients following a stroke. Differences were demonstrated between the goals of care, so that while nurses and doctors believed patients needed to be physiologically stable before mobilising, physiotherapists believed that interventions to mobilise patients should be made even when they were not stable. Little evidence was found of multi-disciplinary working and assessment, and the study concluded that before research into rehabilitation and early mobilisation can be carried out, basic guidelines as to what constitutes early mobilisation, and what physiological parameters can be used to plan care, are required. Ellery and Bernhardt (2008) agreed that nurses and physiotherapists play a major role in initiating and supporting mobilisation. With fifty per cent of patients experiencing functional decline it could be argued that this role is not being carried out effectively.

A Scandinavian questionnaire study (Routasalo, Wagner & Virtanen, 2004) found close collaboration between nurses and physiotherapists, and that the role of nurses in rehabilitation is to maintain the patient’s ability to move and to conserve function, allowing patients to maintain normal daily activities. The study concluded that nurses have a positive attitude and perception to mobilising patients, but thought it required knowledge and experience; and that important factors in achieving effective rehabilitation were teamworking, goal documenting, and working closely with patients and their families. However, it is questionable as to how well one can gain a depth of understanding from a questionnaire study as causative factors and perceptions of events, processes or people lead more towards a phenomenological approach (Parahoo, 1997). In addition, cultural, economic and organisational differences may reduce its relevance to care in the United Kingdom (UK).

A more recent UK national survey showed a less positive attitude to mobilising patients when it was used to explore nurses’ views in relation to the handling of rehabilitation patients (Kneafsey & Haigh, 2009), though with only a 15.6% response rate the results may be treated with caution. The majority of respondents reported feeling confident in their skills to assist patients with movement and mobility, but also felt that more skills, knowledge and training were needed to better enable nurses to help patients mobilise. Only half of the respondents felt that the physiotherapist was the best person to help patients with mobility and movement, meaning nurses valued their role in promoting mobility. This may be due to the nurse’s twenty four hour patient contact and their role in assisting patients with activities of living: nurses have more opportunities throughout the day to encourage movement and mobility. Encouragement, confidence and motivation from healthcare professionals are key factors in patient mobilisation and independence (Crosby, 2001). There was a statistically significant positive correlation between the nurse’s age, the years since they qualified, and the attitudes they had to using mechanical aids and hoists: older, longer qualified nurses felt that patients could not improve their mobility if aids and hoists were used, and that manually helping patients was the only way to help regain mobility. This poor practice and negative attitude to correct and current manual handling techniques could explain why so many older adults experience a decline in functional status. Paradoxically, this suggests that by improving manual handling techniques used in assisting older people, staff would not need to do as much manual handling throughout the person’s hospitalisation period. This study concluded there is a need for further training in assisting patients to mobilise, as well as a need for nurses to evaluate their attitudes, beliefs, knowledge and practices related to patient handling (Kneafsey & Haigh, 2009).

Similarly, in a quasi-experimental observational study of nurses in a stroke rehabilitation unit, nurses spent significant amounts of time ‘doing for’ the patient, in the belief that it was too time-consuming to assist patients and completing tasks themselves was much quicker. However, following seven hours of rehabilitation education, nurses adopted more facilitative and less ‘doing for’ practices while assisting patients in the morning (which had not been recognised as part of rehabilitation), and it was found that adopting a facilitative approach resulted in no extra time demands (Booth, Hillier, Waters & Davidson, 2005). While a systematic review of the literature relating to nurse education in stroke care did not find a direct link between rehabilitation education and health outcomes, education was shown to alter attitudes and rehabilitation practice. The education of health care assistants was seen to be important, due to their high involvement in essential care (Edwards, 2006).

A Norwegian interview study of women’s care following a stroke (Kvigne,Kirkevold & Gjengedal, 2005) found that nurses were very focused on functional and practical aspects of care, such as preventing complications and promoting physical wellbeing. While many rehabilitative strategies were carried out, such as encouraging the use of affected limbs with physical support, mobilisation once recovery was stable, and encouragement to train in the gym and prepare drinks and meals, nurses did not discuss how patients felt about their stroke and what they wanted from their care. This resulted in patients feeling that their care was not individual to them and did not take their specific needs and wishes into account. The study shows different findings to other studies as the nurses perceived the mobilisation of patients as vital, and believed that encouraging exercise and activity was their
key role. The Norwegian nurses in this study (Kvigne et al., 2005) were aware of the importance of maintaining functional status and independence with activities of living, suggesting that there may be significant differences between care in Norway and the UK.

Conclusion
The literature reviewed offers some explanations as to why effective mobilisation of older acute medical patients does not occur, including staff skill mix, insufficient time, poor resources, training and team work. However, Jootun and McInnes (2005) and Kneafsey and Haigh (2009) suggest that nurses’ reluctance to change to current manual handling practices plays a major role in poor patient mobilisation. The ‘doing for’ attitude adopted by nurses in order to save time does not promote patient independence and also contributes to functional decline (Booth et al., 2009). By examining the attitudes nurses have towards patient mobilisation and preventing functional decline, we can better understand the barriers they face and the ways in which change can be implemented. Research into the attitudes of nurses may highlight further training needs and gaps in nursing education. Nurses are with patients twenty four hours a day, and are therefore best placed to offer encouragement and promote independence when assisting with activities of living to reduce functional decline. It is essential that all nurses are able to recognise and help address the specialist needs of the older person (Lawson, 2006); this is an integral part of nursing and not specific to those interested in caring for older people.

References


A literature review: Women’s perceptions of breast reconstruction post-mastectomy

Introduction

Breast cancer is now the most common cancer within the United Kingdom, with 45,700 women diagnosed in 2007, accounting for approximately 125 breast cancer diagnoses daily (Cancer Research UK, 2010). The most effective treatment recommended for around a third of all breast cancer diagnoses is a mastectomy procedure, involving the removal of the breast (Abu-Nab & Grunfeld, 2007). Following a mastectomy, breast reconstruction is an option offered to women; however, this choice is documented to cause dilemmas for many breast cancer sufferers (Abu-Nab & Grunfeld, 2007).

Breast reconstruction offers the availability for a new breast shape to be formed following mastectomy (Macmillan Cancer Support, 2008). The main intention of this surgical procedure is to match the existing breast as much as possible by using an implant, or through the use of tissue from another area of the body (Macmillan Cancer Support, 2008). There are, as with all procedures, positive and negative impacts that face a patient during the contemplation process of reconstruction. Macmillan Cancer Support (2008) have documented some of these, including the benefit of not having to wear a prosthesis, a more similar exterior form when wearing clothes to a person’s pre-mastectomy figure, a boost in a person’s sense of self and a more natural body shape. These positive aspects, however, need to be considered with a key negative factor, that although the appearance of the new breast may be similar to before, it will not feel or look exactly the same (Macmillan Cancer Support, 2008). Additionally, the ability for a person to breast feed is withdrawn, and potentially more than one operation may be required to obtain a final reconstruction (Macmillan Cancer Support, 2008).

What became apparent when reviewing the literature on breast reconstruction was that this area, as Compvoets (2006) highlights, remains a largely unexplored issue in women’s health and social wellbeing. Additionally sociological factors such as societal expectations, behaviours and social roles, and how these impact upon the choices women make following their mastectomy, need further exploration. This paper reviewed these pertinent issues and identified areas for potential research.

Overview of the literature

In order to locate relevant articles for the research proposal, the ‘Cinahl plus with full text’ database was initially used. Using the keywords ‘mastectomy’ and ‘reconstruction’, alongside the use of the Boolean operator ‘and’, the search yielded 375 articles. The search was then repeated using other databases including ‘Medline’, ‘PsycArticles’, ‘Psychological and behavioural sciences collection’ and ‘SociINDEX with full text’. This yielded 3363 results, which was then shortened to 158 articles with the use of ‘self’ and ‘decision making’ as additional keywords. From these, 14 articles were used within the literature review as they were the most relevant to the topic.

Key themes found within the searched articles included ‘body image’, ‘self-esteem’, ‘decision making’ and ‘reconstruction’. These themes assisted in highlighting areas of comparison between the research articles, and facilitated the demonstration of patterns as suggested by Munhill (2007).

There appeared to be little research regarding societal influences on the decisions women make in terms of their reconstruction options following a mastectomy. The search was not limited to a specific time frame, as sociological impact is something that always influences a person. Indeed, Reynolds (2009) noted that initial documentation regarding breast surgery dates back to as early as 1895. However, for the purpose of this review it was decided to write a critical discussion of current research in this field, examining influences affecting the reconstruction decision making process.

It has been argued by Ferguson and Kasper (2000) that from a feminist’s point of view reconstruction is seen as a way of fitting in...
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with the rest of society. Breast reconstruction can also be perceived as being medically superfluous, since it does not provide prevention or cure to morbidity or mortality (Compvoets, 2006). This attitude has led to reported feelings of guilt from women following reconstruction as they felt they were being judged by society as being incapable of effectively coping with their diagnosis, and therefore the decision to have reconstruction (Hill & White, 2008).

It has also been suggested that reconstruction does not meet the ideal anticipated recovery for women in relation to how they look and feel, compared to the social norm, which therefore affects a woman’s sense of self (Kasper, 1995). According to research carried out by Compvoets (2006), it was proposed by the participants that the reconstruction would help regain their femininity and the norm, only to find that, following the procedure, it did not fulfil their expectations of feeling complete. This could be the result of a lack of education in relation to the realism of their expected aesthetic outcome. This research concluded by highlighting that, while there was positive feedback relayed by women who had undergone reconstruction, this may have been due to the fact that reconstruction is considered as a final option (Compvoets, 2006). Their concept of self and body image could therefore not be adjusted until this last resort had been carried out (Compvoets, 2006). This idea of self-reflection, therefore, has substantial impact on the reconstruction decisions that women face from society. Compvoets (2006) went on to question if it is possible to achieve this level of postsurgical acceptance without having reconstructive surgery, and suggested that this is an area for future exploration.

In addition, Abu-Nab and Grunfeld (2007) reported that participants in their research commented that reconstruction images that they had seen prior to surgery did not match their own appearance following reconstruction, and therefore their expectations of the procedure had not been met. A number of these participants revealed a compelling aversion to the impact that scarring had left on their body, with the use of descriptions such as ‘ugly’ and ‘hideous’, and therefore demonstrating a clearly negative impact on a person’s sense of self, reflecting on how they appear to fit within society (Abu-Nab & Grunfeld, 2007). This highlights the importance of the decision making process that women go through. This research recommended that a more individual, patient focused approach would be beneficial, ensuring that their understanding of the given information matches that of the health practitioner, minimising levels of potential dissatisfaction (Abu-Nab & Grunfeld, 2007).

It was discussed within research by Romanek, McCaul and Sandgren (2005) that, similarly to the implications for nursing previously reported by Abu-Nab and Grunfeld (2007), it is fundamental to take an individual approach to each patient. The incorporation of their own situations into the advice given, with particular regard to the patient’s age, then encourages the patient to have a more active involvement in their reconstructive options available, reducing the risks of disappointment due to being dissatisfied with the decision made (Romanek et al., 2005). The individual situation of each participant will therefore influence their reconstruction decisions, thus highlighting the need for further research into decision making processes after a mastectomy. Despite the option to follow through with reconstructive surgery, participants of research carried out in Australia also reported feelings of removal and separation from the rest of society (Hill & White, 2008). In addition to these feelings, other negative feedback following reconstruction was highlighted, including a lack of self-esteem, reduced confidence, depression and an amplified feeling of self-consciousness (Hill & White, 2008). This expected outcome of the increased sense of self was also reflected on by Abu-Nab and Grunfeld (2007), where they reported on the significant lack of research to specifically support these findings. This point again highlights the need for further research to examine the influence of society on a person’s sense of self following a mastectomy.

Compvoets (2006), however, considered why reconstruction may be a positive process to an individual. The research commented on the fact that the lived familiarity of encompassing and existing as a ‘body’ played a fundamental role in the sociological effect of a person’s wellbeing, especially when a part of that body functions abnormally or changes (Compvoets, 2006). This is also supported by Katz, Rodin and Devins (1995), who noted a higher experience of disturbance in self-esteem and self-concept with loss of symbolic body parts in cancer treatment. This may therefore reinforce a woman’s decision to go through with reconstructive surgery as it has been reported that patients who undergo a mastectomy have significant negative changes in body image, including feelings of unattractiveness, which is why reconstruction can be seen as beneficial (Kemeny, Wellisch & Schain, 1988).

The need to wear breast prosthesis is also eliminated by reconstructive surgery and is therefore potentially beneficial, as artificial breasts are seen by some women as being problematic and distressing (Abu-Nab & Grunfeld, 2007). This factor should help to enrich a woman’s everyday living within society, especially those with lower self-esteem as this is related to body image (highlighted in research by Romanek et al. (2005)), and reconstructive surgery is aimed at enhancing the feeling of a more natural body shape (Macmillan Cancer Support, 2008).

Continuing along this theme of self-perception, research carried out in Australia focused on the thoughts and ideas of three groups of women and their feelings of body image and concept of self, including their levels of esteem (Reaby, Hort & Vandervord, 1994). The three groups involved were women who had undergone a mastectomy and wore breast prosthesis, women who had undergone reconstructive surgery following a mastectomy and, finally, women who had not encountered a mastectomy (used as a control group) (Reaby et al., 1994).

The research used questionnaires and an interview within the participants’ own homes for the women who had undergone a mastectomy, and the use of questionnaires only for the control group of women (Reaby et al., 1994). The results were gathered from a total of 173 participants across the groups, who met the research criteria and responded to the questionnaire (Reaby et al., 1994). The findings identified that the women from the two groups that had undergone the mastectomy procedure had enhanced positive attitudes about their bodies, compared to the control group (Reaby et al., 1994). This disproved the initial hypothesis where it was understood from previous research that changes in body image caused psychiatric morbidity (Reaby et al., 1994). It was then considered that this revelation could be
due to an element of denial by the participants (Reaby et al., 1994). The authors proposed that by showing disappointment following the initial decision to go through with the mastectomy, the mastectomy patient’s fulfilment of everyday living could be inhibited (Reaby et al., 1994). Societal attitude, which sees breasts as a sign of femininity, was seen as an influence and the authors suggested that mastectomy patients cannot fulfill the societal image without the use of reconstruction (Reaby et al., 1994).

It was also found that there was no substantial disparity between the groups with regard to their feelings of self-concept (Reaby et al., 1994). This is a significant finding as it contradicted the research of Polivy (1977) and Ray (1978) who both documented diminished levels of self-esteem amongst patients following mastectomy (Reaby et al., 1994). Reaby et al. (1994) highlight a number of aspects related to how societal input affects reconstruction decisions; however, the findings were based on participants from Australia, and therefore may not be representative of the United Kingdom. It was also research carried out in 1994. Eighteen years on, the level of societal impact may have altered and thus demonstrate a different picture.

It has also been disputed that women find it hard to discuss their breast cancer treatment and reconstruction options due to their socialisation, and to the perspectives that others place on them (Denny & Earle, 2008). This is illustrated from a male perspective, for example, as there is a cultural prominence on breasts as objects of male sexual interest and pleasure, and therefore following a mastectomy women can feel inadequate and disfigured due to being different from the cultural norm (Denny & Earle, 2008). Society involves not only the wider community in which women are established, but also their family and friends, and therefore full comprehension of and recovery from what they are going through can only be fulfilled by women who openly convey their thoughts and feelings (Hill & White, 2008). This issue, according to Hill and White (2008), should therefore be highlighted by the relevant healthcare professionals to increase the societal knowledge of the benefits of breast reconstruction as part of the healing process mastectomy patients go through.

Research carried out that examined how age influences the treatment that women selected demonstrated significant findings directly related to age and treatment. It was found that a lumpectomy procedure (breast saving surgery), over a mastectomy, was the desired option for 71% of younger participants (aged 18 to 24), compared to only 26% (breast saving surgery), over a mastectomy, was the desired option for older participants (aged 35 to 60) (Romanek et al., 2005). This was analysed in relation to risk assessment, as the perception of women was that lumpectomy treatment is seen as being more risky than a radical mastectomy, due to more breast tissue remaining in place and therefore potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005). This implies that some women are prepared to consider their psychologically well being, potentially more cancerous tissue left behind (Romanek et al., 2005).

An additional article that examined the effects of body image and sexual problems on younger women in America again related the significance of society on a person’s appearance, describing how body image is seen as the mental picture of how a person perceives themselves and as a physical symbol of social expression, relating back to the concept of self (Fobair et al., 2006). However, validity could then be contradicted in terms of methodology, the data were collected through the use of focus groups and a cross-sectional survey. This approach may limit the true picture of problems that young women with breast cancer face, as the survey may have limited how personal and detailed the response was, as they were related using a Likert scale system. It did however allow for a larger number of participants, yielding a total of 549 women, which then enhanced the validity of the results in terms of population representation (Fobair et al., 2006). However, validity could then be contradicted in terms of the interpretation of the Likert scale response: what one participant highlights as ‘a serious problem’ may be what another highlights as ‘a definite problem’, therefore producing unreliable and invalid data.

The findings from the research are also specific to the younger generation, those aged 50 and under, and so there is a limited ability to compare the older to the younger generation. This could have a significant impact on findings, as many of the research papers from the initial search discussed the impact of age difference in relation to reconstruction decisions following a mastectomy. This was therefore identified as an area for future research, developing the link between the two concepts.

There was research carried out within the United Kingdom that studied the apparent advantages and disadvantages of breast reconstruction, focusing on women who had been recently diagnosed with breast cancer. The study found that 89% of the participants were worried about their appearance following their operation; that 86% thought that reconstruction would allow for more choice in terms of their clothing style, and that their superficial appearance would be further improved with reconstructive surgery, compared to the use of prostheses (Keith, Walker, Walker, Heys, Sarkar, Hutcheon & Eremin, 2003). It was also indicated by 94% of participants that reconstruction would enhance their self-esteem (Keith et al., 2003). These results indicated that a large proportion of those asked were worried about the impact that society
had on them, and how fitting in with the social norm on an everyday basis will have influences on their choice of reconstruction. This article also highlighted the need for more insight into the worries and fears of women in relation to the influences that affect their reconstruction decisions (Keith et al., 2003). This research was carried out by the use of personality and breast reconstruction questionnaires, and a hospital anxiety and depression scale questionnaire, with a total of 125 participants. This quantitative research approach, although yielding a larger number of results compared to using a qualitative semi-structured interview for example, does not allow for an individual response. This may therefore not appear to the participant to be very empathetic in relation to the highly emotional impact that breast cancer can have on a person. A qualitative approach in terms of researching into sociological impact, on the other hand, may be more effective as it would allow for a more detailed and personal answer.

Summary and recommendations
The articles obtained through the search, although containing relevant information, have demonstrated that there is a lack of research material from the United Kingdom. The article by Compvoets (2006), in addition to the research by Hill and White (2008), were both based on participants from Australia, and therefore the findings may not be entirely reflective of the situation within the United Kingdom. This is also true for the articles by Kasper (1995), and Romanek et al. (2005), as these are pieces of research both carried out within the United States of America.

This article has defined breast cancer and breast reconstruction, and has outlined the positive and negative impacts of treatment on the individual. Overall, it has demonstrated that this is a relatively unexplored area in women’s health, but it has become apparent in the limited research presented that society influences women’s perception and decision making.

Areas of possible future research include examining the potential psychological and physical impacts affecting the reconstruction process, incorporating patients’ personal experience into the decision making procedure (Hill & White, 2008). Researchers should also consider the need to investigate the increased sense of self following reconstructive surgery as highlighted by Abu-Nab and Grunfeld (2007). Further investigation into these may prove to be beneficial to future sufferers of breast cancer and to their decision-making process.

References


Learning Disability and Risk seminar: A group reflection using ‘Six Thinking Hats’

Abstract
Reflection has been embraced by the nursing profession particularly in the last thirty years, and pre-registration nurse education programmes have incorporated reflective practice into curricula and assessment schedules. Many models of reflection have been offered as tools which prompt critical thinking through explicit examination of an experience, situation or event, with the aim of improving self-awareness, knowledge and decisions to inform future practice. This paper utilises the Six Thinking Hats model offered by De Bono (1985) to provide an account of a group reflection undertaken by five learning disability branch students in their final year of the programme following attendance at a seminar entitled Learning disability and risk. The reflection effectively assisted the group members to consider their participation in the seminar, identify their feelings, and recognise the negative and positive aspects of the experience. It encouraged the group to identify their learning and think creatively about how attendance and participation in the seminar will inform their future practice. It is recommended that the information gained through reflection is utilised to assist in the formulation of an action plan to ensure that optimum personal and professional development continues for each individual member of the group.

Key words
Learning disability, reflection, risk assessment, violence, aggression, forensic nursing

Introduction
The aim of this paper is to provide an account of a group reflection, using De Bono’s Six Thinking Hats (1985) concept, of a seminar entitled Learning disability and risk. The concept of reflection will be discussed, and its context within nurse education. Kolb’s Learning Cycle (1984), the Reflective Cycle of Gibbs (1988), the Model of Structured Reflection offered by Johns (1992, 2002) and the Six Thinking Hats of De Bono (1985) will be examined, and justification for the chosen method will be provided. The seminar will be described, analysed and evaluated using the model of reflection. The paper will conclude with recommendations for future practice.

Reflection
The concept of reflection is not new having been introduced in 1933 by Dewey, an American educationalist, in his discussion on the activity of thinking. Dewey (as cited by Moon, 1999) described a deliberate process of investigation into one’s own thoughts and behaviours that assists in the acquisition of knowledge, and which he referred to as reflection (Moon, 1999; Palmer, Burns & Bulman, 1994). Dewey’s concept was developed further by Hullfish and Smith (1961) who emphasised reflection as a deliberate activity that should purposefully lead to solutions to problems. They advocated the acknowledgement of feelings, memories and imagination to assist in problem-solving, an area of thought that Dewey was indicted of neglecting by some of his critics (Moon, 1999).

Emotions were acknowledged by Dewey (cited in Moon, 1999), but in a limited capacity. In his discussion, feelings of discomfort and confusion may prompt reflection rather than be integral to the process.
Further criticisms of the works of Dewey were that the framework, a five stage process, offered no flexibility in its linear approach and included no encouragement of interaction, being discussed as an individual activity; nor did he recognise any behavioural aspects of reflection, viewing the activity as purely intellectual (List, 2006).

Boud, Keogh and Walker (1985) reworked the earlier contributions of Dewey, and of Hullfish and Smith (1961), offering a three stage method which incorporated the experience, feelings and evaluation of the experience. This had the aim that the new knowledge, generated through thinking, integrated the experience into one’s own conceptual framework, to be drawn upon when faced with similar experiences. However, again, the activity of reflection was limited, suggesting that reflection was an individual activity, conducted deliberately following an experience (Boud et al., 1985).

The descriptions offered of the activity of reflection generally referred to critical thinking which occurred after an event or experience. It was Schon (1983) who introduced the concept of reflection-in-practice rather than the reflection-on-practice previously described. Schon (1983) described reflection-in-practice as the thinking process that is conducted while still performing actions, proposing that practitioners will make decisions promptly based on previous experiences, their knowledge, education and values, while almost simultaneously acting on the decision they have come to. This approach to reflection appeared to be more spontaneous and flexible, and had a significant impact on the nursing profession which had introduced the need for reflection to enhance and develop personal and professional practice and improve the quality of nursing practice (Andrews, 1996; Palmer et al., 1994).

Reflection has become a common component in the curriculum of pre-registration nurse education programmes with reflective accounts often incorporated into formative and summative assessment criteria (Hannigan, 2001). This requires students to produce written accounts, an activity that has been the subject of much debate in relation to time, confidentiality, truthfulness, meaningfulness, effectiveness and ability (Hannigan, 2001; Mackintosh, 1998; Pierson, 1998). However, as Bowden (2003) countered, it is the very activity of writing that can assist the student to create the time for more in-depth deliberate thought to improve learning. Furthermore, group reflection can increase effectiveness, encouraging discussion and creativity of ideas, particularly when reflecting on a shared experience as in this case (Bowden, 2003).

Models of reflection

As reflection was embraced by the nursing profession, many models were offered within the literature (see for example the Learning Cycle (Kolb, 1984), the Reflective Cycle (Gibbs, 1988) and Johns’ (1992, 2002) Model of Structured Reflection). The quantity of models of reflection can initially be daunting and confusing, particularly to the novice learner, although the models have notable similarities: they are tools which prompt critical thinking through explicit examination of an experience, situation or event with the aim of improving self-awareness, knowledge and decisions to inform future practice (Barnett & O’Mahony, 2006; Gustafsson & Fagerberg, 2004).

In 1985, De Bono published Six Thinking Hats advocating that thinking is a skill. He allocated a colour to six hats (white, red, black, yellow, green and blue) and suggested that each hat represented an area of thought. When wearing the white hat, thinking should be neutral, objectively thinking about the known facts of the situation or experience. The red hat prompts the constructive recognition of feelings and emotions evoked by the situation, experience or the thinking process. The black hat symbolises the negative aspects of the situation, prompting acknowledgement of mistakes and errors or being used to predict the risks and dangers of future actions. The yellow hat’s positivity is viewed as opposite to the black hat’s negativity, prompting recognition of the benefits, opportunities and value of the situation. The yellow hat is also constructive and recognises visions for the future, although the creative generation of alternatives and new ideas is the role of the green hat. The blue hat summarises the thinking process and reviews progression of thought and development (De Bono, 1985).

Although not published as a formal model of reflection, the Six Thinking Hats (De Bono, 1985) appeared to encompass the process of reflection while overcoming many of the limitations noted of other frameworks. De Bono (1985) proposed that by adopting the approach of ‘wearing’ different coloured hats to view a situation or experience, past, present or future, thinking could be guided to improve critical thinking, self-awareness and learning. He did not advocate this as a solely individual activity, discussing the benefits of applying the approach both for individuals and as a group activity. The limitations of the technique, as De Bono (1985) discussed, are in the reflective practitioners’ ability to focus their thinking on one aspect at a time. However, he advocates that the hats are interchangeable, as is their order, and should be applied appropriately to each experience or situation. The complexities of the concepts of reflection-on-learning and reflection-in-learning do not enable the concepts to be merged, but they may be used to complement each other (Palmer et al., 1994). The framework for critical thinking offered by De Bono (1985) can be used to structure and guide thinking through either concept of reflection. It is for these reasons that the group, reported here in this paper, utilised the Six Thinking Hats for their reflection on the seminar.

Many of the authors of literature on the subject of reflection (Dewey, 1933; Gustafsson & Fagerberg, 2004; Kolb, 1984; Moon, 1999; Palmer et al, 1994) acknowledged that it is often situations and/or experiences that cause discomfort, anxiety and unease that are chosen to be reflected on, in search of solutions and understanding to inform future actions when faced with similar experiences. However it is also important to reflect on routine practices, and positive experiences, recognising the components which added value and worth in order to be able to re-create the positive experience again when required.

Group reflection

The group consisted of five female pre-registration nursing students in the final year of the pre-registration nursing learning disability branch programme. Each student had been granted permission to attend the extra-curricular seminar, and documented their thoughts and feelings through the duration of the day, coming together immediately following the closure of the seminar to participate in the group reflection. The first person will be used in the group reflection when discussing the actions, thoughts and feelings of the group members as a whole.
Learning Disability and Risk seminar: A group reflection using ‘Six Thinking Hats’
Briony McNelly, Charlotte Keane, Lorna Fisher, Rebecca Lindley, Rebecca Mayne and Joanne Skellern

The White Hat
De Bono (1985) suggested that the white hat represents neutrality and objectivity, encouraging the identification of only the facts of the experience.

The one day seminar entitled Learning disability and risk was organised and hosted by the University of Chester in conjunction with the Forensic North West Learning Disability Network. There were 70 delegates in attendance from a variety of disciplines including nursing, social work and psychology, and representing the working environments where support is provided for people with a learning disability who are involved (or at risk of becoming involved) with the criminal justice or forensic services. Presentations were given by faculty staff on recent research studies: the professionals’ experience of violence perpetrated by people with learning disabilities, outlining the extent of violence experienced by different staff groups and challenging the conceptualisation of violence; and the relationship between people with learning disabilities and the criminal justice system arising from multiple professional perspectives. Members of the Forensic North West Learning Disability Network introduced their proposed Individual Risk Mitigation Profile (IRMP) and facilitated small group work using case scenarios so that delegates could try out the IRMP. This was followed by a feedback session before the seminar closed.

The Red Hat
The red hat represents emotions according to De Bono (1985), who advocated that whilst wearing the red hat feelings in relation to the experience/situation should be acknowledged.

The group identified positive feelings of ‘excitement’ and ‘curiosity’ prior to the seminar commencing as some of the group had no prior experience of attending a seminar and did not know what to expect. One member acknowledged she felt some ‘apprehension’, questioning whether she would ‘feel out of [her] depth’. However all of the members of the group described an overwhelming feeling of ‘belonging’, as the focus of the presentations and discussions was working with people with a learning disability and all of the delegates were from specialist learning disability services. Additionally, we acknowledged that we were there as delegates rather than student nurses and expressed the feeling of ‘acceptance’ and enjoyment at the equal status, something not often experienced during our pre-registration nurse education programme.

The group also identified some negative emotions, ‘frustration’, ‘anger’ and ‘disappointment’, particularly in response to the presentations on violence and the criminal justice system, which prompted the group to discuss the roles and responsibilities of the various agencies involved in supporting people with a learning disability who come into contact with the criminal justice system and require forensic services. One member of the group articulated the feeling of ‘concern’ in relation to the realisation that the criminal justice system appeared not to cater for people with a learning disability and needed to improve, whilst other members expressed ‘shock’ and ‘concern’ in relation to the degree of violence experienced by some professionals. However, two of the members of the group felt a degree of ‘relief’ and ‘reassurance’ at this when they realised their experiences were shared by many highly qualified specialist staff, enabling them to re-consider and contextualise their own experiences.

The Black Hat
Wearing the black hat, according to De Bono (1985), represented gloominess, and prompted recognition of the negative aspects of an event, experience or situation.

There were no negative aspects that the group could identify in relation to the experience as we all agreed the day had been a resounding success; but there were negative emotions resulting from absorbing some of the information from the presentations, particularly the level of violence experienced by some staff groups. We also acknowledged the potential negative that we perhaps would not have integrated with other delegates as well as we did if it was not for the division into groups by the seminar facilitators: we would have stayed together if asked and therefore would have limited our experience of the day.

One member of the group identified a negative point in regards to the members of her small group: she found that despite the claims of extensive knowledge and qualifications, some professionals were reluctant to ‘think outside of the box’ when it came to supporting offenders within community settings, resulting in her group work being less creative and more restricted than that of other groups.

The Yellow Hat
The yellow hat, suggested De Bono (1985), is symbolic of sunshine and encourages recognition of the positive aspects.

All members of the group found this an easier activity, despite the warning from De Bono (1985, p. 110) that there ‘are generally more natural reasons to be negative than there are to be positive’. This was not the case here and many benefits were identified as resulting from participating in the day. These included the more obvious benefits: the knowledge of current research and practice issues in relation to people with a learning disability requiring support from forensic services; increased awareness of and development of skills in the risk assessment tools available; and the opportunity to network with practitioners working within learning disability services. However, reflecting enabled the identification of less obvious benefits: meeting people whose work we had referenced to support our academic assignments; the recognition that even highly qualified, experienced practitioners ‘did not have all the answers’; and the discovery that we can contribute to the current debates surrounding this client group. Furthermore we were able to envisage what it might be like to be a qualified nurse and a member of the multi-disciplinary team.

The Green Hat
‘Green is grass, vegetation and abundant, fertile growth’, stated De Bono (1985, p. 32), encouraging creativity and the development of ideas.

The group identified the knowledge they could put into practice following attendance at the seminar, specifically in relation to the IRMP. The group were prompted through reflection to consider the significance of critically analysing current service provision, the evidence base available, future research requirements, and the necessity to challenge their own values and beliefs as well as those of other members of the multi-disciplinary team. The group identified the importance of effective multi-agency working and were able to identify ways in which we could encourage this within our future
practice, specifically the inclusion of all professionals within the risk assessment and future care planning for offenders with learning disabilities.

The Blue Hat
The blue hat, according to De Bono (1985), signifies the sky and suggested examination of the thinking process.

The group agreed that participating in the reflection had been effective in relation to contributing to our personal and professional development, adding further depth to an already successful learning experience. Reflecting assisted us to recognise some of the covert learning which had occurred, rather than just being aware of the overt knowledge gained from attending the informative seminar. The whole experience of attending the seminar and the reflection improved the self-confidence and self-belief of the group members through the acknowledgement of the knowledge, experience, skills and abilities which we already possess, and compelled us to conclude that we are not as unprepared for the role of qualified nurse as our self-doubt might have us believe.

Overall, the experience of attending the seminar enhanced self-confidence and self-belief which is essential at this stage of our training, the point of seeking employment. The experience comprised learning from current research initiatives being undertaken by faculty staff, participation in group work with experienced practitioners, and use of a risk assessment tool adapted for people with learning disabilities and offending behaviour, followed by the use of theory to underpin our reflective activity. The seminar also provided us with networking opportunities with a multi-disciplinary group of professionals, all of whom encouraged and welcomed our involvement and participation. The experience will be used to inform our future practice, not only in terms of the knowledge gained from attending the seminar, but also the knowledge gained from participating in the group reflection.

Conclusion
This paper has given an account of a group reflection on a seminar entitled Learning disability and risk held by the University of Chester in conjunction with the Forensic North West Learning Disability Network. The reflection utilised the Six Thinking Hats model offered by De Bono (1985), which effectively assisted the group members to consider their participation in the seminar, identify their feelings in relation to participation, and recognise how these changed throughout the course of the day. It assisted in the recognition of the negative aspects but also established the positive, encouraging the group to identify their learning and think creatively of how attendance and participation in the seminar will inform their future practice. It is recommended that reflective practice remains a central component of the pre-registration nurse education programme, and that students are assisted to reflect both on an individual basis and as a group. The information gained through reflection, and the recognition of improved self-confidence and self-belief, should then be utilised by group members to assist them to formulate an individual action plan to ensure optimum personal and professional development continues as they enter their nursing careers.

References
Book Reviews

For this first edition of New Scholar, many students have submitted book reviews by Faculty academics who have written texts for their programmes. While we have enjoyed this celebration of home-grown scholarship, in future editions of the journal we would welcome your reviews of any texts that are relevant to your programme. Please submit them in the same way as other contributions to New Scholar.
Introducing the topic of sexuality to the social work student, this book explores the considerable implications it has on social work assessment and intervention. A variety of sexualities are discussed in clear, unambiguous text, encouraging students to explore the range of definitions, assumptions and constructs around sexuality. The historical context of such ideas is addressed, along with discussion about how they have shaped our own beliefs around sexuality. The authors highlight that this is an area of neglect in the social work field and that many issues around sexuality remain taboo, making the case that best practice must involve knowledge and consideration of sexuality in relation to service users, their lives and individual identities.

Referring to the two dominant paradigms informing views of sexuality, the naturalist and social constructionist approaches, the book adopts the latter approach. It argues that sexuality is a social construction, learned across cultures, history, and societies. Throughout the book, there is analysis of the discourses around, and the social construction of, sexuality, highlighting the interrelationship between sexuality, power and oppression. It suggests that whether a particular sexuality is regarded as deviant or acceptable is largely a matter of power relations, and why being heterosexual is largely regarded as ‘normal’.

Heterosexism is discussed and shown to operate at all levels of society on a personal, cultural, and structural basis, and the student is encouraged to acknowledge the combined impact of social divisions such as racism, heterosexism and HIV discrimination on different service users. An informative and concise chapter is devoted to each of the following topics: sexuality and diversity, focusing on young people and issues such as power and oppression; older people, sexuality and ageism; disabled people and sexuality – the influence of the medical and social models of disability; sexuality and HIV; sexual violence; and finally, sexual rights and guidance for best practice in social work.

The format of this book is logical and user-friendly, using case studies throughout to invite the reader to explore complex issues such as the difficulties faced by disabled people and their personal assistants in dealing with issues such as facilitated sex (chapter 5).

The reader is actively encouraged to consider difficult issues affecting all sexualities and social work practice. For example, chapter 4 identifies how professionals tend to judge older people by the ‘norm’ of heterosexual sexual intercourse, rather than viewing their sexuality in broad and inclusive terms.

Chapter 6 discusses how HIV discrimination has been used to legitimise other prejudices, such as those against gay men, black people, and promiscuous heterosexual women. It offers excellent advice on how to deliver accurate information on HIV transmission, clearly outlining the myths and inaccuracies surrounding these issues.

Unfortunately, the limited scope of the book means it is unable to go into more detail in some areas, such as the discussion around religion and sexuality. However, a comprehensive reading list follows each chapter and there is information about relevant research where appropriate.

In concluding, the authors state that one aim of the book is to encourage the reader to view sexuality as a ‘right and a pleasure.’ It is possible, however, that they assume a rather negative or generalised version of heterosexuality in the pursuit of championing alternative sexualities. Such a stance may be oversimplifying the complexity and diversity of heterosexuality, especially in terms of heterosexual women in society today. This book undoubtedly advances challenging, thought-provoking and often uncomfortable ideas. It is a fascinating and essential read for social work students, especially those preparing to go on placement.
Book Review


Reviewed by:
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Faculty of Health and Social Care
University of Chester

For a student in the second year of midwifery training, there is a palpable drive towards returning the profession to the holistic, social model of care by promoting childbirth as a normally healthy activity. University prepares students to become strong, autonomous practitioners advocating women’s choice of delivery setting in keeping with government proposals; however, the reality of providing this is challenging in the current climate, with an increase in high risk pregnancies and medical interventions.

‘Supporting Women to Give Birth at Home’ is a comprehensive guide for midwives, student midwives, and women interested in homebirth. It is a well written, approachable, easy-to-read book, broken down into manageable, self-contained chapters, with ample appendices and images to inform and aid the reader. It draws on a generous amount of up-to-date, evidence-based research while incorporating the authors’ own experiences, making this book a good point of reference for homebirth. The comprehensive index also means specifics are easily accessible: a useful tool when in attendance at a home delivery.

By guiding readers through the journey of birthing at home, this book instills assurance in the service and confidence in women’s ability to birth at home, as well as confidence in our own role as midwives. It is difficult in the current environment not to become conditioned by the hospital setting, which itself does little to promote normality. Health professionals are guided by stringent policies and immersed in interventional/labours, and therefore promoting normality in the areas we can control, for example pain relief and labour position, is often forgotten. It could be argued that being at home takes labour and birth back to basics, retaining as much normality as possible. This book positively reinforces the role of the midwife in endorsing, supporting and practising homebirth.

This book covers all aspects of homebirth. It begins with a history of labour and birth, helping the reader to understand how medical intervention has evolved, and the reasons why. It goes on to discuss the safety of homebirth, and how it can once again become a viable option for place of birth. Further chapters explain how midwives play a vital role in returning to the practice of homebirth. There is as much information here to inspire midwives, to reinstat their confidence in the normality of labour, and to have faith in women’s bodies to deliver safely, as there is on how to educate and communicate this to women. Midwives face ethical and moral decisions every day of their practice. This is poignantly debated in the chapters discussing ‘choosing homebirth’ and how midwives can facilitate this choice. All women should be offered a choice for their delivery setting; the very core of our role as midwives, to be ‘with women’, should support even those with high risk pregnancies in their decisions. This book guides the midwife through these ethical dilemmas, ensuring choice is facilitated safely to the best of our abilities.

Other topics include how to care for a woman in labour in the home setting, how to enable her to work with and manage her pain, and how to actively involve the birth partners and facilitate labour to be a positive, family event. The provision of these skills can be very different from our practice in the hospital setting, an environment in which medical care of ‘patients’ and ‘visitors’ is engrained. ‘Supporting Women’ provides practical advice to midwives in attendance at a homebirth, including developing a comfortable relationship with the woman and her partner so as to be able to facilitate the meeting of her needs, while being alert to risk factors and deviations from the norm. Obstetric emergencies in the home setting are without doubt a daunting prospect; however, this book guides readers carefully through the management of such situations. It reassures readers that though emergencies can occur, they can be managed safely in a controlled and expert manner. The case studies in the final chapter of the book confirm this; they also confirm what a positive, controlled and empowering experience giving birth at home can be.

This book guides readers to re-address their understanding of maternity care, and their own attitude towards the practice of this care. As a student midwife, I feel there are still great barriers to achieving a normal birth within the hospital setting; indeed statistics have shown intervention rates are higher there than when birth takes place in the home setting (Wax et al., 2011). With this in mind, offering homebirth to all women, and promoting it to women who are deemed low risk, should be higher on our agenda. Reading this book has reinforced and increased my confidence in the homebirth service. It has shown homebirth to be a positive experience, even for those women who unfortunately need a transfer to an obstetric unit. I would recommend this book as an educational tool to all midwives, student midwives, and women considering homebirth. The book is encouraging and empowering and reinforces the basic skills in promoting normality, which can also be usefully transferred into the hospital setting.
References
The purpose of this edited book is to be a ‘small driver’ toward a multi-professional approach to person-centred learning disability provision. By taking key concepts of learning disability services and elaborating on them, the book aims to help different professionals understand one another and take the first small steps to working together. The book says that it is for the use of all professional groups, charities, carers, interested people and students involved with people with learning disabilities (LD).

The three editors have a wealth of qualifications and years of experience in LD, both professionally and academically, although all three have a nursing background. It could be argued that there is a nursing bias, though the book is aimed at explaining all areas of LD to all professional groups; on the other hand, there is a long list of contributors from a wide array of professions, institutes and countries. Each chapter is written by authorities on the subject, giving relevance and credibility. The book is arranged in alphabetical order of fifty key concepts within learning disability. The structure of the chapters is easy to follow once oriented to the book: a section on ‘how to use the book’ located at the end of the introduction will help the reader. Navigation of the book is user-friendly. When reading through the contents I was unable to find sections on education or ethics; however, upon looking at the index I was quickly guided to sections on education which were informative. Unfortunately I was unable to find anything on ethics in the index, but found them discussed under values. I feel that ethics is a major subject in LD and other areas of health and social care, and that a chapter on ethics written in this format would have been helpful. Having said this, the fifty chapters do cover most of the important areas of learning disability today.

I found that the book is easy to read. Even though there is a set layout, the writing style of each chapter differs owing to the multiple contributing authors, and this variation helps alleviate the monotony that can be associated with reading academic text books. Each concept is broken down into a definition, key points, discussion, case study, cross references, further reading and references, covering four to six pages. This at first seems minimal, given the size of the pages and text; however, I found that there is just enough information to be concise and to the point. Each chapter has a baseline of information and could be used to direct the reader in the right direction if more information is needed. The cross references, references and further reading sections of each chapter are ideal for students writing assignments. The book can help point out evidence for use in analytical or critical writing, and aid the writing process if one is struggling to explain/substantiate a concept in learning disabilities.

This book is reasonably priced and accessible for sale and in nursing libraries. I would strongly recommend it to students as a study aid. I personally found it to be a great help with my assignments.
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