

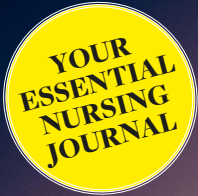
PROMOTING EXCELLENCE IN NURSING CARE

RCNi

# Nursing Standard

Volume 39 No 1 / January 2024

nursingstandard.com X@NurseStandard



**BRIEFING**

## NATIONAL UNIFORM

Who wears what in England's new styles p13

**WORKFORCE**

## OVERSEAS STAFF

What new arrivals need to thrive in the UK p19

**EFFECTIVE PRACTICE**

## NEUROLOGICAL ASSESSMENT

The reasons and tools for these observations p45

**CARE EXPERIENCE**

## MIGRAINE

Recognising and managing the common disorder p76



## Inside

Anorexia nervosa: psychologically informed care in acute hospital settings p38

Students – can you use ChatGPT to help with an assignment? p51

# Bright ideas

Tips for making your vision for patient care improvements a reality p54



# Alexandra

Innovating Workwear Since 1854



A preferred supplier to the NHS and the private healthcare sector, no other single supplier of workwear offers the range Alexandra can offer you, direct from stock and in a huge range of colours, sizes and styles.



[alexandra.co.uk/healthcare](https://alexandra.co.uk/healthcare)

# Contents

Volume 39 No 1 | January 2024 | [nursingstandard.com](https://nursingstandard.com) [X@NurseStandard](https://twitter.com/NurseStandard)



Cover image:  
Alamy



8

## Is remote working feasible for your role?

What you need to do to take advantage of flexible options



16



57

### Briefing

#### 6 News

Round up of the month's news

#### 13 Uniform approach

What nurses in England's NHS can expect from standardised uniforms

#### 15 Under the weather

Damned if you work, damned if you don't

#### 15 Strikes one year on

What, if anything, has changed for nurses in the NHS?

#### 16 Keep your focus

How to maintain equilibrium at work and home when the world news is grim

#### 18 Your views

Toxic 'resilience' expectations, wasteful uniforms and menopause podcast

### Workforce

#### 19 Warm welcome

What nurses from overseas need to thrive

#### 23 Choose your hours

How one employer offers its nurses freedom to decide working hours

#### 25 Supernumerary status

Why it's essential for effective ward leadership

#### 27 Your mental health

Are you afraid to take time off sick if you're feeling mentally unwell?

#### 28 Gender role

The job of a gender identity specialist nurse explained

#### 30 Red flags

Advice on how to raise fundamental concerns, whatever your level

#### 33 Working and studying

Survival guide for students juggling shifts and coursework

### Effective practice

#### 35 Bias in healthcare

Addressing inequalities in patient experience and outcomes

#### 38 Anorexia nervosa

*Peer-reviewed article*  
Psychologically informed care in acute settings

#### 45 Altered mental status

*Peer-reviewed article*  
Undertaking a neurological assessment of a patient

### Professionalism

#### 51 Artificial intelligence

What is ChatGPT and can I use it for assignments?

#### 54 Bright ideas

How to make your vision for patient care improvements a reality

#### 57 Handling conflict

Tips for de-escalation in a difficult situation

#### 60 Autism

*Peer-reviewed article*  
Supporting autistic adults experiencing mental ill health

### Care experience

#### 67 ReSPECT

Resuscitation Council UK experts answer frequently asked questions

#### 70 Person-centred care

*Peer-reviewed article*  
An exploration of how to implement it in practice

#### 76 Migraine

*Peer-reviewed CPD article*  
Recognising and managing migraine

#### 82 Multiple-choice quiz

Test your knowledge of recognition and management of migraine



**NursingStandard**  
podcast

## Listen for free

Available on  

# Meet the contributors



**MARIMOUTOU COUMARASSAMY (COUMAR)** is **deputy chief operating officer** at Birmingham and Solihull Mental Health NHS Foundation Trust, and has experience of working across various mental health specialties. Having completed his nurse training in India in 1994, he migrated to the UK in 2003 and has since gained an MSc in forensic mental healthcare and an MBA in health executive. As a nurse from a minority ethnic background, he has always had a special interest in equity and diversity issues in the UK healthcare system, and is the founder and chair of the British Indian Nurses Association (BINA). His work and influence in this area has been recognised with numerous awards.

See page 19



**NICOLA DAVIS-JOB** is **acute care and leadership adviser** at RCN Wales. She also has a significant role in developing and promoting the RCN's Nursing Workforce Standards in Wales and led on its Ward Manager Project, promoting the importance of supernumerary status for ward managers. Ms Davis-Job was previously a stroke consultant nurse at Aneurin Bevan University Health Board, where she set up the All Wales Stroke Nurse Specialist Group and held an honorary lecturer post at Swansea University and the University of South Wales. She has a Master's degree in neuro-rehabilitation and has worked in the Innovations in Care team for the Welsh government, leading the All Wales Integrated Care Pathway Programme.

See page 25



**LAUREN PALK** is an **advanced nurse practitioner in neurology** at Musgrove Park Hospital in Taunton, Somerset. After qualifying as a registered nurse in 2017, she worked in acute medicine for three years as a registered nurse and then as a junior sister before going on to undertake advanced practitioner training. She has a particular interest in neurology, more specifically brain injury and spasticity, alongside the management of migraine and improving outcomes for patients. She is passionate about educating nursing students and strives to share her knowledge and skills with those who are the future of the profession.

See page 76

## Evidence & practice advisory panel

**Liz Allibone**  
Head of nursing, The Nightingale Academy Guy's and St Thomas' NHS Foundation Trust, London, England

**Irene Anderson**  
Principal lecturer and reader in learning and teaching in healthcare practice, University of Hertfordshire, England

**Freda Browne**  
Lecturer/assistant professor, School of Nursing, Midwifery and Health Systems, University College Dublin, Ireland

**Chris Carter**  
Nursing officer, Queen Alexandra's Royal Army Nursing Corps, Birmingham, England

**Felicia Cox**  
Senior nurse, pain management, Royal Brompton and Harefield NHS Trust, London, England

**Lin Fidgin**  
Nursing student, Teesside University

**William Gage**  
Improvement programme manager – safety, Office of the Medical Director, Imperial College Healthcare NHS Trust, London, England

**Mark Haddad**  
Senior lecturer in mental health and senior tutor for research, City University London, England

**Karen Harrison Denning**  
Head of research & publications Admiral Nursing, Dementia UK, England

**Rebecca Myatt**  
Respiratory diagnostic clinical nurse specialist, Guy's Hospital, London, England

**Christopher Nicholson**  
Directorate manager, Cardiology and Respiratory Directorates, East Lancashire Hospitals NHS Trust, England

**Anne Rowat**  
Senior lecturer, Nursing & Health Care School, University of Glasgow, Scotland

**Nikki Welyczko**  
Associate professor and associate head of school, De Montfort University, Leicester, England

**Sam Willcocks**  
Newly qualified nurse, Barts Health NHS Trust, London, England

# Briefing

## IN THIS SECTION

**News** Government rejects calls to reopen nurse pay talks after new offer for consultants **p7**

**Analysis** Homeworking: making it work for you and your role **p8**

**Expert advice** What to expect from the new NHS uniforms in England **p13**

**Feature** How to stay calm when the world feels chaotic **p16**

## EDITORIAL

# Wave those red flags high this year

**W**hat does the new year promise for nursing? Probably some big things, and possibly even the stuff of your dreams, because 2024 will see the build-up to a general election.

Yes, it will soon be time for pledges for the NHS to rocket in line with waiting lists, and for endless politically driven success stories that you wouldn't believe even if you saw them with your own eyes (just as you have not seen any real impact from those 50,000 extra nurses that the current government pledged ahead of the last election).

And so it will go on... but not beyond 28 January 2025, the date by which a general election legally has to take place.

Try not to get too down about all the electioneering, as this pre-ballot period does offer an opportunity – and not of the management-led kind to do more with less. It presents a platform for the NHS and health and care in general, as they consistently prove to be key battlegrounds for politicians who want to win votes.

There will be mistruths and exaggerated claims but – go figure – nurses enjoy far higher levels of public trust than politicians, with the two being polar opposites in the Ipsos public poll of trusted professions.

It's time to raise those red flags for patient safety whenever possible. These all too familiar alarms include times when patients are being cared for in hospital corridors or even on floors, hooks are set up in waiting rooms to hold intravenous drips and registered nurses are being replaced with less-skilled staff.

These events indicate a broken system that is putting patients at risk and devastating and demoralising staff. In the community nurses are grappling with huge caseloads, with one in ten health visitors providing care for more than 1,000 children, according to a 2022 survey.

These situations shouldn't be part of 'normal' care – they should be never events. Politicians must be shown the red flags.

See careers, page 30



Flavia Munn is editor, Nursing Standard

Write to the editor at [flavia.munn@rcni.com](mailto:flavia.munn@rcni.com) call 020 8872 3181 or [@NSEditor](https://twitter.com/NSEditor)

## HAVE YOUR SAY

Twitter  
[@NurseStandard](https://twitter.com/NurseStandard)

Facebook  
Nursing Standard Journal

Instagram  
[@nursing\\_standard](https://www.instagram.com/nursing_standard)

Website  
[www.nursingstandard.com](http://www.nursingstandard.com)

## RCNi editorial advisory board

### Chair

Alison Dinning  
Senior lecturer (adult nursing), School of Health and Social Wellbeing, College of Health, Science and Society, University of the West of England, Bristol

### Members

Sandra Aitchison  
Assistant director nursing adult services, Public Health Agency, Northern Ireland

Beverly Baker  
Matron, Heartlands Hospital, Birmingham

Joanne Bosanquet  
Chief executive, Foundation of Nursing Studies

Professor James Buchan  
Visiting professor, University of Edinburgh

Professor Clare Cable  
Chief executive and nurse director, Queen's Nursing Institute, Scotland

Professor Dave Clarke  
Associate dean for health, social wellbeing and partnerships, University of the West of England

Nicki Credland  
Reader in critical care, University of Hull

Natalie Elliott  
Community staff nurse, NHS Lanarkshire

Louie Horne  
Workforce Race Equality Standard clinical research fellow (international staff), deputy associate director of nursing, East Suffolk and North Essex NHS Foundation Trust

Emma Hotston  
Nursing student, University of Southampton

Paul Jebb  
Associate director, nursing, experience & engagement, Lancashire & South Cumbria NHS Foundation Trust

Professor Tonks Fawcett  
Professor of student learning (nurse education), University of Edinburgh

Winnie George  
Retention lead, National Retention Programme, NHS England & Improvement

Lorraine Hicking-Woodison  
Healthcare support worker adviser, Kent and Medway GP practices

Professor Daniel Kelly  
RCN chair of nursing research, Cardiff University

Group Captain Di Lamb  
Defence professor of nursing, Royal Centre for Defence Medicine

Manyara Mushore  
Course director, BSc mental health nursing; senior lecturer, London South Bank University

Yana Richens  
Director of midwifery, Liverpool Women's NHS Foundation Trust

## NursingStandard

Nursing Standard is published monthly by RCNi, a wholly-owned subsidiary of the Royal College of Nursing. The RCN protects RCNi's editorial independence, and perspectives and opinions published in our journals, and our online services should not be taken to represent those of the RCN, unless specifically stated. Should you wish to comment on or otherwise respond to editorial content, please contact: [editorial@rcni.com](mailto:editorial@rcni.com)

Acceptance of an advertisement does not constitute a recommendation or endorsement of a product or service, either by the RCN or RCNi. Registered at the Post Office as a newspaper. © Copyright 2024 RCN Publishing Company Limited. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers or a licence permitting restricted copying issued by the Copyright Licensing Agency, 90 Tottenham Court Road, London W1P 9HE. This publication may not be lent, resold, hired out or otherwise disposed of by way of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

**RCNi**  
rcni.com



## Nurses named in the New Year's Honours

Who are the nurses on the list this year?

Find out at [rcni.com/ny-honours-2024](https://rcni.com/ny-honours-2024)

### In brief >>

**Serial killer and former children's nurse** Lucy Letby was struck off the register in a formal move by the regulator. The most prolific child killer in modern British history is serving a whole-life prison term for murdering seven babies and attempting to murder six others in 2015 and 2016 at the Countess of Chester Hospital. She was stripped of her registration at a Nursing and Midwifery Council fitness to practise hearing in December, following her convictions last August. [rcni.com/keywords/lucy-letby](https://rcni.com/keywords/lucy-letby)

**Nurses working in Scotland's NHS** could see a shorter working week and protected learning time if Agenda for Change (AfC) contract reforms are approved. The Scottish Government agreed to review AfC as part of the pay deal for 2022-23 and 2023-24. Recommendations agreed by unions and the Scottish Terms and Conditions Committee include a review of band 5 nursing roles and pay changes and are with ministers for final approval. [rcni.com/shorter-week](https://rcni.com/shorter-week)

**A hospital intruder posing as an** agency nurse helped staff with a patient, then left with personal information on 14 patients. The Information Commissioner's Office reprimanded NHS Fife about the incident at a community hospital. The woman left after being challenged by a member of nursing staff and neither she nor the stolen paperwork have been traced. NHS Fife apologised. [rcni.com/hospital-intruder](https://rcni.com/hospital-intruder)

**Nurses say their professional** judgement and staffing requests are often bypassed in high-level decisions. A study led by Cardiff University researchers found nurses' opinions were relied on to manage day-to-day staffing, but did not carry the same weight at a strategic level. The study suggests data used to determine nurse capacity does not always reflect reality or capture key aspects of care quality and staff well-being. [rcni.com/nurses-views-bypassed](https://rcni.com/nurses-views-bypassed)

### LONG SERVICE

## Norma's the retiring type – after 65 years

A woman believed to be Britain's oldest nurse employed in the NHS has retired from duty after a 65-year career.

School nurse Norma Newcombe, 81, from Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL), celebrated her retirement with colleagues and children she has cared for at the Hindley Health Centre, following her last shift.

Ms Newcombe said: 'I have worked in a job I love since 1958, including 50 years as a school nurse, and have certainly seen many changes.'

'I am humbled and proud to serve such a wonderful institution as the NHS, which has served our country and its people, enabling them to have a better and healthier quality of life.'

Ms Newcombe had worked five days a week at the Hindley Health Centre since 1973. She decided it was time to retire while she is fit and active, but plans to



keep in touch with her schools and do some volunteering with them.

Hindley Health Centre community public health specialist practitioner Sharon Swift said: 'Norma holds a special place in the hearts of the children and families she has helped.'

'She is loved by all for her heart and her dedication.'

[rcni.com/Britains-oldest-nurse](https://rcni.com/Britains-oldest-nurse)

### WORKFORCE

## Invest in nurses to cut agency reliance

The NHS spent more than £3 billion on agency staff over three years, which could have been invested in educating more than 86,000 new nurses, the RCN said.

Freedom of Information requests by the RCN revealed hospital trusts in England spent £3.2 billion on agency nurses between 2020-22. A total of 182 of 202 trusts provided data.

The college's analysis of the figures found the average agency spend every year – just over £1 billion – could have covered the salaries of 30,956 full-time-equivalent (FTE) nurses at the top of a band 5 salary (£34,581), while the total £3.2 billion spend could have helped educate more than 86,000 new nurses. Research conducted by consultants for the college estimates it costs £37,287 to educate one nurse.

The analysis also showed agency costs spiralled by 63% over the three years, rising from £800 million in 2020 to £1.3 billion in 2022.

RCN chief nurse Nicola Ranger said: 'Ministers have got their priorities wrong – forcing trusts to squander billions while they provide miserly funding for fair pay and nurse education.'

'With cuts to nurse education and maintaining unfair pay levels, ministers are choosing to spend the money on much higher private agency bills instead; this is yet another false economy when it comes to NHS spending.'

The Department of Health and Social Care said pressures of the pandemic when staff sickness rates were 'exceptionally high' affected the statistics.

A spokesperson said: 'While temporary staffing allows the NHS to meet fluctuations in demand, we are controlling spending by capping hourly pay and prioritising NHS staff when shifts need to be filled.'

[rcni.com/agency-spending](https://rcni.com/agency-spending)

**In quotes** > **'If we don't give internationally educated nurses a warm welcome and help them thrive, they're going to leave'**

**Bejoy Sebastian**  
General secretary,  
Alliance of Senior Kerala Nurses  
See page 19



**'Some of my patients may not feel comfortable presenting in their true gender. I support them to find peer groups where they can be themselves'**

**Polly Zipperlen**  
Gender service nurse  
See page 28



## HEALTH SERVICE PAY

# 'Greatest pay inequality in NHS relates to nurses'

By Alison Stacey @alibaabra

The government rejected calls to reopen pay negotiations with nurses after a fresh deal was offered to NHS consultants.

The RCN said the senior doctors' offer left nurses pay looking 'increasingly inadequate' and called for renewed talks with the government.

Most consultants will get an additional pay rise of up to 12.8% on top of the 6% increase already awarded, meaning some will see their pay go up by 19%. Members of the British Medical Association can vote on the offer until January 2024.

RCN general secretary Pat Cullen wrote to health and social care secretary Victoria Atkins to call for renewed talks, claiming the college remains in formal dispute over this year's pay deal.

College members voted to reject the 2023-24 pay deal, which gave nurses a 5% pay rise alongside



John Houlihan

a series of one-off payments for last year. However, the offer was accepted by a majority on the NHS Staff Council, of which the RCN is a member.

Ms Cullen said in her letter to the secretary of state: 'It is time for nurses and nursing to be treated with the respect they deserve and

RCN general secretary Pat Cullen meeting striking nurses during the industrial action

for nursing pay to be reformed.

'Nursing is one of the most diverse and female-dominated professions within the public sector, and the injustice of nursing pay is also a gender issue.'

'The greatest pay inequality in the NHS relates to nursing. This must be addressed as a matter of urgency.'

## Nurses-only pay spine

The RCN said ministers promised during pay negotiations to explore the idea of creating a separate pay spine for nurses but have not treated the issue as urgent. However, consideration of a nurses-only pay spine was a condition of the pay offer the RCN membership rejected. The college is alone among the health unions in wanting to deviate from the Agenda for Change pay structure in this way.

A Department of Health and Social Care spokesperson said: 'We continue to work collaboratively, including with the RCN, to deliver a series of agreed reforms but we will not be reopening negotiations on pay. The offer for consultants includes significant reform for a pay scale that has not been modified since 2003.'

[rcni.com/keywords/nurses-strike](https://rcni.com/keywords/nurses-strike)

## RECRUITMENT

# Employers warned over rise in registrations from red-list nations

The number of UK-educated nurses joining the register has hit an all-time high but the number of joiners from red-list countries remains a concern, Nursing and Midwifery Council (NMC) data show.

A record 808,488 nurses, midwives and nursing associates are now registered with the NMC – a rise of almost 20,000 in the six months to September 2023, of whom 93% (748,528) are nurses. In the same period, there were 30,103 joiners, of whom just over half (15,067) were educated in the UK. This is the highest number of domestic joiners ever in the first half of a financial year and is almost 25% higher than the same period last year, an NMC data report states.

However, there was a rise in the number of people joining the register from red-list countries – 3,071 in the six months to last September.

The NMC said there have been 'significant proportional rises' in nursing joining the register from Ghana and Zambia and a steadily high number from Nigeria. The regulator urged employers to be mindful of the government's ethical recruitment code.

Chief executive Andrea Sutcliffe added: 'People from across the world want to come and work in the UK. However, employers must not undermine health systems in countries with the most pressing

workforce challenges through active recruitment.'

The RCN said the headline figures in the report did not reflect what nurses were seeing on the front line and urged the government to invest more in domestic nursing staff rather than relying on staff from red-list countries.

College chief nurse Nicola Ranger said: 'Since 2019, the NHS waiting list has grown four times faster than the nursing workforce, meaning there aren't enough staff to provide the outstanding care patients deserve.'

[rcni.com/domestic-recruits](https://rcni.com/domestic-recruits)

# Want to work from home? Here's what you can do

NHS employers are making flexible and remote working easier to aid staff retention and while it won't work for every nurse, perhaps it could work for you



By Jo Hartley  
health journalist

**C**ould increasing opportunities for nurses to work from home some or all of the time be an effective strategy to improve nurse retention?

New NHS Staff Council guidance calls on employers to review and regularise ad hoc home and hybrid working arrangements introduced during the pandemic, and a new framework supports the implementation of fair and safe home and hybrid working arrangements in England and Wales. But can any nurse ask to work from home? What roles are most likely to offer home and hybrid working? And what are the pros and cons?

## Unpicking the terminology

'Flexible working' is the broad term used for a range of elements that can be adapted to better meet the needs of employees and employers, such as how many hours an individual works, when they work and where they work.

The latter includes 'home working' or 'remote working' – where an individual works entirely from home or another location than an on-site workplace – and 'hybrid working' or 'agile working' is where an individual works both on-site and from home.

## Would working from home work for you and your employer?

Anyone directly employed by the NHS can now ask to work flexibly from their first day in a job, and at any time thereafter, with no limit on the number of requests allowed, says the NHS Staff Council. Applying simply involves speaking to your line manager.

However, the NHS Staff Council advises staff to work through the document *Flexible Working in the NHS: A Toolkit for Individuals* to help map out how flexibility can support them and the organisation before making a request.

Managers should respond positively and in a sympathetic way to all requests, especially given 'overwork and burnout are so commonplace with the staffing crisis', explains Unison deputy head of health Helga Pile.

But flexible working must be beneficial for both the organisation and the employee, so not all requests will be agreed in the way an individual might hope, she says. 'Anyone whose job is patient-facing and based in a hospital may find it hard to make a case for working from home without affecting already hard-pressed colleagues.'

## Flexibility does not always mean working from home

If home working is out of the question, Ms Pile says, managers must try to find an alternative mutually acceptable outcome. This could include working outside standard shift hours, compressed working (where someone does more hours over a shorter number of days), only working during term time, doing staggered or annualised hours, job sharing, or self rostering.

## 'I try and do one or two shifts in the call centre every week because it's nice to have contact with people'

*Debbie James, clinical advisor, NHS 111, Welsh Ambulance Services NHS Trust*

If a solution cannot be found, the next stage is for managers to seek help and advice. This might include looking at other vacancies in the organisation that might be suitable for the person, says Ms Pile.

'This stage is there to ensure line managers don't just say "no" because they can't see a solution within their own team.'

Ms Pile urges managers to ensure that any move to a more flexible working arrangement comes with clear roles and expectations, constant feedback and regular reviews.

## Advice for staff with disabilities

NHS employees with disabilities can also request home and



Remote nursing consultations: how to get them right  
[rcni.com/video-consults](https://www.rcni.com/video-consults)



hybrid working as part of wider considerations to reduce workplace barriers, states the NHS Staff Council.

In such cases Ms Pile advises individuals to make it clear they are applying for flexible working as a 'reasonable adjustment' because it is an additional statutory right on top on their contractual right as an NHS employee with a disability.

Many nurses who work at home have telephone-based roles. These span triage, primary, community, mental health and palliative care. The RCN says there are a number of nursing roles that lend themselves to home working, including in nurse education,

training and research, and health informatics, recruitment, case management and occupational health (see box).

#### **Best of both worlds: telephone triage**

Clinical nurse specialist Anne Porritt works exclusively from home in a part-time role with the single point of contact team at St Christopher's Hospice, which covers five London boroughs. She works three days a week and her job includes triaging palliative care referrals from hospitals, emergency services, GPs, patients and their families.

She does a first telephone assessment to prioritise urgency

### **Tips for managers on ways to implement agile working**

A new framework to support the implementation of fair and safe home and hybrid working arrangements in England and Wales has been added to the NHS Terms and Conditions of Service Handbook.

Tips include:

- » Secure executive and senior leadership support as a top-down approach encourages teams to put changes in place
- » Build agile working into strategic plans
- » Work in partnership with a range of stakeholders (clinical, non-clinical and trade union colleagues) to expand the scheme across the organisation
- » Network with other organisations that have agile working embedded in their systems and learn from their experience

Source: NHS Employers: [tinyurl.com/NHS-Employers-agile-working](https://tinyurl.com/NHS-Employers-agile-working)

and then hands over to the St Christopher's specialist community nursing team. She can also make urgent referrals to acute care, district nursing, social services and continuing healthcare funding and can prescribe remotely if a patient needs medications.

Ms Porritt, who has worked for St Christopher's for more than 30 years, was offered the opportunity to work from home when she decided to move out of London ahead of retirement.

'It gives me the best of both worlds,' she says. 'I get to live where I want and work for an organisation I want to be part of. I have fewer distractions at home and without distractions it is much easier to be focused and disciplined.'

### Flexibility helps beat burnout

Nurse and community midwife Debbie James left her role due to burnout and instead took up a full-time clinical advisor position with NHS 111 at the Welsh Ambulance Services NHS Trust.

She initially worked at the organisation's call centre providing urgent care triage, but once she was confident and her call times and outcomes were good her manager offered her the chance to work remotely in a hybrid arrangement.

'There is a home working policy,' Ms James says. 'What they're looking for from the



Flexible working can help to recalibrate your work-life balance

clinician is that you're quite confident with your decision-making because obviously you will be working alone when you are at home. I was there about eight months before I began working remotely – I didn't rush into it.'

Ms James loves the flexibility hybrid working offers. She does one or two shifts a week in the Swansea call centre and works from home the rest of the time – often at weekends, as it is less noisy, and this gives her time in the week to do her master's course.

'I do it because I like it; it is more flexible for my needs,' she says. 'I'm doing my advanced clinical practitioner course, so it works around my placement hours and uni. It takes a bit of the stress off, not having to get up and go into work every day. I did not have that flexibility as a community midwife. I was never off duty. And you can only be like that for so long. After 24 years, I just got burnt out.'

### A healthy workplace at home

Working at home with computer equipment can lead to musculoskeletal discomfort or pain, headaches and eye strain if your work station is not set up appropriately. Furthermore, isolation, poor home facilities and having to move equipment to and from the workplace can present health and safety issues.

Employers should have clear procedures for home workers to report problems, states NHS guidance, and employees must follow their employer's instructions and report any health and safety concerns or incidents.

The guidance is intended to ensure jobs can be carried out as well at home as they can be in an office or on a ward, Ms Pile says.

With her shift to hybrid working, Ms James was issued with a laptop, keyboard and two big screens so she could work as if she is in a call centre. She says being confident from an IT perspective is important when it comes to home working.

## Home and hybrid work: role definitions

- » **Contractual home worker** An individual who performs most duties from their home. They may travel to a work base or attend events on an ad-hoc basis. Their home is designated as their contractual base
- » **Agile/hybrid worker** An individual who performs their duties across more than one location, which may include their home address. They may be required to attend events or travel to other bases or locations on a more regular or ad hoc basis. Their designated contractual base will be at one of their employer's sites

Source: NHS Staff Council: [tinyurl.com/Staff-council-section-35](https://tinyurl.com/Staff-council-section-35)



istock

Ms James has a specific room she works from, which she refers to as her ‘safe space’, where she cannot be overheard while on calls, to ensure patient confidentiality is maintained.

**Working from home will not suit every role – or every nurse**

Home working will not be an option for all. Clinical nurse specialist Ms Porritt says that exclusively working from home was only available to her because of her experience – and she does not believe the role would suit a more junior nurse.

‘I’ve worked at St Christopher’s since 1987, so I feel very comfortable and confident with what I do,’ she says. ‘But it’s not a remote working job. I do not think it is a job for an inexperienced nurse. It is not a way to learn palliative care.’

Ms Porritt also worries that not being in the office limits her ability to teach junior colleagues, which has been an important part of her role.

‘I was going up to the office once a week, but I don’t do that anymore,’ she says. ‘So, I can’t share or observe others. I can’t support others so easily in the way you can in an office. You can learn a lot by just listening to people. Communication is crucial in palliative care and if you’re listening to some experienced clinicians, it stays with you.’

Home working can also be isolating, agrees Ms James. ‘It can be lonely working from home because you’re literally in, headset on and down to work. I try and do one or two shifts in the call centre each week because it’s nice to have contact with people.’

For Ms Porritt, the move to home working was a way for St Christopher’s Hospice to retain her as she neared the end of her career. However, Ms James was looking for a ‘change’. And

**‘I have fewer distractions at home and without distractions it is much easier to be focused and disciplined’**

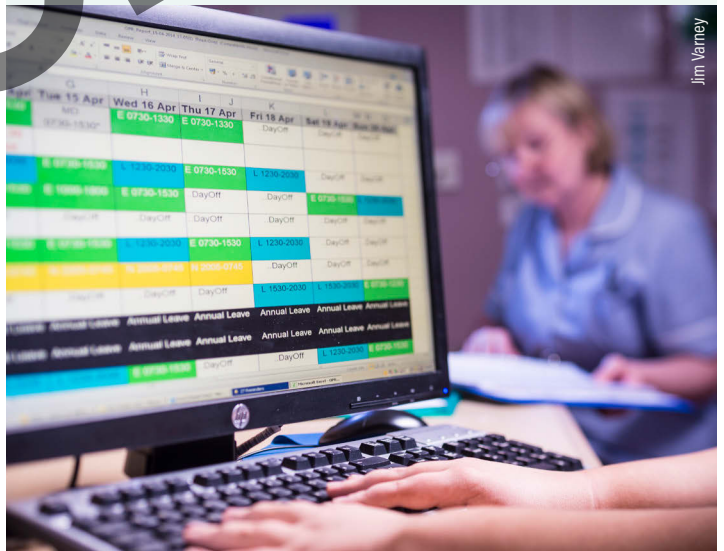
*Anne Porritt, single point of contact team, St Christopher’s Hospice*

**What home working roles for nurses**

Remote working or home working have become more common since the pandemic, says the RCN. Some roles involve working from home most of the time, or part of the time, it says. Examples include:

- » Telephone triage nurse (for GPs or services such as NHS 111)
- » Nurse adviser (telephone based)
- » Practice nurse (telephone based)
- » Occupational health nurse
- » Nursing roles in health insurance/health surveillance/health screening
- » Trainer roles
- » Nursing journalists/editors
- » Nurse expert witness
- » Recruitment
- » Nurse interviewer (interviewing nurses for jobs or agency roles)
- » Health informatics, eHealth or digital roles
- » Counsellor (telephone based)
- » Wellness advisor (telephone based)
- » Life coach (telephone based)
- » Case management – personal independence payment assessment, nurse disability and continuing health assessment
- » Office roles

Source: RCN: [tinyurl.com/RCN-work-life-balance](https://tinyurl.com/RCN-work-life-balance)



Jim Varney

hybrid working at NHS 111 has come with new opportunities.

‘I’ve done the remote clinical decision-making course and now I’m on the advanced practitioner course and I’ve been here just two years,’ she says. ‘It’s all funded and I get the time to do it.’

‘I feel lucky that I’ve got this opportunity, as someone who’s been in the profession a long time.’

**Further information**

NHS Staff Council: Guidance to support regularising ad hoc home and agile/hybrid working arrangements [tinyurl.com/NHS-Employers-hybrid-working](https://tinyurl.com/NHS-Employers-hybrid-working)

NHS Employers Handbook amendments (section 33) [tinyurl.com/NHS-Employers-handbook](https://tinyurl.com/NHS-Employers-handbook)

Flexible working in the NHS: A toolkit for individuals [tinyurl.com/flexible-toolkit](https://tinyurl.com/flexible-toolkit)

# NursingStandard

## Discover a more accessible and engaging read online



### Discover the benefits of your digital journal

- **In your pocket and at your fingertips** – access the latest issues via your smartphone or tablet on the go, making it easier than ever to fit your journal into your busy routine.
- **More engaging and in-depth** – articles in your digital edition include links to further resources online, helping you to develop your understanding of a topic and discover related content of interest.
- **Storage-smart and environmentally friendly** – no need to store all your old print copies with access to a digital archive dating back to 2015. Less paper also means it's kinder to the environment.

Make the most of your digital edition:  
[nursingstandard.com](http://nursingstandard.com)

RCNi

# What to expect from the new NHS uniforms

From colours to fabric weight to pockets, find out the latest on the new standardised uniforms for NHS nurses in England



By Pavan Amara  
nurse, midwife and health  
journalist



A first look at  
the new national  
nurses' uniform  
[rcni.com/first-look-uniforms](https://rcni.com/first-look-uniforms)

**N**ew uniforms are being issued for NHS nurses in England in an attempt to reduce costs and also prevent confusion about different staff jobs and responsibilities. The uniform will have two style options – two-piece scrub set or dress – and will soon be available to trusts. Here is the latest information about England's change in uniform.

## When will the national uniform be ready?

NHS Supply Chain (NHSSC), which sources and delivers health products to NHS organisations, began a consultation with staff in 2021. It drew up a design brief with prototypes and tested them in ten trial sites.

NHSSC category tower director for hotel services Kevin Chidlow says England's NHS national healthcare uniform 'will be ready from summer 2024'.

Nurses in Scotland and Wales have had standardised uniforms since 2010, and Northern Ireland followed in 2011. However, NHS trusts will begin introducing them when their existing uniform contracts come to an end so it could take several years for the complete roll-out.

## Why were some nurses unhappy with the colour choices when the uniforms were revealed?

Currently, each NHS trust chooses its own colour and style of garment for staff. NHSSC says that the new uniform will mean there is one recognisable colour code for different staff roles in all NHS health services.

When the colour scheme was revealed last year, it prompted negative comments on social media from some nurses, with concerns that the colour categories were too broad.

For example, the new uniforms include a blue for nurses and a navy for 'team leaders', but there is no clarity on whether a team leader means junior or senior charge nurses, clinical nurse specialists, educators or one of the many other leadership roles that exist. There was also no colour differentiation between nursing bands.

Writing on X, formerly Twitter, London South Bank University chair of healthcare and workforce modelling Alison Leary said the new uniform was an 'utter confusing mess'.

'Mixing job titles, professions and local arrangements of definitions of work. I really hope @CNOEngland [chief nursing officer for England] et al is not endorsing this. Doesn't recognise Registered Nurse at all.'

NHSSC was inundated with feedback from front-line staff; it said on X 'appreciate the engagement we've received' and that it would update its website with more information. It also told Nursing Standard that the colour code is deliberately 'designed to be generic' so a range of roles can be included.

## Where does my role fit in the colour scheme?

The new uniform will cover all English NHS trusts including acute, community and mental health settings, says Mr Chidlow. He adds that while NHSSC is working towards consistency nationwide, it is speaking to local NHS trusts to find the best way forward for staff.

'We have engaged nationally and continue to engage with NHS England and professional bodies as well as NHS trusts,' he says. 'The colours have been chosen to reflect the different professions and the roles within those professions, where appropriate.'

'We are actively engaging with our pathfinder trusts and senior stakeholders to understand where it is clinically appropriate for professions to align to the chosen colourways. This will then form the basis of national guidance.'

## Will the new uniform be worn by the whole NHS workforce?

NHS trusts will choose when they adopt the new uniform, but the aim is for older versions to be phased out.

For staff who do not wear uniforms nothing will change and they will continue to wear their own clothes. The same goes for those who wear scrubs rather than uniform for infection control reasons. For example, critical care or theatre staff who change into a new pair of hospital-laundered scrubs on every shift will continue to do that.

Mr Chidlow says: 'We are aware that there are many clinical settings where it is not deemed



John Houlihan

 <b>Students</b> Cloud blue with navy contrast trim.	 <b>HCA or Support Worker</b> Lilac with navy contrast trim.	 <b>Nursing Associate</b> Sky blue with sky blue trim.	 <b>Nurse</b> Hospital blue with navy contrast trim.
 <b>Midwife</b> Postman blue with navy contrast trim.	 <b>Team Leader</b> Navy with dark red contrast trim.	 <b>Matron</b> Purple with navy contrast trim.	 <b>Nursing Practitioner</b> Royal blue with navy contrast trim.
 <b>Advanced Practitioner</b> Dark red with navy contrast trim.	 <b>Healthcare Science Practitioner</b> Eau-de-nil with navy contrast trim.	 <b>Healthcare Science Scientist</b> Peacock with navy contrast trim.	 <b>Pharmacy Technician</b> Sherwood green with navy contrast trim.
 <b>Pharmacist</b> Bottle green with navy contrast trim.	 <b>Allied Health Professionals</b> White or ruby. Trim colours below.	 <b>Head of Department</b> Black with red contrast trim.	

Allied Health Professions Trim Colours			
 <b>Physiotherapist</b> White with navy contrast trim.	 <b>Occupational Therapist</b> White with bottle green contrast trim.	 <b>Orthotists</b> White with hospital blue contrast trim.	 <b>Dietitians</b> Ruby with hospital blue contrast trim.
 <b>Speech and Language Therapist</b> Ruby with postman blue contrast trim.	 <b>Orthoptics</b> Ruby with black contrast trim.	 <b>Osteopath</b> Ruby with cloud blue contrast trim.	 <b>Operating Department Practitioner</b> Ruby with sky blue contrast trim.
 <b>Music, Art and Drama Therapist</b> Ruby with sherwood green contrast trim.	 <b>Podiatry</b> Ruby with royal blue contrast trim.	 <b>Diagnostic Radiographer</b> Ruby with Eau-de-nil contrast trim.	 <b>Therapeutic Radiographer</b> Ruby with white contrast trim.

» appropriate to wear a uniform because of the effect this may have on a patient. It is not the intention of this proposal to change that. Where

there is a clinical need to wear scrubs, such as in a theatre, then we anticipate that this will remain the same.’

## When, why and how the new NHS uniform will be introduced

NHS Supply Chain (NHSSC) has outlined some key facts about the new uniforms in England:

- » **Current uniforms will not be immediately replaced** – new uniforms will be phased in at the end of the life cycle of current uniforms to reduce wastage. Options for recycling old ones are being considered
- » **Money could be saved** – NHSSC say the new uniform will save £10 million over two years after it is adopted by all trusts
- » **It is not just nursing staff who will have a new uniform** – physiotherapists, occupational therapists, dietitians and other allied health professionals will have their own colours as part of the scheme, but paramedics will come under a different framework and doctors are not included at all
- » **NHS trusts can register interest in being early adopters** of the new uniforms by emailing [nationaluniforms@supplychain.nhs.uk](mailto:nationaluniforms@supplychain.nhs.uk) These first uniforms will be delivered to trusts in summer 2024

Source: NHS Supply Chain: NHS National Healthcare Uniform

### Will the new uniform keep me cooler than my current uniform? And are they more practical?

The fabric used to design the new uniform is lighter than that used for the current tunic uniforms, says NHSSC, so is likely to keep wearers cooler. This should benefit staff who are experiencing hot flushes as a symptom of the perimenopause.

Some nurses were keen to point out on X that many NHS garments are not practical for the type of work nurses do. Explaining what was wanted from the new uniform, specialist emergency care nurse Chris Elton said he would be happy ‘as long as the trousers have cargo pockets and the tops don’t spill the contents of the pockets when you bend over’.

In response to this, NHSSC’s Mr Chidlow says: ‘The smart scrub and dress will have two waist pockets and one breast pocket, the trousers and shorts will have two cargo-style pockets.

‘In comparison to a traditional tunic, our chosen fabric is considerably lighter, offering a cooler wearing experience. Additionally, this fabric incorporates at least 10% mechanical stretch, which further enhances comfort.’

#### Further information

NHS Supply Chain: NHS National Healthcare Uniform  
[tinyurl.com/national-uniform](https://tinyurl.com/national-uniform)

NHS National Healthcare Uniform key  
[tinyurl.com/uniform-colourways](https://tinyurl.com/uniform-colourways)

JANE BATES

## Damned if you don't work, damned if you do

**Y**ou've coughed continuously for the third night in a row, everything hurts and your sinuses are having a snot fest. What you need is to be tucked up in bed, but either you can't stop thinking about the those you are letting down, or you feel guilt-tripped by management, so you turn up to that 12-hour shift anyway.

And when you get to work, others recoil from you and call you irresponsible for spreading your germs. Sound familiar?

When you're a nurse and you're ill, you just can't win. And it's not just management's attitude that can stink.

### We're all fellow victims of the system

One healthcare assistant I worked with was off sick repeatedly with severe mental health problems, and when she did turn up at work she was bullied relentlessly by one of our colleagues. The rest of the staff were under extreme pressure due to short-staffing, but blaming a fellow victim? It was just cruel.

When I started nursing I was already used to this draconian approach to illness. My mother wouldn't let me stay off school, however bad I was feeling. 'Pull yourself together,' she would say, as I was ushered out of the door.

The approach to nurse sickness needs to change, but will it happen? Not likely. All the guidance in the world won't make an iota of difference while services are so short of staff. Too often, sick nurses feel the need to go to work. Not to mention that those in power often take the attitude of 'better a substandard worker than no worker at all'. If a worker is too sick to function properly and something goes wrong, then they will be held responsible.

I often thought that if I died on duty, they would prop me up in a corner and use me as a drip stand. And someone, somewhere, would be able to tick the box to say that all staff were present and correct.

Jane Bates is a retired nurse



John Houlihan

### READERS' PANEL

## A year on from NHS industrial action, what has changed for nurses?



**Nurses' industrial action was not just** about pay, but patient safety. We made it clear that poor working conditions must improve and the government needs to support nurses to enable patient care to improve. Since the last strike, a proportionate increase in pay was agreed – a significant milestone. The profession now has a stronger voice and public support. This set a precedent for future negotiations that will bring change, and has given nurses a seat at the table when decisions are made. But there is still work that needs to be done. *Jay Trondillo is a social care nursing regional director* [X@jaytrondillo](#)



**Nurses in Northern Ireland (NI) first took** strike action in 2019 and some things did change, such as work to introduce safe staffing legislation and pay parity with England. But since the 2022 action, things have changed for the worse. Nurses in NI, who were promised that pay parity would never again be an issue, are once more the lowest paid in the UK. What has not changed is their determination to deliver safe and effective care, despite the continuing absence of devolved government and staff shortages. *Rosaline Kelly is RCN Northern Ireland senior nurse professional practice* [X@LeeRobekelly](#)



**Not much seems to have changed for** nurses in the past year, or even the past decade. Despite increased demand for our services and a population with greater health needs, nursing remains under-appreciated by those in power. Nurses' responsibilities and educational requirements are growing, yet we still often see our value questioned by employers looking to provide care on the cheap with unregistered staff. The strikes brought improved pay, but nurses have still lost out due to inflation. The fight for a fair deal is far from over. *Grant Byrne is an occupational health nurse in Glasgow*



**The issues driving the protests persist.** While the strikes may have garnered attention, concrete solutions are elusive. Nurses are still financially worse off due to the cost of living crisis and a decade of wage erosion. We need continued dialogue between healthcare professionals, policymakers and the public on safe staffing and ensuring a sustainable healthcare environment. This milestone is a reminder that nurses' commitment to their profession and patients deserves acknowledgment and action to create lasting positive change. *Matthew Osborne is a senior nursing lecturer* [X@MatthewOsborne](#)

For more on this issue, go to [rcni.com/reopen-talks](https://rcni.com/reopen-talks)

Readers' panel members give their views in a personal capacity only

# How to stay calm when the world feels chaotic

Round-the-clock coverage of shocking or grim events can sap your emotional reserves. Follow our tips to maintain your focus at work and your well-being

By Erin Dean



How to switch off and unwind after a shift  
[rcni.com/podcast-unwind](https://rcni.com/podcast-unwind)

Sometimes it can seem like the world is dominated by bad news – from the climate crisis to COVID-19 and devastating conflicts, television coverage, newspapers and social media seem to bring only grim updates.

All this can affect nurses, explains Jayne Ellis, a nurse and chief executive officer at EF Training, which trains healthcare staff in building emotional resilience.

## Nurses can find empathy is difficult to turn off

‘People who go into nursing are naturally empathetic and have to make that strong, therapeutic empathetic connection with people really quickly,’ Ms Ellis

says. ‘Nurses get very good at it. And the problem is they can’t turn that off when they come home and watch the news.’

This means nurses naturally absorb the trauma they observe from the relentless barrage of distressing news we are exposed to, she says.

Here are six simple ways to help protect yourself and maintain your emotional well-being.

## 1 SWITCH OFF THE NEWS

Sometimes the best option for nurses when they get home after a demanding, emotionally intense day, is avoiding the latest headlines about distressing situations around the world, says Ms Ellis.

‘By taking on vicarious trauma, which is trauma you witness or is described to you, you are absorbing all of that distress day by day and, subconsciously, your central nervous system takes you into a fight and flight response,’ she says.

‘Relentless bad news has an enormous additional emotional burden for somebody who is naturally empathetic. Somebody who may not be quite as empathetic can sort of look at it and brush it off. But if you have a natural empathy you will take it on and you will want to do something about it.’

## 2 STOP ‘DOOM SCROLLING’

Mental health charity Mind recommends setting limits for your daily media consumption.

For example, you can set certain amounts of time you will

## ‘Relentless bad news has an enormous additional emotional burden for somebody who is naturally empathetic’

Jayne Ellis, chief executive officer, EF Training

read or watch news or access social media, mute notifications from news websites and apps, seek out some positive stories as an alternative, and focus on facts rather than news commentary.

## 3 CONTROL THE THINGS YOU CAN

There may be horrible, distressing events going on around the world or in the UK, says Ms Ellis, but you need to be clear that you will be unable to do anything about many of them. ‘I encourage nurses to think about locus of control,’ she says. ‘Perhaps you could donate some money to a charity that is making a difference, but that doesn’t mean you have to absorb the situation 24/7.’

Mind suggests taking up volunteering opportunities, but also remaining aware that ‘it is not your responsibility alone to tackle big problems’.

## 4 SEEK GENTLE PLEASURES

Switching off in the evening with gentle television programmes or books can help sooth your mind if you are feeling frazzled by the demands of a day’s nursing.

Avoid dramatic programmes, even soaps like EastEnders and Coronation Street, that can continue to stimulate adrenaline, the ‘fight or flight’ hormone.

‘Something like a makeover show, where the ending is

## Be alert to signs of compassion fatigue

Witnessing the trauma of others can push nurses towards compassion fatigue, warns Jayne Ellis, a nurse and chief executive officer of EF Training.

Life events, which can include what is going on in the wider world, as well as what happens to your family and friends, can contribute to this. So be alert for the signs of compassion fatigue, like anxiety, poor sleep, physical effects such as back and shoulder pain, and irritability.

‘Look out for not wanting to talk about your day and about how you are feeling and becoming quite robotic at work and at home because you’re protecting yourself from any further distress,’ says Ms Ellis.

### Empathetic distress

Negative news can feed into empathetic distress, which can contribute to compassion fatigue, says psychologist and well-being specialist Lee Chambers.

‘Empathetic distress is the impact of emotional and psychological strain caused by having empathy for the suffering of others and it can have a range of sources. While we can find ways to process this healthily, and it is a part of working in healthcare, it can lead to compassion fatigue if not noticed or managed.’



iStock

## Do you have eco-anxiety?

If you feel anxious and stressed about climate change, you are not alone.

A Lancet study of 10,000 young adults (aged 16-25) across ten countries found 59% were very or extremely worried about climate change and 84% were at least moderately worried. More than 50% felt sad, anxious, angry, powerless, helpless and guilty.

The American Psychological Association (APA) cites research showing that gradual, long-term changes in climate, combined with worrying about the future, can lead to a number of different emotions, including fear, anger, feelings of powerlessness or exhaustion.

To tackle climate change-related mental trauma, the APA recommends:

- » Building belief in one's own resilience
- » Fostering optimism
- » Cultivating active coping and self-regulation skills
- » Maintaining practices that help to provide a sense of meaning
- » Promoting connectedness to family, place, culture and community

always going to be happy, is perfect,' says Ms Ellis. 'I always recommend Queer Eye as a feel-good programme. And I find it helpful to read something light like the Thursday Murder Club series by Richard Osman. They are gentle and calming.'

## 5 FIND THE KEY TO SWITCHING OFF

Nurses should find what helps them work through the difficulties that relentless bad news can cause, says Lee Chambers, a psychologist and well-being specialist.

'This could be having an active support network and a space for expression, setting boundaries to ensure you have a reserve of emotional energy, understanding your stress responses and finding techniques to reduce this burden,' he says.

▲ Grim global events can be hard to look away from

'This might include activities such as walking, journaling or mindfulness.'

## 6 DRAW A LINE IN DISCUSSIONS

Many of the big global issues and disputes can provoke strong opinions, which sometimes people are keen to discuss. 'Nurses are often natural people-pleasers,' says Ms Ellis. 'So they get drawn into conversations that they don't want to have. But you have to put some boundaries around yourself and that comes down to having the internal

## 'Not all conversations will be constructive and sometimes you need to put your own well-being first'

Lee Chambers, psychologist and well-being specialist

courage to have self-compassion.

'That takes a while to work on because a lot of people who are very compassionate find it difficult to be self-compassionate and say "I need to stop this."'

Mr Chambers says 'respectful curiosity' can allow discussions to take place and there will be common ground even between people with strongly opposing views. 'But it is important to see that not all conversations will be constructive and sometimes you need to put your own well-being first,' he says.

Erin Dean is a health journalist

## Your views

# Resilience is futile in a failing system

**📄** The expectation for nurses to be resilient and stoic in challenging circumstances can be 'toxic' (news online, 11 December). We should be emotionally present and engaged. This requires self-care and safe working environments with safe staffing levels and reasonable working hours.

**Sarah Bartlett**

**📄** The blame placed on nursing staff for not being 'resilient enough' is damaging. It is a covert projection of a systemic issue onto individuals. This is not an issue that staff must 'fix'. Nurses are flexible, efficient and skilled and we must stand against this narrative.

**Maria Cozens**

✂ In our review for NHS England on the development of health



and well-being leads, three Health Innovation hubs and UCL Partners recommended that NHS trusts should shift their focus from individual accountability to organisational improvements to improve nurses' ability to deliver care in a safe environment.

**@Lukeintohealth**

✂ It is heartbreaking to hear about the growing mental health crisis among colleagues. We must ensure nurses have the support they need.

**@AriesMaximvs**

### New uniform wastes money

🎵 Our roof has been falling in for over a year and we never have enough staff. Why has all the time and effort spent on designing a new uniform not been used to address issues like that (news online, 23 November)? Who cares about a uniform when people are receiving sub-standard care due to dangerous staffing levels?

**Jaded**

✂ The new uniform is confusing. If staff can't figure out who should be wearing what, what chance have the patients got? It's a waste of money.

**@DukeLynsay**

### Specialist support is crucial

✂ It is concerning to hear that mental health and learning disability nurses are reportedly being replaced unlawfully (news online, 27 November). Ensuring specialist care and support for vulnerable individuals is crucial. Addressing staff shortages should be prioritised.

**@linda8475**

### 65 incredible years of service

📄 Britain's oldest nurse retired at 81 – what an incredible achievement (news online, 1 December). Her 65-year career should be honoured.

**Natalie Preston**

### 'Bad apples' protected

📄 Changing the culture is difficult when problems aren't recognised (comment online, 21 November). It is hard to report a bully when trusts often go after the victim, rather than the perpetrator. How are nurses supposed to speak up for someone when the cost to them can be severe? The way bullies are protected is breathtaking; they always seem to 'fail upwards'.

**Andrea\_1086961**

### Staffing warnings go unheeded

📄 Nurses' views are routinely bypassed in higher-level staffing decisions (news online, 24 November). Our staff get moved to other wards and then we are left with unsafe staffing levels. This is not acceptable.

**Juleka Mohamed**

📄 It doesn't matter if we Datix, staff are crying on shift or off with work-related stress. Staffing levels won't change because money comes first.

**Angharad Gammon**

📄 I used to Datix the lack of appropriate staff as serious untoward incidents (SUI), describing the detriment to patient care.

These reports would end up at trust HQ. Nobody could argue with my rationale, but boy, was I unpopular with the senior nurse managers.

**Zeba Arif**

### Over here, doing a great job

📄 I have so much love, respect and appreciation for all my overseas

colleagues in the NHS (features online, 1 December). We couldn't do this without you. I hope you all know that, even when our government makes it seem otherwise.

**Laurikins**

### Applause for menopause talk

📄 Too many nurses are suffering in silence while experiencing symptoms of menopause (podcast online, 28 November). Talking to nurse lead for menopause Wendy Madden on the Nursing Standard podcast is a great way of raising awareness and giving support.

**Nadine\_2923186**

### Troubling rise in suicide calls

✂ It does not surprise me that calls to a nurse helpline about suicide have doubled in one year (news online, 24 November). Some nurses self-medicate to come to work, with their mental health at rock bottom. We spend so much time caring for others but so little on ourselves.

**@RACHELb75**

# Workforce

## IN THIS SECTION

**Careers** What if staff could choose their hours and shifts? **p23**

**Comment** Mental health sick leave: why many nurses don't feel able to take it **p27**

**Careers** A practical guide to reporting concerns, whatever your role **p30**

**Students** The pros and cons of combining study and support worker shifts **p33**



iStock/Annette Taylor Anderson

## What overseas nurses need to thrive – and the impact of racism

The NHS is dependent on international recruitment, so it is imperative nurses from overseas feel valued and welcomed and can achieve career progression in the UK



By Claire Read  
health journalist

**T**he UK's longstanding dependence on the skills of nurses recruited from overseas has deepened in recent years.

The most recent analysis of the professionals who make up the Nursing and Midwifery Council (NMC) register shows that one in five were educated abroad.

Overseas-trained nurses account for more than two thirds of the increase in registrant numbers between September 2019 and March 2023.

### Lack of support after arrival

And because they are a more ethnically diverse group than those on the register they are joining, they have

contributed to the UK's nursing workforce becoming more diverse than ever before.

Yet there are serious questions about whether foreign professionals are being adequately supported and given the respect they deserve. The NMC published its inaugural Spotlight on Nursing and Midwifery report to coincide

with the publication of its 2022-23 register data, and its conclusions were stark: it found racism is affecting both quality of care and staff retention, and that new arrivals to the UK are often poorly supported.

The result is that internationally educated professionals spend less time on the register than those educated in the UK.

For one nurse, such findings are simultaneously depressing and unsurprising. Obi Amadi, now Unite the Union's lead professional officer but previously a midwife, health visitor and nurse practitioner, followed her mother into the profession. 'She used to tell us

about the racism she suffered,' Ms Amadi says. 'She came over from the Caribbean in the late 1950s and she talks about patients saying things like "Take your dirty black hands off me".'

Decades on, Ms Amadi is still hearing stories of mistreatment of nurses from overseas, whether in her union capacity or as general secretary of the Nigeria Nurses Charitable Association. 'None of it is new,' she says.

#### Made to feel under-valued

The sense of being unwelcome can begin the moment someone lands in the UK. One nurse, who asked not to be named, tells Nursing Standard how, having taken a long-haul flight, she

### 'Someone could have been a nurse educator back in their country, but when they come here they have to start at the bottom. Your experience is not counted'

*Bejoy Sebastian, senior nurse at University College Hospital Foundation NHS Trust, and general secretary of the Alliance of Senior Kerala Nurses*

arrived at her trust-provided accommodation to find no food, no cutlery and no bedding.

'That first night, we used our bags as a pillow,' she says. 'Luckily for me and my partner, we had taken the free blankets from the aeroplane. We had cup noodles with us, which we had to eat using our hands. It was not a good experience.'

The sense of being disrespected continued once she took up her staff nurse role. She had practised for several years in her native country, but discovered this experience seemed to count for little.

'They treat you like a like a brand new nurse, like you don't know anything,' she says. 'They don't take into consideration the experience you have back home.'

University College Hospital Foundation NHS Trust senior nurse Bejoy Sebastian, who is general secretary of Alliance of Senior Kerala Nurses says: 'Someone could have been a nurse educator back in their country, but when they come here they have to start at the bottom. Your experience is not counted.'

## Where can a nurse from overseas go to get support?

There are several possible sources of support for any internationally educated nurse who is finding work or life in the UK a challenge.

Growing numbers of employers have international recruitment pastoral support officers, whose focus is helping overseas nurses. Other organisations will offer help via a more general recruitment lead or team.

For worries relating to work on a ward or in a department, the best first contact is typically a line manager. However, it can be challenging to raise concerns,

particularly for nurses whose presence in the country is dependent on an employer-sponsored visa. Another option is Freedom to Speak Up guardians, who are in place to help with anything that is stopping someone from doing their job to their best of their ability.

Several internationally educated nurses have gone on to set up support associations designed to assist others coming to the UK.

NHS Employers has a list of these support organisations: [tinyurl.com/support-for-nurses](https://tinyurl.com/support-for-nurses)



Barney Newman

#### Pastoral care for overseas staff

Mental health nurse Marimou Tou Coumarassamy arrived in the UK 20 years ago, after nine years working in his native India. His first role was staff nurse at Birmingham and Solihull Mental Health Foundation Trust, where he is now deputy chief operating officer.

But he had to change trust three times before ultimately getting to his current role, feeling at points that he had hit a glass ceiling or that he had no further opportunities for progression. It has required an enormous



amount of perseverance and determination, he says.

‘Wherever I’m working, I work very hard,’ says Mr Coumarassamy. ‘I develop the skills, and then I will try to move on to a new level. If the same trust is going to embrace me and help me, I will stay there. If not, I will move on.’

In August 2020, he co-founded the British Indian Nurses Association (BINA) – in large part to make it easier for UK-based Indian nurses to progress in their careers. The organisation offers informal coaching and mentoring, help with interview skills because UK processes often differ significantly from those in other countries, and the chance to think through career aims.

‘I say to people that the NHS is full of opportunities, and within one or two years or arriving you need to find

International nurses may find their experience is not taken into account in the UK, or be less familiar with certain aspects of nursing here, such as palliative care

out where your heart is – we will help you explore,’ says Mr Coumarassamy. ‘I came here 20 years ago and I’m now a deputy chief operating officer, and I have hope that I can progress even further.’

BINA is working with around 40 NHS trusts to support the provision of pastoral care for Indian nurses. This is a focus Mr Coumarassamy believes is crucial. ‘The pastoral support provided to international nurses across this country is patchy. There is nobody checking whether everybody is having the same experience,’ he says.

It is an area where NHS England is seeking to take action. Last year, the NHS Pastoral Care Quality Award

for International Nurses and Midwives was established. Trusts in England can apply for the award, based on their recruitment processes for overseas staff, and are required to meet a set of best-practice standards. The aim is to standardise pastoral care across the NHS, while recognising those organisations demonstrating best practice.

#### Prepared to welcome recruits

If overseas nurses are to truly thrive in the UK, preparing them for their new roles will not be enough; homegrown staff will need help too. As Mr Coumarassamy puts it: ‘The NHS is relying much more on internationally educated

**‘In one country’s culture, it might be that you focused only on the patient and didn’t speak to the family. These nuances can create problems. It becomes “That nurse doesn’t talk to the family”**

*Obi Amadi, pictured left, Unite the Union’s lead professional officer and formerly a midwife, health visitor and nurse practitioner*





## Helping recruits to acclimatise: practical and professional support

Maria Sagucio believes many nurses from overseas use their experience of coming to the UK to make it easier for those who arrive after them.

Ms Sagucio, who qualified and practised in the Philippines before moving to the UK, has been international nurse pastoral support facilitator at Northampton General Hospital NHS Trust since March 2022. She has since built a programme to help overseas nurses settle and thrive.

### Professional advice and social support

The programme combines professional advice with practical support for living in the UK. A pre-arrival webinar covers everything from advice on how to search for accommodation to determining food preferences and dealing with religious needs.

'Then when they arrive, they receive a hot meal and at least two days' worth of groceries,' explains Ms Sagucio. It's a small but significant way of demonstrating respect to overseas professionals from the minute they arrive.

After those initial orientation days are over, Ms Sagucio introduces

the recruits to the trust practice development team who offer support through the OSCE (objective structured clinical examination). But this does not represent the end of the help provided.

### Career progression to reflect individual competence and experience

Indeed, a levelling-up programme has been launched to help the trust's nurses from overseas flourish once they have settled. 'We have a group through which we send

adverts for band 6 positions,' Ms

Sagucio says. 'If they want to apply they can just message us and we can support – practical tips on how to do interviews, using the STAR (situation, task, action, result) method to answer questions, because they may be very experienced but not know about that.'

The support on offer continues to evolve. There are now plans to introduce a seminar on speaking on the phone, and one on end of life care. 'Answering the phone can be hard for a new international nurse, when they have to update families and so on. So we're going to have role-plays to help with that. And because end of life support isn't common internationally, our palliative care team will do a session that addresses that.'

All of this work has led to national recognition. Earlier this year Ms Sagucio won a chief nursing officer's silver award, and Northampton General Hospital NHS Trust received an NHS Pastoral Care Quality Award for International Nurses and Midwives.



Practical support for new international recruits includes provision of a 'starter' groceries box on their arrival



► nurses now, but we haven't prepared people in the UK to receive them and to embrace their talents.'

Ms Amadi says: 'It's about more than giving international nurses a factsheet and saying that when someone says they're going to sit on the throne it means they want to go to the toilet. In one country's culture, it might be that you focused only on the patient and didn't speak to the family. These nuances can create problems. It becomes: "That nurse doesn't talk to the family". It's not that the nurse is wrong, it's just a cultural difference.'

Mr Sebastian adds: 'We need to understand that you don't have to be an active racist to give a discriminatory experience to someone else. You need to understand your own vulnerabilities, your own privileges, and be ready to act as an ally and challenge the norms.'

**'The pastoral support provided to international nurses across this country is patchy. There is nobody checking whether everybody is having the same experience'**

*Marimoultou Coumarassamy, co-founder of the British Indian Nurses Association*

As he points out, the stakes are high. 'If we don't look after internationally educated nurses, if we don't give them a warm welcome, if we don't try to solve the issues and help them thrive in their roles, they're going to leave. All the training we have given will be in vain. So we really need to make people feel at home here.'

# What if staff could choose their hours?

As employers struggle to recruit nurses, a care home has introduced an initiative offering staff freedom on shift patterns



By Lynne Pearce  
health journalist

**W**ith almost nine out of ten care home providers saying they have problems attracting and retaining staff, could offering complete flexibility on working hours be a solution?

One organisation is attempting to turn the tide with a progressive 'tell us the hours you want to work' initiative for new and existing staff.

## Changing our approach to shifts

'With the nursing shortage in the UK, we were struggling to recruit nurses,' says Susan Jones, chief people officer at Maria Mallaband Care Group, which runs 80 care homes in England and Scotland, employing more than 580 nurses.

'When I first came here two and a half years ago, staff could only work full or part-time, and the 12-hour shift was absolutely rigid. We tried to think outside the box, asking if we change our approach, can we offer something that gives more flexibility?'

The resulting initiative was piloted successfully at 24 homes in September 2022, with a follow-up at a further 20 in phase two, before eventually being rolled out across the organisation.

Under the new scheme, the group offers staff a minimum of five hours a week, with individuals able to choose the days and times they would like to work, which can be a fixed pattern or flexible, and includes days and nights.



**'Fast forward a year, and if you ask any of our managers, I think they'd say this is the best thing we've ever done'**

*Laura Finlay, head of talent, Maria Mallaband Care Group*

## Staff are in the driving seat

'They're in the driving seat,' says the group's head of talent, Laura Finlay. 'Already we have a couple of people working six hours a week. They can also top up those hours if they want to or they can join our bank, which we've bolstered so we can accommodate those who are working flexibly.'

At interview, the group will ask what hours the person wants to work and what a good shift looks like for them. 'We then check with the care home manager that it's something they can accommodate – and more than nine times out of ten, they can,' says Ms Finlay.

'We then make the offer on that basis. Since we launched, 62% of our newly hired people have been flexible.'

## Revealing a wider talent pool for recruitment

The flexible hours initiative should be adaptable to other settings too, says Ms Jones. 'It might take a bit more organisation and management time to ensure you've got the right coverage, but it should be transferable.'

Among the benefits has been an enhanced diversity in the workforce, says the group's

## Top tips for introducing a flexible working initiative

- » **Think differently**, says Maria Mallaband Care Group head of talent Laura Finlay. 'We have a distinct lack of people who want to work in social care, so we need to be trying different things,' she says. 'You'll find you attract a diverse range of talent'
- » **Empower those who will be running the initiative**, says the group's chief people officer Susan Jones, by giving them the training, tools and support they need
- » **Ensure managers understand the reasoning behind the change**, she adds. 'It was really important they understood why we were doing this. This includes providing more consistency of care and people not leaving the organisation. If they understand why, they'll put more energy and effort into making it work'
- » **Start small**, advises Ms Finlay. 'We began with 24 homes,' she says. 'You don't have to do everything at once, but trial things instead to see what works'

➤ head of talent, Laura Finlay. ‘We’ve opened ourselves up to such a wide pocket of people,’ she says.

This includes working parents, who want to schedule working hours around school times, and those who are semi-retired, who don’t want to work long shifts.

‘The most searched term in the UK jobs market when it comes to care is “part-time”,’ she says.

#### Impact on staff absence and attrition

Tangible benefits of the initiative also include low staff absence rates, reduced numbers of staff leaving, and feedback showing higher engagement. The group also has its lowest vacancy rate for nurses since the flexible working initiative was introduced.

But it has not been without its challenges. ‘For the home managers, this has been quite a different approach,’ says Ms Jones. ‘I’d say there was a little bit of resistance. If you’re trying to bring people in with part-time hours, drawing up rotas is more complex. But we’ve worked hard to understand, giving them the capability to manage it.’

In the past, many of the group’s care homes used a lot of agency staff to plug gaps, says Ms Finlay. ‘It meant many managers weren’t having to rota because the agency were doing it for their own people.’

## Shifts that work for me, my business and my family

Once a director in charge of 20 care homes, Ioana Pop (pictured) reevaluated her priorities as a result of the pandemic.

‘I decided I wanted to take a step back and look after my family, who I felt had been neglected by my career ambitions,’ says Ms Pop, who came to the UK 12 years ago from Romania and has been a qualified nurse for 23 years.

She decided to start her own business in aesthetics and body contouring. ‘I wanted to combine medicine with beauty,’ she says. But she found working alone could be lonely and she also wanted to maintain her nursing registration.

‘I needed to find a place where I could be with people again and make a big difference in residents’ lives,’ says Ms Pop.

After looking at a variety of options, but struggling to find the hours she wanted, she applied for a vacancy at the Maria Mallaband Care Group’s Highfield Care Home in Saffron Walden, which provides residential nursing care for older people, alongside dementia care, with 54 residents in total.

‘The home has been extremely flexible with my hours,’ says Ms Pop, who joined the team just under two months ago. ‘That’s why I chose them. It’s been so amazing I almost can’t believe it.’

In practice, Highfield asks her in advance when she would like to work, checking to see that she is still happy with the arrangements. ‘At the moment, I’m working on Tuesdays and Wednesdays, or sometimes Thursdays, on 12-hour shifts, which is my choice,’ says Ms Pop. ‘It depends on my availability. They always accommodate my requests, with no problems.’

#### Shifts fill the gaps in income from my other work

The arrangements are enabling Ms Pop to build up her own business steadily, but with the safety net of a regular income. Looking ahead, she knows that there will be peaks and troughs in demand for her aesthetics services, with the care home already agreeing to provide more or less work during those times.

‘It means so much to me,’ she says. ‘I have an income every month, which gives me security, and I’m working in a great environment, with an amazing team. It’s also about my life and my family. I’m so delighted that I found this company.’

## ‘The most searched term in the UK jobs market when it comes to care is “part-time”

Laura Finlay, head of talent, Maria Mallaband Care Group

‘When managers had to plan their own rotas, it was a bit confusing at first, especially thinking about being flexible and the impact that might have.’

#### Enabling the experts to train others

To help, they created experts in the organisation, who had been involved in the initiative from its first phase. ‘We’ve been able to use those managers to train others and that’s worked really well for us,’ says Ms Finlay.

Reducing dependency on agency staff has improved the consistency of care residents receive, Ms Finlay believes, with positive feedback also coming from residents and their friends and families, who enjoy seeing staff who are familiar.

‘It’s had so many benefits and I think the care home managers can see that now,’ she says. ‘They’re not having to use agency staff and the workforce is happier, with teams that know each other. Fast forward a year, and if you ask any of our managers, I think they’d say this is the best thing we’ve ever done.’



Would the ability to choose your shift patterns stop you from quitting?  
[rcni.com/flexible-shifts-retention](https://rcni.com/flexible-shifts-retention)





# Our ward leaders need to be supernumerary

Leadership takes time, so ward managers should not be counted as part of the nurse staffing needed for safe care



By Nicola Davis-Job  
acute care and leadership  
advisor at RCN Wales

**W**ard managers provide valuable clinical leadership in the delivery of quality care to patients. Their role should be supernumerary – not counted as part of the staffing needed for safe care – affording those in post the time to lead and manage.

## Protecting the supernumerary status of ward managers

Having been a ward manager and now as RCN Wales acute care and leadership adviser, I was proud to be part of the college's project to ensure this status is protected, at a time when workforce pressures are compromising it.

The ward manager project in Wales involved gathering real-life evidence and is influenced by the college's new UK Nursing Workforce Standards, which set out detailed expectations on issues including setting staffing, practice development and rostering for employers, regulators and organisations to support nurses' work and patient safety.

The project puts forward to the Welsh government recommendations on the necessity that the ward manager role be supernumerary.

## Ability to lead often hampered by short-staffing

Much of the ward manager's role and responsibilities directly enables the workforce standards to be met, by ensuring nurses can work safely and effectively.

But with increasing pressures and staff vacancies, ward managers are being taken further away from their primary role and are assisting in direct patient care to make up for this shortfall. When this happens, it makes leadership more difficult.

## Ward managers put compassionate leadership into action

Effective, compassionate leadership in nursing is important to staff, patients, and their loved ones. It is a leadership style to which many people working in healthcare aspire.

Emphasis is being placed on the role of nurses as advocates for their patients and profession, whereby they speak up and use their expertise to improve processes and outcomes and make meaningful change.

The ward manager is a perfect example of what this can look like, as they establish the values and culture of their ward, and can lead by example with authenticity and expertise.

All these qualities build personal and team resilience, an indispensable asset during challenging times.

Ward managers can be advocates for staff well-being, ensuring their colleagues avoid burnout. Exhibiting bravery in making decisions that uphold the core values and best interests of your team and patients is just as important as planning and delegating the workload.

## Stability and consistency for staff and patients

Having a mentor is beneficial at any point in a nurse's career. As role models to their team members, ward managers should be supported with continued professional development to reach their full potential.

The ward manager is the face of the ward for most patients, and their daily presence and interaction with patients provides consistency and stability.

Their knowing patients clinically and personally greatly assists with continuity of care during times >

## What are the duties of a ward manager?

A ward manager is the leader of a given ward and undertakes managerial, operational, administrative, pastoral and clinical tasks to ensure that their unit runs efficiently, using expert clinical judgement.

The duties of a ward manager includes, but is not limited to:

- » Data collection and collation
- » Allocating and auditing of staff and equipment
- » Managing overall patient flow across the whole patient journey
- » Clinical teaching, upskilling and assessment

  
Nurse leadership:  
why compassion can  
work wonders  
for morale  
[rcni.com/compassion-  
morale](https://rcni.com/compassion-morale)

› when the make up of teams can change often, due to the inclusion of agency staff or a high staff turnover, for example.

The ward manager can facilitate handovers, briefings and seamless integration of staff wider teams. Given all this, and their wider-ranging responsibilities and leadership role, can we afford for them not to be supernumerary?

#### Looking for the next challenge in your career?

We are excited to be developing an RCN Wales clinical leadership programme for ward managers in the NHS and independent sector. This is for ward managers who want to strengthen and develop their leadership skills, such as emotional intelligence, conflict management, coaching styles, establishing a vision and direction.

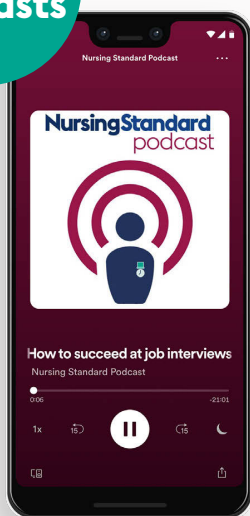
If you are thinking about whether the role of ward manager is right for you, there has never been a more relevant time to strengthen the voice of nursing in a leadership role that directly impacts patient care.

### Having time to lead as a ward manager: what are the benefits for patients?

Some of the benefits of ward managers being free to lead their teams, according to the RCN project findings, include:

- › **Happier staff, happier patients** It is proven that increased emotional well-being in staff (being well-rested, motivated and happy in their work) correlates to better patient care and better working relationships
- › **Fewer incidents** By allowing the ward manager to manage data, plan, delegate and anticipate, there is far less opportunity for missed details and mistakes
- › **Quicker discharge rates** Better overall patient journey and so potentially increased space for patients waiting for treatment
- › **Implementing existing legislation** Ward managers use their professional judgement to determine the number of staff and the skill mix required for the setting and can monitor if, for example, government standards are being met
- › **Assisting** Upskilling, role modelling and supporting career development for their colleagues

free  
podcasts



## NursingStandard podcast

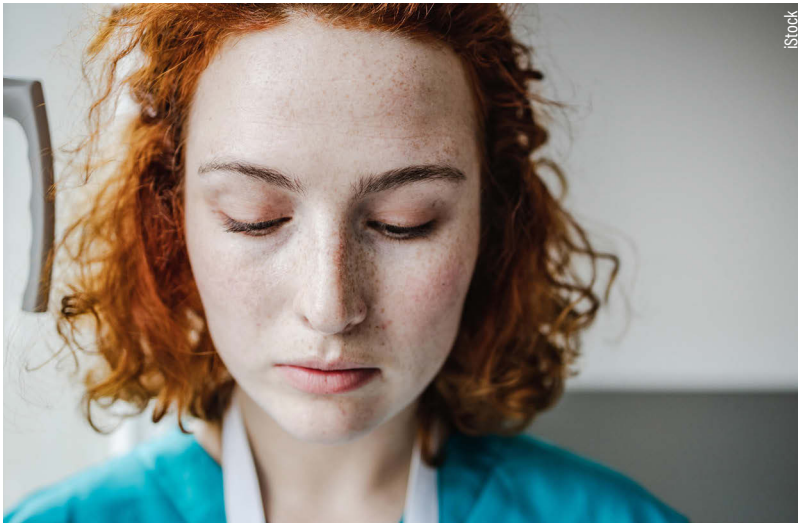
Join us as we discuss the  
hot topics in nursing

Listen to regular new episodes online,  
on Apple Podcasts or Spotify



Visit: [nursingstandard.com/podcast](https://nursingstandard.com/podcast)

RCNi



# Do you take mental health sick leave?

Nurses' mental ill health is pushing up sickness absence, yet many staff struggle into work because of insensitive workplace policy



By Brian Webster  
a critical care nurse  
in an intensive care unit  
in Scotland

**N**Hs sickness absence rates are rising, with mental ill health a leading cause. The NHS needs to have policies and procedures in place to function effectively but do these policies function as they should, especially in relation to mental health?

The Once for Scotland policies cover all of Scotland's health boards. The attendance policy standardises staff absence processes. But is a blanket approach appropriate for all sickness absences?

## Fear of repercussions makes nurses work when ill

At least NHS policies offer some protection and benefit – some private sector employers offer even less to their sick staff. Yet despite these policies, it is still common for nurses in the NHS to carry on working when they should be off.

Some of them fear the sickness policy and its implications, with dismissal being the most extreme. When sick nurses come to work they are putting themselves, colleagues and patients at risk.

NHS Employers states staff should be symptom-free for 48 hours before returning to work when they have had sickness and/or diarrhoea. However, it does not advise a timeframe to return after, for example, a cold or flu. In such situations, nurses may carry on working possibly making themselves worse, through fear of letting people down. And the same is surely true of mental health issues.

We have a professional obligation to prioritise our patients, but we also have an obligation to ourselves to ensure we stay well enough to practise safely and effectively. But nurses often put their patients' health

ahead of their own mental health and well-being, which can lead to burnout. Some may worry about stigma or believe a decline in mental health and well-being does not warrant absence.

NHS Employers recognises that mental health can fluctuate in the same way physical health can. It offers recommendations to encourage positive well-being, including the use of reasonable adjustments. But it is not explicit about entitlement to time off.

Certain physical conditions, such as a sickness bug, have a quick recovery time. Analgesia or medication can be prescribed for pain. But it is not as easy and can take much longer to get our mental health and well-being back to where it should be.

At the RCN's 2023 congress, members voted to lobby for an integrated suicide prevention programme for UK nurses. Yet recently, mental health leaders have raised concerns over the loss of mental health hubs to support nursing staff. Mental health sick days and suicide among nurses continue to rise, but where is the investment to tackle this? And are workplace policies doing enough?

## Including staff mental health in workplace policy

Everyone's mental health is different and this means their recovery and recuperation from a decline or change is also different. Some nurses return to work too soon or do not take time off because they believe they do not deserve it. Others feel they cannot take time off sick because this adds to the pressures already faced by the NHS.

Is a 'one size fits all' policy appropriate? Workplace policies that are explicit in their treatment and prioritisation of mental health would be a good start, but there needs to be a culture shift too. A change in policy has limited relevance when nurses continue to work when sick regardless.

NHS England sickness statistics show anxiety, depression and other mental health conditions were the most reported reason for absence in March 2023, accounting for 507,100 full-time-equivalent days lost. What causes NHS staff to be absent for these reasons? And is there more the NHS can do?

There has been talk of the NHS considering a four-day working week in a bid to try to increase productivity, reduce sickness and improve retention while increasing recruitment, and making the NHS a more attractive workplace. However, nurses have been quick to question the feasibility of this, given the ongoing staff crisis.

## Nurses deserve to feel valued and supported

The NHS England Long Term Workforce Plan is a long-overdue commitment to address the many crises in the health service, including staffing. The plan promises a big recruitment drive and a programme of strategic workforce planning.

With more nurses than ever leaving the profession, care, compassion, understanding, empathy and leadership need to be shown and practised in relation to nurses' health and sick leave. Nurses deserve to be supported, valued and able to take time off sick when they need it.

  
Nurses' well-being:  
'burnout' too gentle a  
term for mental distress  
[rcni.com/burnout-  
distress](https://rcni.com/burnout-distress)



# What does a gender identity nurse specialist do?

Nurses working in gender health services support patients to access a range of care, both surgical and non-surgical. Find out about the role and the skills required



By Erin Dean  
health journalist

**G**ender services care for people with gender incongruence, the term used for a discrepancy between an individual's birth-assigned sex and their gender identity, or how they feel about their gender.

NHS guidance says that gender incongruence is frequently accompanied by the symptom of gender dysphoria, a strong and persistent cross-gender identification – such as stating a desire to be the other sex or frequently presenting as the other sex – coupled with persistent discomfort with one's sex.

## How are gender services provided?

Care within the NHS is provided through specialist centres and includes assessment, non-surgical care packages, certain surgical interventions and associated immediate after care.

There are also some privately run clinics that provide gender care services.

## What kind of treatments do gender clinics provide?

A wide range of aspects of care are covered by gender health services. This can include hormone therapy, discussions about the impact of treatment on fertility, masculinising or feminising surgery, hair removal, supporting people to speak with a voice that reflects their gender identity, and psychotherapy.

NHS England has set out two main adult care pathways, one for those who are having surgical interventions and the other for those who are not.

The NHS is creating new services for children and young people with gender incongruence, following controversy that led it to announce the planned closure of the Gender Identity Development Service, based at the Tavistock and Portman NHS Foundation Trust.

## What is a gender nurse specialist?

Gender nurse specialists work in gender services at all levels and in a variety of roles. Nurses working in gender identity care may also work in other services, including children and young people's mental health services.

Many nurses who work in these services are non-medical prescribers, or are training to be, with titles varying across services and depending on nurse seniority.

## What does the role involve?

While the roles can vary, nurses in gender services will often undertake initial patient assessments, discuss the options service users may want to pursue, carry out ongoing reviews and oversee hormone treatment.

Laura Garner, a transgender health clinician (senior clinical nurse specialist and lead clinician) works at the Nottingham Centre for Transgender Health Network, a large centre that employs 13 nurses and a range of other staff.

'Nurses within our team undertake the majority of the case management for patients, so they will be the people that see patients throughout their time and carry out their regular review appointments,' says Ms Garner.

'They will also oversee prescribing advice to GPs, so they'll be reviewing blood results and responding to any issues or questions that come from the patient or their GP, acting as that central point of contact for each patient as well.'

## How is the gender nurse specialist role developing?

Many nurses who work in these services will be, or will be supported to become, non-medical prescribers so that they can oversee the prescribing of suitable hormone treatment.

Nurses may also be supported through training and master's programmes to further enhance their skills.

'We want our nurses to be the best they can be,' says Ms Garner. 'We support them to develop professionally in whatever direction they want to go, as long as it's going to benefit the patient group. Some of our team have used this opportunity to become nurse psychotherapists.'

Ms Garner recently trained to be a lead clinician as part of a pilot programme at the trust, and is able to diagnose patients with gender incongruence. She can now care for a patient

  
Caring for trans and non-binary people: overcoming the fear of 'getting it wrong'  
[rcni.com/trans-NB-care](https://rcni.com/trans-NB-care)

throughout their journey, from assessment, diagnosis and prescribing, to starting hormone treatment and providing surgical opinions. There are plans to roll out this role more widely across the country, she says.

### What band is the role?

The pay for specialist nurses working in gender identity services varies depending on the role and experience, but generally ranges from band 6 to 8.

### Which professionals do gender identity specialist nurses work with?

Gender identity services are truly multiprofessional, with teams generally comprising doctors, nurses and allied health professionals. This can include surgeons, endocrinologists (doctors who specialise in hormones), pharmacists, psychologists, psychiatrists and speech and language therapists.

Waits for these services can be long, with patients often waiting two years or more for their first appointment.

### What skills and background do you need for the role?

Nurses come into gender services from a range of different backgrounds, and this diversity of experience adds to the strength of the team, says Ms Garner.

The team at the Nottingham centre where she works has nurses with backgrounds in mental health, sexual health, care of older people, intensive care and drug and alcohol services.

'The main criteria is an interest in transgender health, and we use people's backgrounds in terms of providing really individualised care for our patients,' she says. 'There is no background that would stop someone coming into this field. We constantly share our knowledge formally and informally.'

### What skills and attributes are helpful?

Being open, non-judgemental and able to quickly establish a good, trusting relationship with patients is essential.

'Nurses need to be accepting and want to learn and develop in terms of professional practice,' says Ms Garner. 'A key part of our job is to build rapport and demonstrate understanding.'

'Really listen to the patient and make them feel like they've been properly listened to, so they get the most out of their appointments,' she adds. 'Listen to any questions they have and take the time to answer so it's not a tick-box exercise.'

### What is great about working in these services?

Trans patients are a wonderful cohort to work with, and there is strong morale among a team motivated to provide the best care, says Ms Garner.

But hearing what some service users have gone through can be hard, she adds. 'It can be distressing to hear the experience of some of our patients. It is such a marginalised and targeted group, and a lot of them are heavily affected by the way they are spoken about in the media and increasingly by the government.'

'It affects them quite deeply. We do our best to provide a safe space.'

### Further information

NHS: Gender dysphoria [tinyurl.com/NHS-gender-dysphoria](https://tinyurl.com/NHS-gender-dysphoria)

NHS England (2023) Implementing advice from the Cass Review [tinyurl.com/Cass-review](https://tinyurl.com/Cass-review)

The Nottingham Centre for Transgender Health: For health professionals [tinyurl.com/NCTH-HCP](https://tinyurl.com/NCTH-HCP)

The King's Fund (2022) Acting on the evidence: ensuring the NHS meets the needs of trans people [tinyurl.com/kings-fund-trans](https://tinyurl.com/kings-fund-trans)

## 'By the time patients see me, they are very relieved'

Gender service nurse Polly Zipperlen supports trans patients to get care near their homes in rural west Wales.

Ms Zipperlen and her colleague, a consultant endocrinologist, are referred patients who want to start hormone treatment after they have been screened and assessed by the Welsh Gender Service, based in Cardiff.

She speaks to the patient, checks their medical history and can then oversee the beginning of their hormone treatment and the blood tests that go with it, or support them to receive that care from their local GP.

'Providing support to patients is an essential part of the job,' says Ms Zipperlen, who works one day a week in the role for Hywel Dda University Health Board in west Wales.

'It is really important to find out how patients are feeling and whether they have good social support from friends, family or peers. I work in a rural area, where some patients may not feel comfortable presenting in their true gender. Part of my role is to support these patients to find peer groups where they can truly be themselves.'

### 'People have had a long wait to get care'

Some patients have been on waiting lists for up to 24 months before they are assessed and hormone treatment can be started, she says.

'It is a wonderful service to work in. People have had a long wait to get care and perhaps a difficult journey, in some cases taking decades to access services,' says Ms Zipperlen.

'By the time patients see me, they are very relieved to be commencing treatment and to feel they are making some progress on their transition journey, whether that be hormone treatment or surgery.'

Ms Zipperlen, who hopes to become a nurse prescriber, has worked in sexual health for a decade and says this is a useful background for the role. 'Sexual health and the gender specialist nurse are autonomous roles that give you the chance to diagnose, treat and manage patients.'

'Through my work in sexual health, I have become accustomed to establishing an instant rapport with patients, which is essential for the personal nature of the consultations around sexual health and gender care.'

# Reporting concerns, whatever your role

Our practical guide explains how and in what circumstances to use 'red flags' to raise nurse staffing gaps, whether you're a ward manager or leader, or a staff nurse



By Pippa Clark  
lead nurse for safe staffing  
at University Hospitals  
Leicester NHS Trust

**F**eeling safe to raise concerns in the knowledge that any issues will be listened to and acted on is essential to our well-being at work. Whether about patient safety or staffing levels, we must have the courage to raise and escalate our concerns using the tools and support available, such as a red flag system.

## 'Red flags' introduced to help highlight staffing shortfall

In 2014, the National Institute for Health and Care Excellence (NICE) published guidance on safe staffing levels on hospital wards. This followed the 2013 publications of the Francis Inquiry report into poor care at Mid Staffordshire NHS Foundation Trust and the Berwick report on patient safety – both of which identified that inadequate staffing levels contributed to poor quality care.

The NICE guidance recommended the use of 'red flags' for safe staffing – a system that warns the nurse in charge that there may not be enough nursing staff to meet the needs of patients on that shift, so that immediate action can be taken.

## What are my responsibilities in raising concerns about staffing?

From students and support workers to the most senior nurses in an organisation, everybody has a role in raising concerns about safe staffing.

The level of responsibility for acting on these concerns depends on your role and level of experience, but if you have any concerns about staffing levels as a nursing student, healthcare support worker or newly registered nurse, raise these with the nurse in charge of the shift as soon as you can.

Nurses at band 5 should also raise any concerns with the nurse in charge. For example, if there is only one registered nurse on the ward who can administer intravenous (IV) medications and the majority of patients require IVs, raise this with the nurse in charge so they can help.

The responsibilities of those at band 6 include assessing staffing, discussing it with the nurse in charge and supporting them in coming up with solutions or mitigations. The nurse in charge is responsible for assessing staffing against bed occupancy and patient acuity and dependency, so listening to colleagues' concerns is vital.



## Raising a red flag – the cycle of communication

This cycle of communication is essential when raising, reviewing and resolving red flags. It reassures staff that any concerns raised are being listened to and acted on promptly, improving staff well-being while ensuring patient safety.

- » The nurse in charge assesses staffing levels for the day at the earliest opportunity – ideally during or immediately after handover – then compares their findings to the types of red flags set out by the organisation
- » If the assessment of staffing triggers a red flag, the nurse in charge creates a red flag via the system used by the organisation. This triggers an auto-alert to senior nursing colleagues – usually nurses at band 8a and above, such as matrons – to respond to the alert
- » Senior nurse reviews the red flag at the earliest opportunity during the same shift period, looking at staffing levels and implementing mitigations where possible and appropriate. An example is weighing whether a staff member can be redeployed to another area for part of the shift, to avoid the use of bank or agency staff
- » The decision-making process and resolution of the red flag is then documented, with the senior nurse providing feedback on actions taken to the nurse in charge

  
Letby: the safeguarding  
support nurses need  
to raise concerns  
[rcni.com/Letby-  
safeguarding-support](https://rcni.com/Letby-safeguarding-support)



Daniel Mitchell

### Who should raise a red flag?

Many factors can affect safe staffing levels during a shift, such as increases in patient acuity or someone going home sick.

Red flag systems enable real-time monitoring during the course of a shift, giving senior nurses continuous oversight of staffing levels and patient acuity, allowing them to determine whether the staffing level is safe enough to meet patient demand. Either the nurse in charge or the ward manager should raise a red flag. This ensures continuity and eliminates the risk of power struggles between colleagues.

### Maintaining nurse staffing oversight – software and face-to-face reporting

The nurse in charge of any shift should have access to software for raising a red flag. At University Hospitals of Leicester NHS Trust, red flags are raised electronically using Allocate SafeCare, which provides live visibility of staffing levels in relation to patient demand.

Technology is key to safe staffing. Although red flags can be raised in person – at staff meetings, for example, or if the ward manager or nurse in charge speaks directly to the matron – an automated escalation system enables senior colleagues to respond quickly as soon as a red flag is raised, so that a timely solution can be found.

Organisational oversight of staffing is essential for senior nurses' daily operational management. SafeCare uses a traffic light system, with red, amber or green status allocated depending on the staff required versus the staffing hours actually available.

The system also highlights areas where red flags have been raised, allowing the data to be analysed so any themes or patterns can be identified. For example, if the data show most of the red flags for one area or specialty are being raised on a Monday long day shift, senior nursing staff can examine what is happening during that shift and how can they respond.

The monitoring and analysis of trends is critical to enabling continuous improvement of services and response to patient need.

### Red flag systems improve communication and teamwork

It is essential red flags are not neglected or disregarded, with safe staffing guidance from the National Quality Board highlighting the importance of a 'triangulated approach' to safe staffing. This combines patient outcomes, evidence-based tools and professional judgement to ensure we have the right staff with the right skills in the right place at the right time.

As well as enabling staffing concerns to be identified and acted on quickly, a red flag system improves communication, team work and nurses' problem solving skills, and ensures staff are listened to when they raise concerns.

Safe staffing is everybody's business and should be monitored from ward to board. This promotes a transparent culture and positive working relationships that make it possible to deliver high-quality patient care.

### Further information

NICE (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals [tinyurl.com/NICE-safe-staffing](https://www.tinyurl.com/NICE-safe-staffing)

National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time [tinyurl.com/NQB-right-staff](https://www.tinyurl.com/NQB-right-staff)

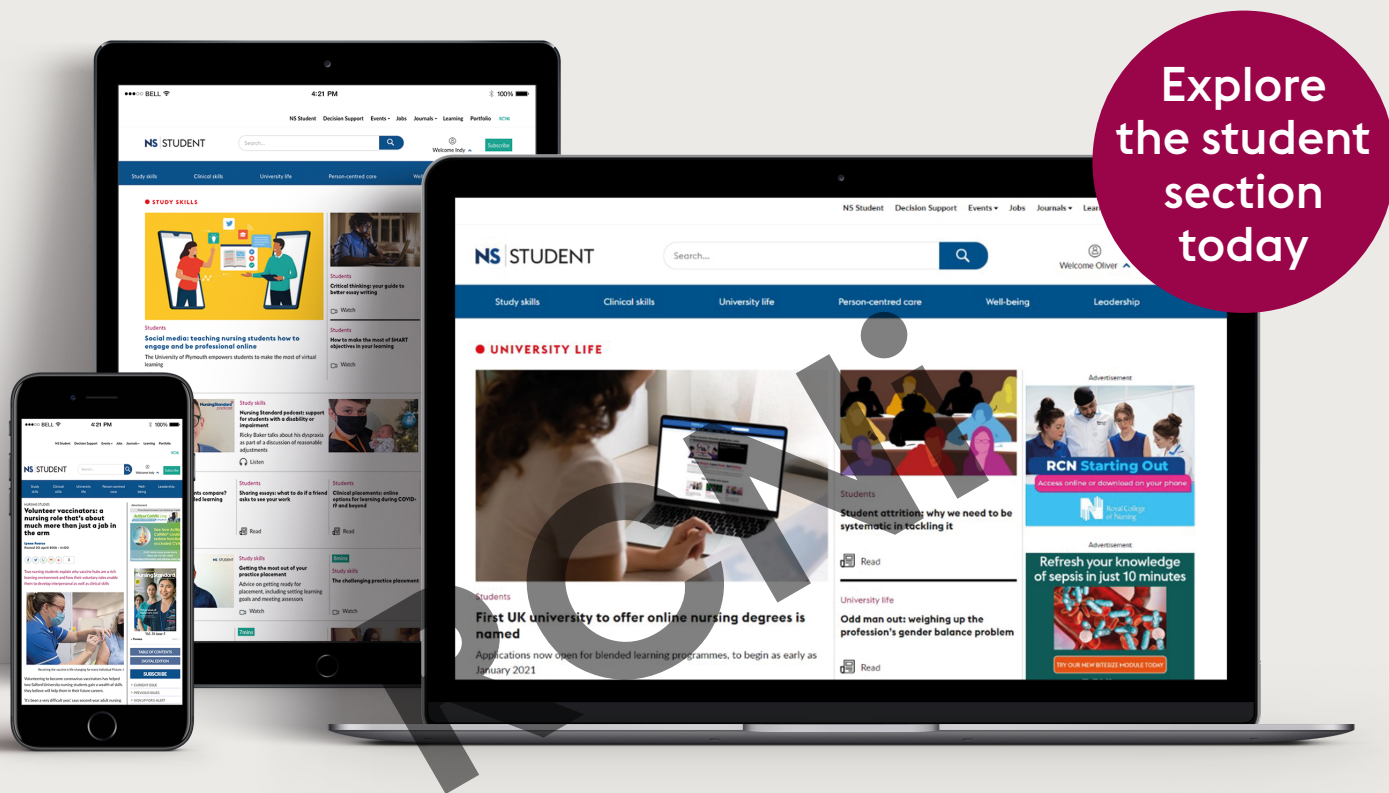
## Nurse staffing red flags

The core nursing red flags in the NICE guidance are:

- » Planned medicine administration is missed
- » More than 30 minutes' delay in providing someone with pain relief
- » Failure to record or assess a patient's vital signs in line with the person's care plan
- » Delayed or missed regular checks on patients to ensure fundamental care needs are being met, such as pain assessment, meeting hydration needs, ensuring patients are comfortable and assessment and monitoring of pressure ulcer risk
- » Fewer than two registered nurses being present on a ward during a shift
- » A shortfall of more than eight hours, or 25% (whichever is reached first) in the registered nurse time available, compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if fewer than 32 hours of registered nurse time was available for that shift

The NICE guidance says red flags can also be agreed locally – not having enough staff to provide continuous patient observation, for example, could be an additional red flag.

# Make the most of your studies with **Nursing Standard's** student resources



Explore  
the student  
section  
today

## Supporting you from theory to practice:

- **Nursing studies** – practical advice, clinical articles and inspiration from other students to help you find your feet on your course.
- **Advice and development** – make an informed decision about the kind of nurse you want to be with guidance from these careers and development articles.
- **Clinical placements** – entering a clinical setting for the first time can be a daunting experience. Learn how to enhance your skills through reflection and put your theory into practice.
- **Newly qualified nurses** – confidently make the transition from student to qualified nurse with this dedicated collection of articles.

Available in the  
Nursing Standard app



[Nursingstandard.com/students](https://www.nursingstandard.com/students)

**RCNi**

# Should I be a support worker while I study?

Many nursing students need to work while studying to cover costs, but it can be tough to keep up with coursework and avoid burnout



By Lynne Pearce  
health journalist

**N**ursing students working while they are studying is less a question of want and more of need, says RCN professional lead for nursing students Rachel Wood. 'It's a financial necessity to find some kind of income,' she says. 'Unless a student is fortunate to have private means then the funding they can access is insufficient for them to live.'

## Why students work, and the funding they are entitled to around the UK

'In England, they're entitled to a cost of living loan, but it's not enough to pay rent and meet their daily living costs,' she adds.

While students in Scotland and Wales have a bursary, which usually covers course fees, they still don't have enough money to cover their living expenses, says Ms Wood.

An RCN Scotland survey published in June 2023 found that students are facing serious financial hardship, with many struggling to make ends meet. In the survey of more than 1,000 students in the country, 99% said their finances cause them some level of concern, with 90% saying they are working 11 or more hours a week on top of studies and clinical placements to supplement their income.

'So many of us are struggling, given the financial difficulties we all face,' says University of the Highlands and Islands third-year nursing student Lou Hyett-Collins, one of the Scotland representatives on the RCN students committee. 'Behind every statistic are hundreds

of individual nursing students trying to persevere with so many odds stacked against them.'

Chloe Jackson, a third-year nursing student at Robert Gordon University in Aberdeen and also a member of the RCN students committee, adds: 'Nursing is not like other degrees. There are many nursing students who must work to supplement their income. Working long hours on top of completing clinical placements and studying can lead to burnout before students even start their nursing career.'

The RCN's Ms Wood says putting students under the kind of pressure they are facing 'might be a short-term fix, but will have long-term implications. There's real concern about nursing students who complete their programmes but don't end up registering to practise,' she says. 'We lose people who have great potential.'

## Why is working and studying different for nursing students?

Other students often get long summer breaks, which means they can take a job and build a nest egg to draw on, says Ms Wood. 'But nursing students don't have those long breaks, so there's no opportunity for them to do that. It means they are having to work during term times.'

Placements add to the pressures. 'On placements, they may be doing shifts, or it could involve lengthy journeys – up to an hour and a half in some situations – so they're struggling to fit everything in,' says Ms Wood.

  
Finances, placements  
and well-being: support  
for nursing students  
[rcni.com/student-  
finances-support](https://rcni.com/student-finances-support)



## Top tips for students on juggling work and study

- » **Prioritise your own needs**, advises RCN professional lead for nursing students Rachel Wood. 'You must put your own health and well-being first. Recognise your limitations and if you're struggling, ask for help.' This includes seeking support from your university or seeking advice from the RCN
- » **Find work that is flexible** and fits around your studies, says newly registered nurse Lenka Huntley. 'It's impossible to do it the other way around'
- » **Put your studies first**, advises Ms Huntley. 'At the end of the day, being a registered nurse is where you want to be. Don't lose sight of the bigger picture'
- » **Learn how to say no** if you are working for an agency, don't feel guilty about turning work down, says final-year nursing student Sam Moffat. 'I used to get phone calls at 5.30am and you just have to say a firm no'
- » **Plan shifts carefully** Don't book them too far in advance, advises Mr Moffat. 'Things change,' he says. 'And you also don't know how you're going to feel. In a lot of places, you can often book a shift the day before'

- Ms Jackson adds: ‘Many nursing students are older and have existing financial commitments, children or other dependants, and many are responsible for providing more than half or all of their household’s income while studying. We need more financial support to prevent so many falling into hardship and experiencing burnout.’

### What is the advice for students working as healthcare support workers?

While students can take on a healthcare support role, it should not go beyond their competence or skill base, says the RCN in its advice for nursing students.

‘It should be clearly understood by all staff that you are working as a healthcare assistant and not in a nursing student capacity,’ it says.

Before agreeing to the work, students should discuss the arrangements with their clinical supervisor, ensure they will be paid the rate for the job, ensure the nursing bank or agency specifies the basis of their attendance, and have the same access to all local agreements and terms and conditions as other employees, advises the RCN.

‘Nursing education continually enforces the importance of accountability,’ says Ms Wood. ‘When a student is working as a healthcare support worker, it’s a challenge for them to remember the role in which they’re working and the expectations of that role.’

In an emergency or when there are staff shortages, this can be doubly difficult. ‘It can be hard for them not to use the skills and competences they may have already gained,’ she adds.

Placements may also be affected. ‘If someone has built skills and competences in a paid healthcare role, they should not be using them inappropriately when they’re a student on placement,’ says Ms Wood.

‘It’s important to value those transferable skills, but equally students are not there to be an extra pair of hands, and their supernumerary status needs to be protected.’

### Can working while studying be beneficial?

While placements should be designed to give students what they need to achieve their goals, a wide range of work experience can enhance knowledge, says Ms Wood. ‘It could be a good thing, complementing the programme,’ she says.

For newly registered nurse Lenka Huntley, who graduated in 2022 from Brighton University, the primary aim was to gain experience. ‘Although the extra cash is good, it also gives you many transferable skills,’ says Ms Huntley, who worked as a healthcare support worker on the bank for her local trust alongside a paid role with her university as a student ambassador.

Ms Wood says concerns about working while studying relate to achieving a good work-life balance and the detrimental effect having to work could have on a student’s health and well-being, as well as their ability to learn.

Almost three quarters (74%) of students who responded to the RCN Scotland survey said financial worries were having a high or very high impact on their mental health, with 58% saying this was having a high or very high impact on their academic performance.

### Where can you find work as a student?

Try your local trust for bank work as a healthcare support worker, advises Ms Huntley, whose book *How to Thrive as a Mature Student Nurse*, published last year, includes a chapter on working while studying.

‘If you’re on placement with them, they’ll usually take you on in a support worker role,’ she says. Other options include your local care home.

It is also worth looking at any opportunities with your university. ‘They usually advertise for student ambassadors around September,’ says Ms Huntley. She was able to choose when she worked in a role that also included blogging about her experiences as a student.

### Further information

RCN: advice for nursing students  
[tinyurl.com/RCN-student-advice](https://tinyurl.com/RCN-student-advice)

Huntley L (2023) *How to Thrive as a Mature Student Nurse*  
[tinyurl.com/thrive-mature-student](https://tinyurl.com/thrive-mature-student)

## ‘It can be tricky to get the work-study balance right’

Now in his final year at Dundee University, Sam Moffat has worked most of the way through his adult nursing degree.

‘I do have the advantage of having a Scottish bursary and that covers a good chunk of what I need,’ he says. ‘But to be able to live a life, rather than just pay the bills, I work too.’

Initially, he continued working at a care home where he had been employed before he became a nursing student. He then worked as a community carer with an agency where he could choose his hours.

‘That’s important for students,’ he says. ‘When you’re doing theory, you want to work more, but you have to bear in mind you have essays to do as well. It can be tricky to get the balance right and you need to work out what’s best for you.’

### Working can give you a more holistic view

Although he loved the community role, he found working conditions so poor he left. ‘We’re only paid for the time we’re booked into someone’s house, so I could end up doing a six-hour shift, but only being paid for three and a half hours,’ says Mr Moffat. Being a nursing student also made him appreciate that the care he was able to give fell short of what he wanted to deliver.

Despite the difficulties, he believes working can give students insights they may not otherwise gain. ‘It can really open your eyes to other areas of healthcare and you understand the relationship between different providers, giving you a more holistic view,’ says Mr Moffat.

‘I loved going into people’s homes and being able to work a bit more independently. In a hospital, people are often reduced to beds – such as ‘bed number one needs this’ – but in someone’s home, you’re going into their environment and it’s about them being able to live their lives.’

# Effective practice

## IN THIS SECTION

**Comment** Why finding human connection and showing warmth are powerful ways to reduce care inequalities **p35**

**Peer-reviewed article** Meeting the challenges of caring for people with anorexia nervosa on an acute ward **p37**

**Peer-reviewed article** How to conduct a neurological assessment of a patient **p45**



## Empathy for diverse patient perspectives

The healthcare experience for patients of minority ethnic heritage can be tainted by bias, with outcomes suffering. So what can we do to address that inequality?



By **Damien Ridge**  
professor of health studies at  
the University of Westminster  
and a co-investigator for  
SURECAN

**T**he issues patients from minority ethnic backgrounds experience when seeking healthcare – like lack of empathy, discrimination, and poor outcomes – are well documented.

My colleagues and I set out to investigate the social influences on healthcare interventions, with a particular focus on psychological approaches, especially in cancer care.

The team, led by the University of Westminster and including Queen Mary University London, Oxford University the University of Portsmouth and Kings College London, featured individuals from a range of ethnic backgrounds, ensuring a broad perspective in the interpretation of the data. The study was funded by the National Institute for Health and Care Research.

**'It is the everyday human things that connect us and that are important to us, that have been overlooked in treatment of patients from minority ethnic backgrounds'**

### Understanding healthcare interactions from patients' diverse perspectives

Our meta-ethnographic method – bringing together all relevant studies on a topic to see if a better understanding can be developed – uncovered a 'hidden' but emotionally vibrant world in healthcare consultations, a world that was easy for professionals to miss.

The study focus was patient perspectives, providing a rich understanding of the patient experience, while acknowledging the absence of professional perspectives on this issue. However, concentrating on patient perspectives allowed us to delve more deeply into the experience of individuals from minority ethnic backgrounds, shedding light on the unique challenges and needs they may have when accessing psychological interventions and cancer services.

We found patients essentially yearned to have, but less frequently achieved, professional recognition and valuing of their life circumstances in the round. Or, as one participant in one of the studies we examined said, professionals 'who will listen to us, who will allow us to talk'.

Essentially, we found it is the everyday human things that connect us and that are important to us, that have been overlooked in the treatment of patients from minority ethnic backgrounds. If this was better understood by professionals, it could help to improve care – otherwise, patients risk becoming distanced and even alienated from their healthcare.

### Patients want to feel empathy from healthcare professionals

Warmth shown by professionals was especially longed for. For example, one participant in an included study said of her practitioner: 'Even though she is a white person, I know that she sympathises with me... When I am uncomfortable, you can tell that she feels my pain...'

Interestingly, the language of affection and connection was used to describe successful

partnerships with professionals. An asylum seeker from Sudan in a UK study said: 'If she has not won my love, some of the things, it's not easy to talk about it...[but she's shown me] she's concerned with my life.' Others talked about valued and skilled practitioners as being like a member of their family.

Many participants in the studies reviewed turned to their relationship with a higher power, or to their families, for the sense of comfort they longed for. This could be especially the case if healthcare was not seen as a safe place, which was frequently the case.

We found that religion could be, in the words of one included study, a 'force which sustained' patients in their struggles and 'hard lives', while health decisions could be made by families, rather than individuals. For example, in another study, a participant noted how 'we make decisions as a family'.

### Individuals' emotional issues and responses frequently overlooked in healthcare

In summary, our study uncovered a whole world of emotional issues that played out largely behind the scenes in healthcare interventions and that professionals were frequently thought to overlook, for example, the potential for facing stigma, issues of safety, fear of rejection; and connection, for example love, affection, hope.

While different patients will want different approaches, the importance of warmth, empathy and acceptance in health consultations should be explored as a way of improving care for patients from minority ethnic backgrounds. Interestingly, this poses the question: why don't health practitioners routinely offer this type of positivity to every patient? What gets in the way?



### Discrimination can make some patients feel less cared for

Patients, irrespective of their background, want to feel connected to their healthcare professionals. But discrimination adds more distance, meaning patients from minority ethnic groups can end up feeling less cared for than their white counterparts.

Our study underscores the importance of understanding the central role of making connections in care, suggesting a shift in focus from developing competencies related to a range of cultures, to a focus on fostering more meaningful connections with patients. Given that creating meaningful links is something we all strive for in life, presumably it is something that is easier to teach than cultural competence.

#### Further information

The study's co-authors were: Karen Pilkington, Sheila Donovan, Elisavet Moschopoulou, Dipesh Gopal, Kamaldeep Bhui, Trudie Chalder, Imran Khan, Ania Korszun and Stephanie Taylor

^ Human connection is a hallmark of effective therapeutic relationships

## 5 ways to improve the healthcare experience of patients from minority ethnic groups

### 1. Assume patients are already 'weathered' by racism

Your patient has probably experienced subtle and not so subtle forms of discrimination and racism in healthcare and/or more widely in society. So, they might lack trust and be disengaged.

What is the one thing you can do that says you value your patient just as they are?

### 2. Challenge systemic racism in your own practice

The prioritisation of European knowledge and ways of doing things is thought to be embedded in our ways of

thinking, theories, practices, regulations and laws. Are you at least willing to negotiate with patient concerns and beliefs if they depart from western medical orthodoxy?

**3. Be open in your approach** For example, be curious about differences, and be inclusive of them. Can you find ways to connect with patients as whole people – people with lives, worries and loved ones who care about them?

**4. Recognise that support comes from many sources** Patients are likely to get support from a whole

range of sources, including their families, religious institutions, spirituality, alternative medicine, and/or communities

**5. Communicate warmth** If nothing else, appreciate that all patients want to be treated as a whole person, and with warmth. Recognise the ways you show people you have seen them and accept them. How do you communicate this kind of friendliness? Who knows, you could be the one to transform a patient's experience

# Looking for a new job?

Register on [rcninursingjobs.co.uk](https://rcninursingjobs.co.uk) and take advantage of a range of benefits to support you in finding your perfect job.

Hundreds of new jobs uploaded daily covering a range of sectors, bands and locations

Upload your CV and let employers find you

Never miss an opportunity again by signing up to our targeted emails

Improve your knowledge and skills with access to unique careers content from RCNi



Take the first step in securing your next job.  
Scan QR code or visit [rcninursingjobs.co.uk](https://rcninursingjobs.co.uk)



### Why you should read this article:

- To increase your knowledge of the physical and psychological effects of anorexia nervosa
- To recognise the challenges of providing care to patients with anorexia nervosa in acute hospital settings
- To enhance your ability to deliver psychologically informed care to patients with anorexia nervosa

# Psychologically informed care of patients with anorexia nervosa on an acute medical ward

Francesca Purvis and Jasmine Snowden

### Citation

Purvis F, Snowden J (2023)  
Psychologically informed care of patients with anorexia nervosa on an acute medical ward.  
doi: 10.7748/ns.2023.e12199

### Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

### Correspondence

f.purvis@soton.ac.uk  
X@fcpurvis

### Conflict of interest

None declared

### Date accepted

14 November 2023

### Published online

December 2023

### Permission

To reuse this article or for information about reprints and permissions, contact [permissions@rcni.com](mailto:permissions@rcni.com)

### Abstract

Anorexia nervosa is a challenging and highly distressing illness associated with significant and often debilitating symptoms that affect the person's physical and mental well-being, as well as their wider social networks. Although some patients can make important steps in their recovery in the community, many will become significantly unwell and require medical stabilisation and refeeding in an acute medical ward as a result of significant weight loss. This article describes some of the challenges experienced by adult nurses when caring for patients with anorexia nervosa on acute medical wards and explores how the patient's distress may manifest and complicate the recovery process. The article also discusses the principles of psychologically informed care and therapeutic interactions that nurses can use to promote recovery and ensure optimal practice.

### Author details

Francesca Purvis, senior teaching fellow and specialist nurse in eating disorders, Department of Nursing, Midwifery and Health, School of Health Sciences, University of Southampton, Hampshire, England; Jasmine Snowden, master's of nursing programme lead and child and adolescent mental health services clinical nurse specialist, Department of Nursing, Midwifery and Health, School of Health Sciences, University of Southampton, Hampshire, England

### Keywords

anorexia, eating disorders, mental health, mental health therapies, patient experience, patients, psychological interventions, stigma

Eating disorders are distressing and challenging illnesses that can affect people of all ages and backgrounds, although they are much more common in women than in men (Galmiche et al 2019). They often have profound effects on individuals and families, disrupting their social, psychological, physical and occupational functioning. The most common eating disorders are anorexia nervosa, bulimia nervosa and binge eating disorder (Hay et al 2017).

It is challenging to determine the number of people with an eating disorder accurately due to the likelihood of underreporting. However, a meta-analysis by Galmiche et al (2019) identified that the lifetime prevalence rates for eating disorders worldwide were 8.4% for women and 2.2% for men. For anorexia nervosa, prevalence was around 1.4% in women and 0.2% in men, with a significant increase over

the past two decades (Galmiche et al 2019). However, the 2019 Health Survey for England (NHS Digital 2020) identified that 16% of adults surveyed screened positive for a possible eating disorder, revealing the potential scale of the issue. The prevalence of eating disorders has also likely increased as a result of the coronavirus disease 2019 (COVID-19) pandemic (Taquet et al 2022), due to factors such as social isolation and changes to people's routine and structure (Touyz et al 2020, Brown et al 2021).

Eating disorders often start in adolescence, with one study suggesting that onset began before the age of 22 years in 75% of cases (Volpe et al 2016). Of the 24,300 hospital admissions in England in 2020-23 due to eating disorders, almost half (11,700) were young people under the age of 25 years (Children's Commissioner 2023). Eating disorders are also associated with

a high mortality rate, with a nine times greater risk of death at five years among those with anorexia nervosa compared with their peers without the condition (Auger et al 2021), emphasising the need to optimise treatment outcomes for those affected.

## Overview of anorexia nervosa

### Symptoms and aetiology

Anorexia nervosa is characterised by a person's drive to restrict their energy intake relative to their body's physical requirements, leading to a significantly low body weight in the context of their age, sex, developmental trajectory and physical health (American Psychiatric Association 2022). The individual will also likely present with a strong preoccupation with their weight and body shape, typically an overvaluation of these which is likely to cause them significant distress (Fairburn et al 2008, Mitchison et al 2017).

Alongside the drive for thinness, the individual may often find it challenging to recognise how unwell they have become. This is often coupled with demonstrating significant body image distortion and dissatisfaction, which perpetuates the cycle of disordered eating and weight loss through the negative mood states it generates (Mitchison et al 2017). Many individuals who experience menstruation will notice that this will cease (amenorrhoea). Although this symptom is no longer diagnostic, it suggests significant physical health risks and impairment in functioning when combined with low body weight (Lopes et al 2022).

Symptoms such as binge eating and compensatory behaviours, for example purging and laxative use, are often evident in eating disorders such as bulimia nervosa and binge eating disorder. In anorexia nervosa, these symptoms may or may not be present alongside low weight. For many people who initially had a restrictive form of anorexia, bingeing and purging symptoms can become apparent over time (Serra et al 2022).

While multifactorial in its aetiology, the development of anorexia nervosa is likely related

to a complex and interlinked series of biological, psychological and social risk factors. For many people, certain focuses and pressures in society have a significant role in the development of their eating disorder; for example, social comparisons and the 'thin/fit ideal' are prevalent on social media platforms, which may influence body image perceptions (Dane and Bhatia 2023).

The course of anorexia nervosa can be highly variable, with recovery possible at any stage; however, the risk of relapse and enduring illness often remains high for many people (National Institute for Health and Care Excellence (NICE) 2019). When diagnosed at an early stage, recovery outcomes are more favourable (Treasure et al 2015), however recovery rates remain modest, estimated at between 13-50% after 1-2 years (Wonderlich et al 2020). Recovery is likely to be complicated by the effects of social stigma, as there are many misconceptions about the presentation and causes of eating disorders (Schaumberg et al 2017); such stigma has led some individuals to delay seeking help for their symptoms (Ali et al 2017).

### Treatment

Outpatient psychological therapy is the preferred first-line treatment for anorexia nervosa; however, many people are unable to access this in a timely manner since the process of seeking help for onward referral and accessing a specialist service can take several years (Austin et al 2021). This delay may contribute to deterioration of the person's symptoms (Vall and Wade 2015). A lack of training for GPs in the core knowledge about eating disorders may also act as a barrier to timely identification of the early signs of these illnesses and to individuals accessing treatment (Beat 2023).

Many people with anorexia nervosa will need more intensive treatment, such as day patient care, admission to a specialist eating disorder unit or admission to an acute medical ward in the event of significant deterioration to prevent loss of life (Treasure et al 2021). In accordance with NICE (2020)

## Key points

- People with anorexia nervosa may require admission to an acute medical ward in the event of significant deterioration to prevent loss of life
- The priority in acute medical wards is safe refeeding and weight restoration, but nurses also have an important role in supporting patients' day-to-day care
- Nurses should be aware of the psychological symptoms patients may present with and how these can affect their response to treatment
- Nurses can take several approaches to providing effective psychologically informed care to patients with anorexia nervosa in the acute medical ward

guidelines, this should be to an age-appropriate setting and in a hospital as close to the person's home as possible. In a specialist eating disorder unit, treatments are likely to combine weight restoration and psychological therapies and support, whereas medical stabilisation, safe refeeding and weight restoration will be prioritised in an acute medical ward.

### Medical care for patients with anorexia nervosa

Given the rise in admissions and physical complications associated with anorexia nervosa (NHS Digital 2022), attention has focused on the safe care and management of patients presenting with an urgent need for refeeding in acute medical hospitals. In some cases, the care of patients with anorexia nervosa has been found to be suboptimal, often due to the complex nature of the illness and concerns about refeeding complications, which can be fatal (Staab et al 2022).

Failings in the care of patients with eating disorders were highlighted in the Parliamentary and Health Service Ombudsman (2017) report on the case of Averil Hart, a patient with anorexia nervosa who died in 2012 of hypoglycaemia in what was considered a preventable death. The report identified serious shortcomings in communication and coordination between services

and emphasised the importance of appropriate training for healthcare professionals.

These concerns have been addressed in the Managing Medical Emergencies in Eating Disorders guidance (Royal College of Psychiatrists 2023), which seeks to support safe practice by outlining clearer physical parameters indicating severity of medical risk. The guidance includes a risk assessment framework and accessible checklists to ensure that acute medical risk is identified early and acted on.

While the patient should always be considered an active participant in their recovery, at this stage in their treatment it is possible that high levels of ambivalence may preclude their ability to make the behaviour changes that would be expected in most psychological therapies (Gulliksen et al 2015). Although the priority must be safe refeeding and weight restoration in acute medical wards (Attia and Walsh 2023), nurses have an important role in supporting day-to-day care while patients recover enough physically to access specialist mental health interventions.

### Challenges in the acute medical ward environment

The acute medical ward environment is fast-paced and often not designed optimally to monitor patients with eating disorders whose physical health is severely compromised (Royal College of Psychiatrists 2023). Due to the nature of the ward environment, patients who engage in compensatory behaviours can often do so successfully, which can lead to significant deterioration if they avoid weight restoration. This deterioration and potential risk of death is preventable; however, in this environment it is highly challenging for healthcare staff to constantly monitor these patients' mealtimes, periods off the ward and visits to the bathroom (Royal College of Psychiatrists 2023).

Patients with anorexia nervosa who are admitted to an acute medical ward need to be weighed frequently and assessed on this. However, due to the busy

environment, it can be challenging for nurses to provide adequate psychological support during this emotive task. As a result, patients may feel distressed because of the continual emphasis on their appearance while neglecting their internal emotions (Eiring et al 2021).

In addition, there is a significant link between eating disorders and neurodiversity (Westwood et al 2017, Kerr-Gaffney et al 2021). Research has demonstrated a higher prevalence of autism in individuals receiving treatment for anorexia nervosa and many autistic women experience prolonged eating disorder symptoms (Saure et al 2020). Furthermore, inpatient settings can present challenges for autistic women due to the high-stimulus environment and the need to adapt to new routines as part of their care (Babb et al 2021). An awareness of the needs of this group is important to support implementation of tailored treatments that could improve recovery outcomes (Tchanturia et al 2019).

### Psychological effects of anorexia nervosa

Despite clearer guidance on the care of patients with eating disorders in medical emergencies (Royal College of Psychiatrists 2023), there remain many challenges for nurses in caring for patients with anorexia nervosa on acute medical wards. A particular challenge is how to support the recovery process in patients experiencing an insidious and challenging illness that often seeks to undermine the life-saving care plans implemented by the multidisciplinary team (Fixsen et al 2023).

From a psychological perspective, an intense anxiety related to weight gain likely underlies a patient's presentation, but this can present in different ways. For example, in the authors' clinical experience, many individuals will demonstrate a high level of treatment adherence but will be internally terrified at the prospect of change and weight gain and may turn their distress and turmoil inwards, perhaps resulting in self-harm behaviours. Evidence shows that up to 72% of people

with eating disorders also engage in self-harm behaviours, particularly those with a binge-purge element to their illness (Kostro et al 2014, Sagiv and Gvion 2020).

Conversely, other patients with anorexia nervosa may be experiencing feelings of desperation and low motivation to recover and may perceive benefits of continuing to restrict their energy intake. As a result, they may become overtly distressed and even aggressive towards those treating them, seeking to undermine treatment – for example, by declining oral food and supplements or covertly tampering with or purging nasogastric feeds (Kells and Kelly-Weeder 2016). Individuals may also seek to influence others to inadvertently collude with their illness to interfere with their treatment plan, in an attempt to satisfy their drive for thinness and control (Kells and Kelly-Weeder 2016).

It is important that nurses are aware of the psychological symptoms that the patient may present with and understand how these symptoms could affect their response to treatment. For example, a distorted body image, compounded by the effects of starvation on the brain, might mean that the patient feels unable to agree to life-saving treatment, such as refeeding, and their anxiety associated with weight gain might manifest as panic attacks and episodes of high expressed emotions (Royal College of Psychiatrists 2023). The patient may also feel a sense of achievement when they lose more weight, despite already being gravely unwell.

Some patients who are undergoing refeeding may attempt to compensate for the increase in oral or nasogastric intake through potentially harmful means, such as taking laxatives, diuretics or diet pills they may have brought in from home. Furthermore, some patients may induce vomiting or exercise in a covert way in an attempt to lose calories (Royal College of Psychiatrists 2023).

The presentation of anorexia nervosa may be complicated further by the presence of mood disorders such as depression, which often

originates from a combination of psychological and physical factors that may be pre-morbid and/or related to the eating disorder (Godart et al 2007). Anorexia nervosa may give rise to self-harm behaviours and suicidal ideation, as well as cognitive deficits such as memory issues and low concentration (Smith et al 2018). This can complicate the process of orienting a patient to their treatment plan or may mean they find it challenging to understand certain ward routines.

### Psychologically informed nursing care

Caring for someone with anorexia nervosa can be challenging and highly stressful, even for experienced and specialised teams. Nurses strive to care compassionately and to collaborate with patients to achieve shared goals and outcomes. However, when the person does not agree with their care plan, or if this is being enforced in their best interests under the Mental Health Act 1983 (amended 2007), then significant challenges can arise, including fractures in the therapeutic relationship and the healthcare team.

There are several approaches nurses can take to provide effective psychologically informed care to patients with anorexia nervosa who have been admitted to an acute medical ward.

#### Addressing stigma

Arguably one of the most significant challenges for people with mental illness is the associated stigma. Some healthcare professionals hold stigmatising beliefs about eating disorders, for example attributing blame to the individual and feeling that they are at least partly responsible for their illness (McNicholas et al 2016). Such beliefs may be driven by healthcare professionals' lack of knowledge and/or confidence in caring for this patient group due to limited experience or training, which may lead to fear or avoidance. Stigma may compound the shame and isolation that the individual feels due to their self-stigmatisation, thus reinforcing the negative symptoms of the illness and adversely affecting

their longer-term recovery (Foran et al 2020).

To address stigma, it is important that nurses use a non-judgemental approach when supporting patients with an eating disorder and recognise and reflect on any pre-existing biases or judgements they might have about these illnesses. Supervision and oversight of the individual's overall care from an adult community eating disorders service, in collaboration with the mental health liaison team, can also be beneficial.

#### Communicating effectively

Communication with patients can be challenging and might be intensified by a sense of mutual distrust between the nurse and the patient. Communication can be further complicated when the patient is subject to restrictions under the Mental Health Act 1983 (amended 2007) and nurses may be unsure about whether honesty and clarity in terms of divulging treatment plans is likely to be helpful or perceived as inflammatory. In the context of healthcare environments such as acute medical wards, which can be highly stressful and emotionally demanding for patients receiving treatment for anorexia nervosa, communication is likely to become increasingly fraught (Yorke et al 2018). Therefore, it is vital to recognise the likely effects of starvation on the patient's cognitive function, understand their underlying emotions and acknowledge that they may currently feel ambivalent about change.

Even if the patient requires treatment under the Mental Health Act 1983 (amended 2007), it is essential that nurses work collaboratively with them and their family and are clear about treatment and recovery goals to ensure the patient feels they are being treated as an equal and active participant in their care (Sly et al 2014). Weight restoration is often a highly sensitive area, but keeping conversations out in the open can dissuade the secretive aspect of the illness and establish clear expectations and boundaries. The patient may feel relieved to have

responsibility over the agonising decision to eat taken from them, and may find that a calm, clear and honest communication style assists in developing a trusting relationship (Salzmann-Erikson and Dahlén 2017). In the authors' clinical experience, it is preferable to sidestep conversations about calories, specifics of weight gain and body image and to focus instead on the underlying emotion or more neutral topics.

While the nurse may wish to provide reassurance – for example, about the patient's weight or appearance – the relief the patient may experience in response can be short lived, and the nurse may inadvertently collude with or reinforce eating disorder cognitions (Treasure et al 2011). Talking about interests outside of their eating disorder and engaging patients in meaningful activities while on the ward is likely to have a greater therapeutic effect (Snowden and Gelling 2022). Even having simple conversations and encouraging the use of distraction techniques can be beneficial at particularly challenging or distressing times for the patient, such as during and after mealtimes (Monaghan and Doyle 2023). Any attempts to enhance the therapeutic relationship when the patient is in distress can have a positive effect on treatment outcomes (Sly et al 2013), thus supporting their recovery.

#### Providing support during refeeding and monitoring

When supporting a patient to engage with refeeding and the associated physical health monitoring, it is vital to provide as much psychological support as possible to improve adherence and optimise recovery. Nurses can find it particularly frustrating when the patient appears ambivalent about behaviour change (Tierney 2008), which may tempt the nurse to enter into a 'battle of wills' or to try to convince the patient with reasoning.

When the risk to life is severe, physical restraint may need to be used with an individual who is so unwell they are compelled to tamper with or decline nasogastric feeding. Due to the risk of harm associated with restraint, it should be undertaken only as a last resort for

**Write for us**  
For information  
about writing  
for RCNi  
journals,  
contact  
[writeforus@rcni.com](mailto:writeforus@rcni.com)

For author  
guidelines,  
visit [rcni.com/publish-article-with-rcni](http://rcni.com/publish-article-with-rcni)

the least time possible and under the Mental Health Act 1983 (amended 2007), to ensure that all safeguards are adhered to and that other supportive techniques are used first. Restraint should also be planned and managed with mental health liaison teams. These teams are usually based in the hospital and comprise specialist practitioners, such as mental health nurses, psychologists and psychiatrists. Mental health liaison teams are well placed to support and inform care planning from a psychological perspective and with an understanding of how eating disorders may manifest and the physical complications of the illness (Royal College of Psychiatrists 2023).

Supportive techniques to encourage the patient to feel empowered in relation to their treatment should be prioritised. This might involve education on the effects of starvation and the rationale for refeeding, undertaken in collaboration with specialist dietitians, and discussing the risks associated with compensatory behaviours (Attia and Walsh 2023). It may be helpful for some patients to conceptualise oral or nasogastric food intake as 'medicine', which nurses can encourage if appropriate.

At times of feeds, nurses can provide support by validating the patient's effort and acknowledging their difficulties so that they feel heard and understood. These meaningful interactions can also encourage a sense of connection and foster feelings of hope, which may reduce the emotional distress and suicidal ideation a person may experience from feeling they are 'a burden' (Stavarski et al 2019).

#### Working collaboratively

Partnership working between the ward team, the mental health liaison team and specialist eating disorder services can support monitoring of the patient's mental health and its effects on their physical health. This may be particularly useful to enhance the ward team's understanding of the complexities of anorexia nervosa and how it may be manifesting for patients on the ward. Additionally, collaboration can support the ward team to understand and manage risks related to physical deterioration, for example if the patient is still losing weight, which may not be immediately explainable.

When a person is admitted to an acute medical ward for medical stabilisation, it is best practice

for their family and carers to be involved in their care, to have a clear care and management plan across all services and to support their transition to appropriate settings, such as a specialist eating disorder unit, as part of their recovery (NICE 2018).

#### Conclusion

Caring for patients with anorexia nervosa in an acute medical ward can be highly emotive, stressful and challenging for nurses. Complications can arise when the patient is unable to agree to life-saving care due to their illness, thus complicating the dynamic between the nurse and patient and potentially preventing provision of optimal care. Knowledge of the medical risks and psychological effects commonly experienced by patients with anorexia nervosa is essential when caring for this group. To support patients' recovery, nurses should adopt a calm, empathic and non-judgemental approach. In addition, communicating directly and honestly and attempting to maintain a therapeutic relationship with the patient can enhance the quality of care provided and improve treatment outcomes.

## References

- Ali K, Farrer L, Fassnacht DB et al (2017) Perceived barriers and facilitators towards help-seeking for eating disorders: a systematic review. *International Journal of Eating Disorders*. 50, 1, 9-21. doi: 10.1002/eat.22598
- American Psychiatric Association (2022) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*. APA, Washington DC.
- Auger N, Potter BJ, Ukah UV et al (2021) Anorexia nervosa and the long-term risk of mortality in women. *World Psychiatry*. 20, 3, 448-449. doi: 10.1002/wps.20904
- Austin A, Flynn M, Richards K et al (2021) Duration of untreated eating disorder and relationship to outcomes: a systematic review of the literature. *European Eating Disorders Review*. 29, 3, 329-345. doi: 10.1002/erv.2745
- Attia E, Walsh T (2023) *BMJ Best Practice: Anorexia Nervosa - Straight to the Point of Care*. [bestpractice.bmj.com/topics/eng/440/pdf/440/Anorexia%20nervosa.pdf](https://bestpractice.bmj.com/topics/eng/440/pdf/440/Anorexia%20nervosa.pdf) (Last accessed: 6 December 2023.)
- Babb C, Brede J, Jones CR et al (2021) 'It's not that they don't want to access the support... it's the impact of the autism': the experience of eating disorder services from the perspective of autistic women, parents and healthcare professionals. *Autism*. 25, 5, 1409-1421. doi: 10.1177/1362361321991257
- Beat (2023) *Early Intervention on Eating Disorders. The Crucial Role of GPs*. [www.beateatingdisorders.org.uk/about-beat/policy-work/policy-and-best-practice-reports/early-intervention-on-eating-disorders-the-crucial-role-of-gps](http://www.beateatingdisorders.org.uk/about-beat/policy-work/policy-and-best-practice-reports/early-intervention-on-eating-disorders-the-crucial-role-of-gps) (Last accessed: 6 December 2023.)
- Brown SM, Opitz MC, Peebles AI et al (2021) A qualitative exploration of the impact of COVID-19 on individuals with eating disorders in the UK. *Appetite*. 156, 104977. doi: 10.1016/j.appet.2020.104977
- Children's Commissioner (2023) *Young People with Eating Disorders in England on The Rise*. [www.childrenscommissioner.gov.uk/blog/young-people-with-eating-disorders-in-england-on-the-rise/#\\_edn1](http://www.childrenscommissioner.gov.uk/blog/young-people-with-eating-disorders-in-england-on-the-rise/#_edn1) (Last accessed: 6 December 2023.)
- Dane A, Bhatia K (2023) The social media diet: a scoping review to investigate the association between social media, body image and eating disorders amongst young people. *PLOS Global Public Health*. 3, 3, e0001091. doi: 10.1371/journal.pgph.0001091
- Eiring K, Wiig Hage T, Reas DL (2021) Exploring the experience of being viewed as "not sick enough": a qualitative study of women recovered from anorexia nervosa or atypical anorexia nervosa. *Journal of Eating Disorders*. 9, 1, 142. doi: 10.1186/s40337-021-00495-5
- Fairburn CG (2008) *Cognitive Behavior Therapy and Eating Disorders*. The Guilford Press, New York NY.
- Fixsen A, Ridge D, Ponsford O et al (2023) Battles over 'unruly bodies': practitioners' interpretations of eating disorders and the utility of psychiatric labelling. *Sociology of Health & Illness*. 45, 3, 560-579. doi: 10.1111/1467-9566.13601
- Foran AM, O'Donnell AT, Muldoon OT (2020) Stigma of eating disorders and recovery-related outcomes: a systematic review. *European Eating Disorders Review*. 28, 4, 385-397. doi: 10.1002/erv.2735
- Galmiche M, Déchelotte P, Lambert G et al (2019) Prevalence of eating disorders over the 2000-2018 period: a systematic literature review. *American Journal of Clinical Nutrition*. 109, 5, 1402-1413. doi: 10.1093/ajcn/nqy342
- Godart NT, Perdereau F, Rein Z et al (2007) Comorbidity studies of eating disorders and mood disorders. *Critical review of the literature*. *Journal of Affective Disorders*. 97, 1-3, 37-49. doi: 10.1016/j.jad.2006.06.023
- Gulliksen KS, Nordbo RH, Espeset EM et al (2015) The process of help-seeking in anorexia nervosa: patients' perspective of first contact with health services. *Eating Disorders*. 23, 3, 206-222. doi: 10.1080/10640266.2014.981429
- Hay P, Mitchison D, Collado AE et al (2017) Burden and health-related quality of life of eating disorders, including avoidant/restrictive food intake disorder (ARFID), in the Australian population. *Journal of Eating Disorders*. 5, 21. doi: 10.1186/s40337-017-0149-z
- Kells M, Kelly-Weeder S (2016) Nasogastric tube feeding for individuals with anorexia nervosa: an integrative review. *Journal of the American Psychiatric Nurses Association*. 22, 6, 449-468. doi: 10.1177/1078390316657872
- Kerr-Gaffney J, Hayward H, Jones EJ et al (2021) Autism symptoms in anorexia nervosa: a comparative study with females with autism spectrum disorder. *Molecular Autism*. 12, 1, 47. doi: 10.1186/s13229-021-00455-5
- Kostro K, Lerman JB, Attia E (2014) The current status of suicide and self-injury in eating disorders: a narrative review. *Journal of Eating Disorders*. 2, 19. doi: 10.1186/s40337-014-0019-x

- Lopes MP, Robinson L, Stubbs B et al (2022) Associations between bone mineral density, body composition and amenorrhoea in females with eating disorders: a systematic review and meta-analysis. *Journal of Eating Disorders*. 10, 173. doi: 10.1186/s40337-022-00694-8
- McNicholas F, O'Connor C, O'Hara L et al (2016) Stigma and treatment of eating disorders in Ireland: healthcare professionals' knowledge and attitudes. *Irish Journal of Psychological Medicine*. 33, 1, 21-31. doi: 10.1017/ipm.2015.24
- Mitchison D, Hay P, Griffiths S et al (2017) Disentangling body image: the relative associations of overvaluation, dissatisfaction, and preoccupation with psychological distress and eating disorder behaviors in male and female adolescents. *International Journal of Eating Disorders*. 50, 2, 118-126. doi: 10.1002/eat.22592
- Monaghan M, Doyle L (2023) 'It stopped you thinking about food' – The experiences of mealtimes and attending a post-meal support group for young people with anorexia nervosa. *International Journal of Mental Health Nursing*. 32, 1, 128-138. doi: 10.1111/inm.13068
- NHS Digital (2020) Health Survey for England, 2019: Data Tables. [digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019/health-survey-for-england-2019-data-tables](https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019/health-survey-for-england-2019-data-tables) (Last accessed: 6 December 2023).
- NHS Digital (2022) Hospital Admissions with a Primary or Secondary Diagnosis of Eating Disorders. [digital.nhs.uk/supplementary-information/2022/hospital-admissions-with-a-primary-or-secondary-diagnosis-of-eating-disorders](https://digital.nhs.uk/supplementary-information/2022/hospital-admissions-with-a-primary-or-secondary-diagnosis-of-eating-disorders) (Last accessed: 6 December 2023).
- National Institute for Health and Care Excellence (2018) Eating Disorders. Quality standard No. 175. NICE, London.
- National Institute for Health and Care Excellence (2019) Eating Disorders: What is the Prognosis? [cks.nice.org.uk/topics/eating-disorders/background-information/prognosis](https://cks.nice.org.uk/topics/eating-disorders/background-information/prognosis) (Last accessed: 6 December 2023).
- National Institute for Health and Care Excellence (2020) Eating Disorders: Recognition and Treatment. NICE guideline No. 69. NICE, London.
- Parliamentary and Health Service Ombudsman (2017) Ignoring the Alarms: How NHS Eating Disorder Services are Failing Patients. [www.ombudsman.org.uk/sites/default/files/page/ACCESSIBLE%20PDF%20-%20Anorexia%20Report.pdf](https://www.ombudsman.org.uk/sites/default/files/page/ACCESSIBLE%20PDF%20-%20Anorexia%20Report.pdf) (Last accessed: 6 December 2023).
- Royal College of Psychiatrists (2023) Medical Emergencies in Eating Disorders: Guidance on Recognition and Management. College Report CR233. [www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr233-medical-emergencies-in-eating-disorders-\(meed\)-guidance.pdf?sfvrsn=2d327483\\_63](https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf?sfvrsn=2d327483_63) (Last accessed: 6 December 2023).
- Sagiv E, Gvion Y (2020) A multi factorial model of self-harm behaviors in anorexia-nervosa and bulimia-nervosa. *Comprehensive Psychiatry*. 96, 152142. doi: 10.1016/j.comppsy.2019.152142
- Salzmann-Erikson M, Dahlén J (2017) Nurses' establishment of health promoting relationships: a descriptive synthesis of anorexia nervosa research. *Journal of Child and Family Studies*. 26, 1, 1-13. doi: 10.1007/s10826-016-0534-2
- Saure E, Laasonen M, Lepistö-Paisley T et al (2020) Characteristics of autism spectrum disorders are associated with longer duration of anorexia nervosa: a systematic review and meta-analysis. *International Journal of Eating Disorders*. 53, 7, 1056-1079. doi: 10.1002/eat.23259
- Schaumberg K, Welch E, Breithaupt L et al (2017) The science behind the academy for eating disorders' nine truths about eating disorders. *European Eating Disorders Review*. 25, 6, 432-450. doi: 10.1002/erv.2553
- Serra R, Di Nicolantonio C, Di Febo R et al (2022) The transition from restrictive anorexia nervosa to bingeing and purging: a systematic review and meta-analysis. *Eating and Weight Disorders*. 27, 3, 857-865. doi: 10.1007/s40519-021-01226-0
- Sly R, Morgan JF, Mountford VA et al (2013) Predicting premature termination of hospitalised treatment for anorexia nervosa: the roles of therapeutic alliance, motivation, and behaviour change. *Eating Behaviors*. 14, 2, 119-123. doi: 10.1016/j.eatbeh.2013.01.007
- Sly R, Morgan JF, Mountford VA et al (2014) Rules of engagement: qualitative experiences of therapeutic alliance when receiving in-patient treatment for anorexia nervosa. *Eating Disorders*. 22, 3, 233-243. doi: 10.1080/10640266.2013.867742
- Smith KE, Mason TB, Johnson JS et al (2018) A systematic review of reviews of neurocognitive functioning in eating disorders: the state-of-the-literature and future directions. *International Journal of Eating Disorders*. 51, 8, 798-821. doi: 10.1002/eat.22929
- Snowden J, Gelling L (2022) Eating disorders and other specified feeding or eating disorders: a post-pandemic challenge for all nurses. *Journal of Clinical Nursing*. 31, 21-22, e37-e38. doi: 10.1111/jocn.16513
- Staab R, Campagna J, Ma J et al (2022) Rapid refeeding in anorexia nervosa: a dialectic balance. *International Journal of Eating Disorders*. 55, 5, 653-663. doi: 10.1002/eat.23698
- Stavarski DH, Alexander RK, Ortiz SN et al (2019) Exploring nurses' and patients' perceptions of hope and hope-empowering nurse interventions in an eating disorder facility: a descriptive cross-sectional study. *Journal of Psychiatric and Mental Health Nursing*. 26, 1-2, 29-38. doi: 10.1111/jpm.12507
- Taquet M, Geddes JR, Luciano S et al (2022) Incidence and outcomes of eating disorders during the COVID-19 pandemic. *British Journal of Psychiatry*. 220, 5, 262-264. doi: 10.1192/bjp.2021.105
- Tchanturia K, Adamson J, Leppanen J et al (2019) Characteristics of autism spectrum disorder in anorexia nervosa: a naturalistic study in an inpatient treatment programme. *Autism*. 23, 1, 123-130. doi: 10.1177/1362361317722431
- Tierney S (2008) The individual within a condition: a qualitative study of young people's reflections on being treated for anorexia nervosa. *Journal of the American Psychiatric Nurses Association*. 13, 6, 368-375. doi: 10.1177/1078390307309215
- Touyz S, Lacey H, Hay P (2020) Eating disorders in the time of COVID-19. *Journal of Eating Disorders*. 8, 19. doi: 10.1186/s40337-020-00295-3
- Treasure J, Crane A, McKnight R et al (2011) First do no harm: iatrogenic maintaining factors in anorexia nervosa. *European Eating Disorders Review*. 19, 4, 296-302. doi: 10.1002/erv.1056
- Treasure J, Oyeleye O, Bonin EM et al (2021) Optimising care pathways for adult anorexia nervosa. What is the evidence to guide the provision of high-quality, cost-effective services? *European Eating Disorders Review*. 29, 3, 306-315. doi: 10.1002/erv.2821
- Treasure J, Stein D, Maguire S (2015) Has the time come for a staging model to map the course of eating disorders from high risk to severe enduring illness? An examination of the evidence. *Early Intervention in Psychiatry*. 9, 3, 173-184. doi: 10.1111/eip.12170
- Vall E, Wade TD (2015) Predictors of treatment outcome in individuals with eating disorders: a systematic review and meta-analysis. *International Journal of Eating Disorders*. 48, 7, 946-971. doi: 10.1002/eat.22411
- Volpe U, Tortorella A, Manchia M et al (2016) Eating disorders: what age at onset? *Psychiatry Research*. 238, 225-227. doi: 10.1016/j.psychres.2016.02.048
- Westwood H, Mandy W, Tchanturia K (2017) Clinical evaluation of autistic symptoms in women with anorexia nervosa. *Molecular Autism*. 8, 12. doi: 10.1186/s13229-017-0128-x
- Wonderlich SA, Bulik CM, Schmidt U et al (2020) Severe and enduring anorexia nervosa: update and observations about the current clinical reality. *International Journal of Eating Disorders*. 53, 8, 1303-1312. doi: 10.1002/eat.23283
- Yorke E, Steinegger C, Toulany A (2018) From under-eating to overindulgence – clinician perspectives on caring for adolescents with eating disorders. *International Journal of Adolescent Medical Health*. 32, 4. doi: 10.1515/ijamh-2017-0198

## Publish with RCNi

Do you have an idea for an article that will help other nurses enhance the healthcare they or their teams deliver? Share your expertise for the benefit of colleagues and those receiving care. A published article can also be used as part of revalidation or registration renewal.

Nursing Standard welcomes submissions on the following themes:

- Pain management
- Nutrition
- Skin management
- Continance
- Medicines management
- Infection prevention and control
- End of life care

Find out more by going to [rcni.com/publish-article-with-rcni](https://rcni.com/publish-article-with-rcni) or contacting senior nurse editor Dr Richard Hatchett at [richard.hatchett@rcni.com](mailto:richard.hatchett@rcni.com)



# Find your perfect nursing job

RCNi  
Nursing  
Careers &  
Jobs Fair

**GLASGOW - 21 FEBRUARY**  
DOUBLETREE BY HILTON GLASGOW CENTRAL

## What are you waiting for?

- + Meet nurse recruiters and be interviewed on the day.
- + Build your CPD hours in our FREE seminars.
- + Get tips on how to prepare and succeed in your interviews.
- + Learn how to write supporting statements and CVs for your job applications.

**REGISTER FREE TODAY**

RCNi  
**CPD**  
USE FOR REVALIDATION

Find out more and view our future events at  
[careersandjobsfair.com](https://careersandjobsfair.com) or scan the QR code



**Why you should read this article:**

- To familiarise yourself with the reasons why a patient may require a neurological assessment
- To understand the pathophysiology of raised intracranial pressure
- To refresh your knowledge of the use of neurological assessment tools

# Undertaking a neurological assessment

Chris Carter and Joy Notter

**Citation**

Carter C, Notter J (2023)  
Undertaking a neurological  
assessment. *Nursing Standard*.  
doi: 10.7748/ns.2023.e12173

**Peer review**

This article has been subject  
to external double-blind  
peer review and checked  
for plagiarism using  
automated software

**Correspondence**

Chris.Carter@bcu.ac.uk

**Conflict of interest**

None declared

**Accepted**

5 July 2023

**Published online**

November 2023

**Abstract**

Neurological observations are an essential aspect of assessment in patients with altered mental status and require the nurse to collect and analyse information using a validated assessment tool. Assessing a patient's pupil size and response is also an important element of a neurological assessment. This article summarises the pathophysiology of raised intracranial pressure and lists some of the conditions that may contribute to an alteration in a patient's mental status. The article details the use of two commonly used neurological assessment tools and the assessment of a patient's pupil size and response. The authors also consider the challenges related to accurate recording of neurological observations.

**Author details**

Chris Carter, associate professor, Faculty of Health, Education and Life Sciences, Birmingham City University, Birmingham, England; Joy Notter, professor of community healthcare studies, Faculty of Health, Education and Life Sciences, Birmingham City University, Birmingham, England

**Keywords**

clinical, early warning scores, neurology, nursing care, observations, patient assessment, patients, professional, vital signs

Neurological observations provide vital information on the functional integrity of an individual's central nervous system (Derbyshire and Hill 2019) and form part of a comprehensive assessment based on airway, breathing, circulation, disability (neurological) and exposure (ABCDE) in patients with acute deterioration and/or acute neurological insults, such as head injury (Resuscitation Council UK 2021). Neurological observations must be included in all ongoing assessments of such patients to identify further deterioration and enable early intervention (Oughton and Subramanian 2023).

As well as acute deterioration or acute neurological insult, various health conditions and comorbidities may contribute to an alteration in a patient's mental status and consequently their neurological status. Therefore, it is important that nurses in all settings are able to monitor and record patients' neurological observations accurately. The National Institute for Health and Care Excellence (NICE) (2023) guidance on assessment and early management of head injury states that neurological observations should only be undertaken by an appropriately trained and competent practitioner. The Nursing and Midwifery Council (NMC) (2018) standards of proficiency require nurses in all disciplines to use 'evidence-based, best practice approaches' to

'undertake, respond to and interpret neurological observations and assessments'. Therefore, nurses must remain up to date with the skills and training required to ensure patient safety and quality care.

This article describes the pathophysiology of raised intracranial pressure (ICP) and some of the health conditions and comorbidities that may cause an alteration in a patient's mental status. The article also describes the use of two validated tools to assess and monitor patients' neurological function – the Alert, Confusion (new), responds to Voice, Pain or Unresponsive (A(C)VPU) approach and the Glasgow Coma Scale (GCS) – and explains how to measure a patient's pupil size and response as part of any neurological assessment.

**Raised intracranial pressure**

Raised ICP is a potentially life-threatening condition that can occur as a result of a brain injury or a wide range of health conditions. One of the symptoms of raised ICP is altered mental status. Changes in ICP can be caused by alterations in heart rate and blood volume due, for example, to haemorrhage or sepsis, or by cerebral trauma or neurological disease. These alterations disrupt the normal mechanisms that maintain ICP which, if not recognised and

**Permission**

To reuse this article or for  
information about reprints  
and permissions, contact  
permissions@rcni.com

treated, can result in sustained raised ICP (Karakis et al 2017). Raised ICP affects blood flow to the cerebrum, causing hypoxia and increased levels of carbon dioxide, which in turn causes arteriolar dilation further increasing the ICP (Waugh and Grant 2014).

It is important that nurses have an understanding of the maintenance of ICP. This process can be explained by the Monro-Kellie hypothesis (Benson et al 2023), which is summarised as follows. The cranium is a rigid compartment containing non-compressible contents, including brain tissue, blood and cerebrospinal fluid. The volume of these three components is restricted by the fixed space in which they are contained, with the ICP being the pressure within the cranium. Cerebral perfusion pressure (CPP) (the pressure required to push blood through all of the vessels in the brain) is the difference between the mean arterial pressure (MAP) and the ICP ( $CPP=MAP-ICP$ ) and must be maintained within a very narrow limit (Thomas et al 2015). Any alteration in ICP will affect the CPP, which then increases the risk of reduced perfusion to the brain tissue (Waugh and Grant 2014). Under normal circumstances, ICP is maintained by changes in intracranial blood volume and the pressure exerted by cerebrospinal fluid, which circulates around the brain and spinal cord. Normal ICP should be between 7 mmHg and 15mmHg in adults (Canac et al 2020).

The vasomotor centre in the medulla oblongata (comprising the lower section of the brainstem) maintains cerebral perfusion by regulating blood pressure, respiration and heart rate in response to the body's status; however, if the ICP begins to rise due to brain injury for example, the medulla becomes compressed by the increasing pressure in the cranial space, resulting in cerebellum herniation through the foramen magnum (one of several openings at the base of the skull) into the upper spinal canal (Waugh and Grant 2014). Herniation of the cerebellum causes cardiorespiratory instability, with symptoms of hypertension, high pulse pressure, bradycardia,

Cheyne-Stoke respirations (abnormal breathing pattern) and reduced level of consciousness. The combination of bradycardia and hypertension is known as Cushing Reflex, a late sign of raised ICP which is difficult to reverse (Waugh and Grant 2014).

### Neurological assessment

In patients with altered mental status a neurological assessment should be completed using a validated tool to identify the extent of the alterations (NICE 2023, Royal College of Physicians and Surgeons of Glasgow 2023). For patients with acute and/or life-threatening injuries or conditions, the neurological assessment should form part of the ABCDE assessment and should not be undertaken in isolation (Resuscitation Council UK 2021). Additionally, the use of a 'track-and-trigger' tool, such as the National Early Warning Score (NEWS) 2 (Royal College of Physicians 2017), will support timely identification of deteriorating patients and prompt appropriate intervention. In the NEWS 2 tool, a score is allocated to vital signs already recorded in routine practice; a higher score means the parameter is further from the normal range, which triggers appropriate clinical interventions (Royal College of Physicians 2017).

Various factors may contribute to an alteration in a patient's mental status, including: metabolic or systemic conditions; medicines or toxins; hospital-acquired factors; and primary neurologic conditions (Srikanth 2022). The patient's past and current medical history can assist in identifying factors which may have contributed to their altered mental status (Srikanth 2022), therefore the nurse must take account of this information when undertaking a neurological assessment. Table 1 lists factors that may contribute to alteration in mental status and includes corresponding potential sources and/or causes.

Two neurological assessment tools commonly used in clinical practice are the AVPU (Alert, responds to Voice, Pain or Unresponsive) – or the more recent A(C)VPU – and the GCS. Alongside

the use of these tools, nurses must undertake an assessment of the patient's pupils for size and reaction (Carter and Notter 2023).

### Alert, responds to Voice, Pain or Unresponsive assessment

The AVPU approach enables rapid assessment of a patient's mental status, responsiveness or level of consciousness and requires no formal training (Royal College of Physicians 2012, Williams 2019). There is no numerical scoring for this tool and assessment is recorded as 'responds to voice' or 'unresponsive', for example.

The AVPU assessment tool was modified in the revised NEWS 2 to include 'confusion' (A(C)VPU) (Royal College of Physicians 2017) to enable identification of 'new onset confusion', which can be a sign of clinical deterioration in an otherwise alert patient. The assessment of new onset confusion can help to identify any deviation from the patient's normal mental status. However, the Resuscitation Council UK (2021) guidelines on management of the deteriorating patient still refer only to the AVPU method. Nurses must therefore be alert to variations in local and national guidelines and training programmes.

If the nurse has any concerns about, or there are any changes in, the patient's mental or neurological status, the nurse must escalate these concerns immediately to the nurse in charge and, if trained, undertake a comprehensive neurological assessment using the GCS.

### Glasgow Coma Scale

The GCS was developed in the 1970s and is an internationally recognised and validated neurological assessment tool (Teasdale and Jennett 1974, Teasdale et al 2014, Royal College of Physicians and Surgeons of Glasgow 2023). The GCS has also been incorporated into national training courses, such as Resuscitation Council UK (2021) programmes. Clinicians, including nurses, must be trained to use the GCS to assess a patient's level of consciousness and to compare their findings with previous assessments (Cook et al 2019).

The GCS uses a scoring system based on scores awarded for best eye opening, best verbal response and best motor response (Table 2), which, when added together, provide a total score of between three and 15 (Mehta and Chinthapalli 2019). The highest score of 15 indicates the patient is alert and oriented, while a score of three indicates deep unconsciousness. The GCS score must be documented on a GCS chart to enable recognition of improvement or deterioration based on previous assessments. Nurses should recognise that the score alone does not explain the cause of any changes in neurological status. For example, a total score of eight could be based on ‘eye opening=2, verbal=2 and motor=4’ or ‘eye opening=1, verbal=1 and motor=6’ – these parameters have very different implications for the severity of the patient’s condition and only become evident when charted (Royal College of Physicians and Surgeons of Glasgow 2023).

**Eye opening**

Eye opening has a maximum score of four, which is given if the patient opens their eyes spontaneously and unprompted. It is important to note that this is a measure of arousal and not awareness (Derbyshire and Hill 2019). If the patient opens their eyes in response to speech, for example the nurse calling their name or asking them to open their eyes, they are scored three.

If the patient does not open their eyes then a pressure stimulus should be applied to the supraorbital notch or to the trapezius (Resuscitation Council UK 2021, Royal College of Physicians and Surgeons of Glasgow 2023) (Box 1). If there is no response to verbal or pressure stimuli, the patient is given the lowest score of one. If the patient cannot open their eyes due to swelling, then ‘C’ for ‘closed’ is recorded on the GCS chart along with the score. However, other factors can affect this score, for example loss of hearing, particularly in older people (Derbyshire and Hill 2019).

**Verbal**

Assessment of a patient’s verbal response determines higher cerebral function. To score a maximum of

five, the patient must be able to respond accurately to all parts of a question (or questions) that aims to determine if they are oriented to time, place and person (Derbyshire and Hill 2019). Examples of such questions include: ‘What is your name?’, ‘Where are you?’, ‘Which month/year is it?’

If the patient is disoriented, they might speak in sentences that have a logical sequence in terms of words and phrasing, but may be confused about time, place or person. In this case they would be scored four. If the person uses inappropriate or random audible words that are irrelevant to the context, they are scored three. If the patient makes sounds such as groaning, they are scored two and if there are no audible responses, they are scored one (the minimum score).

If the patient has an artificial airway in place, such as an endotracheal or tracheostomy tube, the letter ‘T’ for ‘tube’ is recorded on the GCS chart along with the score. Additionally, if the patient has a known condition such as dysphasia it may be appropriate to record the letter ‘D’ on the chart (Derbyshire and Hill 2019).

**Key points**

- Neurological observations provide vital information on the functional integrity of an individual’s central nervous system
- In patients with altered mental status, a neurological assessment should be completed using a validated tool to identify the extent of the alterations
- If the nurse has any concerns about, or there are any changes in, the patient’s mental or neurological status, the nurse must escalate these concerns immediately to the nurse in charge
- Guidelines on the assessment and early management of head injury recommend that any patient who presents to an emergency department with a head injury must be assessed within a maximum of 15 minutes of arrival

**Motor**  
While all elements of the GCS are regarded as crucial, the viability of a patient’s motor responses has been identified as the most likely indicator of an undamaged motor cortex (the

**Table 1. Factors that may contribute to alteration in mental status**

Factor	Potential source and/or cause
Metabolic or systemic	<ul style="list-style-type: none"> <li>» Pulmonary: hypoxia, hypercarbia</li> <li>» Cardiac: hypoperfusion, heart failure</li> <li>» Renal: uraemia, hypercalcemia, acidosis or alkalosis</li> <li>» Gastrointestinal: hepatic encephalopathy, elevated ammonia, nutritional deficiencies (for example, thiamine, vitamin B12)</li> <li>» Infection: sepsis</li> <li>» Endocrinologic: hypoglycaemia or hyperglycaemia, hypothyroidism, hypothermia or hyperthermia</li> <li>» Psychiatric: catatonia, pseudodementia (symptoms that mimic dementia but have other causes)</li> </ul>
Medicines or toxins	<ul style="list-style-type: none"> <li>» Intoxication or withdrawal from a substance (illicit or legal)</li> <li>» Carbon monoxide poisoning</li> <li>» Use of benzodiazepines, opioids or muscle relaxants</li> <li>» Use of antihistamine or anticholinergic medicine</li> <li>» Use of antiepileptic medicines</li> <li>» Use of corticosteroids (illicit or legal)</li> </ul>
Hospital acquired	<ul style="list-style-type: none"> <li>» Pain</li> <li>» Delirium</li> </ul>
Primary neurologic conditions	<ul style="list-style-type: none"> <li>» Vascular: intracerebral haemorrhage, ischaemic stroke, venous thrombosis</li> <li>» Traumatic brain injury</li> <li>» Elevated intracranial pressure</li> <li>» Seizure</li> <li>» Infection (for example, meningitis, encephalitis, brain abscess)</li> <li>» Autoimmune response</li> <li>» Neoplasm</li> </ul>

(Adapted from Srikanth 2022)

area of the brain responsible for voluntary movements) (Healey et al 2003, Derbyshire and Hill 2019). However, this is the most challenging aspect of the assessment (Royal College of Physicians and Surgeons of Glasgow 2023).

To complete this part of the GCS, the nurse must first determine that the patient can understand the terms used, particularly if English is not their first language, as well as following simple commands (Derbyshire and Hill 2019).

If the patient can obey one-stage commands, for example 'raise your arms', they are scored six (maximum). If they are unable to comply with this command,

they should be assessed using a pressure stimulus. Rubbing the knuckles on the sternum, which was previously accepted practice, is no longer recommended because it can cause bruising and the patient's responses can be difficult to interpret (Royal College of Physicians and Surgeons of Glasgow 2023). Instead, the Resuscitation Council UK (2021) recommends applying pressure to the supraorbital notch, the trapezius (as described in Box 1) or to the side of the fingernail (not to the nail bed). However, nurses should be familiar with and follow local policies on applying pressure stimuli and apply their clinical judgement; for example, it would not be advisable to use the supraorbital notch in a patient with facial injuries.

When a pressure stimulus is applied, the patient should make a purposeful movement in the direction of the pain. For example, if stimulus was applied to their right supraorbital notch, then they should move their hand towards it involuntarily, which would give a score of five. Only one limb needs to move to be scored five or lower. If the patient displays flexion in response to, or withdraws from, the pain – that is, where a limb moves away from the painful stimulus – they are scored four.

Abnormal flexion to pain, which can involve adduction (movement of a limb or other part towards the centre of the body) or internal rotation of the arms and extension of the legs, termed 'decorticate' movements, indicates damage above the level of the red nucleus in the midbrain (the section of the brain that is mainly involved in limb control, particularly during reaching movements), such as cortical or thalamic injury (Derbyshire and Hill 2019). In this case the patient is scored three.

An extension response, where the patient's elbow and wrist extend, usually accompanied by a leg extension (referred to as 'decerebrate' posturing), is an abnormal response to pressure stimuli and suggests damage at or below the level of the red nucleus in the midbrain (part

of the brain involved with limb control), for example in brainstem injury, and indicates severe brain damage (Waugh and Grant 2014). Decerebrate posturing is given a score of two. A score of one is given where there is no response to pressure stimuli.

Limb power and movement also form part of the motor assessment and provide an indicator of motor response and the extent of neurological dysfunction. Assessment involves testing each limb for strength, starting with the arms, remembering that each side of the brain controls the opposite limbs. When recording limb power, the nurse should use the letters 'L' and 'R' to identify left and right (Derbyshire and Hill 2019).

### Pupil response

Pupil size and reaction to light are important components of a neurological assessment because they can indicate the quality of the patient's third cranial nerve (oculomotor) function or a lack of function. Normal pupil size is 3-5mm and pupils constrict briskly in response to light. Before assessing the patient's pupil response, the nurse must observe both pupils to check if they are of equal size, because some medicines such as atropine sulfate and some health conditions such as eye surgery can alter pupil size, shape and reaction (Waugh and Grant 2014).

Using a bright pen torch, the nurse should assess each pupil separately by shining the light from the side of the eye and observing the reaction of the pupil. It is crucial that the light is shone from the side of the eye because the pupil will constrict in response to an approaching object – termed the 'accommodation response' – which will affect the accuracy of the assessment (Waugh and Grant 2014).

Pupil size is recorded in millimetres (Figure 1). If the reaction is brisk, it is charted as positive (+); if it is slow or sluggish it is recorded with the letter 'S'; if there is no reaction, or the pupil is fixed, it is recorded as negative (-). The neurological observation chart or the side of the pen torch may

Table 2. Glasgow Coma Scale

Response	Criteria	Score*
Eye opening	» Spontaneously	4
	» To sound	3
	» To pressure	2
	» None	1
Verbal	» Oriented	5
	» Confused	4
	» Words	3
	» Sounds	2
	» None	1
Motor	» Obeys commands	6
	» Localises (purposeful movement towards pain)	5
	» Normal flexion/withdrawal to pain	4
	» Abnormal flexion	3
	» Extension	2
	» None	1

\*The highest score of 15 indicates the patient is alert and oriented; a score of 3 indicates deep unconsciousness

(Adapted from Royal College of Physicians and Surgeons of Glasgow 2023)

### Box 1. Application of pressure stimuli using the trapezius 'pinch' or supraorbital notch

- » Trapezius 'pinch' – this involves the clinician using their thumb, index and middle finger to hold then gradually apply increasing pressure to the trapezius muscle (which extends across the back of the shoulders from the middle of the neck) for a maximum of 30 seconds
- » Supraorbital notch – there is a small notch just below the inner aspect of the eyebrow through which a branch of the facial nerve runs. The clinician rests their hand on the patient's head and places the flat of their thumb or their knuckle on the supraorbital ridge under the eyebrow. Pressure is gradually increased for a maximum of 30 seconds. This technique should not be applied if there is any orbital damage or a skull fracture. Pressure to the supraorbital notch must only be applied by a trained clinician

(Adapted from Ellis and Cavanagh 1992)

include an infographic showing a range of pupil sizes, similar to the image shown in Figure 1, to assist with the assessment.

If a pupil is fixed, dilated and does not react to light this could indicate injury or pressure on one side of the brain and the patient will require an urgent neurological review (Carter and Notter 2023).

### Frequency of neurological observations in patients with head injury

NICE (2023) guidelines on the assessment and early management of head injury recommend that any patient who presents to an emergency department with a head injury must be assessed within a maximum of 15 minutes of arrival. Those with impaired consciousness (GCS <15) must be assessed immediately and observations should be undertaken and recorded every 30 minutes until there is a GCS score of 15. Minimum frequency of observations for people with an initial GCS score of 15 should be half-hourly for two hours, then one hourly for four hours, then two hourly (NICE 2023).

Senior clinicians or medical staff may request neurological observations to be recorded every 15 minutes depending on the clinical situation (Derbyshire and Hill 2019), for example in patients with trauma, concussion or acute deterioration. In addition, patients with head injury should be reassessed urgently if any of the following signs of neurological deterioration are observed (NICE 2023):

- » Agitation or abnormal behaviour.
- » A sustained (for at least 30 minutes) drop of one point in GCS score (particularly if the drop of one point is in the motor response score).
- » Any drop of three or more points in the eye opening or verbal response scores of the GCS score or two or more points in the motor response score.
- » Severe or increasing headache or persistent vomiting.
- » New or evolving neurological signs or symptoms, such as pupil inequality or asymmetry of limb or facial movement.

A noted limitation of using the GCS is inter-observer reliability, which may result in over or underassessment, therefore NICE (2023) recommends that a second practitioner who is competent to undertake neurological observations should assess the patient before escalating any concerns. When handing over patients it is also good practice for the nurse going off shift to undertake a set of neurological observations with the nurse coming on shift so that they can compare findings and maintain consistency (NICE 2023).

### Potential challenges in recording of neurological observations

Every effort must be made by nurses to maintain accuracy when undertaking and documenting patients' neurological observations. However, while there are few studies on the accuracy of recording neurological observations, there is evidence of inaccurate recording of vital signs, incomplete neurological observations and failures in the early escalation of deteriorating patients (Downey et al 2017). NICE (2023) has identified strategies to improve neurological assessment, including training and education, use of standardised charts and use of NEWS 2.

To try to address issues related to inadequate recording of neurological and other observations and failure to escalate deteriorating patients, some organisations use electronic documentation systems. Such systems have been shown to support consistency and accuracy of recording vital signs by prompting the healthcare professional to undertake a full set of vital signs, which are automatically calculated and, in some instances, referred on to the appropriate clinical team (Vincent et al 2018, Watson and Carberry 2021). The use of an electronic documentation system may assist in the identification of missing vital signs and prompt nurses to undertake the relevant observations, which could reduce the risk of lost data and improve nurses' adherence (Watson and Carberry 2021). However, the lack of availability of computers in some clinical

areas may limit the effectiveness of this approach and conversely increase the risk of missed or delayed recording of vital signs, in turn delaying the recognition of a deteriorating patient (Watson and Carberry 2021).

Another potential challenge with regards to recording neurological observations is nurse staffing levels. For example, an observational study of nurses and nursing assistants on surgical and acute general wards in England found that late or missed vital signs were frequent, but that higher nurse staffing levels resulted in a lower rate of missed or delayed vital sign recording (Redfern et al 2019). The nurse staffing crisis in the UK may therefore adversely affect the monitoring of patients at risk of deterioration (Mitchell 2022, Royal College of Nursing 2022). Nurses must recognise the importance of prioritising patients who require neurological observations. If care for these patients is delegated to a junior colleague or nursing student, supervision and monitoring of their practice is essential.

### Conclusion

The ability to undertake an effective neurological assessment is an essential skill for nurses in all areas of practice, because patients may develop altered mental status in response to acute neurological insults as well as a range of other health conditions and comorbidities. It is vital that nurses respond quickly to symptoms of altered mental status by undertaking an appropriate neurological assessment, documenting the findings accurately and escalating the patient as appropriate. Early escalation promotes prompt intervention and treatment, which is essential to prevent patient deterioration. All clinicians, including nurses, must be trained to use the GCS to assess a patient's level of consciousness and to compare the findings with previous assessments.

**Write for us**  
For information about writing for RCNi journals, contact [writeforus@rcni.com](mailto:writeforus@rcni.com)

For author guidelines, visit [rcni.com/publish-article-with-rcni](http://rcni.com/publish-article-with-rcni)

Figure 1. Pupil size scale



## References

- Benson JC, Madhavan AA, Cutsforth-Gregory JK et al (2023) The Monro-Kellie Doctrine: a review and call for revision. *American Journal of Neuroradiology*. 44, 1, 2-6. doi: 10.3174/ajnr.A7721
- Canac N, Jalaaluddin K, Thorpe SG et al (2020) Review: pathophysiology of intracranial hypertension and non-invasive intracranial pressure monitoring. *Fluids and Barriers of the CNS*. 17, 1, 40. doi: 10.1186/s12987-020-00201-8
- Carter C, Nottter J (Eds) (2023) *Handbook for Registered Nurses*. Elsevier, London.
- Cook NF, Braine ME, Trout R (2019) Nurses' understanding and experience of applying painful stimuli when assessing components of the Glasgow Coma Scale. *Journal of Clinical Nursing*. 28, 3827-3839. doi:10.1111/jocn.15011
- Derbyshire J, Hill B (2019) Performing neurological observations. *British Journal of Nursing*. 27, 19, 1110-1114. doi: 10.12968/bjon.2018.2719.1110
- Downey CL, Tahir W, Randell R et al (2017) Strengths and limitations of early warning scores: a systematic review and narrative synthesis. *International Journal of Nursing Studies*. 76, 106-119. doi: 10.1016/j.ijnurstu.2017.09.003
- Ellis A, Cavanagh SJ (1992) Aspects of neurosurgical assessment using the Glasgow Coma Scale. *Intensive Critical Care Nursing*. 8, 2, 94-99. doi: 10.1016/0964-3397(92)90037-K
- Healey C, Osler TM, Rogers FB et al (2003) Improving the Glasgow Coma Scale score: motor score alone is a better predictor. *Journal of Trauma*. 54, 4, 671-678. doi: 10.1097/01.TA.0000058130.30490.5D
- Karakis I, Nuccio AH, Amadio JP et al (2017) The Monro-Kellie doctrine in action: posterior reversible leukoencephalopathy syndrome caused by intracranial hypotension from lumboperitoneal shunt placement. *World Neurosurgery*. 98, 868.e11-868.e15. doi: 10.1016/j.wneu.2016.12.046
- Mehta R, Chinthapalli K (2019) Glasgow coma scale explained. *BMJ*. 2, 365, 11296. doi: 10.1136/bmj.11296
- Mitchell G (2022) Nurse Staffing Across the UK 'Now Well Past the Point of Crisis'. [www.nursingtimes.net/news/workforce/nurse-staffing-across-the-uk-now-well-past-the-point-of-crisis-07-02-2022](http://www.nursingtimes.net/news/workforce/nurse-staffing-across-the-uk-now-well-past-the-point-of-crisis-07-02-2022) (Last accessed: 29 September 2023.)
- National Institute for Health and Care Excellence (2023) *Head Injury: Assessment and Early Management*. NICE guideline No. 232. NICE, London.
- Nursing and Midwifery Council (2018) *Standards of Proficiency for Registered Nurses*. NMC, London.
- Oughton N, Subramanian P (2023) *Trauma Nursing 3: Assessing and Managing Head Injury*. [cdn.ps.emap.com/wp-content/uploads/sites/3/2022/12/221219-Trauma-nursing-3-assessing-and-managing-head-injury.pdf](https://cdn.ps.emap.com/wp-content/uploads/sites/3/2022/12/221219-Trauma-nursing-3-assessing-and-managing-head-injury.pdf) (Last accessed: 29 September 2023.)
- Redfern OC, Griffiths P, Maruotti A et al (2019) The association between nurse staffing levels and the timeliness of vital signs monitoring: a retrospective observational study in the UK. *BMJ Open*. 9, e032157. doi: 10.1136/bmjopen-2019-032157
- Resuscitation Council UK (2021) *The ABCDE Approach*. [www.resus.org.uk/library/abcde-approach](http://www.resus.org.uk/library/abcde-approach) (Last accessed: 29 September 2023.)
- Royal College of Nursing (2022) *8 in 10 Shifts Unsafe: RCN Survey Reveals Shocking Extent of Staffing Crisis*. [www.rcn.org.uk/news-and-events/news/uk-rcn-survey-reveals-shocking-impact-of-nurse-staffing-crisis-on-patient-safety-060622](http://www.rcn.org.uk/news-and-events/news/uk-rcn-survey-reveals-shocking-impact-of-nurse-staffing-crisis-on-patient-safety-060622) (Last accessed: 29 September 2023.)
- Royal College of Physicians (2012) *National Early Warning Score (NEWS): Standardising the Assessment of Acute-Illness Severity in the NHS*. RCP, London.
- Royal College of Physicians (2017) *National Early Warning Score (NEWS) 2*. [www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2](http://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2) (Last accessed: 29 September 2023.)
- Royal College of Physicians and Surgeons of Glasgow (2023) *The Glasgow Structured Approach to Assessment of the Glasgow Coma Scale*. [www.glasgowcomascale.org](http://www.glasgowcomascale.org) (Last accessed: 29 September 2023.)
- Srikanth P (2022) *Altered mental status*. In Albin CS, Zafer SF (Eds) *The Acute Neurology Survival Guide*. Springer, Cham, 129-132.
- Teasdale G, Jennett B (1974) Assessment of coma and impaired consciousness. A practical scale. *The Lancet*. 13, 2, 81-84. doi: 10.1016/S0140-6736(74)91639-0
- Teasdale G, Maas A, Lecky F et al (2014) The Glasgow Coma Scale at 40 years: standing the test of time. *The Lancet Neurology*. 13, 8, 844-854. doi: 10.1016/S1474-4422(14)70120-6
- Thomas E, Czosnyka M, Hutchinson P (2015) Calculation of cerebral perfusion pressure in the management of traumatic brain injury: joint position statement by the councils of the Neuroanaesthesia and Critical Care Society of Great Britain and Ireland (NACCS) and the Society of British Neurological Surgeons (SBNS). *British Journal of Anaesthesia*. 115, 4, 487-488. doi: 10.1093/bja/aev233
- Vincent JL, Einav S, Pearce R et al (2018) Improving detection of patient deterioration in the general hospital ward environment. *European Journal of Anaesthesiology*. 35, 5, 325-333. doi: 10.1097/EJA.0000000000000798
- Watson D, Carberry M (2021) Nurses' experiences of recording vital signs electronically: a pilot study. *Nursing Times*. 117, 2, 55-58.
- Waugh A, Grant A (2014) *Ross and Wilson Anatomy and Physiology in Health and Illness*. 12<sup>th</sup> edition. Elsevier, Amsterdam, The Netherlands.
- Williams B (2019) The National Early Warning Score and the acutely confused patient. *Clinical Medicine*. 19, 2, 190-191. doi: 10.7861/clinmedicine.19-2-190

# Become an RCNi reviewer

Nursing Standard is seeking peer reviewers to assess the quality of Evidence & Practice articles before publication.

If you would like to contribute to the sharing of best practice and have experience in the following areas, contact Nick Liplely at [nick.liplely@rcni.com](mailto:nick.liplely@rcni.com)

- Communication
- Leadership
- Clinical research
- Diabetes
- Cardiology
- Urology

To find out more about reviewing articles with RCNi, go to [rcni.com/write-us/become-a-reviewer](http://rcni.com/write-us/become-a-reviewer)



# Professionalism

## IN THIS SECTION

**Students** The rules on using artificial intelligence to help with your studies **p51**

**Careers** What is imposter syndrome – and what can you do about it? **p54**

**Feature** De-escalation techniques: tips for handling conflict situations **p57**

**Peer-reviewed article** Effective care for autistic adults with mental health issues **p60**

## What is ChatGPT and can I use it for an assignment?

Students need to be AI-literate, but must use the technology with caution. Find out how it can help you, and how to stay within the rules for coursework

By Nick Evans  
health journalist

**T**he fast-developing field of artificial intelligence (AI) has the potential to change society – but as well as the possibility for positive impact, there is the prospect of its misuse.

Nowhere is the potential for this more obvious than in education and the use of tools such as ChatGPT. So what do nursing students need to know?

### What is ChatGPT?

AI refers to computer systems or machines that can perform tasks that previously have typically required human thought.

It has led to the development of tools such as ChatGPT, which can answer questions on almost any topic by using vast

databases of information and generate text that appears to have been created by a human.

Launched in November 2022, ChatGPT marked a huge step forward in chatbot technology, with previous examples including Apple's Siri and Amazon's Alexa.

The big difference is the ability of ChatGPT to engage in elaborate dialogue and follow-up discussion with its users. After the user types questions or comments, ChatGPT responds within seconds, providing detailed text.

The material can be fine-tuned through further requests from the user and has been found to be good enough to pass university exams and assessments.

### » What are the weaknesses of ChatGPT?

Like all emerging technologies, ChatGPT has its limitations. It does not always make use of the latest information, and the text it generates can be written in different styles even when asked the same question. Unclear commands or information may be misinterpreted.

It can contain inaccuracies as the information it uses is garnered from a wide range of sources, including those that are poorly referenced or incorrect.

What is more, it represents information developed by others and so there is a risk of plagiarised content and copyright infringement. New iterations of ChatGPT are being released, however, which aim to improve the accuracy and reliability of its sources.

### Can nursing students use ChatGPT?

Yes, but it must be used as an aid to learning, rather than as a substitute. Asking it to produce a written assignment, or a part of it, is not appropriate.

The Quality Assurance Agency for Higher Education (QAA)



issued guidance to universities and colleges at the start of 2023, setting out its concerns for academic integrity if students chose to present AI-generated assignments as their own work, and the steps that should be taken to safeguard against that.

Updated guidelines published in May took a more proactive approach, with the QAA saying that following 'considerable reflection' there was now a desire in the sector to look at how such tools could support learning, while being careful to maintain academic integrity.

This was reinforced by a Department for Education policy paper published last year – although that largely focused on schools and colleges.

The key is that students should be open and transparent about how they are using AI and ChatGPT, says the QAA. It states that the ability to use, check facts from and authenticate

information derived from AI software is a key attribute graduates will need for their 'future employability'. As a nurse, they may find AI useful in a range of circumstances, for example, developing easily accessible information for patients, helping with research and continuing professional development (CPD), and potentially in completing paperwork.

Following the release of this guidance, the Russell Group, which represents 24 of the leading research universities, published a new set of principles to help students and staff capitalise on the opportunities presented by technology such as ChatGPT. These suggest students and educators should embrace AI and universities develop a culture of open discussions about AI.

**What changes might be seen in nurse education?**  
Sheffield Hallam University

### 5 ways you could use ChatGPT in assignments

Online academic support service Scribbr recommends five ways to use ChatGPT – although it says university guidance, if in place, should take precedence:

- » **Writing a research question** Help narrow down a topic by asking ChatGPT to write three possible research questions
- » **Developing an outline** Once you have decided on the research question, ChatGPT can help keep you on track by giving a clear idea of what topics you want to discuss and in what order
- » **Finding source recommendations** Be sure to track them down to check that they are credible
- » **Summarising and paraphrasing text** During writing you can use the summarising tool to condense your text to its essential ideas or to paraphrase in clear, accessible language
- » **Getting feedback** Once you have written your essay, you can prompt ChatGPT to provide feedback and recommend improvements

Source: Scribbr [tinyurl.com/scribbr-chatgpt](https://tinyurl.com/scribbr-chatgpt)

### 'Future professionals must have the digital and technological skills to meet people's care needs'

Anne Trotter, assistant director of professional practice, Nursing and Midwifery Council

senior lecturer in nursing and digital lead Leisa Anderton says: 'When ChatGPT was first launched I think there was a lot of fear and the knee-jerk reaction was to try to ban it. The technology developed so quickly, it was difficult to keep up.'

'But we now recognise in education, and also in healthcare more widely, that it has huge potential. There are risks too, but we need to mitigate them.'

She says, given the pace the technology is evolving at, it will soon be nearly impossible to tell if students are doing assignments via AI.

'There is an argument for introducing oral assessments alongside written assessments to make sure students have done the work. But it is the benefits that we need to embrace. I think in time we will adapt, and this will just become something we use in our work, in our learning and in our daily lives.'

'It will be there in the background – just as things like spellcheck and smart phones are.'

### How are nursing course providers responding to AI?

It is still a mixed picture, with some centres, but not all, encouraging students to make use of AI technologies.

The focus is largely on its ability to aid research, much as search engines can, by asking ChatGPT to summarise and find information or produce notes.

In some places staff are even receiving training encouraging them to use AI by developing study guides and course materials and test questions.

Northumbria University head of nursing, midwifery and health Debbie Porteous, a member of the RCN education forum, says her university has adopted the Russell Group principles and is providing training sessions for academic staff.

She says the field has developed 'rapidly' in recent months but it is essential to remember the results are 'only as good as the training data and the algorithms performed on them'.

'It is important you learn

to use them in an ethical, responsible and professional manner,' says Professor Porteous.

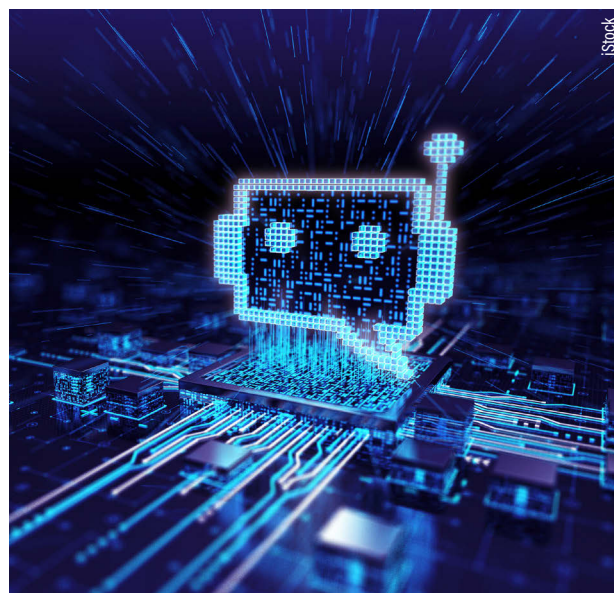
Fellow RCN education forum member Rachael Major says AI technologies can be particularly helpful for students who may struggle at times with the phrasing of their work. This includes neurodiverse and international students; a recent report looking at how students are using AI, conducted by Jisc, which provides digital support to universities, highlighted this very use.

But Dr Major says not all universities are as proactive as those following the Russell Group principles. 'In some places, current guidance is that the use of AI may infringe university regulations, which makes students nervous,' she says.

'I am even aware of assessments being changed to ensure that even if AI is used, the assessment methods demonstrate student understanding – for example adding oral examinations in addition to essays.'

### What does the Nursing and Midwifery Council say about AI use by students?

The Nursing and Midwifery Council (NMC) says whether AI tools are suitable for use by students in their nursing programmes is



## The Russell Group's five principles for AI in education

- » Universities will support students and staff to become AI-literate
- » Staff should be equipped to support students to use generative AI tools effectively and appropriately
- » Universities will adapt teaching and assessment to incorporate the ethical use of generative AI and support equal access
- » Universities will ensure academic rigour and integrity is upheld
- » Universities will work collaboratively to share best practice

Source: The Russell Group [tinyurl.com/Russell-Group-AI](https://tinyurl.com/Russell-Group-AI)

a matter for universities and education providers.

It says what matters from the regulator's perspective is that those providers give the NMC the necessary assurances that their graduates have the 'right knowledge and skills to deliver safe, effective and kind care'.

But it also recognises it is important that nursing students became AI-literate.

'Our standards are clear that future professionals must have the digital and technological skills to meet people's health and care needs,' says NMC assistant director of professional practice Anne Trotter.

'It's important that students are prepared for and understand the way in which rapidly evolving digital technologies are increasingly influencing the future delivery of services and the potential they can bring to people's health and well-being.'

### Further information

Quality Assurance Agency for Higher Education: Maintaining quality and standards in the ChatGPT era: advice on the opportunities and challenges posed by Generative Artificial Intelligence [tinyurl.com/QAA-AI](https://tinyurl.com/QAA-AI)

Department of Education: Generative artificial intelligence (AI) in education [tinyurl.com/Gov-gen-AI](https://tinyurl.com/Gov-gen-AI)

Jisc: National centre for AI in tertiary education: student perceptions of generative AI [tinyurl.com/Jisc-AI](https://tinyurl.com/Jisc-AI)

# Bright ideas: how to make your vision a reality

Nurses who turned inspired ideas into real-world patient-care improvements share their tips on devising, developing and funding their projects



By Yvonne Covell  
health journalist

**H**ave you ever had an idea that you knew would improve patient care?

We spoke to nurses who have turned their innovative ideas into fully fledged businesses and social enterprises to find out how they made it work.

## Understanding patient need

As an advanced nurse practitioner in a general practice in a small Yorkshire community, Helen O'Connell was aware that many people coming to the surgery were not in need of medical treatment.

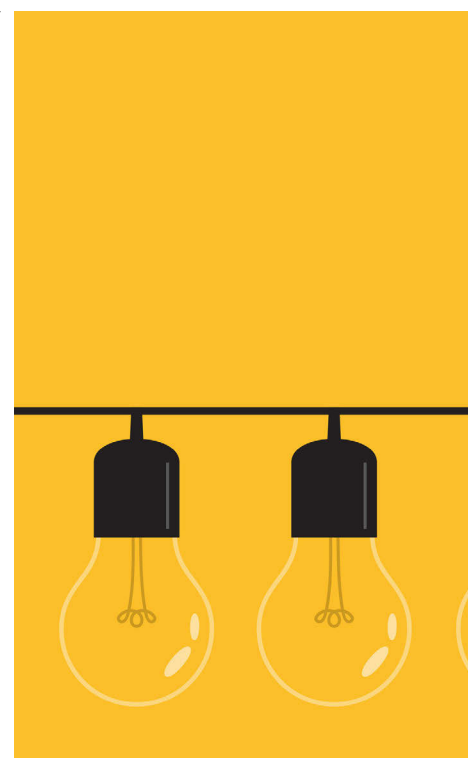
'Whether they were hungry, lonely, or, for example, struggling to cope with their teenager's mental health issues, I would say that for 20% of our patients, the need was more for what we would call social prescribing,' she says.

Ms O'Connell wanted to do something practical to help, so decided to set up a food bank. 'Talking to people who came

to use the food bank made me realise people don't know where to go to seek help when something goes wrong in their lives – that's how I formed the idea for social prescribing website Treacle.me.'

Treacle.me is a free and easy to use social prescribing directory, which gathers together information about small local groups – as well as national help and support – in one site. 'I spoke to a web designer who lived in the village, who told me it would cost £1,000 to create the kind of website I was after,' says Ms O'Connell, a finalist in the community and general practice nursing category at the 2023 RCN Nursing Awards for creating Treacle.me.

'Some years ago, a patient had left the practice some money in their will, to be spent for the good of the community,' she says. 'At the next practice meeting, I said "I've got an idea for a website, and could I have



£1,000 from the fund for it?'. Everyone at the meeting liked the idea and said yes.

'It was the spring of 2020, I had the £1,000 and I was off. I spent two to three months working with the web designer.

'There are so many small enterprises helping people, but they don't have the money to promote themselves, so they were happy to be on the website. I wanted it to be super-easy to log on and find help.'

## What it took to develop my innovation, and what I've learned

Neomi Bennett won the innovations category at the 2019 RCN Nursing Awards for inventing Neo-Slip, designed to help people put on compression stockings.

'I came up with the idea when I was a student on placement and saw patients struggling to put on their compression stockings,' says Ms Bennett. 'I knew these stockings were potentially life-saving for them, but they just couldn't manage them. I remember visiting one couple in their home and they were using the stockings as curtain ties because they couldn't get them on.

'My lecturers were really enthusiastic about the idea, which helped. I even had business meetings at the university as I was getting the product off the ground.

'It's a myth that you need to have lots of money to get started – it's better to do things bit by bit and use the resources you have around you. I also had some financial support from the Florence Nightingale Foundation.

'There were lots of obstacles along the way, and it took a lot of determination to get the product out to patients. Getting into the NHS supply chain is difficult – they do a huge amount of due diligence, so everyone can have confidence in the products the NHS use.

'Feedback from real patients was invaluable.

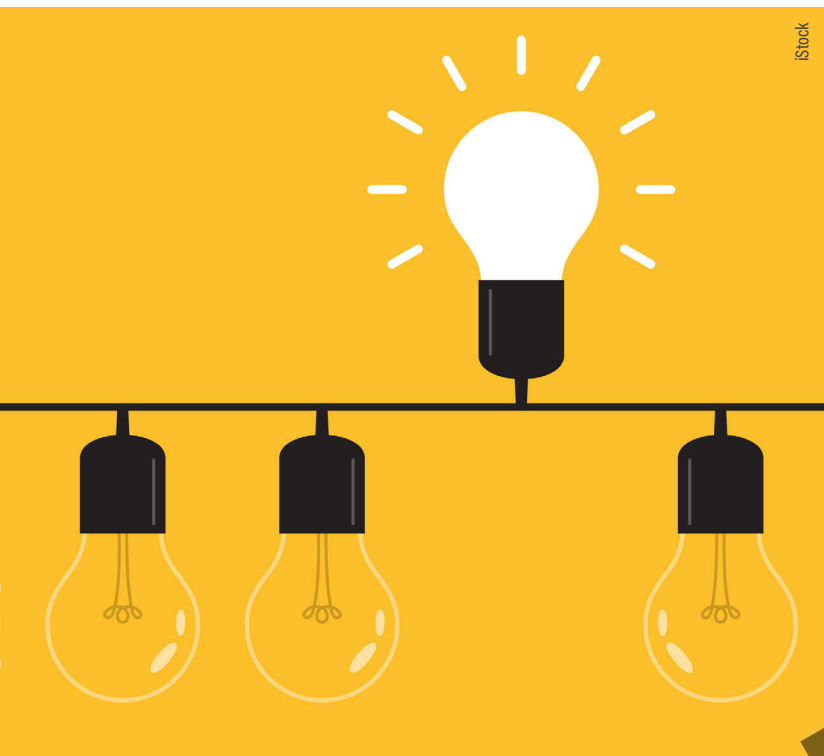
'My advice to nurses who are thinking of starting something would definitely be to go for it. There are so many opportunities for innovating.'

## Nurses' start-ups

Other nurse-innovators funded initial startups themselves, as well as researching and applying for grants.

RCN Nurse of the Year 2020 Ana Waddington won the award for her work founding YourStance, an initiative in which healthcare professionals teach life-saving skills to young people in London at risk of serious violence.

She says finding funding was her biggest obstacle in the early days. 'For two years, I did everything with my own funding and donated items. I became quite exhausted by it,' she says. 'I then successfully applied for a grant from Barts Charity,



which helped me to build the foundations of the organisation.'

Mental health nurse Matty Caine set up mental health support centre First Person Project in 2019. 'I worked as an independent nurse for a while to raise the money to put into practice my vision for a people-powered mental health centre in Liverpool, which I was later able to set up and fund as a social enterprise,' he says.

'I had lots of ideas, straight from when I was at university, but I was always told things couldn't be done a different way. It was only when gained more experience that I had the confidence to innovate.'

### The skills to get an idea going

He says tenacity and determination are key to getting any project off the ground, alongside a belief in yourself and your idea. 'Don't stop asking: "Are we as efficient as possible?" You have to have the courage to be disliked, to be misunderstood when you come up with ideas for doing things differently,' he says.

All the nurse entrepreneurs we spoke to say they used their transferable nursing skills when

getting their initiatives off the ground – alongside learning along the way, both on the job and through taking courses.

'I had to learn the business administration side of things, often by trial and error,' says Ms O'Connell. 'I worked out we needed to be registered with Companies House as a community interest company with directors. I opened a social enterprise bank account with the bank that seemed the easiest to deal with. I now employ three people part-time to keep the website up to date. That leaves me to do what I'm good at – going out to talk to people.'

Ms Waddington agrees that it's about knowing what your skills are and then finding people who have skills to complement yours. 'I'm not skilled at grant writing but my co-director is amazing at it and has experience of grant applications. She is focused

**'It's a myth that you need to have lots of money to get started – it's better to do things bit by bit and use the resources that you have around you'**

*Neomi Bennett, nurse inventor of a compression stocking fitting aid*

## Nurse innovators' tips for getting your idea off the ground

- » **Start writing things down** 'If you have an idea, draw pictures of it, make notes and gradually add to it,' advises nurse and founder of Neo-Slip Neomi Bennett
- » **Value your skills and experience** 'Nurses think they don't have certain skills, such as sales, but they do,' says Ms Bennett. 'For example, selling your product or idea is like persuading a patient to take their medication or do more exercise – even if they don't want to. Nurses are good at communication, problem solving and risk assessment'
- » **Be bold** 'If you've spotted a gap, you know the context and you've thought through the pros and cons, don't let go of it,' says mental health nurse and founder of First Person Project Matty Cain
- » **Attend trade fairs and exhibitions** 'These can be invaluable for meeting people who can help you,' says Ms Bennett. 'One company even invited me to display Neo-Slip on their stand in the early days'
- » **Try not to worry about others stealing your idea** 'It takes a lot to get an idea up and running – you can't steal someone's passion to do that and overcome the obstacles,' says Ms Bennett
- » **Surround yourself with people who believe in you** Helen O'Connell, nurse and founder of social enterprise Treacle.me, says: 'I met people who were so positive about Treacle that they wanted to come and work with me. Having positive voices around you spurs you on'
- » **Research training courses**, advises Ms O'Connell. For example, the NHS Innovation Accelerator provides significant support and training to individuals innovating in the healthcare system

on applying for funding, and is the reason we are surviving financially.'

### How to take it to the next level

For Ms O'Connell, expanding the reach of Treacle.com has been a step-by-step process. 'Since getting Treacle up and running, it's been a continuing journey of facing challenges and trying to get the idea taken up at a larger level. I had a significant two-year NHS investment, but that is due to run out in April, so our future is uncertain.

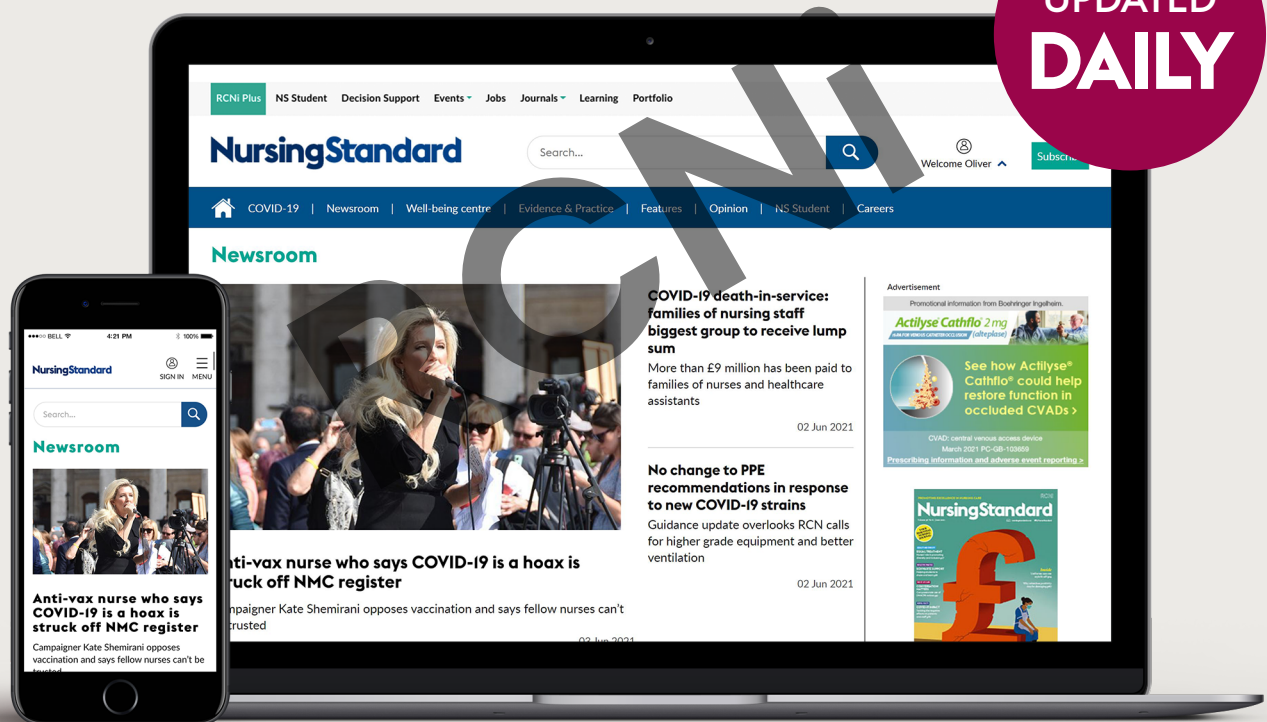
'The most rewarding thing I've experienced is the positive feedback from so many different types of people – social workers, teachers, job centre staff – all of whom come into contact with people who use the website.

'I also have such positive messages from the public – that's what I live and breathe for.'

# NursingStandard

## Looking for the latest nursing news?

UPDATED  
DAILY



Head to our online newsroom for breaking news stories and policy updates relevant to your practice



Stay up to date and visit  
[rcni.com/nursing-standard.com/newsroom](https://rcni.com/nursing-standard.com/newsroom)

RCNi

# DE-ESCALATION

## 7 tips for handling conflict situations

Tension involving patients, families and even colleagues can arise in any setting – but there are things you can do to manage it

By Erin Dean

**H**ealthcare often involves strong emotions and difficult situations, making staying calm when things are starting to escalate a vital skill for nurses.

While often associated with mental health settings, de-escalation strategies and techniques for conflict situations are so essential they are taught to students across all four fields of nursing, in line with Nursing and Midwifery Council standards.



➤ **Using de-escalation skills with patients, families and colleagues**

National Violence Reduction Network for Nurses chair Ana Waddington, who is rough sleeper outreach nurse for University College Hospital NHS Foundation Trust, says she has used de-escalation skills in all the places she has worked, with patients, families and, when needed, colleagues.

‘These skills are needed more than ever,’ says Ms Waddington, who was the 2020 RCN Nurse of the Year. ‘Tensions are high. Things are tough for everyone, there are long waits in healthcare, plus the cost of living crisis – I feel that everyone is very tense and gets angry quite quickly. It doesn’t look like it’s going to get any easier any time soon.’

Here she offers some tips for nurses on how to help prevent a situation escalating and deal with tension when it arises.

**1 Prepare before meeting people who are agitated or angry**

When called in to help diffuse a situation, Ms Waddington tries to first take some time to read the patients’ notes and history.

While time is tight in all healthcare settings, this can make a big difference when trying to build a relationship with the person who is upset, she says.

‘Try and gather information so that you know a bit about what is going on and find out people’s names,’ she says. ‘Going in with the wrong name or pronoun really doesn’t help.’



RCNi

**2 Introduce yourself to patients and relatives**

Having worked for many years in child emergency departments, Ms Waddington says establishing good communication with a frustrated patient or relative starts with stating your first name, then asking if they are happy to be addressed by their first name.

‘Don’t call them Mr or Mrs, or Mum and Dad, unless that is what they want. I always say ‘I’m Ana, I would like to call you by your first name if that is okay?’

**3 Move into a private but safe space**

Don’t try to discuss a situation with an angry relative or service user in a corridor or busy, overlooked spot.

Guidance from the National Institute for Health and

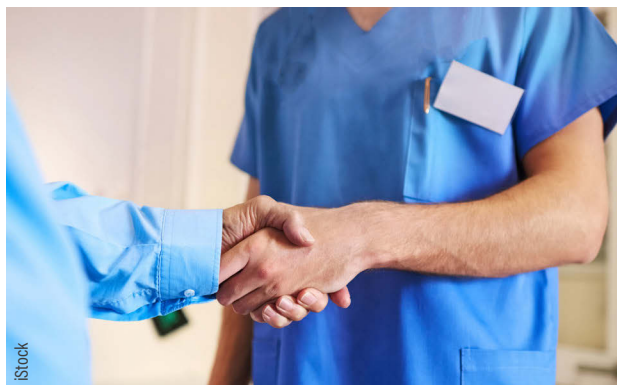
Care Excellence (NICE) recommends moving agitated people away from others to quiet areas of the ward, bedrooms, comfort rooms or gardens, while avoiding staff becoming isolated.

‘I always tell a colleague where I am going and leave the door open, but try to find somewhere calm and peaceful,’ says Ms Waddington.

‘I also leave the bleep with someone else and switch my phone to silent. When people are in fight or flight mode, their emotional responses are very quick, and these sounds can be really distracting.’

**4 Think about your physical position**

Sitting down is the first thing Ms Waddington does in a tense situation, and this can help bring down the tension.





iStock

◀ Listen to people and validate their concerns



How to resolve three common sources of conflict for nurses  
[rcni.com/flare-ups-in-nursing](https://rcni.com/flare-ups-in-nursing)

‘Often people won’t sit down initially, they will be angry and remain standing – but they quite quickly don’t like looming over me and, in most cases, will also sit. This really calms a situation rapidly.’

‘Also, by sitting, you are showing that you will give people time and attention, which is often what they most need at that point.’

## 5 Respond with empathy

Go into a situation without judgement and respond with compassion.

NICE calls for empathy and respect to de-escalate aggression and agitation, and UK research in mental health settings has emphasised this.

A study in the *Journal of Mental Health Systems* in 2020 found that ‘specific

psychological and interpersonal skills including empathy, respect, reassurance, sincerity, genuine concern and validation of the patient perspective’ are needed for de-escalation.

## 6 Listen to people and be honest

People often get angry and frustrated due to fear. This can be because they don’t know what is happening, so taking the time to listen properly is essential, says Ms Waddington.

‘If people get angry this is mainly due to fear, and this can be due to poor communication or miscommunication.’

‘Listen to them, validate their concerns and be honest – if you don’t know the answer, tell them that. If you say you are going to find something out, actually do that and come straight back. This helps build trust.’

## 7 Accept that sometimes de-escalation will not work

Staff must have boundaries to protect both themselves and other patients, says Ms Waddington. Always refer to their local violence and aggression policies and undertake appropriate training.

When a patient or carer becomes aggressive and violent, Ms Waddington advises:

- » Be clear that you are ending the conversation.
- » Keep a safe distance.
- » Leave the area.
- » If the aggression escalates, call security.
- » Document and escalate through your local channels.
- » Do not tolerate any violence towards yourself or staff.

**‘Things are tough for everyone, there are long waits in healthcare, plus the cost of living crisis – I feel that everyone is very tense and gets angry quite quickly. It doesn’t look like it’s going to get any easier any time soon’**

Ana Waddington, chair, National Violence Reduction Network for Nurses

## Moves to prevent violence against NHS staff

- » All healthcare staff should receive de-escalation training to help them with patients who display violence or aggression, National Institute for Health and Care Excellence guidance says
- » Violence against NHS staff remains an ongoing problem, however. The 2022 NHS Staff Survey found almost 15% of NHS staff had experienced at least one incident of physical violence by patients, service users, relatives or others in the previous 12 months
- » In the same survey, almost 1% of NHS staff reported violence from their managers, and 2% from other colleagues
- » Almost 28% said they had experienced bullying, harassment or abuse from service users, patients or their relatives



iStock

- » Always debrief with your team using the HOT debrief tool. ‘About nine times out of ten, these steps will help calm a situation, but sometimes it doesn’t work, and that doesn’t mean we have failed,’ she says. ‘Many different aspects, often beyond our control, contribute to situations escalating.’

Erin Dean is a health journalist

### Why you should read this article:

- To enhance your knowledge of co-occurring mental health issues and autism
- To recognise the challenges that autistic adults may experience in receiving appropriate care
- To understand the role of the nurse in supporting autistic people with mental health issues

# Providing effective care and support for autistic adults with mental health issues

Christopher Francis Barber

### Citation

Barber CF (2023) Providing effective care and support for autistic adults with mental health issues. *Nursing Standard*. doi: 10.7748/ns.2023.e12042

### Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

### Correspondence

cfbarber@hotmail.com

### Conflict of interest

None declared

### Accepted

10 October 2023

### Published online

December 2023

### Permission

To reuse this article or for information about reprints and permissions, contact [permissions@rcni.com](mailto:permissions@rcni.com)

### Abstract

Autism is a neurodevelopmental condition that is characterised by features such as persistent differences in social interaction and communication, specialised interests and sensory processing issues. It has been identified that autistic people are increasingly likely to experience various mental health issues, and often encounter challenges in accessing appropriate healthcare and a lack of understanding from healthcare professionals. This article explores the co-occurrence of autism and mental health issues in adults, and explains the role of nurses in providing care and support for this population.

### Author details

Christopher Francis Barber, PhD candidate, University of Aberdeen, Aberdeen, Scotland

### Keywords

autism, discrimination, diversity, learning disability, mental health, professional, reasonable adjustments

Around 25% of the UK population will experience mental health issues each year (Mental Health First Aid England 2020). It has also been estimated that 1-3% of people are autistic (Anorson et al 2021, Centers for Disease Control and Prevention 2021, 2023, National Autistic Society 2023a), meaning there are between 700,000 and two million autistic adults and children in the UK. Moreover, these figures only refer to those who are formally diagnosed as autistic, so the incidence and prevalence is likely to be higher because there will also be people who are self-diagnosed or undiagnosed. Therefore, many healthcare professionals, including nurses, will encounter and provide care for patients or service users who experience mental health issues, autism or both.

Knowledge of autism appears to have improved among the general public (Dillenburger et al 2015, White et al 2019), with Zeidan et al (2022) stating that: 'In recent years, the international community witnessed tremendous positive improvements in public awareness and public health response for autism.' However, Shand et al (2020) suggested there is a lack of research into people's attitudes towards autism and those who are autistic.

This article defines autism and mental health issues, and explores the co-occurrence of these conditions. It also discusses the various issues in accessing healthcare that people with co-occurring autism and mental health issues may experience, and explains how nurses can provide effective care and support for this group. The terms 'autism' and 'autistic' used throughout this article will refer to adults unless it is necessary to refer to autistic children and/or adolescents specifically.

### Definitions of autism and mental health issues

It is important for nurses and other healthcare professionals to understand the meaning and characteristics of autism and mental health issues. There are two main sources for diagnosing these conditions: the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, Text Revision (DSM-V-TR) (American Psychiatric Association 2022), which is favoured in the US, and the International Classification of Diseases 11th Revision (ICD-11) (World Health Organization (WHO) 2023), which is widely used in Europe. However, the DSM-V-TR criteria are also influential in Europe (The Open University 2022).

## Autism

Autism is a lifelong neurodevelopmental condition (Anorson et al 2021, National Institute for Health and Care Excellence (NICE) 2021) which involves a different, but no less valid, way of communicating and interacting with the world and the people in it. The core features of autism are (NICE 2021):

- » Persistent difficulties or differences in social interaction and communication.
- » Presence of rigid and repetitive behaviours, resistance to change or specialised interests.
- » Challenges with cognitive and behavioural flexibility.
- » Altered sensory sensitivity.
- » Sensory processing issues.
- » Emotional regulation differences.

Historically, it was often believed that autistic people could not experience or express empathy towards other people, since to do so requires an individual to be able to observe, process, understand and respond appropriately to the outward signs of other people's emotions (Fletcher-Watson and Bird 2020). However, the author suggests that such a position on empathy and emotions is overly simplistic and is based on flawed terminology, measurement and theory, together with the lack of a clear definition of empathy. These issues have all contributed to the misrepresentation of autistic people as lacking empathy, which has led to autistic people being further misunderstood and stigmatised (Fletcher-Watson and Bird 2020). Therefore, it is important to recognise that autistic people will experience and show empathy but may do so in a different way compared with non-autistic people.

## Mental health issues

Various terms are often used interchangeably in relation to mental health, such as mental health issues or problems, mental illness and mental health disorders (Meltzer et al 2000, Leighton and Dogra 2009). The ICD-11 (WHO 2023) uses the broad term 'mental, behavioural or neurodevelopmental disorders', which includes mood disorders such as depression and bipolar disorder, anxiety disorders,

personality disorders, eating disorders, substance use disorders and neurocognitive disorders such as dementia. Hampshire Child and Adolescent Mental Health Services (2023) stated that a mental illness negatively affects the way people think, feel, behave or interact with others and subsequently hinders their ability to function. They also emphasised that suboptimal mental health and struggling to cope are different from having a mental illness.

The WHO (2022) defines mental health as 'a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community'. However, Galderisi et al (2017) critiqued this definition, asserting that its emphasis on well-being and productivity might not be applicable to some groups. The author of this article suggests that there needs to be an open, honest and constructive dialogue around the narrative of what is considered 'good' mental health in autistic people, since this may differ to what is considered good mental health in non-autistic people. This dialogue could result in a tentative definition of mental health that would be acceptable to autistic and non-autistic people alike.

## Co-occurring autism and mental health issues

Several studies have indicated that autistic people are likely to be more at risk of developing and experiencing mental health issues. However, it should be noted that the means used to assess mental health issues in autistic people are inconsistent across studies, and this may have contributed to the variations in the prevalence of such issues among this population (Hossain et al 2020).

Hossain et al (2020) undertook a multi-national review of 26 systematic reviews and 12 meta-analyses that focused on co-occurrence of autism and mental health issues, identifying that most autistic people had at least one co-occurring mental health issue. The synthesised findings found an increased likelihood of co-occurring conditions such as attention-deficit

## Key points

- **Autism is a lifelong neurodevelopmental condition, which involves a different, but no less valid, way of communicating and interacting with the world and the people in it**
- **There needs to be an open, honest and constructive dialogue around the narrative of what is considered 'good' mental health in autistic people, since this may differ to what is considered good mental health in non-autistic people**
- **Mental health care and support for autistic people is often inadequate, with a lack of availability of appropriate mental health services and long waiting times for accessing these services**
- **The role of the nurse in supporting autistic people who experience mental health issues may involve active listening, putting reasonable adjustments in place and ensuring that the healthcare environment is autism-aware and friendly**

hyperactivity disorder (ADHD) and other neurodivergent conditions, anxiety disorders, depressive disorders, bipolar and mood disorders and schizophrenia among autistic people. Each of the individual research authors that were included in this meta-analysis suggested that the prevalence of co-occurring mental health issues was higher in autistic people than in the general population. Similarly, a systematic review and meta-analysis by Lai et al (2019) reviewed 96 articles that focused on autism and co-occurring mental health issues. They found that the prevalence of ADHD, anxiety disorders, sleep-wake disorders, depressive disorders, obsessive-compulsive disorder, bipolar disorder and schizophrenia were all increased in autistic people.

Stadnick et al's (2017) research investigated the links between, and co-occurrences of, autism and mental health issues in children, suggesting that more than 70% of autistic children met the criteria for at least one co-occurring mental health issue when assessed using structured diagnostic interviews, and these conditions often persisted into adolescence.

While Stadnick et al's (2017) research focused on the experiences of co-occurring mental health issues in children, many of these mental health issues will persist into adulthood, including older adulthood (NHS England et al 2019). Therefore, there is a need for research into the links between autism in older adults and various mental health issues, including dementia, in terms of prevalence, presentation and management. The aim should be for seamless, well-researched, well-resourced, 'all-age' person-centred care to become the norm.

A report by the All-Party Parliamentary Group on Autism and National Autistic Society (2019) identified that:

- » 76% of autistic adults have 'reached out' for mental health support during the previous five years.
- » 82% of autistic adults have said that the waiting times for receiving support from mental health services are too long.
- » 86% of autistic adults have suggested that there are not enough mental health services in their areas to meet their needs.

Furthermore, the National Autistic Society and Mind (2021) reported that 83% of autistic people will experience depression and Young Minds (2022) stated that 70% of autistic people will experience a mental health issue. Doughty et al (2021) suggested 51% of autistic people have mental health issues, which is more than 4.5 times higher than people who are not autistic (11%). Doughty et al (2021) further suggested that the severity of mental health issues is increased among autistic people, stating that more than 25% of them have been diagnosed with two or more mental health issues and that 15% of autistic people are hospitalised as a result of mental health issues, compared with 3% of non-autistic people.

While autistic people are at increased risk or likelihood of developing and experiencing a range of mental health issues, it should be noted that not all of this population will experience mental health issues and it should

not be assumed that a person's mental health issues are caused by their autism. Autism and mental health issues are separate entities and must not be confused; to do so would be seen as 'diagnostic overshadowing', which occurs when an individual's mental health issues are attributed to their primary diagnosis – in this case autism (Middleton et al 2022). Such diagnostic overshadowing would mean that opportunities for accurate diagnosis of a mental health issue along with appropriate therapeutic interventions would be missed, and would in turn affect the range, type and quality of care experienced by autistic people who also have mental health issues (Fodstad 2019).

Cage et al's (2018) study focused on the prevalence of mental health issues in relation to people's acceptance of an autism diagnosis. They found that an increased acceptance of autism both as a diagnosis and a lived condition on the part of autistic people, their families and social networks led to a decrease in diagnosable mental health issues, specifically depression and anxiety. Cage et al (2018) also found that there was a greater prevalence of depression, anxiety and stress symptoms among autistic adults who were less accepting of the diagnosis and/or experienced less acceptance from others.

### Challenges with accessing healthcare

Mental health care and support for autistic people is often inadequate, with a lack of availability of appropriate mental health services and long waiting times for accessing these services (Mind 2022). Furthermore, many autistic people with mental health issues experience inadequate or low-quality care, with a qualitative study by Weir et al (2022) identifying that autistic patients were more likely to experience lower quality healthcare than non-autistic patients. The author suggests that this may be due in part to a lack of understanding of what autism is and the links between mental health and autism, alongside a possible lack of

willingness for different services to communicate and work together. Therefore, healthcare organisations need to address these issues when designing and delivering care to autistic patients.

A systematic review of 35 international studies suggested that healthcare professionals' limited knowledge and self-efficacy in working with autistic people is variable and may be a barrier to the provision of effective healthcare for this population (Corden et al 2021). Camm-Crosbie et al (2019) explored the unmet or inadequately met needs of autistic adults who experience mental health issues, which included issues in accessing diagnosis, assessment and appropriate treatment or management of co-occurring mental health issues. They and other authors have suggested that there is a potential risk of these individuals' autism and/or any co-occurring mental health issues being overlooked by healthcare service providers (Tam 2013, Ono et al 2019).

The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the UK government's recommended training for health and social care staff (Health Education England (HEE) 2023). The training is co-delivered by autistic people and is divided into two tiers: the first tier is for health and social care staff who require general awareness of the support autistic people may need, and the second tier is for care staff who provide ongoing care to autistic people (HEE 2023). The Oliver McGowan training programme and resources (House of Lords 2021, HEE 2023) should lead to significant improvements in healthcare professionals' knowledge regarding autism, although further research is needed to ascertain whether this subsequently results in improved services and care.

## Importance of using appropriate language

Healthcare professionals need to consider and understand how the use of language can affect the care of all patients, regardless of their diagnosis or population group. When caring for autistic people, it is important to be aware that most of this group prefer identity-first terms such as 'autistic' or 'autistic person or patient' rather than person-first terms such as 'person with autism' (Monk et al 2022). Therefore, nurses and other healthcare professionals should promote and adhere to the terminology preferred by the autistic community to ensure that humane, acceptable and appropriate language and ways of addressing autistic patients are used.

Table 1 shows the preferred terminology in relation to autism.

## Role of the nurse

The role of the nurse in supporting autistic people who experience mental health issues may involve active listening, putting reasonable adjustments in place and ensuring that the healthcare environment is autism-aware and friendly. Nurses also need to be aware that disclosing that another person is autistic or is experiencing mental health issues without their consent is a breach of confidentiality that may lead to disciplinary procedures (Department of Health

2003, Nursing and Midwifery Council 2018).

McKenzie (2016) focused on the roles of the primary care nurse in supporting autistic people and suggested that these roles may include:

- » Being aware of the differences in how autism presents in children and adults, as well as in those with co-occurring mental health issues. Such differences could include communication and social abilities, for example adults are typically more skilled than children at hiding their autism to 'fit in' (NHS 2022a).
  - » Recognising that autistic people may have different sensory sensitivities – for example they may find certain sounds, smells, textures and types of touch aversive – and taking that into consideration when providing care and support.
  - » Identifying people who are or who may be autistic, with or without co-occurring mental health issues, then referring them to the local mental health team, psychology services, the National Autistic Society and/or local autism organisations for appropriate diagnosis and support, in accordance with the person's wishes.
  - » Providing clear information and communicating in a manner that the patient can process. For example, some autistic people may prefer information in written form, in visual forms such as diagrams, photos or pictures, or in auditory forms such as audio tapes or CDs.
- Additional nursing roles in supporting autistic people could include:
- » Obtaining and recording the person's history. This involves asking questions about their medical, family, social and psychological history, as well as how the person experiences their autism and mental health issues, in an appropriate way. Doing so will encourage the person to be forthcoming in their responses and consequently enable appropriate care and support to be provided.
  - » Supporting medicines optimisation. There is evidence that many autistic people have been inappropriately or over-prescribed psychotropics (Royal College of Paediatrics and Child Health and NHS England 2019), or are taking medicines that were appropriately prescribed but may no longer be needed. Deprescribing and medication reviews should be considered where this has been identified as an issue.
  - » Referring individuals to mindfulness programmes and 'talking therapies' such as counselling and cognitive behavioural therapy (CBT), which

**Table 1. Preferred terminology in relation to autism**

Terms to avoid	Preferred terms
Autism spectrum disorder (ASD)	Autism, autistic
Person-first language, for example 'person with autism'	Identity-first language, for example 'autistic person'
Autism symptoms and impairments	Specific autistic experiences and characteristics
At risk of autism	May be autistic. Increased likelihood of being autistic
Co-morbidity	Co-occurring
Functioning (for example high or low functioning) and severity (for example mild, moderate or severe) labels	Specific support needs
Cure, treatment or intervention	Specific support or service
Restricted interests and obsessions	Specialised, focused or intense interests
Normal person	Allistic or non-autistic person

(Adapted from Monk et al 2022)

**Write for us**  
For information  
about writing  
for RCNi  
journals,  
contact  
[writeforus@rcni.com](mailto:writeforus@rcni.com)

For author  
guidelines,  
visit [rcni.com/publish-article-with-rcni](http://rcni.com/publish-article-with-rcni)

have been used to manage anxiety and depression (Mental Health Foundation 2021). The NHS (2022b) provides an informative online resource that explains the range of talking therapies that are available.

Table 2 details some of the considerations for nurses when caring for autistic adults with mental health issues.

Mandy (2022) indicated that further research is needed on how various health and social care facilities and environments can affect the mental health of autistic people and to modify the environment if possible. For example, in hospital settings such modifications could include: using a health passport (a document designed to assist autistic people in communicating their needs to

healthcare professionals); enabling family members to stay with the patient; asking how the autistic person prefers to communicate; mitigating the risk of sensory overstimulation where possible; and conducting pre-admission visits for the autistic person (National Autistic Society 2023b).

Nurses need to actively engage in evidence-based, autistic-led continuing professional development (CPD) regarding autism and mental health issues to improve their knowledge regarding people's narratives and lived experiences (Livingston and Cooper 2018, Mandy 2022). It is important that the learning outcomes of any CPD activities nurses undertake are then implemented and monitored in practice, and that they gain clinical

experience of providing care and support that is tailored to meet the needs of the autistic person.

### Conclusion

Many people with co-occurring autism and mental health issues receive inadequate healthcare and support from services. Therefore, it is important that nurses work towards providing effective care for this population by using appropriate language, adapting their communication, ensuring modifications to the healthcare environment are made where possible, and undertaking relevant CPD activities to enhance their knowledge. By doing so, nurses can become champions of inclusion, diversity and equality for those with co-occurring autism and mental health issues.

**Table 2. Considerations for nurses when caring for autistic adults with mental health issues**

Area	Considerations
Before the consultation	<ul style="list-style-type: none"> <li>» Ask the patient or carer to bring their personal health record</li> <li>» Determine any specific mobility or sensory requirements</li> <li>» Arrange for a longer appointment time where appropriate</li> <li>» Taking these measures can improve clinical assessments and optimise the person's experience during subsequent appointments</li> </ul>
Communication	<ul style="list-style-type: none"> <li>» Use simple, non-ambiguous language</li> <li>» Leave pauses when speaking and wait for the person to respond</li> <li>» Communicate one idea at a time</li> <li>» Speak in a normal tone</li> <li>» Consider the most appropriate communication style to use, for example written or verbal</li> <li>» Consider using multiple techniques, for example verbal communication supported by written materials</li> <li>» Be aware that changes in the person's communication may reflect changes in their mental health</li> <li>» Improved communication can improve the accuracy and quality of an assessment</li> </ul>
Behaviour that challenges	<ul style="list-style-type: none"> <li>» Untreated physical and mental health issues commonly exacerbate behaviour that challenges. This may then lead to exclusion from participation, which may have a negative effect on mental health</li> <li>» Perform an assessment that considers how the person's physical and mental health issues might be contributing to behaviour that challenges</li> <li>» Refer the person to appropriate specialist behaviour support or a specialist psychiatrist</li> </ul>
Carers	<ul style="list-style-type: none"> <li>» Carers can provide important information about the autistic adult, for example about their changes in behaviour, communication, nutritional uptake and medical history</li> <li>» Refer carers to support services where appropriate, since they may be experiencing suboptimal mental health that in turn affects the mental health of the autistic adult</li> </ul>
Co-occurring physical health conditions	<ul style="list-style-type: none"> <li>» Chronic conditions such as pain, epilepsy and gastrointestinal disorders may increase the likelihood of mental health issues and behaviour that challenges</li> <li>» Autistic people experience similar physical health issues to the general population</li> <li>» Screen for common co-occurring physical health conditions</li> <li>» Annual general health checkups and routine preventive screening measures are recommended</li> </ul>
Sensory environment	<ul style="list-style-type: none"> <li>» Overwhelming sensory environments can increase stress and anxiety, subsequently complicating the assessment and management of mental health disorders</li> <li>» Consider the lighting of waiting rooms and offices, for example avoid bright fluorescent lights if possible</li> <li>» Consider a referral to an occupational therapist for an assessment of the adult's sensory processing</li> </ul>

(Adapted from Foley and Trollor 2015)

## References

- All-Party Parliamentary Group on Autism, National Autistic Society (2019) The Autism Act: 10 Years On. [pearsfoundation.org.uk/wp-content/uploads/2019/09/APPGA-Autism-Act-Inquiry-Report.pdf](https://pearsfoundation.org.uk/wp-content/uploads/2019/09/APPGA-Autism-Act-Inquiry-Report.pdf) (Last accessed: 30 November 2023.)
- American Psychiatric Association (2022) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision. APA, Arlington VA.
- Anorson N, Male I, Farr W et al (2021) Prevalence of autism in Europe, North America and Oceania, 2000-2020: a systematic review. *European Journal of Public Health*, 31, Suppl 3. doi: 10.1093/eurpub/ckab164.786
- Cage E, Di Monaco J, Newell V (2018) Experiences of autism acceptance and mental health in autistic adults. *Journal of Autism and Developmental Disorders*, 48, 2, 473-484. doi: 10.1007/s10803-017-3342-7
- Camm-Crosbie L, Bradley L, Shaw R et al (2019) 'People like me don't get support': autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality. *Autism*, 23, 6, 1431-1441. doi: 10.1177/1362361318816053
- Centers for Disease Control and Prevention (2021) Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2018. [www.cdc.gov/mmwr/volumes/70/ss/ss7011a1.htm](https://www.cdc.gov/mmwr/volumes/70/ss/ss7011a1.htm) (Last accessed: 30 November 2023.)
- Centers for Disease Control and Prevention (2023) Data & Statistics on Autism Spectrum Disorder. [www.cdc.gov/ncbddd/autism/data.html](https://www.cdc.gov/ncbddd/autism/data.html) (Last accessed: 30 November 2023.)
- Corden K, Brewer R, Cage E (2021) A systematic review of healthcare professionals' knowledge, self-efficacy and attitudes towards working with autistic people. *Review Journal of Autism and Developmental Disorders*, 9, 386-399. doi: 10.1007/s40489-021-00263-w
- Department of Health (2003) Confidentiality: NHS Code of Practice. [assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/200146/Confidentiality\\_-\\_NHS\\_Code\\_of\\_Practice.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf) (Last accessed: 30 November 2023.)
- Dillenburger K, Jordan JA, McKerr L et al (2015) The Millennium child with autism: early childhood trajectories for health, education and economic wellbeing. *Developmental Neurorehabilitation*, 18, 1, 37-46. doi: 10.3109/17518423.2014.964378
- Doughty B, Taylor M, Martini M (2021) Mental Health Problems in Autistic People. [www.mqmentalhealth.org/mentalhealth-and-autism](https://www.mqmentalhealth.org/mentalhealth-and-autism) (Last accessed: 30 November 2023.)
- Fletcher-Watson S, Bird G (2020) Autism and empathy: what are the real links? *Autism*, 24, 1, 3-6. doi: 10.1177/1362361319883506
- Fodstad JC (2019) Editorial: special issue on mental health issues in autism spectrum disorder. *Review Journal of Autism and Developmental Disorders*, 6, 243-245. doi: 10.1007/s40489-019-00178-7
- Foley KR, Trollor J (2015) Management of mental ill health in people with autism spectrum disorder. *Australian Family Physician*, 44, 11, 784-790.
- Galderisi S, Heinz A, Kastrup M et al (2017) A proposed new definition of mental health. *Psychiatria Polska*, 51, 3, 407-411. doi: 10.12740/PP/74145
- Hampshire Child and Adolescent Mental Health Service (2023) Mental Health/Illness and Resilience. [hampshirecamhs.nhs.uk/issue/mental-health-and-mental-illness-professional](https://hampshirecamhs.nhs.uk/issue/mental-health-and-mental-illness-professional) (Last accessed: 30 November 2023.)
- Health Education England (2023) The Oliver McGowan Mandatory Training on Learning Disability and Autism. [www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism](https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism) (Last accessed: 30 November 2023.)
- Hossain MM, Khan N, Sultana A et al (2020) Prevalence of comorbid psychiatric disorders among people with autism spectrum disorder: an umbrella review of systematic reviews and meta-analyses. *Psychiatry Research*, 287, 112922. doi: 10.1016/j.psychres.2020.112922
- House of Lords (2021) Mandatory Training on Learning Disabilities and Autism Bill [HL], bills. [parliament.uk/publications/44205/documents/1111](https://parliament.uk/publications/44205/documents/1111) (Last accessed: 30 November 2023.)
- Lai MC, Kassee C, Besney R et al (2019) Prevalence of co-occurring mental health diagnoses in the autism population: a systematic review and meta-analysis. *The Lancet Psychiatry*, 6, 10, 819-829. doi: 10.1016/S2215-0366(19)30289-5
- Leighton S, Dogra N (2009) Defining mental health and mental illness. In Dogra N, Leighton S (Eds) *Nursing in Child and Adolescent Mental Health*. Open University Press, Maidenhead, 7-18.
- Livingston G, Cooper C (2018) User and carer involvement in mental health training. *Advances in Psychiatric Treatment*, 10, 2, 85-92. doi: 10.1192/apt.10.2.85
- Mandy W (2022) Six ideas about how to address the autism mental health crisis. *Autism*, 26, 2, 289-292. doi: 10.1177/13623613211067928
- McKenzie K (2016) Supporting People with Autism Spectrum Disorder. [www.nursingpractice.com/cpd/supporting-people-with-autism-spectrum-disorder](https://www.nursingpractice.com/cpd/supporting-people-with-autism-spectrum-disorder) (Last accessed: 30 November 2023.)
- Meltzer H, Gatward R, Goodman R et al (2000) *The Mental Health of Children and Adolescents in Great Britain*. The Stationery Office, London.
- Mental Health First Aid England (2020) Mental Health Statistics. [mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics](https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics) (Last accessed: 30 November 2023.)
- Mental Health Foundation (2021) Mindfulness. [www.mentalhealth.org.uk/explore-mental-health/a-z-topics/mindfulness](https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/mindfulness) (Last accessed: 30 November 2023.)
- Middleton C, Hayutin L, Reaven J (2022) Special populations: youth with developmental disabilities and co-occurring mental health problems. In Asmundson GJ (2022) *Comprehensive Clinical Psychology*, Second edition. Elsevier, London, 402-427.
- Mind (2022) Mental Health and Autism. [www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/mental-health-and-autism](https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/mental-health-and-autism) (Last accessed: 30 November 2023.)
- Monk R, Whitehouse AJ, Waddington H (2022) The use of language in autism research. *Trends in Neurosciences*, 45, 11, 791-793. doi: 10.1016/j.tins.2022.08.009
- National Autistic Society (2023a) What is Autism? [www.autism.org.uk/advice-and-guidance/what-is-autism](https://www.autism.org.uk/advice-and-guidance/what-is-autism) (Last accessed: 30 November 2023.)
- National Autistic Society (2023b) Making Macclesfield Hospital Accessible to Autistic People. [www.autism.org.uk/advice-and-guidance/professional-practice/accessible-hospital](https://www.autism.org.uk/advice-and-guidance/professional-practice/accessible-hospital) (Last accessed: 30 November 2023.)
- National Autistic Society, Mind (2021) Good Practice Guide for Professionals Delivering Talking Therapies for Autistic Adults and Children. [s2.chorus-mk.thirdlight.com/file/24/asDKIN9as.KlK7easFdsalAZtC/NAS-Good-Practice-Guide-A4.pdf](https://s2.chorus-mk.thirdlight.com/file/24/asDKIN9as.KlK7easFdsalAZtC/NAS-Good-Practice-Guide-A4.pdf) (Last accessed: 30 November 2023.)
- National Institute for Health and Care Excellence (2021) Autism Spectrum Disorder in Adults: Diagnosis and Management. Clinical guideline No. 142. NICE, London.
- NHS (2022a) NHS Talking Therapies. [www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies](https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies) (Last accessed: 30 November 2023.)
- NHS (2022b) Signs of Autism. [www.nhs.uk/conditions/autism/signs](https://www.nhs.uk/conditions/autism/signs) (Last accessed: 30 November 2023.)
- NHS England, NHS Improvement, National Collaborating Central for Mental Health (2019) *The Community Mental Health Framework for Adults and Older Adults*. [www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf](https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf) (Last accessed: 30 November 2023.)
- Nursing and Midwifery Council (2018) *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates*. NMC, London.
- Ono E, Friedlander R, Salih T (2019) Falling through the cracks: how service gaps leave children with neurodevelopmental disorders and mental health difficulties without the care they need. *BC Medical Journal*, 61, 3, 114-124.
- Royal College of Paediatrics and Child Health, NHS England (2019) STOMP and STAMP: A Leaflet for Families of Children and Young People with a Learning Disability, Autism or Both who may be Prescribed (or are Prescribed) Psychotropic Medication. [www.england.nhs.uk/wp-content/uploads/2019/06/stomp-stamp-family-leaflet.pdf](https://www.england.nhs.uk/wp-content/uploads/2019/06/stomp-stamp-family-leaflet.pdf) (Last accessed: 30 November 2023.)
- Shand A, Close S, Shah P (2020) Greater autism knowledge and contact with autistic people are independently associated with favourable attitudes towards autistic people. *Experimental Results*, 1, E46. doi: 10.1017/exp.2020.46
- Stadnick N, Chlebowski C, Baker-Ericzen M et al (2017) Psychiatric comorbidity in autism spectrum disorder: correspondence between mental health clinician report and structured parent interview. *Autism*, 21, 7, 841-851. doi: 10.1177/1362361316654083
- Tam P (2013) Autism's New Frontiers, Part 3: Falling Between the Cracks. [ottawacitizen.com/health/family%20%20child/autisms-new-frontiers-part-3-falling-between-the-cracks?r](https://ottawacitizen.com/health/family%20%20child/autisms-new-frontiers-part-3-falling-between-the-cracks?r) (Last accessed: 30 November 2023.)
- The Open University (2022) Understanding Autism. [www.open.edu/openlearn/mod/oucontent/view.php?id=66953&section=2.2](https://www.open.edu/openlearn/mod/oucontent/view.php?id=66953&section=2.2) (Last accessed: 30 November 2023.)
- Weir E, Allison C, Baron-Cohen S (2022) Autistic adults have poorer quality healthcare and worse health based on self-report data. *Molecular Autism*, 13, 1, 23. doi: 10.1186/s13229-022-00501-w
- White D, Hillier A, Frye A et al (2019) College students' knowledge and attitudes towards students on the autism spectrum. *Journal of Autism and Developmental Disorders*, 49, 7, 2699-2705. doi: 10.1007/s10803-016-2818-1
- World Health Organization (2022) Mental Health. [www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response](https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response) (Last accessed: 30 November 2023.)
- World Health Organization (2023) ICD-11 for Mortality and Morbidity Statistics. [icd.who.int/browse11/l-m/en](https://icd.who.int/browse11/l-m/en) (Last accessed: 30 November 2023.)
- Young Minds (2022) A Guide for Young People: Autism and Mental Health. [www.youngminds.org.uk/young-person/mental-health-conditions/autism-and-mental-health](https://www.youngminds.org.uk/young-person/mental-health-conditions/autism-and-mental-health) (Last accessed: 30 November 2023.)
- Zeidan J, Fombonne E, Scorch J et al (2022) Global prevalence of autism: a systematic review update. *Autism Research*, 15, 5, 778-790. doi: 10.1002/aur.2696

INTRODUCING

# RCNi<sup>plus</sup>

## All ten RCNi Journals at your fingertips



Access all ten RCNi journals online, including Nursing Standard, to keep you informed across a range of nursing disciplines.

### Looking for something specific?

Use the search function to explore thousands of articles in the digital archive and find exactly what you're looking for.



SCAN ME

Get started today at: [rcni.com/rcniplus](https://rcni.com/rcniplus)

# Care experience

## IN THIS SECTION

**Feature** Your guide to making a summary plan for a future care emergency **p67**

**Peer-reviewed article** Exploring the implementation of person-centred care **p70**

**CPD** Recognising and managing migraine **p76**

**Multiple-choice quiz** Test your knowledge on migraine **p82**



## ReSPECT

A step-by-step guide from Resuscitation Council UK

Experts address commonly asked questions about the process for discussing and creating a recommended summary plan for emergency care and treatment

By Catherine Baldock and Alex Ruck Keene

**R**eSPECT stands for the Recommended Summary Plan for Emergency Care and Treatment – a summary of personalised recommendations for a person's clinical care in a future health emergency.

Here, some of the most-asked questions about the process are answered by Resuscitation Council UK ReSPECT clinical

lead Catherine Baldock and legal adviser for the ReSPECT process barrister Alex Ruck Keene KC.

### Personalised recommendations

The ReSPECT process creates personalised recommendations for a person's care in a future emergency in which they are

unable to make clear or express what is important to them.

These recommendations are created through conversations between the person, their family, and health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. ➤

- It includes a recommendation about whether cardiopulmonary resuscitation (CPR) should be performed. CPR recommendations should be discussed as part of overall care and treatment goals to ensure they are put in context.

#### Is this a voluntary process?

It is voluntary and a person can refuse to have a ReSPECT conversation or make a plan.

However, it may be that the person needs more time to consider what is important to them and to speak to their family or those close to them before having such a conversation.

If the person still does not want to have a ReSPECT conversation and create a plan, alternative approaches need to be considered.

#### How should a ReSPECT conversation be undertaken?

It should take place with a person at a time when they have capacity and ideally are well, and with their healthcare professional present.

The conversation should cover what is important to the person in relation to a future emergency as well as what they fear and what they value. The healthcare professional should then discuss appropriate care and treatment options, including CPR.

#### Where should the details of the conversation be recorded?

A summary is recorded on the ReSPECT plan. The plan may be handwritten or electronic.

Once completed it should be given to the person, or if they

- A ReSPECT plan includes personalised recommendations to be used when emergency care is needed

✓ *Planning conversations should be held between the person, their family and health professionals*



lack capacity it should be given to those who have been involved in the conversation as people interested in their welfare.

#### Does a ReSPECT plan need to be reviewed?

It is best practice to have another conversation and update the plan when a person's clinical condition changes or there is a change in care setting, such as admission to a hospital or care home.

The ReSPECT plan should be a fluid document that is reviewed and updated as needed.

#### Is a ReSPECT plan legally binding?

A ReSPECT plan is not legally binding. It contains recommendations about a person's care and treatment and is a guide for clinicians who are responding to an emergency and who have to make a decision about how to manage and treat the person.

If a person is clear about certain treatments they would not want and the circumstances in which these decisions would apply, they should complete an advance decision to refuse treatment (ADRT).

#### What about when the patient does not have capacity?

A ReSPECT plan should not be created without involvement of the person – if they have capacity. If the person lacks capacity to participate in a conversation, anyone who has lasting power of attorney for health and welfare or their personal welfare deputy should be involved, as well as family and those close to them so that they can communicate what is important to the person.

The only exception to including the attorney, deputy or family/friends is where it is impracticable to do so, but there is a high threshold to be satisfied before clinicians can say that this is the





case. It is important to understand that none of these people can either refuse or demand treatments or an intervention on the person's behalf.

#### **What if a person lacks capacity to participate in a conversation and has no family or anyone close to them?**

If the decision-making is taking place in a hospital, and it is likely the recommendation would be applied there, the trust should arrange for an independent mental capacity advocate (IMCA) to be involved.

The duty to arrange for an IMCA does not apply outside the hospital setting or where a non-NHS body is responsible for care where CPR might be required.

However, in either case, where the person is 'unbefriended' – with no one to represent them – medical professionals need to be astute to try to identify all relevant evidence as to what the person would wish.

#### **Do the same principles apply to those under 18?**

The concept of mental capacity only applies to those aged over 16. Below age 16, the question is whether the child is Gillick competent to participate in the decision-making process.

The most important consultation if the child lacks capacity or competence to participate decisions should be with the person with parental responsibility, even though that person does not have the ability to consent to or refuse the making of the recommendation.

#### **What is the difference between a ReSPECT plan and an advance decision?**

Under the Mental Capacity Act 2005, covering England and Wales, an ADRT is defined as a document that a person over 18 has drawn up when they had the capacity to do so in which

## **'The ReSPECT plan should be a fluid document that is reviewed and updated as needed'**

they stipulate certain treatments they would not wish to receive, and the circumstances in which those decisions would apply.

There is no specific format for an ADRT, but an ADRT to refuse life-sustaining treatment must be in writing, witnessed, and make clear that it applies even if life is at risk.

A clinician who attempts CPR in full knowledge of a valid ADRT would be criminally and civilly liable.

#### **When the patient has a ReSPECT plan with 'CPR attempts NOT recommended'**

If a patient is known to have a recommendation that CPR not be performed, it is appropriate not to perform CPR after a cardiac arrest, providing the clinician is confident the recommendation is still applicable and pertinent to the person they are dealing with.

The clinician at that point can have a reasonable belief that they are acting in the person's best interests.

CPR should be performed if a patient is choking because this is a potentially reversible cause and CPR may dislodge or relieve the obstruction.

A recommendation not to perform CPR should not affect the overall care and treatment a person receives.

---

Catherine Baldock was ReSPECT clinical lead at the Resuscitation Council UK at the time of writing

---

Alex Ruck Keene KC (Hon) is legal adviser for the ReSPECT process at the Resuscitation Council UK

---

**Further information**  
Resuscitation Council UK  
[tinyurl.com/Resus-respect](https://tinyurl.com/Resus-respect)

**Why you should read this article:**

- To increase your understanding of person-centred care
- To recognise some of the barriers and facilitators to delivering person-centred care
- To enhance your knowledge of different approaches that can be used to support person-centred care

# Exploring the implementation of person-centred care in nursing practice

Lucille Kelsall-Knight and Rhian Stevens

**Citation**

Kelsall-Knight L, Stevens R (2023) Exploring the implementation of person-centred care in nursing practice. *Nursing Standard*. doi: 10.7748/ns.2023.e12190

**Peer review**

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

**Correspondence**

L.M.Kelsall-Knight@bham.ac.uk  
✉@LKelsallKnight

**Conflict of interest**

None declared

**Accepted**

30 October 2023

**Published online**

December 2023

**Permission**

To reuse this article or for information about reprints and permissions, contact [permissions@rcni.com](mailto:permissions@rcni.com)

**Abstract**

Person-centred care involves nurses working in partnership with patients to ensure their needs and preferences are at the centre of their healthcare, as well as considering the biographical and social factors that are relevant to the person's health. This aims to support patients in developing the knowledge, confidence and skills to make informed decisions about treatment and to manage their own care where possible. This article discusses the concept of person-centred care and considers some of the facilitators and barriers that may affect its implementation in healthcare practice. It also explores some of the approaches that nurses can use to support person-centred care, such as cultural humility and role modelling.

**Author details**

Lucille Kelsall-Knight, lecturer in children's nursing, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, England; Rhian Stevens, lecturer in children's and international nursing, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, England

**Keywords**

holistic care, nursing care, patient-centred care, patient experience, patients, person-centred care, practice development, professional, professional issues

Person-centred care has become an established concept in nursing, focusing care on the needs of the individual. However, several authors have suggested that although the concept is well known to nurses, it remains ill-defined and there are disparities in how it is operationalised (Byrne et al 2020, Giusti et al 2020, Moore et al 2021). McCormack (2020) asserted that the use of terms such as 'person-centred', without offering a definition, is prolific in research. This means that it can be challenging for nurses and other healthcare professionals to develop a clear understanding of person-centredness and the elements they need to focus on to implement it effectively in practice.

One issue is that various terms have been used to define the concept. 'Patient-centred care' emerged to promote holism and to counter the reductionistic nature of the traditional biomedical model and disease-oriented approach, while a move to 'person-centredness' emphasised the concept of the whole person and the broader idea of wellness (Giusti et al 2020). 'Person-centredness' is an approach that relies on the

development of effective therapeutic relationships between healthcare professionals, patients and others who are significant in their lives (McCance and McCormack 2017). It is underpinned by values such as respect for personhood, the individual right to self-determination and mutual respect and understanding (McCance and McCormack 2017). The term 'people-centredness' has also emerged to consider broader challenges by recognising that before people become patients, they need to be informed and empowered in promoting and protecting their own health (World Health Organization 2007).

There is a wide range of literature exploring the concept of person-centred care in healthcare and nursing practice (Vennedey et al 2020, Dewing et al 2021, Engle et al 2021, McCormack et al 2021). This article outlines some of the definitions, principles and benefits of person-centred care and explores the main barriers and facilitators that can affect its application in practice. It also explains how nurses can use approaches such as cultural humility and role

modelling to support delivery of person-centred care.

### Emergence of person-centred care

One way to consider person-centred care is to focus on the reasons for its emergence and the possible driving factors behind this approach. Ekman et al (2011) identified the significant burden of long-term conditions, with patients navigating a fragmented healthcare system and having to adapt to the customs and procedures of healthcare organisations and professionals. This runs counter to receiving care focused on individuals' needs, preferences and values.

In addition, the increased focus on evidence-based healthcare has meant that standardised care models are often applied based on the response of cohorts to treatment, which some authors have suggested fails to capture the responses of individuals (Ekman et al 2011). Other authors have suggested that person-centred care and evidence-based healthcare can co-exist; for example, Sackett et al (1996) incorporated person-centred care into a definition of evidence-based medicine that includes a focus on patient preferences. Although there may be tensions when applying varying models (Engle et al 2021), person-centred care aims to provide nuance to the evidence-based care model through its focus on the individual (Ekman et al 2011).

Byrne et al (2020) suggested that patients can now easily access healthcare information and are no longer seen as passive recipients of care but as valuable and active members of the healthcare team – which is an important aspect of person-centred care. However, healthcare professionals need to be mindful that not all patients want to access healthcare information or be active members of the healthcare team (Thomas et al 2023). Lee et al (2021), therefore, regard person-centred care more as a philosophy that views people using health and social care services as equal and collaborative partners in planning, designing and achieving effective care to ensure their needs are met. The extent

to which this is achievable and desired by individuals is part of the ongoing discussion about person-centred care.

In the UK, it is a requirement of The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council (NMC) (2018) that nurses put the needs of those receiving care first, while considering cultural sensitivities to better understand and respond to people's personal and health needs. It should be noted that this idea of the nurse putting needs first demonstrates the requirement for careful use of language, as it may suggest a power imbalance with a passive patient or service user; 'working with' or 'in partnership with' may be more appropriate terms.

### Applying person-centred care in practice

Person-centred care is a concept that may appear obvious and understandable yet is challenging to operationalise in healthcare research and practice, partly due to its complexity and the lack of a single agreed definition (Burgers et al 2021). Therefore, it is important to carefully examine individual studies as the conceptualisation of person-centred care used in research varies (Burgers et al 2021, Rennie et al 2021).

Taking a person-centred approach to care involves focusing on the elements of support and treatment that matter most to the patient, their family and/or carers (The Health Foundation 2016). It also considers biographical and social factors that are relevant to the person and their health, for example their age, gender, race and disabilities. If these factors are not considered, the person's fundamental care needs might be neglected and inequalities in healthcare access may be exacerbated, for example in the older adult population or for people with learning disabilities (Tieu et al 2022). Furthermore, rather than following a traditional perspective of doing something 'to' or 'for' a patient, Santana et al (2018) suggested that person-centred care promotes doing something 'with'

## Key points

- The lack of a clear definition of person-centred care makes it challenging to implement effectively in practice
- Person-centred care may be best understood as the collection of principles under which it operates
- Identifying the facilitators and barriers to person-centred care is an essential early step in its implementation
- Cultural humility and role modelling may support effective implementation of person-centred care

the patient or service user. This requires listening to and reflecting on what makes each person unique and putting their needs first (NMC 2018).

In addition, the application of person-centred care is dynamic – it is much more than the interaction between the healthcare professional and the patient or service user. Smith et al (2022) asserted that person-centred care can be best understood as the collection of principles it operates under, rather than a strict definition of an approach to care. Some authors view the concept at three levels (Byrne et al 2020, Vennedey et al 2020):

- » Macro level – this includes government policy, financing and regulatory interpretation of person-centred care.
- » Meso level – this focuses on health and social care organisations.
- » Micro level – this focuses on the patient-provider interaction at a local level.

Considering this wider application of person-centred care is important and can indicate how well the concept is embedded in an organisation's culture, values and beliefs; some organisations may be well-intentioned but offer an inconsistent application of person-centred care.

### Principles and benefits of person-centred care

The Health Foundation (2016) outlined four principles of person-centred care:

- » Affording people dignity, compassion and respect.
- » Offering coordinated care, support or treatment.
- » Offering personalised care, support or treatment.
- » Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

It should be noted that these principles were developed several years ago, and it is worth reflecting on whether terms such as ‘affording’ and ‘offering’ still place the power more with the healthcare professional or service.

McCormack and McCance (2006, 2021) developed a person-centred nursing framework which comprises four domains: prerequisites of the nurse; the care environment; person-centred processes; and expected outcomes. These domains determine the provision of effective care through the person-centred care processes of:

- » Working with the patient’s beliefs and values.
- » Engagement.
- » Shared decision-making.
- » Having sympathetic presence.
- » Providing holistic care.

There is growing evidence of the effectiveness of person-centred care in areas such as improved general health, more appropriate use of health services and reduced hospital admissions (Bertakis and Azari 2011, Wynia et al 2018) and of benefits for people with specific conditions, such as dementia (Kim and Park 2017). McCormack (2020) noted a variety of benefits of person-centred care in several environments. For example, in nursing home settings person-centred care has led to improvements in the care environment, greater resident satisfaction, improved staff well-being, reduction in falls and reduced use of psychotropic medicines (McCormack et al 2010, Buckley et al 2014, Mekki et al 2017, McCormack 2020). However, there remains a lack of theoretical frameworks based on empirical evidence that could be used to implement person-centred care in areas such as serious illness (Giusti et al 2020).

Person-centred care can enable healthcare professionals and patients to work jointly to develop treatment plans, which may improve health outcomes and increase patient satisfaction with care (Ekman et al 2011, Phelan et al 2020). For this to occur, nurses need to listen and respond to patients’ concerns and preferences. In practice this involves developing a therapeutic relationship with patients, which enables the provision of information in a way that is conducive to the individual’s communication style and level of understanding and which respects their views on treatment and care (Moore et al 2021).

### Facilitators and barriers to person-centred care

Identifying the facilitators and barriers to person-centred care is an essential early step in the implementation of this approach within healthcare services (Hower et al 2019). Several studies have explored these facilitators and barriers, often based on the patient or person perspective (Moore et al 2017, Lloyd et al 2018, Vennedey et al 2020). These studies have recognised that one notable facilitator is effective leadership, which encompasses support from senior leaders acting as champions for change, a core team to drive change, role modelling, training in person-centred communication and multidisciplinary teams that view patients as equal partners.

Vennedey et al (2020) explored the views of 25 people with chronic conditions on the facilitators and barriers to person-centred care. Participants felt that person-centred care was compromised when the organisational climate felt like a ‘conveyor belt’. They expected healthcare professionals to possess a comprehensive knowledge base and take a holistic view that considered their family history, their current personal situation and the social environment.

In addition, Vennedey et al (2020) found that healthcare professionals required various personal characteristics and skills to facilitate person-centred care, including ‘being present’ by focusing on the person without being distracted or

pressured. This links to the idea of ‘having sympathetic presence’ as detailed in McCormack and McCance’s (2006, 2021) person-centred nursing framework. Other facilitators identified in Vennedey et al’s (2020) study were a pleasant and friendly atmosphere and healthcare professionals having time to answer questions and explain treatment options. Flexibility was also mentioned as important when developing treatment plans, since patients seek individualised care based on their personal needs and circumstances. Of note was participants’ need to be active, interested and willing to facilitate person-centred care. However, the researchers emphasised that patients require guidance and access to easily understandable information and therapies to do this (Vennedey et al 2020).

Barriers to delivering person-centred care can be due to a simple lack of understanding of patient needs (Moore et al 2017, Lloyd et al 2018). The Health Foundation (2016) suggested that a potential barrier is that person-centred care may take additional time in the short term, for example adopting shared decision-making may take longer than a standard consultation. However, they also emphasised that a resulting medicine prescription that does not meet the person’s needs, for example, may result in increasing care time due to non-adherence and worsening symptoms.

Ekman et al (2011) undertook a series of studies exploring person-centred care in practice from the perspective of the person, the healthcare professional and the organisation. They observed that person-centred care is generally regarded by healthcare professionals as an important facet of care, yet one of the main challenges was not persuading staff to practise person-centred care but convincing them that they were not practising it at times, at least not consistently. Ekman et al (2011) noted that providing person-centred care can be time-consuming and that when time was pressured, healthcare staff tended to stop applying it and returned temporarily to a disease-oriented approach. Ekman

et al's (2011) solution focused on three specific routines to ensure systematic and consistent practice in person-centred care:

- » Initiate a partnership early on by inviting the patient or person to talk about their disease, the symptoms and its effects. This sends an early message that the person's feelings, beliefs and preferences are valued and important.
- » Focus on shared decision-making, through giving information and making decisions about care and treatment, building on the initial invitation.
- » Document person-centred care to ensure it is a recognised and valued part of care in the organisation. This documentation can include the person's preferences, beliefs and values.

Measuring person-centred care in practice is challenging, with no single solution; however, using patient-reported measures in evaluation is essential because the person is best positioned to determine whether care aligns with their values, preferences and needs (The Health Foundation 2016).

### Cultural humility

In healthcare practice, personal beliefs, attitudes and biases may be additional challenges to the effective implementation of person-centred care. A personal commitment to practising cultural humility and delivering person-centred care concurrently can assist in addressing these challenges (Kelsall-Knight 2022). Cultural humility has been described as a process of being aware of how people's culture can influence their health behaviours, then using this awareness to cultivate sensitive approaches to their treatment (Miller 2009).

The concept of cultural humility has been contrasted with that of cultural competence, which has been viewed more as learning a set of attitudes and communication skills for effective working within a person's cultural context. Leks et al (2020) asserted that the concept of cultural competence may be limiting, since culture is not stagnant and the ability to 'become competent' in any culture suggests that there is a set of values

and beliefs that remain unchanged and are shared by all members of a specific group. This appears to be opposed to the flexibility and individualised approach taken in person-centred care.

In contrast, cultural humility does not have a specific end point. There are no set skills to learn; instead there is a need to be culturally sensitive as a continual process. This includes being aware that one's personal biases may lead to incorrect assumptions about a person's culture due to a lack of knowledge (Leks et al 2020). To practise cultural humility, self-reflection on one's interactions with other people is essential (Prasad et al 2016). This may be challenging initially due to unfamiliarity, so authors such as Prasad et al (2016) suggested that approaches such as self-questioning, immersion in the individual patient's point of view, active listening and flexibility can assist in addressing cultural biases or assumptions.

Furthermore, activities such as reading about different cultures can support personal or group reflection, while writing personal reflections on one's attitudes and thoughts regarding the care provided to patients can be explored with a skilled lecturer or during clinical supervision. Such activities may reveal factors that affect care such as unintentional bias – that is, a bias that a person is unaware of. An example of unintentional bias would be language or general conversation that assumes patients are heterosexual (Grundy-Bowers and Read 2019). Although clinical supervision is recommended as a strategy to enhance person-centred care, Edgar et al (2023) suggested that it remains under-researched at present.

### Addressing biases and discrimination

It is important that nurses are aware that UK law requires them to make reasonable adjustments on the basis of protected characteristics, with a need to consider personal and institutional biases in the context of person-centred care, and how these may manifest in diverse populations. The Equality Act 2010, which applies in England, Scotland and Wales, identifies nine protected

characteristics – age, gender reassignment, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and disability. These protected characteristics identify people at increased risk of oppression and discrimination, and a person may have none, one or more than one of them.

Protected characteristics, as well as other aspects of a person's identity, may affect multiple areas of their lives – for example, their home life, work and social circle – and can result in unique opportunities, experiences and challenges. Having an increased knowledge and understanding of these aspects, and acknowledging their effects on a person, can assist nurses in delivering person-centred care that is tailored to an individual's needs (Ruiz et al 2021). This can also enable nurses to ensure appropriate reasonable adjustments are made as part of providing person-centred care, for example by altering the communication style used with a person with a learning disability or ensuring that a food menu meets a person's dietary needs based on their religious beliefs.

Regardless of whether a person has protected characteristics, it is important that nurses recognise, assess and respond to their individual needs without making assumptions, such as their preferred pronouns, sexuality or religious affiliation, about them (Kelsall-Knight 2022). Such biases may also occur at an organisational level; for example, assumptions may be made about gender and/or sexuality in hospital documentation, such as identifying a family as only consisting of two parents of different genders (Kelsall-Knight 2021, 2022).

If biases are present at an organisational level it may be more challenging for individuals to address them, since they are considered 'the cultural norm' (Adams et al 2020). However, witnessing nurses challenging discriminatory practice and behaviours can foster belonging, inclusion and empowerment of individuals, which is in keeping with person-centred care.

**Write for us**  
For information about writing for RCNi journals, contact [writeforus@rcni.com](mailto:writeforus@rcni.com)

For author guidelines, visit [rcni.com/publish-article-with-rcni](http://rcni.com/publish-article-with-rcni)

### Role modelling

Role models are essential to effective implementation of person-centred care and to address the challenges that patients may experience because of, but not limited to, their protected characteristics. Any nurse or other healthcare professional can be a role model; it is not determined by seniority. A role model and advocate for person-centred care should actively listen to staff, patients and their families and/or carers, show empathy and recognise people's diversity. Where appropriate, role models should also work towards overcoming any challenges that the patient may experience, for example in relation to their religious beliefs, family dynamics or altered communication style (Sprik and Gentile 2019, Moore et al 2021).

A role implemented in the nursing workforce in England is the professional nurse advocate (PNA) (NHS England 2023). PNAs can act as role models by demonstrating leadership through emotional intelligence and by supporting a culture of autonomy, belonging and contribution to inspire continuous improvement and empower staff in all positions to innovate and provide optimal patient care. The PNA training programme aims to provide nurses with the skills, competencies and confidence to lead improvement programmes, fostering a culture of learning and development in their clinical settings. The PNA role could be used to support person-centred care as it aims to enable nurses to continuously improve the quality of care they provide to patients and their families and/or carers (NHS England 2023).

### Conclusion

Ensuring patients receive person-centred care should be a priority for all nurses when developing, implementing and delivering healthcare. This involves developing a therapeutic relationship with patients, listening and responding to their concerns and preferences, working in partnership with them to develop treatment plans and providing them with appropriate information. It is also important to recognise and understand people's individual differences and to incorporate these into care approaches.

The promotion of cultural humility and role modelling by reflecting on one's own biases and advocating for open and honest healthcare environments can foster belonging and inclusion in healthcare.

## References

- Adams BG, Meyers MC, Sekaja L (2020) Positive leadership: relationships with employee inclusion, discrimination, and well-being. *Applied Psychology*. 69, 4, 1145-1173. doi: 10.1111/apps.12230
- Bertakis KD, Azari R (2011) Patient-centered care is associated with decreased health care utilization. *Journal of the American Board of Family Medicine*. 24, 3, 229-239. doi: 10.3122/jabfm.2011.03.100170
- Buckley C, McCormack B, Ryan A (2014) Valuing narrative in the care of older people: a framework of narrative practice for older adult residential care settings. *Journal of Clinical Nursing*. 23, 17-18, 2565-2577. doi: 10.1111/jocn.12472
- Burgers JS, van der Weijden T, Bischoff EW (2021) Challenges of research on person-centered care in general practice: a scoping review. *Frontiers in Medicine*. 8, 669491. doi: 10.3389/fmed.2021.669491
- Byrne AL, Baldwin A, Harvey C (2020) Whose centre is it anyway? Defining PCC in nursing: an integrative review. *PLoS One*. 15, 3, e0229923. doi: 10.1371/journal.pone.0229923
- Dewing J, McCormack B, McCance T (2021) *Person-Centred Nursing Research: Methodology, Methods and Outcomes*. Springer, Cham.
- Edgar D, Moroney T, Wilson V (2023) Clinical supervision: a mechanism to support person-centred practice? An integrative review of the literature. *Journal of Clinical Nursing*. 32, 9-10, 1935-1951. doi: 10.1111/jocn.16232
- Ekman I, Swedberg K, Taft C et al (2011) Person-centered care - ready for prime time. *European Journal of Cardiovascular Nursing*. 10, 4, 248-251. doi: 10.1016/j.ejcnurse.2011.06.008
- Engle RL, Mohr DC, Holmes SK et al (2021) Evidence-based practice and patient-centered care: doing both well. *Health Care Management Review*. 46, 3, 174-184. doi: 10.1097/HMR.0000000000000254
- Giusti A, Nkhoma K, Petrus R et al (2020) The empirical evidence underpinning the concept and practice of person-centred care for serious illness: a systematic review. *BMJ Global Health*. 5, 12, e003330. doi: 10.1136/bmjgh-2020-003330
- Grundy-Bowers M, Read M (2019) Developing cultural competence in caring for LGBTQI+ patients. *Nursing Standard*. doi: 10.7748/ns.2019.e11390
- Hower KI, Vennedey V, Hillen HA (2019) Implementation of patient-centred care: which organisational determinants matter from decision maker's perspective? Results from a qualitative interview study across various health and social care organisations. *BMJ Open*. 9, 4, e027591. doi: 10.1136/bmjopen-2018-027591
- Kelsall-Knight L (2021) Qualitative exploration of lesbian parents' experiences of accessing healthcare for their adopted children in England. *BMJ Open*. 11, 10, e053710. doi: 10.1136/bmjopen-2021-053710
- Kelsall-Knight L (2022) Practising cultural humility to promote person and family-centred care. *Nursing Standard*. doi: 10.7748/ns.2022.e11880
- Kim SK, Park M (2017) Effectiveness of person-centred care on people with dementia: a systematic review and meta-analysis. *Clinical Interventions in Aging*. 12, 381-397. doi: 10.2147/CIA.S117637
- Lee S, Vibhuti M, Therikildsen T (2021) Sustainable person-centred communities design and practice. In Manley K, Wilson V, Oye C (Eds) *International Practice Development in Health and Social Care*. Second edition. John Wiley & Sons, Chichester, 39-51.
- Lekas HM, Pahl K, Fuller Lewis C (2020) Rethinking cultural competence: shifting to cultural humility. *Health Service Insights*. 13. doi: 10.1177/1178632920970580
- Lloyd B, Elkins M, Innes L (2018) Barriers and enablers of patient and family centred care in an Australian acute care hospital: perspectives of health managers. *Patient Experience Journal*. 5, 3, 55-64. doi: 10.35680/2372-0247.1270
- McCance T, McCormack B (2017) The person-centred practice framework. In *Person-Centred Practice in Nursing and Healthcare: Theory and Practice*. Second edition. John Wiley & Sons, Chichester, 36-67.
- McCormack B (2020) *The Person-centred Nursing and Person-centred Practice Frameworks*: from conceptual development to programmatic impact. *Nursing Standard*. 35, 10, 86-89. doi: 10.7748/ns.35.10.86.s40
- McCormack B, Dewing J, Breslin E et al (2010) Developing person-centred practice: nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nursing*. 5, 2, 93-107. doi: 10.1111/j.1748-3743.2010.00216.x
- McCormack B, McCance TV (2006) Development of a framework for person-centred nursing. *JAN*. 56, 5, 472-479. doi: 10.1111/j.1365-2648.2006.04042.x
- McCormack B, McCance T (2021) The person-centred nursing framework. In Dewing J, McCormack B, McCance T (2021) *Person-Centred Nursing Research: Methodology, Methods and Outcomes*. Springer, Cham, 13-27.
- McCormack B, McCance T, Bulley C et al (Eds) (2021) *Fundamentals of Person-Centred Healthcare Practice*. John Wiley & Sons, Chichester.
- Mekki TE, Oye C, Kristensen BM et al (2017) The inter-play between facilitation and context in the promoting action on research implementation in health services framework: a qualitative exploratory implementation study embedded in a cluster randomised controlled trial to reduce restraint in nursing homes. *JAN*. 73, 11, 2622-2632. doi: 10.1111/jan.13340

Miller S (2009) Cultural humility is the first step to becoming global care providers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*. 38, 1, 92-93. doi: 10.1111/j.1552-6909.2008.00311.x

Moore L, Britten N, Lydahl D et al (2017) Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*. 31, 4, 662-673. doi: 10.1111/scs.12376

Moore H, Farnworth A, Watson R et al (2021) Inclusion of person-centred care in medical and nursing undergraduate curricula in the UK: interviews and documentary analysis. *Patient Education and Counseling*. 104, 4, 877-886. doi: 10.1016/j.pec.2020.09.030

NHS England (2023) Professional Nurse Advocate A-EQUIP Model: A Model of Clinical Supervision for Nurses. Version 2. [www.england.nhs.uk/long-read/pna-equip-model-a-model-of-clinical-supervision-for-nurses](http://www.england.nhs.uk/long-read/pna-equip-model-a-model-of-clinical-supervision-for-nurses) (Last accessed: 23 November 2023.)

Nursing and Midwifery Council (2018) *The Code: Professional Standards of Practice and Behaviour for Nurses*,

Midwives and Nursing Associates. NMC, London.

Phelan A, McCormack B, Dewing J et al (2020) Review of developments in person-centred healthcare. *International Practice Development Journal*. 10, Suppl 2, 3. doi: 10.19043/ipdj.10Suppl2.003

Prasad SJ, Nair P, Gadhvi K et al (2016) Cultural humility: treating the patient, not the illness. *Medical Education Online*. 21, 30908. doi: 10.3402/meo.v21.30908

Rennie K, Gibson CE, Saev E (2021) Phenomenological and hermeneutic approaches to person-centred nursing research. In Dewing J, McCormack B, McCance T (Eds) *Person-Centred Nursing Research: Methodology, Methods and Outcomes*. Springer, Cham, 103-113.

Ruiz AM, Luebke J, Klein K et al (2021) An integrative literature review and critical reflection of intersectionality theory. *Nursing Inquiry*. 28, 4, e12414. doi: 10.1111/nin.12414

Sackett DL, Rosenberg WM, Gray JA et al (1996) Evidence based medicine: what it is and what it isn't. *BMJ*. 312, 7023, 71-72. doi: 10.1136/bmj.312.7023.71

Santana MJ, Manalili K, Jolley RJ et al (2018) How to practice person-centred care: a conceptual framework. *Health Expectations*. 21, 2, 429-440. doi: 10.1111/hex.12640

Smith JB, Willis EM, Hopkins-Walsh J (2022) What does person-centred care mean, if you weren't considered a person anyway: an engagement with person-centred care and Black, queer, feminist, and posthuman approaches. *Nursing Philosophy*. 23, 3, e12401. doi: 10.1111/nup.12401

Sprick P, Gentile D (2019) Cultural humility: a way to reduce LGBTQ health disparities at the end of life. *American Journal of Hospital & Palliative Care*. 37, 6, 404-408. doi: 10.1177/1049909119880548

The Health Foundation (2016) *Person-Centred Care Made Simple: What Everyone Should Know about Person-Centred Care*. [www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf](http://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf) (Last accessed: 23 November 2023.)

Thomas N, Atherton H, Dale J et al (2023) General practice experiences for parents of children with intellectual disability: a systematic review. *BJGP Open*. 7, 3. doi: 10.3399/BJGPO.2023.0010

Tieu M, Mudd A, Conroy T et al (2022) The trouble with personhood and person-centred care. *Nursing Philosophy*. 23, 3, e12381. doi: 10.1111/nup.12381

Vennedey V, Hower KI, Hillen H et al (2020) Patients' perspectives of facilitators and barriers to patient-centred care: insights from qualitative patient interviews. *BMJ Open*. 10, 5, e033449. doi: 10.1136/bmjopen-2019-033449

World Health Organization (2007) *People-Centred Health Care: A Policy Framework*. WHO, Geneva.

Wynia K, Spoorenberg SL, Uittenbroek R et al (2018) Long-term advantages of person-centred and integrated care: results of a longitudinal study on Embrace. *International Journal of Integrated Care*. 18, S2, A362, 1-8. doi: 10.5334/ijic.s2362

## Open access

Are you interested in making your article available to everyone, not just RCNi subscribers?

RCNi Open Access enables authors to pre-pay and make the final version of their journal article freely available to all when it's published online.

This service makes your article more discoverable and can increase its overall impact on nursing practice and patient care.

Contact Evidence & Practice editor  
Tanya Fernandes at [tanya.fernandes@rcni.com](mailto:tanya.fernandes@rcni.com)

**NursingStandard**

**RCNi**

### Why you should read this article:

- To update your knowledge of the 'red flag' migraine symptoms that could indicate a more serious condition
- To familiarise yourself with the non-pharmacological and pharmacological management strategies available to treat migraine
- To contribute towards revalidation as part of your 35 hours of CPD (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

# Recognising and managing migraine

Lauren Elizabeth Palk

### Citation

Palk LE (2023) Recognising and managing migraine. *Nursing Standard*. doi: 10.7748/ns.2023.e12059

### Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

### Correspondence

Lauren.palk@somersetft.nhs.uk

### Conflict of interest

None declared

### Accepted

30 November 2022

### Published online

November 2023

### Permission

To reuse this article or for information about reprints and permissions, contact [permissions@rcni.com](mailto:permissions@rcni.com)

### Abstract

Migraine is a common neurological disorder characterised by a severe, pulsating headache, sometimes accompanied with photophobia or phonophobia and nausea and/or vomiting. The symptoms of migraine can have a significant adverse effect on a person's ability to undertake normal activities. Nurses have an important role in assisting patients in identifying migraine triggers and in supporting them to manage the symptoms of migraines through lifestyle changes and pharmacological treatments. This article describes different types of migraines and some differential diagnoses and 'red flag' symptoms that could indicate a more serious condition. The author also discusses non-pharmacological and pharmacological management strategies and treatments.

### Author details

Lauren Elizabeth Palk, advanced nurse practitioner, neurology, Musgrove Park Hospital, Taunton, England

### Keywords

clinical, headache, health promotion, lifestyles, migraine, neurology, nursing care, pain, professional, signs and symptoms

### Aims and intended learning outcomes

The aims of this article are to enhance nurses' understanding of migraine and their ability to recognise the signs and symptoms of common types of migraine and to increase their awareness of management and treatment options. After reading this article and completing the time out activities you should be able to:

- » Discuss the signs and symptoms of migraine without aura and migraine with aura.
- » Recognise some of the less common types of migraine.
- » Identify some health conditions that may mimic the symptoms of migraine, including other headache disorders.
- » Recognise 'red flag' symptoms associated with headache that require escalation.
- » Describe some common migraine triggers.
- » Discuss non-pharmacological and pharmacological management and treatment options for people who experience migraine.

### Introduction

Migraine is a common neurological disorder that affects around 15% of the population (Al-Hassany et al 2020). It is three to four times more common in women than in men, a disparity believed to be partly mediated by

fluctuations in oestrogen and progesterone levels, although the precise mechanisms are not fully understood (Al-Hassany et al 2020). Migraine is classified as a primary headache disorder meaning there is no underlying pathology, in contrast with a secondary headache which has an underlying cause, such as temporal arteritis (inflammation of the vessels that supply blood to the head) (British Association for the Study of Headache 2019).

Symptoms commonly associated with migraine include a unilateral and severe pulsating headache, sometimes accompanied by photophobia (aversion or extreme sensitivity to light) or phonophobia (aversion or extreme sensitivity to sound) and nausea and/or vomiting. These symptoms can adversely affect an individual's ability to undertake normal activities and can be exacerbated by simple actions (International Headache Society 2018a).

The British Association for the Study of Headache (2019) and the National Institute for Health and Care Excellence (NICE) (2021) have published guidelines for the diagnosis and management of headaches, including migraines, but do not discuss the potential adverse effects of migraine on a person's life. It is important that nurses understand the symptoms

of migraine and consider their potentially debilitating effects on an individual so that they can offer patients appropriate advice on management, including recognising migraine triggers.

This article gives an overview of the signs and symptoms of common types of migraine, describes some differential diagnoses and 'red flag' symptoms and discusses migraine triggers. The author also describes some non-pharmacological and pharmacological approaches to management.

### TIME OUT 1

Have you cared for a patient who experiences migraine or do you, or someone you know, experience migraine? Make a note of the signs and symptoms. Reflect on how these symptoms affect the person's (or your own) life

### Types of migraine

The two most common types of migraine are migraine without aura and migraine with aura. The most common of these is migraine without aura, with around 70-90% of people who experience migraine having this type (Dodick 2018, Stroke Association 2023). Migraine without aura is characterised by a unilateral, severe, pulsating pain in the head sometimes with associated symptoms such as photophobia or phonophobia and nausea and/or vomiting. This type of migraine can affect the individual's ability to continue normal activities of daily living and the symptoms can be exacerbated by simple tasks or actions, such as walking up the stairs (International Headache Society 2018a). Diagnostic criteria for migraine without aura are shown in Box 1.

Migraine with aura is less common, with an estimated 10-30% of people who experience migraine having this type (Dodick 2018). This type of migraine involves sensory disturbances – referred to as aura – which often precede a headache and which progress over a short period of time (5-20 minutes) and tend to reduce in less than an hour (Greenberg et al 2020). These sensory disturbances commonly manifest as visual disturbances, for example flashing lights, blind spots, tunnel vision or wavy lines

in the field of vision. Less common aura can include pins and needles, dizziness, numbness or tingling sensation or weakness on one side of the body (International Headache Society 2018c). Box 2 lists diagnostic criteria for migraine with aura.

Although migraine with and without aura are the most common types, other less common types of migraine can have symptoms that may be concerning to the person experiencing them. It is important that the nurse has an awareness of different types of migraine so that they can offer reassurance to the person. Some examples of less common migraine types in adults are shown in Table 1.

### Differential diagnoses

As mentioned previously, migraine is a primary headache disorder with no underlying pathology. However, other health conditions – including non-migraine headache disorders – can mimic migraine symptoms, so it is vital that the nurse undertakes a comprehensive patient history and assessment to exclude or identify an underlying pathology (Japp et al 2018).

Table 2 shows examples of health conditions and headache disorders that may mimic the symptoms of migraine.

While most headaches are benign, it is important that nurses can

#### Box 1. Diagnostic criteria for migraine without aura

- » A. At least five attacks fulfilling criteria B-D
- » B. Headache attack lasting 4-72 hours (untreated or unsuccessfully treated)
- » C. Headache has at least two of the following characteristics:
  - Unilateral
  - Pulsating quality
  - Moderate or severe pain intensity
  - Aggravated by, or causing avoidance of, routine physical activity (for example, walking or climbing the stairs)
- » D. During the headache, the individual experiences at least one of the following:
  - Nausea and/or vomiting
  - Photophobia/phonophobia
- » E. Symptoms cannot be more accurately accounted for by another diagnosis from the International Classification of Headache Disorders 3rd edition (International Headache Society 2018b)

(International Headache Society 2018a)

## Key points

- Migraines may be caused by abnormal brain activity which affects the nerve signals, chemicals and blood vessels in the brain temporarily
- While most headaches are benign, it is important that nurses can recognise 'red flag' symptoms so that they can escalate the patient's care as appropriate
- The overall aim of management is to reduce the frequency and severity of migraines and to avoid migraine triggers

recognise 'red flag' symptoms so that they can escalate the patient's care as appropriate. Red flag symptoms include (NICE 2022):

- » Headache with systemic signs and symptoms, such as rash, fatigue, neck stiffness – may indicate meningitis.

#### Box 2. Diagnostic criteria for migraine with aura

- » A. At least two attacks fulfilling criteria B and C
- » B. One or more of the following fully reversible aura symptoms:
  - Visual
  - Sensory
  - Speech and/or language
  - Motor
  - Brainstem
  - Retinal
- » C. At least three of the following characteristics:
  - At least one aura symptom spreads gradually over  $\geq 5$  minutes
  - Two or more aura symptoms occur in succession
  - Each individual aura symptom lasts 5-60 minutes\*
  - At least one aura symptom is unilateral†
  - At least one aura symptom is positive‡
  - The aura is accompanied, or followed within 60 minutes, by headache
- » D. Symptoms cannot be more accurately accounted for by another diagnosis from the International Classification of Headache Disorders 3rd edition (International Headache Society 2018b)

\*When for example three symptoms occur during an aura, the acceptable maximal duration is 3×60 minutes. Motor symptoms may last up to 72 hours  
 †Aphasia is always regarded as a unilateral symptom; dysarthria (slurred speech) may or may not be  
 ‡Scintillations and pins and needles are positive symptoms of aura

(International Headache Society 2018c)



**Revalidation**

Prepare for revalidation: read this CPD article, answer the quiz and write a reflective account. For more information, go to [rcni.com/revalidation](https://www.rcni.com/revalidation)

- » Headache with neurological signs and symptoms, such as loss of consciousness or focal neurological signs (that is, impairment of nerve, spinal cord or brain function that affects a specific part of the body) and which are not typical aura signs – may indicate transient ischaemic attack or stroke.
- » Sudden onset headache with maximal intensity occurring within seconds to minutes (also known as a thunderclap headache) – may indicate subarachnoid haemorrhage.
- » New headache in patients aged >50 years – may indicate temporal arteritis.
- » Headache with evidence of papilloedema (swelling of the optic

- nerve) on fundoscopy – may indicate space occupying lesion.
- » Positional headache, particularly if symptoms deteriorate when sitting in the upright position – may indicate a cerebrospinal fluid leak and resulting intracranial hypotension.
- » Patients with secondary risk factors; for example, new onset headache in patients who are immunocompromised or following trauma – may indicate central nervous system infection or subarachnoid haemorrhage.

Nurses can encourage people to keep a diary of their migraine experience to help to identify triggers. Box 3 shows some examples of migraine triggers.

**TIME OUT 3**

You have an appointment with a patient who has recently been experiencing two to three migraines every month. The patient is a 42-year-old married woman who has three children and works part time in an office. What questions might you ask the patient to help her identify possible triggers? Think about emotional, physical, dietary, environmental and medicine-related triggers

**TIME OUT 2**

Think about any patients you have cared for who presented with a migraine-type headache (with or without a previous diagnosis of migraine). How did you rule out other potential causes? Were there any red flag symptoms? What did you do if you identified red flag symptoms? If you have not cared for a patient with this presentation, imagine such a scenario and consider what information you would require from the patient to rule out other potential causes of the headache

**Management**

Management to support people who experience migraines can be categorised as lifestyle and trigger management (non-pharmacological), acute treatment (medicines taken during migraine) and preventative treatment (medicines that aim to reduce the likelihood of developing a migraine) (Weatherall 2015). The overall aim of management is to reduce the frequency and severity of migraines and to avoid headaches related to medicine overuse. For most people who experience migraine, a combination of lifestyle and trigger management and pharmacological treatment is the most effective option (Manning et al 2007).

Management and treatment plans should be tailored to an individual's needs, taking into account their lifestyle and the potential effect of any lifestyle changes on their quality of life, as well as the potential adverse effects and contraindications of any medicines. Non-pharmacological management approaches are particularly important for women who are pregnant or trying to conceive and for people who wish to avoid medicines for other reasons (Manning et al 2007).

**Lifestyle and trigger management**

Robblee and Starling (2019) proposed evidence-based lifestyle modifications based on the acronym 'SEED' – sleep, eat, exercise and diary – as a way of supporting people to modify migraine triggers and reduce the severity of symptoms.

**Migraine triggers**

The pathophysiology of migraine is complex and not fully understood. There are various emerging theories – for example, activation of the trigeminal nerve and possible inflammation of the meningeal vasculature causing a change in the way pain is processed by the brain (Grossman and Porth 2014) – that are beyond the scope of this article. Migraines are, however, understood to be caused by abnormal brain activity which affects the nerve signals, chemicals and blood vessels in the brain temporarily. It is also believed that genes may have a role because the condition is often familial (NHS Inform 2023).

More is understood about migraine triggers – the factors involved in activating a migraine. A trigger in this context has been described as something that happens to a person, or something that they do, that results in them experiencing a migraine (Migraine Trust 2021b). Common migraine triggers can be categorised as emotional, physical, dietary, environmental and medicine-related (Knott 2021, NHS Inform 2023).

**Table 1. Examples of less common migraine types in adults**

Migraine type	Features
Menstrual migraine	<ul style="list-style-type: none"> <li>» Migraine linked to menstruation and which generally occurs in the two days leading up to a period and during the first three days once bleeding commences</li> <li>» Symptoms tend to be more severe and can last longer than other migraine types and are less responsive to treatment</li> </ul>
Hemiplegic migraine	<ul style="list-style-type: none"> <li>» A rare type of migraine where the individual experiences weakness on one side of the body during a migraine, which may be accompanied by:                             <ul style="list-style-type: none"> <li>— Visual disturbances</li> <li>— Slurring of speech</li> <li>— Dizziness or vertigo</li> <li>— Hearing problems or ringing in the ears</li> <li>— Confusion</li> </ul> </li> <li>» The weakness may last between one hour and several days but usually resolves within 24 hours</li> <li>» The person may experience a headache before or after the weakness or may not develop a headache at all</li> </ul>
Migraine with brainstem aura	<ul style="list-style-type: none"> <li>» A rare type of migraine associated with at least two of the following neurological symptoms:                             <ul style="list-style-type: none"> <li>— Dysarthria (slurred speech)</li> <li>— Vertigo</li> <li>— Tinnitus</li> <li>— Diplopia (double vision)</li> <li>— Ataxia (unsteady gait)</li> <li>— Syncope (temporary decreased consciousness)</li> <li>— Pins and needles and/or numbness in both arms and/or legs</li> <li>— Alterations in eyesight in both eyes, for example seeing patterns or flashing lights</li> </ul> </li> </ul>

(Adapted from Migraine Trust 2021a)

**Sleep**

Inadequate sleep is a well-recognised migraine trigger (Kim et al 2017). Sleep apnoea and insomnia are associated with increased frequency of migraines, therefore this should be identified when taking the patient’s history (Robblee and Starling 2019, Agbétou and Adoukonou 2022). If inadequate sleep is identified during history taking, nurses can provide advice on sleep hygiene, for example establishing a bedtime routine, such as going to bed at the same time each night, avoiding stimulants such as nicotine or caffeine before bed and putting mobile phones on silent (Swann 2017).

**Eat**

There is no specific diet recommended for managing migraine, however some evidence suggests elimination diets and diets high in certain nutrients such as folates can reduce the severity of symptoms (Hindiyeh et al 2020). An elimination diet involves removing foods from the diet that are suspected migraine triggers; for example, removing caffeine, cheese, chocolate and milk from the diet has been found to reduce the frequency of migraines in some people (Hindiyeh et al 2020). Elimination diets are controversial, however, as removing foods can result in inadequate intake of protein, energy and micronutrients, resulting in undernutrition (Gazerani 2020).

If a patient decides to try to identify and eliminate certain foods, the nurse can encourage them to make a note of these foods and record whether this has reduced the frequency and/or severity of their migraine symptoms. However, it may be more realistic to encourage the person to maintain a regular eating pattern, explaining that missing meals or irregular eating can trigger migraine (Weatherall 2015). Another important principle of dietary management is maintaining optimal fluid intake, as dehydration is a recognised migraine trigger, and reducing caffeine intake (Migraine Trust 2021b).

**Exercise**

While the relationship between migraine frequency and obesity is not well understood, a case control study concluded that migraine is significantly associated with obesity (defined by the researchers as body mass index  $\geq 30$ ) and overweight (Adoukonou et al 2018). Although the effect of losing weight on the frequency and intensity of migraine is unknown, this modification is advised and should be encouraged by nurses where appropriate (Marmura 2018).

**Diary**

Keeping a headache diary can identify the number of days per month an individual experiences a migraine as well as the days they are migraine free (Agbétou and Adoukonou 2022). The main information that should be recorded is the date of the migraine, the severity of the pain and the type, dose and effectiveness or lack of effectiveness of any analgesia taken. This information can help to determine the severity of symptoms and support development of an individual treatment plan. Additionally, it may help to identify if the person is experiencing medicine overuse headaches (Dean 2020).

A headache diary can also be used to identify migraine triggers and/or patterns, for example by recording foods eaten, fluids taken, sleep pattern and menstrual cycle.

**TIME OUT 4**

Choose three triggers from the list of examples in Box 2. Thinking again about the patient in Time out 3, consider what lifestyle management advice you might offer, based on the acronym SEED (sleep, eat, exercise, diary), for each trigger

**Acute treatment**

The main goal of acute treatment is to identify a reliable and effective way of restoring an individual’s ability to function. NICE (2023a) recommends monotherapy with either aspirin, a non-steroidal anti-inflammatory (such as ibuprofen) or a 5HT1-receptor agonist (a triptan), which should be taken as soon as the person knows they are developing a migraine. In people

with migraine with aura, NICE (2023a) recommends taking a 5HT1-receptor agonist at the start of the headache rather than at the start of the aura, unless they both start at the same time.

Opioids should not be prescribed for the acute management of

**Table 2. Examples of health conditions and headache disorders that may mimic the symptoms of migraine**

Condition	Characteristics
Transient ischaemic attack (TIA)	<ul style="list-style-type: none"> <li>» TIAs and migraine have similar symptoms, including headache and visual disturbances. However, a migraine headache usually develops gradually whereas a headache associated with TIA develops suddenly</li> </ul>
Brain tumour	<ul style="list-style-type: none"> <li>» Very rare cause of headache</li> <li>» Characterised by a throbbing or dull headache that deteriorates over time and can be more painful in the morning</li> <li>» Occurs as a result of a build-up of pressure in the cranium, due to blocking of the flow of cerebrospinal fluid or the tumour pressing on nerves or other vessels</li> </ul>
Temporal arteritis (giant cell arteritis)	<ul style="list-style-type: none"> <li>» Chronic vasculitis characterised by granulomatous inflammation in the walls of medium and large arteries</li> <li>» Symptoms include new-onset, unilateral headache in the temporal area alongside visual disturbances</li> <li>» Usually affects people aged &gt;50 years</li> </ul>
Subarachnoid haemorrhage	<ul style="list-style-type: none"> <li>» A sudden, severe, acute headache caused by cerebral bleeding</li> <li>» This may be accompanied by stroke-like symptoms, blurred vision and nausea and/or vomiting</li> </ul>
Sinusitis	<ul style="list-style-type: none"> <li>» Caused by inflammation of the sinuses</li> <li>» The person may experience headache with pain around the eyes, across the forehead and over the cheeks</li> </ul>
Medicine overuse headache (rebound headache)	<ul style="list-style-type: none"> <li>» A headache that occurs due to frequent use of analgesics, such as triptans, opioids, non-steroidal anti-inflammatories or paracetamol</li> <li>» Often develops in people with a primary headache disorder such as migraine or who have a family history of migraine</li> <li>» Headache usually occurs <math>\geq 15</math> days per month</li> </ul>
Cluster headache	<ul style="list-style-type: none"> <li>» A primary headache disorder characterised by sudden onset of severe pain on one side of the head, often around the eye</li> <li>» Often occurs in cycles or clusters and is more common in men than in women</li> <li>» Can last between 15 minutes and three hours</li> <li>» Often develops during the night</li> </ul>

(Adapted from Perry 2019, Migraine Trust 2021a, National Institute for Health and Care Excellence 2021)

**Write for us**  
For information about writing for RCNi journals, contact [writeforus@rcni.com](mailto:writeforus@rcni.com)

For author guidelines, visit [rcni.com/publish-article-with-rcni](http://rcni.com/publish-article-with-rcni)

migraine as these medicines are ineffective for this type of pain, may increase the risk of rebound headache (medicine overuse headache) and are associated with a risk of addiction. An oral anti-emetic should be considered in addition to acute treatment for migraine even in the absence of nausea and vomiting (NICE 2021); gut absorption slows down during a migraine attack, therefore taking an anti-emetic may improve absorption (Migraine Trust 2021c).

While acute treatments can be effective in reducing the severity of symptoms during a migraine attack, if they are taken too often (10-15 days or more per month, depending on the medicine) this can result in medicine overuse headache (Migraine Trust 2021d). Medicine overuse headache is one of the most common complications of primary headaches such as migraine (Gillies 2009). When a high level of an analgesic is taken on a regular basis, the pain returns as each dose wears off resulting in withdrawal symptoms, which the person then attempts to relieve by further use of the analgesic, resulting in a cycle of medicine overuse. Eventually, the analgesic stops relieving the original pain and starts to cause more pain (Migraine Trust 2021d).

Pregnant women should be advised to take paracetamol for the acute treatment of migraine. A non-steroidal anti-inflammatory or a triptan can be considered once the risks compared with the benefits of the use of these medicines during

pregnancy have been discussed between the prescribing clinician and the patient (NICE 2021).

### Preventative treatment

Preventative treatment is usually considered when the frequency and severity of migraines have significant adverse effects on the person's daily life. Choice of treatment is dependent on patient preference, medicine interactions and comorbidities (NICE 2023a). The main medicines used as preventative treatments are beta blockers, such as propranolol hydrochloride, tricyclic antidepressants, such as amitriptyline hydrochloride, and anticonvulsants, for example topiramate or sodium valproate; sodium valproate must not be taken by pregnant women (NICE 2023a).

When discussing preventative treatment options with the person it is important that the nurse explains that the first-choice option may not work and that other medicines may need to be tried. NICE (2023a) recommends first-line treatment with propranolol or topiramate, both of which have contraindications and cautions. For example, propranolol is contraindicated in people with a known history of asthma or bronchospasm due to potential side-effects which can cause bronchospasm. Topiramate should be used with caution in women of childbearing age because there is a risk of fetal malformation, particularly when used in the first trimester. Women of childbearing age should therefore be advised to take effective contraception such as medroxyprogesterone acetate depot injection or to have an intrauterine device inserted if they decide to take migraine preventative medicines. If they are taking a contraceptive pill, this should be used along with a barrier method such as a condom (Joint Formulary Committee 2023).

### Calcitonin gene-related peptide receptor agonists

Calcitonin gene-related peptides (CGRP) are a type of protein which have a role in pain transmission. A relatively new treatment for migraine is CGRP monoclonal antibodies (CGRP receptor agonists), which target CGRP

proteins to prevent migraine developing by blocking or reducing the body's absorption of CGRP to interrupt the process that leads to migraine symptoms (Ho et al 2010, Edvinsson 2017, Migraine Trust 2021e). These medicines are administered subcutaneously due to potential adverse effects on the digestive system (Berger 2022). Advantages of CGRP monoclonal antibodies medicines in the prevention of migraine include a long half-life (which can be weeks to months), limited toxicity and low risk of medicine interaction (Migraine Trust 2021e). However, CGRP monoclonal antibodies are not advised for use during pregnancy due to some reported incidences of toxicity, premature labour and spontaneous abortion (Migraine Trust 2021e).

At the time of writing, three CGRP monoclonal antibodies – erenumab, fremanezumab and galcanezumab – were available on NHS prescription (Weatherley 2022, Joint Formulary Committee 2023). In July 2023, NICE (2023b) published guidance recommending the use of rimegepant, a CGRP receptor antagonist, for the prevention of episodic migraine in adults who have at least four and fewer than 15 migraine attacks per month, only if at least three preventative treatments have not worked. Rimegepant does not constrict or tighten blood vessels, making it a potential option for people with cardiovascular related risks (Migraine Trust 2021f).

### Headache clinics

Most people who experience headache are managed in primary care, usually by their GP or practice nurse. However, some patients may be referred to a headache clinic, which may be linked to a hospital neurology department and staffed by a multidisciplinary team, including a consultant neurologist, a headache nurse specialist and a pharmacist (Migraine Trust 2021g). The headache nurse specialist has a crucial role in providing patients with a diagnosed primary headache disorder such as migraine with support, education and management (Bhola and Ertem 2022).

### Box 3. Examples of migraine triggers

**Emotional** – stress, anxiety, tension, shock, depression, excitement

**Physical** – tiredness, inadequate sleep quality or amount, shift work, suboptimal posture, hypoglycaemia, strenuous exercise

**Dietary** – missed, delayed and/or irregular meals, dehydration, alcohol, caffeine, chocolate, citrus fruits, foods containing tyramine

**Environmental** – bright lights, flickering screens, smoking, loud noises, changes in climate, strong smells

**Medicine-related** – combined oral contraceptive pill, hormone replacement therapy

(Adapted from NHS Inform 2023)

**TIME OUT 5**

Is there a headache clinic in your locality? If so, what is the referral process? Could you meet with and/or shadow one of the multidisciplinary team members to enhance your practice in supporting patients with migraine? You could write a reflection of this experience. You can also access the NHS RightCare: Headache & Migraine Toolkit ([www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/01/rightcare-headache-and-migraine-toolkit-v1.pdf](http://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/01/rightcare-headache-and-migraine-toolkit-v1.pdf)) which aims to support healthcare services to improve headache and migraine care delivery

**Conclusion**

Migraine is a primary headache disorder, the symptoms of which

can significantly disrupt people's ability to function normally. Some health conditions, including headache disorders, can mimic the signs and symptoms of migraine, so it is important that the nurse can distinguish between these and can recognise red flags that may indicate that patients require escalation.

Nurses can support patients to identify migraine triggers, which may help to reduce the frequency and severity of migraine, and can offer advice regarding management and treatment, which generally consists of a combination of lifestyle changes and pharmacological treatments. Treatment plans

should be individualised and take account of the patient's lifestyle, the potential effect of any lifestyle changes to the person's quality of life, and potential adverse effects and contraindications of medicines.

**TIME OUT 6**

Identify how recognising and managing migraine applies to your practice and the requirements of your regulatory body

**TIME OUT 7**

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: [rcni.com/reflective-account](http://rcni.com/reflective-account)

**References**

- Adoukonou T, Agbétou M, Gahou A et al (2018) Migraine and obesity in Parakou in 2017: case control study. *Pain Studies and Treatment*, 6, 15-23. doi: 10.4236/pst.2018.63003
- Agbétou M, Adoukonou T (2022) Lifestyle modifications for migraine management. *Frontiers in Neurology*, 13. doi: 10.3389/fneur.2022.719467
- Al-Hassany L, Haas J, Piccininni M et al (2020) Giving researchers a headache – sex and gender differences in migraine. *Frontiers in Neurology*, 11. doi: 10.3389/fneur.2020.549038
- Berger K (2022) Managing Migraine: From Acute Treatments to CGRPs. [www.drugtopics.com/view/managing-migraine-from-acute-treatment-to-cgrps](http://www.drugtopics.com/view/managing-migraine-from-acute-treatment-to-cgrps) (Last accessed: 31 October 2023.)
- Bhola R, Ertem DH (2022) The role and impact of the headache nurse specialist. *Agri*, 34, 1, 75-76. doi: 10.14744/agri.2020.67365
- British Association for the Study of Headache (2019) National Headache Management System for Adults 2019. [headache.org.uk/wp-content/uploads/2023/02/bash-guideline-2019.pdf](http://headache.org.uk/wp-content/uploads/2023/02/bash-guideline-2019.pdf) (Last accessed: 31 October 2023.)
- Dean E (2020) More Than a Headache: How Migraine Treatment Often Falls Short. [www.rcni.com/nursing-standard/features/more-a-headache-how-migraine-treatment-often-falls-short-161231](http://www.rcni.com/nursing-standard/features/more-a-headache-how-migraine-treatment-often-falls-short-161231) (Last accessed: 31 October 2023.)
- Dodick DW (2018) Migraine. *The Lancet*, 391, 10127, 1315-1330. doi: 10.1016/S0140-6736(18)30478-1
- Edvinsson L (2017) The trigeminovascular pathway: role of CGRP and CGRP receptors in migraine. *Headache*, 57, 52, 47-55. doi: 10.1111/head.13081
- Gazerani P (2020) Migraine and diet. *Nutrients*, 12, 6, 1658. doi: 10.3390/nu12061658
- Gillies C (2009) Preventing medication overuse headache: the nurse's role in educating patients. *British Journal of Neuroscience Nursing*, 5, 6, 278-282. doi: 10.12968/bjnn.2009.5.6.42756
- Greenberg DA, Aminoff MJ, Simon RP (2020) *Clinical Neurology*, 11th edition. McGraw Hill, London.
- Grossman S, Porth CM (2014) *Porth's Pathophysiology: Concepts of Altered Health States*, Ninth edition. Lippincott, Williams and Wilkins, Philadelphia PA.
- Hindiyeh NA, Zhang N, Farrar M et al (2020) The role of diet and nutrition in migraine triggers and treatment: a systematic literature review. *Headache: The Journal of Head and Face Pain*, 60, 7, 1300-1316. doi: 10.1111/head.13836
- Ho TW, Edvinsson L, Goadsby P (2010) CGRP and its receptors provide new insights into migraine pathophysiology. *Nature Reviews. Neurology*, 6, 10, 573-582. doi: 10.1038/nrneuro.2010.127
- International Headache Society (2018a) Migraine Without Aura. [www.ichd-3.org/migraine/1-1-migraine-without-aura](http://www.ichd-3.org/migraine/1-1-migraine-without-aura) (Last accessed: 31 October 2023.)
- International Headache Society (2018b) The International Classification of Headache Disorders 3rd edition. [www.ichd-3.org](http://www.ichd-3.org) (Last accessed: 31 October 2023.)
- International Headache Society (2018c) Migraine With Aura. [www.ichd-3.org/migraine/1-2-migraine-with-aura](http://www.ichd-3.org/migraine/1-2-migraine-with-aura) (Last accessed: 31 October 2023.)
- Japp AG, Robertson C, Wright RJ et al (2018) *Macleod's Clinical Diagnosis*, Second edition. Elsevier, London
- Joint Formulary Committee (2023) *British National Formulary*, No. 85. BMJ Group and the Royal Pharmaceutical Society of Great Britain, London.
- Kim J, Cho S, Kim WJ et al (2017) Insufficient sleep is prevalent among migraineurs: a population-based study. *Journal of Headache and Pain*, 18, 50. doi: 10.1186/s10194-017-0756-8
- Knott L (2021) *Migraine Management*. [www.patient.info/doctor/migraine-management](http://www.patient.info/doctor/migraine-management) (Last accessed: 31 October 2023.)
- Manning K, Janssen P, Dowson A (2007) Optimal medicines use and lifestyle in migraine management and prevention. *British Journal of Neuroscience Nursing*, 3, 9, 410-414. doi: 10.12968/bjnn.2007.3.9.27133
- Marmura MJ (2018) Triggers, protectors, and predictors in episodic migraine. *Current Pain and Headache Reports*, 22, 12, 81. doi: 10.1007/s11916-018-0734-0
- Migraine Trust (2021a) Types of Migraine. [migrainetrust.org/understand-migraine/types-of-migraine](http://migrainetrust.org/understand-migraine/types-of-migraine) (Last accessed: 31 October 2023.)
- Migraine Trust (2021b) Migraine Attack Triggers. [migrainetrust.org/live-with-migraine/self-management/common-triggers/#page-section-1](http://migrainetrust.org/live-with-migraine/self-management/common-triggers/#page-section-1) (Last accessed: 31 October 2023.)
- Migraine Trust (2021c) Acute Medicines. [www.migrainetrust.org/live-with-migraine/healthcare/treatments/acute-medicines](http://www.migrainetrust.org/live-with-migraine/healthcare/treatments/acute-medicines) (Last accessed: 31 October 2023.)
- Migraine Trust (2021d) Medication Overuse Headache. [migrainetrust.org/understand-migraine/types-of-migraine/medication-overuse-headache](http://migrainetrust.org/understand-migraine/types-of-migraine/medication-overuse-headache) (Last accessed: 31 October 2023.)
- Migraine Trust (2021e) Calcitonin Gene-Related Peptide (CGRP) Monoclonal Antibodies. [migrainetrust.org/live-with-migraine/healthcare/treatments/calcitonin-gene-related-peptide-mono-clonal-antibodies](http://migrainetrust.org/live-with-migraine/healthcare/treatments/calcitonin-gene-related-peptide-mono-clonal-antibodies) (Last accessed: 31 October 2023.)
- Migraine Trust (2021f) Gepants. [migrainetrust.org/live-with-migraine/healthcare/treatments/gepants](http://migrainetrust.org/live-with-migraine/healthcare/treatments/gepants) (Last accessed: 31 October 2023.)
- Migraine Trust (2021g) Headache Clinics. [migrainetrust.org/live-with-migraine/healthcare/migraine-clinics/#page-section-1](http://migrainetrust.org/live-with-migraine/healthcare/migraine-clinics/#page-section-1) (Last accessed: 31 October 2023.)
- NHS Inform (2023) Migraine. [www.nhsinform.scot/illnesses-and-conditions/brain-nerves-and-spinal-cord/migraine](http://www.nhsinform.scot/illnesses-and-conditions/brain-nerves-and-spinal-cord/migraine) (Last accessed: 31 October 2023.)
- National Institute for Health and Care Excellence (2021) Headaches in Over 12s: Diagnosis and Management. Clinical guideline No. 150. NICE, London.
- National Institute for Health and Care Excellence (2022) Scenario: Headache – Diagnosis. [cks.nice.org.uk/topics/headache-assessment/diagnosis/headache-diagnosis](http://cks.nice.org.uk/topics/headache-assessment/diagnosis/headache-diagnosis) (Last accessed: 31 October 2023.)
- National Institute for Health and Care Excellence (2023a) Treatment Summaries. Migraine. [bnf.nice.org.uk/treatment-summaries/migraine/#acute-migraine-treatment](http://bnf.nice.org.uk/treatment-summaries/migraine/#acute-migraine-treatment) (Last accessed: 31 October 2023.)
- National Institute for Health and Care Excellence (2023b) Rimegepant for Preventing Migraine. Technology Appraisal Guidance No. 906. NICE, London.
- Perry M (2019) Assessment and management of migraines in primary care settings. *Independent Nurse*, 7, 21-24. doi: 10.12968/indn.2019.7.21
- Robblee J, Starling AJ (2019) SEEDS for success: lifestyle management in migraine. *Cleveland Clinic Journal of Medicine*, 86, 11, 741-749. doi: 10.3949/ccjm.86a.19009
- Stroke Association (2023) Migraine and Stroke. [www.stroke.org.uk/what-is-stroke/are-you-at-risk-of-stroke/migraines-and-stroke](http://www.stroke.org.uk/what-is-stroke/are-you-at-risk-of-stroke/migraines-and-stroke) (Last accessed: 31 October 2023.)
- Swann J (2017) Insomnia: promoting a good night's sleep. *British Journal of Mental Health Nursing*, 6, 4, 161-164. doi: 10.12968/bjmh.2017.6.4.161
- Weatherall MW (2015) The diagnosis and treatment of chronic migraine. *Therapeutic Advances in Chronic Disease*, 6, 3, 115-123. doi: 10.1177/2040622315579627
- Weatherley S (2022) Q&A: CGRP Medication. [migrainetrust.org/news/qa-cgrp-medication](http://migrainetrust.org/news/qa-cgrp-medication) (Last accessed: 31 October 2023.)

## Recognising and managing migraine

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

**1. Migraine is classified as:**

- a) A secondary headache disorder
- b) A medical emergency
- c) A primary headache disorder
- d) A minor injury

**2. Photophobia can be described as:**

- a) Aversion or extreme sensitivity to sound
- b) Aversion or extreme sensitivity to light
- c) Aversion or extreme sensitivity to smells
- d) Aversion or extreme sensitivity to touch

**3. Characteristics of migraine without aura include:**

- a) A unilateral, severe, pulsating pain in the head
- b) A bilateral, mild, ache in the head
- c) A unilateral, mild, sharp pain in the neck
- d) A bilateral, severe, sharp pain in the neck

**4. Which of the following are sensory disturbances referred to as aura?**

- a) Flashing lights
- b) Tunnel vision
- c) Pins and needles
- d) All of the above

**5. Hemiplegic migraine is associated with which of these characteristics?**

- a) Weakness on one side of the body
- b) Syncope
- c) Irregular menstruation
- d) Numbness in both arms and legs

**6. Which of these can be described as a primary headache disorder characterised by sudden onset of severe pain on one side of the head, often around the eye?**

- a) Sinusitis
- b) Temporal arteritis
- c) Transient ischaemic attack
- d) Cluster headache

**7. Which of the following are not regarded as red flag symptoms?**

- a) Headache with rash, fatigue, neck stiffness
- b) Headache with focal neurological signs
- c) Headache with pain around the eyes, across the forehead and over the cheeks
- d) Sudden onset headache with maximal intensity occurring within seconds to minutes

**8. Examples of environmental migraine triggers do not include:**

- a) Excitement
- b) Bright lights
- c) Flickering screens
- d) Strong smells

**9. The acronym SEED stands for:**

- a) Stop, environmental, elements, distracting
- b) Sleep, eat, exercise, diary
- c) Stress, excitement, elimination, dehydration
- d) Shock, effort, exhaustion, depression

**10. Acute treatments can reduce the severity of symptoms during a migraine, but if taken too often can result in:**

- a) Urinary tract infection
- b) Premature labour
- c) Migraine with aura
- d) Medicine overuse headache

### How to complete this quiz

This multiple-choice quiz will help you to test your knowledge. It comprises ten questions that are broadly linked to the CPD article. There is one correct answer to each question.

- » You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- » You might like to read the article before trying the questions.

Subscribers making use of their RCNi Portfolio can complete this and other quizzes online and save the result automatically.

Alternatively, you can cut out this page and add it to your professional portfolio. Don't forget to record the amount of time taken to complete it.

**Further multiple-choice quizzes are available at [rcni.com/cpd/test-your-knowledge](http://rcni.com/cpd/test-your-knowledge)**

This multiple-choice quiz was compiled by **Ruth Williams**

*The answers to this quiz are:*

6.d, 7.c, 8.a, 9.b, 10.a  
1.c, 2.b, 3.a, 4.d, 5.a

This activity has taken me \_\_\_ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent  Good  Satisfactory  Unsatisfactory  Poor

As a result of this I intend to: \_\_\_\_\_

*In next month's issue...*



## Professionalism

**Blood culture pathway: steps to improve your practice, and why it matters**



## Briefing

**Creating positive, inclusive experiences of care for transgender people**



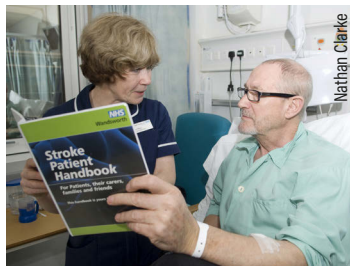
## Workforce

**How to make a business case and gain funding for your nurse-led project**



## Effective practice

**Diagnosing, assessing and managing cellulitis – and preventing recurrence**



## Care experience

**Post-operative stroke after surgery: early recognition and management**

## RCNi Learning

Now included in RCNi Plus subscriptions  
[rcnlearning.com](https://www.rcnlearning.com)



## YOUR SUBSCRIPTION

Visit our website for all the latest news and to browse our 30-year archive  
[nursingstandard.com](https://www.nursingstandard.com)

# Find your perfect nursing job

RCNi  
Nursing  
Careers &  
Jobs Fair

LONDON WEST - 2 FEBRUARY  
NOVOTEL LONDON WEST

## What are you waiting for?

- + Meet nurse recruiters and be interviewed on the day.
- + Build your CPD hours in our FREE seminars.
- + Get tips on how to prepare and succeed in your interviews.
- + Learn how to write supporting statements and CVs for your job applications.

**REGISTER FREE TODAY**

RCNi  
**CPD**  
USE FOR REVALIDATION

Find out more and view our future events at  
[careersandjobsfair.com](https://careersandjobsfair.com) or scan the QR code

