Care Work and Nursing at Hospitals and Health Centres in Scotland, United Kingdom

Content

Introduction

Dear Student

◆ *Welcome to Scotland! We are delighted that you have chosen to consider Scotland for your exchange visit practice placement and we hope your time here will exceed your expectations.*

Using this handbook will help you prepare for your foreign study placement. It will provide you with useful background information on the nursing care of adults within the hospitals of Scotland. It is important to remember that like many things in life, the healthcare system is constantly subjected to change at both national and local level. The Scottish Government Health Department is responsible for legislation and policy development within the healthcare system of Scotland. As a result of this many new initiatives are continuously being developed and implemented in an attempt to improve the system and facilities for users and employees of the National Health Service (NHS). Whilst every effort has been made to reflect up to date information at the time of writing this handbook, you may hear of new initiatives during your practice placement with us in Scotland. If there is anything that you are uncertain about the staff in your placement area will be happy to offer you support and guide you towards relevant information.

There is a lot of information contained within this handbook. The contents page will give you an idea of the different chapters which can be used as preparatory reading for your exchange visit practice placement or as a reference guide during your time with us.

We hope you enjoy your visit to Scotland and trust that this handbook will assist you in your learning experience.

1. A Typical Day of a Practical Nurse at a Hospital in Scotland

◆ During your exchange visit practice placement you may be allocated to one of a variety of health care settings within our NHS Board area. Wherever you are placed for this practice placement experience you will be allocated a registered nurse as your 'mentor'. This person will orientate you to the placement and provide you with guidance and support throughout your time on placement in Scotland. You should aim to follow your mentor's working shift pattern as closely as possible. A typical working day in an NHS hospital consists of three main working periods known as shifts. An 'early' shift typically starts around 7am and finishes at 3.30pm. A 'late' shift generally starts at 2pm and finishes at 10pm. The 'night' shift commences at 9.30pm and finishes at 7.30am. During your practice placement experience you will gain experience of both early and late shift working periods, but will not be expected to undertake any night shifts. You will be allocated 5 shifts per week during your placement.

In an attempt to prepare you for this practice placement experience we have identified two potential health care settings and have developed some sample case studies for you to think about. We hope that by reading these case studies you will gain some idea of the medical conditions which may be experienced by patients within these settings as well as an understanding of the patient's journey and working routines within the NHS in Scotland.

In an attempt to give you a 'learner' nurses view of a typical working day we have asked some healthcare students to keep a daily diary during their time in an assessment and rehabilitation' ward and an 'orthopaedic' speciality ward. It is hoped that their accounts of the working day will give you insight as to what sort of experience to expect. The health care student diaries will follow each of the case studies. Happy reading!!!

1.1 Case Study 1 – Orthopaedic Speciality Unit

◆ Mr Alistair Fraser is an overweight 50 year old police officer. Recently he had been experiencing more and more pain in his right hip and is finding it increasingly difficult to function in his role as crime prevention officer within the local community. Much of Alistair's working day is spent patrolling the local neighbourhood developing strong relations with all the residents within the community. He decided to visit his General Practitioner (GP) concerned not

only with the pain, but also about the impact this pain was having on his life – at this point Alistair had been off work for one week and he felt that his hip was too painful to consider returning to work in the near future.

Alistair's GP conducted a full medical assessment on Alistair and suspected a diagnosis of osteo-arthritic changes. He decided to refer Alistair to an orthopaedic consultant at the local Adult Acute Hospital. A referral was made and Alistair received an appointment to attend the hospital out-patient department where he was reviewed by an orthopaedic consultant. Following investigation as an out-patient the consultant confirmed that Alistair was indeed suffering from severe osteo-arthritic changes affecting his right hip and that he needed a total hip replacement (arthroplasty). Alistair was placed on the waiting list for surgery (see Access Targets – Section 6). During this waiting period Alistair had several episodes where he was unable to work due to the pain associated with his condition and at times he became concerned regarding the future of his employment if his operation was not performed soon. Whilst Alistair was on the waiting list he was sent a 'health questionnaire' by post and asked to bring it with him when he attended the pre-admission clinic (section 5) a few days before his operation was due to take place. This would provide more background information to the health care team prior to surgery.

Mr Fraser was reviewed three days ago in the pre admission clinic and has now been admitted to ward S/19 for total hip arthroplasty. On admission to the ward it is likely that you may be asked to be involved in the completion of an initial multidisciplinary assessment on Mr Fraser using an Integrated Care Pathway (section 3), as well as performing and recording routine observations of vital signs, urinalysis etc. Have a read of Jamie–Leigh's diary below and see what her typical day is like on placement in ward S/19.

Student Diary

Hi there! My name is Jamie-Leigh McDonald. I am a health care student currently studying a Higher National Certificate (HNC) in Healthcare at Dundee College. I have recently been allocated to Ward S/19 for a period of 6 weeks. Ward S/19 has 30 bed spaces – these are arranged in four 'bays' with six beds in each and six 'side' rooms with en-suite facilities. This is my third week in this placement. Before becoming a health care student I worked for 15 months as a health care assistant in an elderly care ward in a nearby hospital. Just like you, I have come to the orthopaedic area to get some experience of surgical nursing. Because of the type of educational programme I am studying I spend three days per week on placement and two days at Dundee College studying the HNC modules. When I finish my 6 weeks here I will return to my original elderly ward to

continue gaining experience until I complete the HNC programme in June. The programme takes just under a year to complete. If I am successful in the theory and practical assessments I will then be able to go straight into year 2 of the Nursing Diploma/ Degree programme at the University of Dundee. So watch out in just over 2 years time from now I should be a registered nurse!

I have been asked to keep a diary of a typical day on placement. To give you the best understanding of what this placement is like I will describe what I got up to on 2 shifts to give you a better idea. So here we go then…….

Day 1

Today I am on a 2-10pm shift – we call this a 'late' shift or 'back' shift. The 'early' shift staff will go off duty at 3.30 pm so we have a little time for a patient handover report. There are three registered nurses on this late shift with me today (a charge nurse, a senior staff nurse and a staff nurse), one other third year nursing student and a health care assistant.

2.00pm - we receive the handover report from the early shift staff. This gives us information on how our patients have been since we last saw them and identifies the priorities for the day. I am working in Bay 3 today. We are to have four admissions this afternoon. Mr Alistair Fraser and Mr Gordon Hunter are being admitted for total hip replacement operations tomorrow. A further two patients are being admitted for total knee replacement operations tomorrow. Staff nurse has asked if I would like to be involved in assessing Mr Fraser using the integrated care pathway (ICP – section 3). This bay already contains a post operative patient, a Mr Forsyth, who had his right knee replaced this morning at theatre. I think I am in for a busy day!

Once the handover report is over I set about taking Mr Forsyth's observations. Staff nurse has advised that I should check his temperature, pulse, blood pressure, respirations and oxygen saturation every two hours.

He also has an intravenous infusion (IVI) in situ in his right arm so I need to check that this is running to prescription time and check the insertion site for trauma. This will be checked approximately every hour throughout the shift today as it has 'tissued' twice in the last 24 hours. Mr Forsyth also has a catheter in situ so his urine volumes need to be checked and recorded hourly in the immediate post operative period. I also need to check his wound dressing for signs of soakage every four hours. Thank goodness I have a staff nurse here with me to keep me right! Staff nurse shows me how to check and record observations of Mr Forsyth's leg for colour, sensation and movement as I have not assessed

these observations before. Staff nurse has been administering drugs to her patients whilst I have been busy doing the observations. She checks if Mr Forsyth needs any pain relief but he reports that he is quite comfortable.

2.30pm - the health care assistant comes around the ward asking the patients if they would a cup of tea or coffee.

3.00pm - visitors start to arrive, visiting time is 3pm-8pm. Mr Forsyth doesn't have anybody to visit him so I sit with him for a while and chat to him about how he managed at home before his operation and his previous employment as a farmer. Following this staff nurse requests that I go for my tea break with one of the other registered nurses and the healthcare assistant.

4.00pm – I am up to date with the observations and recordings when two of our admissions arrive in the ward. We settle them into the environment and help them unpack their belongings and show them around the ward. Staff nurse advises the junior doctor that Mr Fraser has arrived and we then accompany him to complete Mr Fraser's assessment using the ICP.

This takes some time but we collect the required information. We advise Mr Fraser than he will need to provide us with a specimen of urine and that once he has signed the consent form the doctor will mark his operation sight with a permanent marker pen. Mr Fraser will need to be fasted from midnight so I collect a "Nil by Mouth" sign and position it on his bedside locker.

5.30pm – I help the healthcare assistant distribute the evening meal to the patients in my bay. Once the meal is over I record the patients' fluid intake on their fluid charts.

6.00pm - continuing to check Mr Forsyth's observations, catheter drainage, dressing and IVI – all seems well. New admissions have now all arrived, so their routine observations are to be done now to give us a baseline for their patient record.

6.30pm - I am sent for my evening break with the other student. We have 30 minutes for this break and have a good chat over the day's events. Gillian has also been busy, but mainly with performing post-operative care.

6.30~9.30pm - the majority of time this evening has been taken up with caring for Mr Forsyth, checking his observations and making sure he is comfortable. We have been checking his pressure areas regularly to ensure that his skin does not breakdown. All our new patients have had their ICPs completed and I was able to watch the doctor taking blood samples from these gentlemen for analysis and cross matching of blood group. I spent some time observing the staff

nurse advise the new patients of what expect on return from theatre the following day. It's good to be able to spend some time getting to know these gentlemen and trying to put them at ease.

9.45pm – listened to staff nurse giving the night staff the handover report on our patients – she asked me for some input on Mr Fraser and Mr Forsyth and this made me feel really valued.

10.00pm – end of shift – home to bed and sleep – back on duty at 7.00am tomorrow morning.

Day 2

7.00am – arrived on the ward for my early shift and received the handover report on my five patients from the previous evening.

7.30~8.00am - initial activity is to give out the breakfasts in my bay. I need to remember which of my patients are fasting and which can have a light breakfast as two of them are having a spinal anaesthetic and are allowed to eat a light breakfast. I wonder if Mr Forsyth is looking forward to having some breakfast.

8.00am – our new patients have been off having showers prior to changing into their theatre gowns and having their pre-operative checks done. Staff nurse asked me if I would like to assist her with the 8 o'clock medicine administration round – this is only the second time I have been able to assist with the 'drug round' since coming to this placement. There is such a lot to check and remember when administering medicines!

Medicine round completed, we strip the theatre patients' beds and re-make them into theatre packs. Staff nurse then supervises me doing Mr Fraser's pre-operative checks and countersigns the checklist. Staff nurse then instructs me as to what documents we need to collect together to accompany our patients to theatre i.e. case notes, medicine prescription and recording sheets, X-rays etc. Staff nurse goes on a 'ward round' to review our patients with the medical staff the physiotherapist and the occupational therapist.

The patients are advised to relax this morning whilst awaiting their operation.

9.00am – staff nurse from the other bay comes into our bay and takes me for my morning break.

9.25am – on return from coffee, the physiotherapist has arrived and is with Mr Forsyth assessing the movement on his operated leg. She advises us that he can get up to sit in a chair today with the assistance of two nurses and a mechanical hoist to move him. I will help staff nurse with this later.

10.00am – staff nurse asks me to check and record the patients' routine observations again. She is doing the medicine round again, but on her own this time. Jeanie the healthcare assistance comes into the ward to offer hot drinks to the patients who are not fasting.

10.30am – it's time for Mr Fraser to go down to theatre and I am asked to escort him along with the theatre porter. I gather up all the required paperwork and walk down to theatre beside Mr Fraser who is lying safely on his theatre bed. In theatre the reception area nurse introduces himself to Mr Fraser and checks all his documentation is correct. I stay with Mr Fraser until the anaesthetist arrives and sedates Mr Fraser prior to giving him full anaesthesia.

11.00am – back in ward staff nurse and I offer Mr Forsyth a bed bath. We screen off his bed area and spend the next half hour attending to his personal hygiene, catheter care and observation of his wound and IVI site. Once freshened up, we change Mr Forsyth's gown and assist him to sit up in a chair beside his bed.

11.45am – the 'senior staff nurse' caring for a patient with diabetes in a side room comes to ask if I would like to come and observe her patient's blood sugar (glucose) level being checked. I tell her that I have seen this many times before so she offers to supervise me performing this skill.

12.15pm – the lunch trolley arrives and I help distribute the lunches to the patients within the ward. Senior staff nurse asks me if I could assist an elderly lady with her lunch in bay 2 as she is feeling a little tired today and would appreciate a helping hand. Staff nurse checks if any of our patients are due to receive any lunchtime medication. Mr Hunter has now been taken down to theatre for his surgery.

12.45pm – I check over my patients' ICPs with the staff nurse and make sure our records are up to date before the late shift comes on duty. Staff nurse and I help Mr Forsyth back onto the top of his bed for a rest after lunch.

13.10pm – lunchtime at last! Charge nurse Dorward asks me to go for lunch with her and the healthcare assistant. We walk the short distance to the staff dining room and have a quick lunch.

13.50pm – back on the ward. I make sure Mr Fraser's bed space is prepared with all the equipment that he will need on return from theatre. Theatre phones the ward to say that they are ready to receive our third patient. When the porter arrives I accompany this man down to theatre.

14.00pm – the 'late shift' staff arrive on the ward and receive the handover report. I check the routine observations which need to be done on our patients. When the doctor visited the ward this morning he said that Mr Forsyth's IVI

could be removed after lunch if he was managing to drink fluids orally. Staff nurse and I assemble the necessary equipment and she shows me how to remove the IV infusion.

14.30pm – senior staff nurse takes the four students that are on the ward into the ward seminar room for a teaching session on pain assessment tools used within the orthopaedic unit.

15.00pm – home time!! It's been a busy couple of days but I have enjoyed working with the staff on the ward. I think I might like to work in the orthopaedic specialty when I qualify. I hope you enjoy your placement wherever you are placed.

1.2 Case Study 2 – Assessment and Rehabilitation Ward

◆ Mrs Lorna Campbell is a 75 year old lady who has recently been transferred to an assessment and rehabilitation ward similar to where you may undertake your exchange visit practice placement. Lorna retired from her job as a nursing auxiliary when she was 60 years old and has been enjoying her retirement by spending time with her husband Richard and volunteering two afternoons per week in a local charity shop. Lorna would not describe herself as particularly active, she is slightly overweight for her height (BMI=21), smokes 10 cigarettes per day and drinks alcohol socially. Lorna's GP prescribed her medication for high blood pressure two years ago. Lorna and Richard have five children residing throughout Scotland.

Lorna has generally enjoyed good health throughout her lifetime. She required some gynaecological surgery approximately 35 years ago and remained healthy until recently. She became unwell just over three weeks ago when Richard came in from the garden one afternoon to find Lorna slumped in the chair unable to move freely and unable to speak clearly. He telephoned their GP who visited and immediately arranged for Lorna to be taken to hospital by ambulance. Lorna was admitted directly to the medical admissions ward and was assessed by medical and nursing staff. Over a period of hours her condition improved greatly and all signs of muscle weakness eventually subsided and her speech returned to normal. It was suspected that she had had a transient ischaemic attack (TIA) resulting from a temporary blockage in the blood supply to the brain. She was discharged home the following day with advice on eating a healthy diet, reducing her smoking and alcohol intake and taking gentle exercise. Lorna was advised to visit her GP within the next few days for review.

Lorna remained well until three weeks later when Richard awoke one morning at 6am to find Lorna drowsy, with a

dense right sided muscle weakness (including her facial muscles), she was unable to speak and had been incontinent of urine. He immediately called the GP only to find that he was greeted by a voice message advising him to contact 'NHS 24' (section 6) if he required urgent medical assistance. He telephoned NHS 24 and was answered by an operator who took some details and asked him some questions. He was then transferred to a nurse who conducted a more detailed assessment of Lorna's condition and assured Richard that an ambulance would be with them within a matter of minutes. On admission to the hospital Lorna was first seen in the 'admissions and emergency' department as on this occasion there was not a bed available in the medical admissions ward. She was assessed by the medical and nursing staff and a provisional diagnosis of cerebrovascular accident (CVA) or 'stroke' was made. In order to determine if the underlying cause of Lorna's symptoms was a cerebral haemorrhage or a thrombus, an emergency computerised tomography (CT) scan was arranged. This would help determine the precise location of the CVA and the most appropriate treatment to be given. On return from the scan Lorna was transferred to the medical admissions ward where she and Richard were advised that Lorna had indeed had a CVA. As the CT scan confirmed that the underlying cause was a thrombus in a cerebral blood vessel a dose of the 'clot bursting' drug Streptokinase was administered in an attempt to reduce the long term damage. Lorna was stabilised within a period of 24 hours and was then transferred to a specialised 'Stroke Unit' as advised by national guidelines (see SIGN section 6). Here Lorna would undergo more detailed assessment of her condition and her future care would be planned and prioritised. Within five days it appeared that Lorna was progressing well and arrangements were made to transfer her to the assessment and rehabilitation ward. In this setting her care will continue until the point of discharge, hopefully to her home environment. It is in this care setting that you are likely to be involved in Lorna's admission, care planning and discharge process. Her assessment will probably be conducted using an Activities of Living Model (see section 3). If you are not familiar with this model your mentor will provide instruction and supervision in how to use it.

Student Diary

Thanks for taking the time to read my diary – I hope it helps prepare you for your time on the assessment and rehabilitation ward. My name is Rachael Shaw and I am a first year nursing student at the University of Dundee. This is my first placement in healthcare since starting my degree programme in September. I have been recently allocated to Ward A/4 for a period of 11 weeks. Ward A/4 has 26 bed spaces

arranged in bays – most patients here have to share the bay with other two or three other patients. This is my eighth week in this placement. Prior to starting my placement I completed an 11 week study block at University to provide me with some of the skills and knowledge that I needed before coming to this placement. I spend 5 days a week on placement and have two rest days. When I finish my 11 weeks here I have a short holiday and will then return to University to start semester 2. If I complete the theory and practical element of my Common Foundation Programme (CFP) I will enter the Adult Branch nursing programme where the HNC health care students like Fiona above will join our programme.

One of my lecturers has asked me to keep a diary of a typical day on this placement. The staff here are great – really supportive so I am sure you will have a fabulous time!!

Day 1

7.00am – arrived on the ward for my early shift and received the handover report from the nightshift staff. Most of the patients on the ward had a settled night by all accounts.

7.30-9.00am – spent time with staff nurse helping to get patients out of bed and assisted them with washing and dressing as required. The emphasis in this unit is all about assessment and rehabilitation, so we need to encourage the patients to self-care in order to promote their independence and recovery. Sometime I feel like I just want to help them more, but I know this would not be good for them. Only one of my patients wanted to shower this morning so I assisted her in and out of the shower.

9.00am – breakfast arrives in the ward and I help with the serving of the food, tea and coffee. One or two of the patients need a little assistance to eat breakfast so the healthcare student and I help out.

10-12noon - I was asked yesterday if I would like to accompany a patient (Mrs Caird) this morning to observe the Occupational Therapist (OT) conduct an assessment of the patient's home environment. Mrs Caird is progressing well and hopefully will be discharged home soon. We leave the ward at ten o'clock and travel the short distance to the patient's home. It is really interesting to see all the things that the OT takes into account in planning for Mrs Caird's discharge. It is also surprising how difficult it may be for her to adapt to living with the limitations imposed by her stroke in the home environment where space is so limited. The OT assesses Mrs Caird's ability to perform all daily living skills within this environment.

Whilst I have been away from the ward some of the patients will have been attending physiotherapy, whilst

others will have been having ward based assessments relating to washing, dressing, feeding swallowing reflex and communication skills.

12-12.30pm – on return to the ward I have my lunch break and consider how interesting the morning has been, and how good it was to see another professional from the health care team functioning in her own specialist role.

12.30pm – patients are eating their lunch when I come back from my break.

13.00pm - after lunch we encourage patients who like to have an afternoon rest period to retire to their bed areas for a 'cat nap'. Other patients may choose to watch television, read or listen to music.

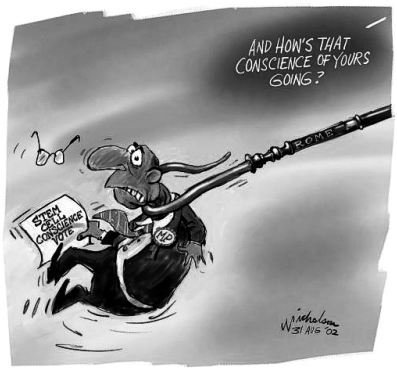
14.00pm – some patients need routine observations of their vital signs to be done at this time. Once I have completed these observations on my patients I remember that I need to measure the urine volumes for those patients that have a urinary catheter. I check the care plans to see which patients have a catheter and I measure and record their urine output. The staff nurse in charge of the ward today commences the medicine administration round with the health care student. The 'activities therapist' visits the ward and encourages the patients to engage in some craft type activities. The late shift come on duty and the nurse in charge gives them a handover report.

15.00pm – at this point in the day the patients are offered a cup of tea and the visitors start to arrive. The dietician is due to visit my patient Mrs Campbell this afternoon to talk to her and the staff about the need for thickened fluids to assist with her swallowing difficulties.

For me, another day is over and it has been a very good one – enjoy yours!

2. How to Nurse and Care in Scotland

◆ Nursing is a profession focused on assisting individuals, families, and communities in attaining, maintaining, and recovering optimal health and functional ability. Modern definitions of nursing define it as a science and an art that focuses on promoting quality of life and care of the individual and their families, throughout their life experiences from birth to the end of life. Nursing is primarily the caring relationship between the nurse and the person in their care.



Definitions

Although nursing practice varies throughout its various specialties and countries, these nursing organisations offer the following definitions:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (International Council of Nurses).

The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death (Royal College of Nursing, 2003).

Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in health care for individuals, families, communities, and populations (American Nurses Association)

2.1 Principles and Values

◆ In the United Kingdom we believe that as nurses the people in our care must be able to trust us with their health and wellbeing (NMC, 2008).

To justify that trust we must:

Make the care of people your first concern, treating them as individuals and respecting their dignity, by

- treating people as individuals
- respecting people's confidentiality
- collaborating with those in your care
- ensuring you gain consent
- maintaining clear professional boundaries

Work with others to protect and promote the health and wellbeing of those in our care, their families and carers, and the wider community, by

- sharing information with your colleagues
- working effectively as part of a team
- delegating effectively
- managing risk

Provide a high standard of practice and care at all times, by

- using the best available evidence
- keeping our skills and knowledge up to date
- keeping clear and accurate records

Be open and honest, act with integrity and uphold the reputation of your profession, by

- acting with integrity
- dealing with problems
- being impartial
- upholding the reputation of your profession.

As registered nurses our practice and conduct is guided by the NMC Standards of Conduct, Performance and Ethics, known as "The Code". As autonomous practitioners we are thereby responsible and accountable for our decisions and actions. As patients' advocate, we ensure that patients are given appropriate information to inform choices made relating to their care and treatment.

In providing nursing care, nurses are implementing a nursing care plan, which is based on a thorough nursing assessment.

2.2 The Nursing Process (Plan)

◆ The nursing process is the process by which nurses deliver care to patients. It is a method used to systematically translate the assessment made via the nursing model into practice and evaluate the outcomes of the care provided.

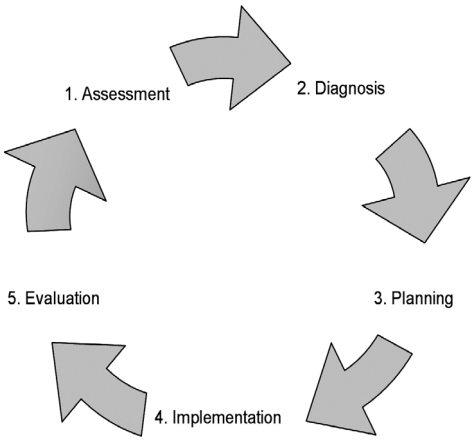
The nursing process is supported by nursing models or diverse philosophies which assist nurses to direct their activities towards achieving specific goals.

The nursing process was originally adapted form of a problem-solving approach to patient care.

Characteristics of the nursing process

The nursing process is a cyclical and ongoing process that can end at any stage if the problem is solved. The nursing process is applied to every problem that the patient has, and for every element of patient care. The nurse's evaluation of care will lead to changes in the implementation of care and the patient's needs are likely to change during their stay in hospital as their health either improves or deteriorates.

The cyclical nature of the Nursing Process is demonstrated on the following diagram:



The nursing process not only focuses on ways to improve the patient's physical needs, but on the individual's social and emotional needs as well. It provides a means of providing holistic care to individual patients.

The nursing process is not something foreign or unusually complex. On the contrary, we use similar processess on a daily basis without even realizing it. For example, a trip to the petrol station to buy fuel requires:

Assessing the various prices, types of fuel and the number of people waiting to buy fuel at each pump.

Diagnosis is subsequently made based on the former criteria. This may include pulling into the petrol station to fuel up or going down the road for better prices and/or less of a crowd. If the price is right and there's not much of a crowd, we decide to drive in.

Planning now takes place. This may include which pump to use, how much fuel to put in the tank, whether or not to clean the windows etc. We're at the pump and ready to fuel up.

Implementation of the plan is now put into action. We pull up on the driver's side because the fuel tank is on that side of the car, part of our plan. We have given ourselves enough room to exit the vehicle without bumping the car door on the pump, another part of our plan. We now unscrew the fuel cap and begin refueling i.e. Implementing what we planned.

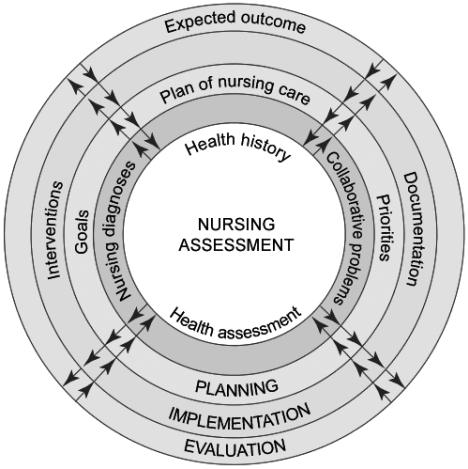
Evaluation of the trip - things went well! We are fueled up and have exited the fuel station without complication. The trip to the fuel station has been successful. We may choose to use this garage again in the future. The Nursing process is as simple as this in theory. However, as a nurse, the nursing process tool will be used for

more complex and difficult situations but its application is the same as in the fuel station analogy.

Stages of the nursing process
The stages of the Nursing process is often remembered by the acronym **ADPIE** ("A Delicious PIE")

- **A**ssessment (of patient's needs)
- **D**iagnosis (of human response needs that nursing can assist with)
- **P**lanning (of patient's care)
- **I**mplementation (of care)
- **E**valuation (of the success of the implemented care).

Only recently in the United Kingdom has the the 'diagnoses' stage of the process been implemented in some healthcare areas. Pay particular attention during your practice placement with regard to the introduction of this aspect of the process!



'Overview of nursing assessment'

Stage one: assessment

The nurse should carry out a complete and holistic nursing assessment of every patient's needs. Usually, an assessment framework, such as Roper et al's (2000) model, or specific needs assessment tool is used. The purpose of the assessment stage is to identify the patient's nursing problems. These problems can be expressed as either actual or potential problems. For example, a patient who has become immobile as a result of surgery may be assessed as having the "potential for a breakdown of skin integrity resulting from this immobility".

Stage two: diagnosis

In the U.S.A., nurses make a nursing diagnosis which is a standardized statement about the health of a client for the purpose of providing nursing care. Nursing diagnoses express the result of the assessment of the patient's problems. Nurses in the U.K. are now commonly formulating a nursing diagnosis as part of the cycle of care planning.

Nursing diagnoses are part of a movement in nursing to standardize terminology. Those supporting the development of standardized terminology believe that it will help nursing become more scientific and evidence based.

Stage three: planning

In consultation with the patient, the nurse addresses each of the problems identified during the planning phase. For each problem a measurable goal is set e.g. for the patient discussed above, the goal would be for the patient's skin should remain intact and that their mobility should be maintained or improved as their recovery progresses. The result is a nursing care plan.

Stage four: implementation

The specific actions required to achieve the set goal are recorded at this stage. The actions or activities of implementation must be recorded in an explicit and tangible format in a way that the patient and all nurses will understand. Clarity is essential to aid communication between those involved in implementing the patient care.

Stage five: evaluation

The purpose of this stage is to evaluate progress toward the goals identified in the previous stages. If progress towards the goal is slow, or if the patient's health status has deteriorated, the nurse must change the plan of care accordingly. Conversely, if the goal has been achieved then the specific aspect of care delivery can cease. During the evaluation stage new problems may be identified, and if so, the process will start all over again. It is due to this stage that realistic and measurable goals must be set - failure to set appropriate goals will result in poor evaluations.

The entire process is recorded in an agreed format in the patient's care plan to enable all members of the nursing team to perform the agreed care and make changes where appropriate.

2.3 Nursing Models

◆ Nursing models provide a framework to help nurses assess, plan, and implement patient care. Utilising such a framework enables nurses to achieve uniformity and seamless care.

All nursing models involve some method of assessing a patient's individual needs and implementing appropriate patient care. An essential component of each nursing model is measurable goals so as the process can be evaluated. Evaluation of the process promotes better care for the patient as the care process continues in the future. Most nursing models are used to formulate a document known as a care plan that is used to determine a patient's treatment by nurses, and other healthcare professionals or auxiliary workers. These documents are considered to be dynamic documents — they are evaluated and evolve on a daily basis as the patient's condition and level of ability change.

The models used vary greatly between healthcare institutions and countries. Furthermore, different branches of nursing have their own "preferred" nursing models.

The **Roper, Logan and Tierney** (2000) model of nursing (originally published in 1980) is a popular model of nursing based upon activities of living. It is extensively used by 'Adult Nurses' in the United Kingdom, particularly with in the NHS. You will probably find this model, or an adaptation of this model, being used in the rehabilitation unit where Mrs. Ferguson (our stroke case study) will be nursed. The model is named after the authors - Roper, Logan and Tierney.

Since it was introduced, this model has been widely adopted by nurses in medical, surgical and other adult care settings. There are five components (concepts) in this model namely:

- Activities of Daily Living (ADL)
- Lifespan continuum
- Dependence/independence continuum
- Factors influencing the Als
- Individuality in living

The model is based around the 'activities of living' (ADL) which evolved from the original work of Virginia Henderson in 1966. Whereas Henderson identified 14 activities of living that people engage in so as to survive, Roper et al's model focuses only on 12.

What are the 'Activities of Daily Living?'

The current model attempts to define 'what living means' and it divides living into the following activity based categories:

- Maintaining a safe environment
- Communication
- Breathing
- Eating and drinking
- Elimination
- Washing and dressing (personal hygiene)
- Controlling body temperature
- Mobilisation
- Working and playing
- Expressing sexuality
- Sleeping
- Death and dying

These activities are considered in association with the individual's level of dependence/independence as reflected in the **dependence continuum**.

The dependence/independence continuum

This continuum considers that when newborn the individual is almost totally dependent on adults for survival, but generally the individual gains in independence as they grow and develop. In later life, however, the individual may depend upon others or equipment for assistance with some aspects of their life, whilst being fully independent in others. During periods of ill health the nurse will assist individuals towards independence in

the activities of living whilst at other times they may have to help them accept dependence.

Dependence/independence status in each activity of living is therefore linked to the factors identified below.

Factors influencing activities of living

The following factors that affect ADL are identified:

- Biological factors
- Psychological factors
- Sociocultural factors
- Environmental factors
- Politicoeconomic factors

Lifespan continuum

The lifespan is a continuum indicating movement of an individual from birth to death. The individual's stage on their individual lifespan continuum will affect their ability to fulfill each ADL. The nurse must consider her patient's lifespan stage so as to use the appropriate nursing knowledge and skills to ensure that the care they plan and deliver meets the individual's needs.

Individuality in living
This acknowledges that each individual is unique and will experience and perform the ADL differently to other individuals. This individuality is influenced by the individual's stage on the lifespan, the degree of dependence/ independence and the interplay of the biological, psychological, sociocultural, environmental and politicoeconomic factors.

Modifications

Within some healthcare settings it is common for certain modifications to be made to the activities of living model. You may experience such modifications within your placement area for example, 'sexuality' and 'death' are often combined into one named 'other' and in some areas the addition of an activity 'pain' is sometimes introduced. Such modifications are common and depend upon the particular healthcare setting.

Integrated Care Pathways

Whilst nurses have striven to develop a systematic approach to care planning over the years they need to be able to respond to the social and political changes within healthcare and its management. The ever present requirement for healthcare to be evidence based influences the way in which nurses are educated, care is delivered and how healthcare professionals collaborate in the planning and delivery of care. Current healthcare policy supports collaboration between nurses and other health professionals in an attempt to address the following:-

Increasing complexity of health and welfare services

- Expansion of knowledge and the increase in specialisation

- A perceived need for rationalisation of resources
- A need for lessening of duplication of care
- The provision of more effective, integrated and supportive services for both users and professionals.

An example of where this policy has been successfully implemented is in the development of integrated care pathways (**ICPs**). Integrated care pathways have been extensively used in America, and enthusiasm for their use is growing in some healthcare settings within the UK.

Integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem. You are likely to utilize ICPs within the Orthopaedic surgical unit where Mr Alistair Fraser, our case study, on hip replacement is nursed. ICPs encourage the transfer of up to date clinical evidence from national guidelines into local protocols which may then be applied into clinical practice.

Integrated care pathways are task orientated care plans which detail essential steps in the care of patients with a specific clinical problem and describe the patient's expected progress of the patient.

Aims of integrated care pathways:
Facilitate the introduction of research based clinical guidelines
Improve multidisciplinary communication and care planning
- Reach or exceed existing quality standards
- Decrease inappropriate variations in clinical practice/standards
- Improve clinician-patient communication and patient satisfaction

For each specified clinical condition the integrated care pathways describes the tasks to be carried out together with guidance on timing and sequence of these tasks and the discipline involved in completing the task. The ICP consist of a single multidisciplinary record which is part of the patient's clinical record together with a patient summary sheet.

The integrated care pathway records essential clinical information which becomes part of the patient's case notes in a way that is easy to complete. Checklists of all necessary activities to complete and tick boxes for specific results to be recorded make them easy to use. Their format results in more legible, succinct and complete clinical records containing minimum essential information.

The advantages of integrated care pathways to clinical practice include:
- improved communication between members of the healthcare team
- increased participation of patient or carer in patient care
- reduction in the time staff spend completing lengthy paperwork

- improved patient outcomes (reduced variation in care standards, reduced complications, improved quality of life)
- a reduction in the length of the patient's stay in hospital
- reduction in the costs of patient care
- increased patient satisfaction with the healthcare service

Hopefully during your exchange visit practice placement you will get the opportunity to observe the healthcare team utilising an ICP to provide an integrated approach to care planning and documentation.

2.4 Methods of Nursing in Scotland

Once admitted to an Adult hospital setting in Scotland the care which the patient receives is usually organised in one of three ways: primary nursing, patient allocation or team nursing. A fourth system called 'task allocation' involves nurses and carers being allocated to various tasks and doing these for all the patients that required them. This system used to be popular in the 1980's but is no longer recommended within the profession.

Primary Nursing

This is a method of nursing where a 'named nurse' (the primary nurse) is responsible for the care of individual patients. Primary nursing originated in America due to concerns regarding the potential fragmentation of care within the hospital setting.

On admission to a healthcare setting or 'ward' the patient will be assigned to a 'primary nurse' and an 'associate nurse'. The primary nurse will formulate the care plan and direct the nursing care. The associate nurse will follow the care plan when the primary nurse is not available, for whatever reason. The primary nurse has responsibility for the assessment, planning, implementation and evaluation of the patient's care plan from the time of admission to discharge. Primary nurses (usually a registered nurse) are generally responsible for up to about 6 patients within the ward setting and therefore develop a good relationship with the patient and a sound knowledge and understanding of all their needs. Ersser and Tutton (1991) identified the key requirements of quality nursing care:

- Comprehensiveness of care
- Accountability of care
- Continuity of care
- Coordination of care

One of the most important advantages of primary nursing is the consistency and continuity of care which it is said to promote. Primary nursing within the NHS demands that a large number of qualified and experienced nurses are employed within each ward setting to ensure that the role can be implemented effectively.

Primary nursing is the delivery of comprehensive, individualized, co-ordinated and continuous patient care through the primary nurse. The primary nurse has autonomy, accountability and authority to act as the nurse in charge of his or her patient's care. The principles which underpin primary nursing are:

- Assessment by a specific nurse who provides day to day care until the patient's discharge or transfer
- The primary nurse plans patient care for a 24-hour period. Care is planned for associate nurses to give when they are not available
- Patient involvement in both the identification and achievement of goals in relation to their condition and lifestyle is encouraged
- Communication between nurses and other members of the healthcare team is promoted
- Better discharge planning, patient teaching, family involvement and appropriate referrals are fostered.

You will experience primary nursing in practice in some of the placement areas to which you may be allocated. Here is some information which is given locally to patients on admission to hospital to advise them about how they will be cared for.

"Information about how we will care for you in hospital"

On admission you and your carer will be introduced to all staff on duty. You will also be introduced to your own 'named nurse'. Your named nurse is a qualified member of the ward nursing team. They will introduce themselves to you on admission or as soon as possible thereafter. The named nurse is your special nurse allocated to you when you are in hospital. They will plan, implement and evaluate your treatment in order to provide the best quality care. Your named nurse will be the person your relatives and carers should speak to, as they will be in a position to give the most up to date information on your treatment and any other information they may require……If, for whatever reason you would like another nurse to be responsible for your care, please ask to speak to the Senior Charge Nurse who will be happy to discuss the matter with you.

Just stop and think for a few minutes……..What do you think the advantages of primary nursing may be and what do you consider to be the drawbacks?

Team Nursing

This method of nursing exists in some health care settings or wards where the nursing staff is divided into a number of teams, usually two or three. Each team is then responsible for the care of a group of patients. Each team is led by an experienced nurse, who is responsible for coordinating the team and the care of the patients throughout their stay. Team leaders are also responsible for supervising the

nurses and HCAs in the team and for planning professional development and performance review of team members. Team nursing has some of the features of primary nursing, but the responsibility for the group of patients is shared within the team rather than falling to one primary nurse. This can sometimes result in lack of clarity relating to some aspects of responsibility and accountability.

Patient allocation

This method of nursing involves the allocation of a group of patients to one or more nurses. Individual nurses are accountable for the care they provide, but the nurse in charge maintains overall control. This method of nursing is similar to team nursing in that the patients are cared for by a similar number of nurses. However, unlike team nursing the allocation of patients is generally for the duration of the shift or a similar period of time.

Task Allocation

This is a system on which nursing care is broken down into small individual tasks. During the shift each nurse or HCA is given responsibility for a number of tasks e.g. fluid balance or vital signs observation. Tasks are allocated by the senior nurse appropriate to that nurse's level of ability. The senior nurse retains responsibility for care planning and the patient will receive care from a variety of nurses/carers, each providing different aspects. Task allocation thus leads to a fragmentation of care and is often criticised because of this and is not adopted by many areas. In some ways, however, it is an efficient way of organising care as it is planned by experienced nurses and then delivered by staff according to their level of competence and experience. During your practice placement you may find that you are allocated certain tasks to perform whilst utilising a system of primary nursing.

You are also likely to come across a variety of healthcare staff, many of whom wear very similar uniforms and it may therefore be confusing for you to understand the differences between the roles of these staff members. The following summary should help you unravel the mysteries of these staff members and always remember, if you are unsure, just ask!!

Nursing staff titles

Nursing assistants, auxiliary nurses, healthcare assistants: These healthcare workers are not registered nurses but work both in acute and primary settings, under the supervision of registered nurses. They assist nurses by giving essential care to patients, taking vital signs, administering personal hygiene, assisting with feeding, giving basic psychosocial care, housekeeping and similar duties.

Nursing Student/ healthcare student: A learner nurse who is undertaking a programme of study to enhance their knowledge and skills to enable them to work as part of a health care team or to progress towards registration.

Staff nurse/senior staff nurse: All newly qualified nurses begin at this level and make up the majority of the registered nursing staff. Senior staff nurses are more experienced and usually take "charge" in the absence of a junior sister or charge nurse.

Junior sister/junior charge nurse/ deputy ward manager: These nurses are deputy to the ward manager/charge nurse and as such have more of a managerial role.

Senior sister/senior charge nurse/ ward manager: 24 hour responsibiltiy for the management of their ward/ clinic/unit.

Senior Nurse/manager: Usually manages an area, for example, Orthoapedic unit, surgical specialities, accident and emergency (usually responsible for several wards or departments).

Registered nurses

To become a nurse within the United Kingdom, one must at the very minimum hold a Diploma in Nursing and have trained for a minimum three years and be eligible to register with the Nursing and Midwifery Council.

Since 1992 nurses have been educated to diploma, bachelor's degree or undergraduate master's degree levels. There are also post-graduate courses for graduates with a degree in a health related subject. Nursing students undertake their education at universities and undertake placements in a variety healthcare settings. Nursing students complete a one year Common Foundation Programme and then specialise in either adult, child, mental health or learning disabilities nursing by completing a further two year Branch programme. They are then eligible to apply for entry to the NMC register.

Upon qualification as a nurse in the UK the opportunities are vast from working in general adult wards and departments in hospital to community nursing, teaching, research, clinical speciality roles or management. Also the practise areas can be in hospital, in the community or both.

3. The Scottish Educational System

◆ Scotland's education system is quite different to that of the rest of the United Kingdom as well as to the system in your own country.

When Scotland got its own parliament in 1999, as a result of devolution, the responsibility for education became that of the new Scottish Parliament.

The education and training policy in Scotland is overseen and administered by the Scottish Governments Education Department and the Scottish Governments Enterprise and Lifelong learning Department.

At a local level it is the responsibility of one of the 32 councils to deliver the education services in preschool, primary and secondary education. The Scottish Government gives a sum of money each year to support education and it is up to each local authority to decide how to allocate the money given to them. Both Further and Higher Education are funded by the Scottish Government. The Funding Council supports both Further and Higher Education.

3.1 Scottish Qualifications Authority (SQA)

◆ The SQA is a very important body in Scotland and has responsibility for the vast majority of qualifications which are completed in school and college environments. They are not responsible for developing, accrediting, assessing or certification of University qualifications. The SQA can best be described as a 'national body' for qualifications in Scotland. There are many different types of qualifications which people can undertake and which allow for progression to take place.

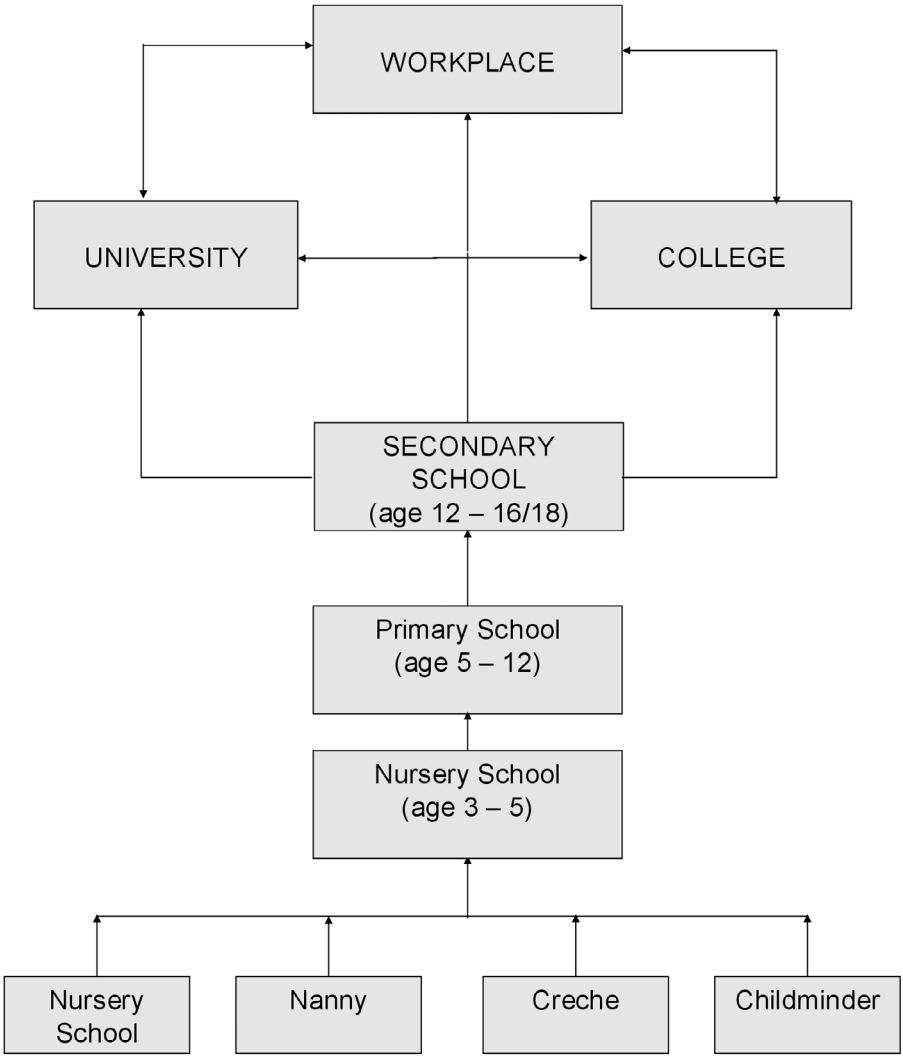
SQA is responsible for different qualifications which can be described as: Units, Courses and Group Awards.

Each Unit taught to a student must be assessed and this is marked by the teacher/lecturer and is the cross marked by SQA to ensure consistency and standardisation of the award.

3.2 Scottish Credit Qualifications Framework

◆ Each unit is allocated a number of points in relation to how much learning has had to be done to achieve it. This is known as the Scottish Credit Qualifications Framework (SCQF). There are a number of different levels ranging from 1 to 12 with 1 being the least difficult up to 12 which is the most challenging. Each qualification that a student undertakes is allocated a level and a number of credit points.

Overview of the Scottish Education System



3.3 Nursing Studies at University

◆ For students to progress to study at University many of them will attend College first and undertake the necessary qualifications. Different Universities set their own academic entrance requirements to study nursing. At present it is usually 2 or 3 'Highers' for students who progress directly from school. The minimum age is 16 years to begin nursing at University.

Many students who attend Colleges in Scotland will undertake a Higher National Certificate (HNC) in Health Care. An HNC is usually studied by students in a College environment. An HNC qualification is composed of a number of Higher National Units, usually 12 in total to achieve the award. Many of the students who study an HNC qualification in Health Care will progress to University to study for example Nursing, Physiotherapy, Speech Therapy, Occupational Therapy or Behavioural Science.

3.4 Scottish Vocational Qualification (SVQ) Units/Courses

◆ Scottish Vocational Qualification (SVQ) units are undertaken by many individuals in care work and are an excellent way for a worker to gain a qualification which is specific to their work role. SVQ's are often described as 'gaining a qualification on the job'. This means that people can continue to work and achieve a recognised qualification at the same time. These qualifications recognise the many skills, experience and knowledge which an individual has already in the work place.

All SVQ units are based on National Occupational standards. This applies to the Care sector as well as any other industry. These standards are drawn up by a 'sector skills council' and each of the units which the student studies will assess their level of competency. Each student must produce a portfolio of written evidence as well as being assessed actually demonstrating the particular skill they are being assessed on.

Each SVQ unit which the student achieves will be built up into a SVQ qualification which is transferable qualification in the work place. By law care establishments have to have their staff trained and this has led to an increase in the number of staff undertaking this type of qualification in the work place. Staff that work in the Social Care and Health Care sectors can complete SVQ qualifications.

Education of Practical Nurse in Scotland

The Scottish Healthcare System does not have a role which relates directly to that

of the 'Practical Nurse' as found in other European countries. The nearest role within the Scottish Healthcare System is the role of 'Healthcare Assistant' or more specifically that of the 'Healthcare Student'.

3.5 Health Care Assistants (HCAs)

◆ Also known as Nursing Auxiliaries or Auxiliary Nurses, these individuals work in a variety of settings such as hospitals, care homes and the wider community. Their role is supporting other healthcare professionals with the day-to-day delivery of healthcare.

The role of the HCA in the adult care team has developed significantly in recent times. HCAs make a significant contribution to the delivery of care to patients. The delegation of routine procedures to HCAs can facilitate the more effective use of the registered nurses' time for personal, professional or practice development purposes. Some specialised HCAs roles directly contribute to the achievement of health promotion and disease prevention targets and to the fulfillment of certain access targets (see chapter 5).

HCAs work under the guidance of a registered nurse and in some settings provide support to more specialised healthcare staff e.g. radiographers, technicians etc. Some HCAs already perform phlebotomy, take blood pressures and carry out registration health checks in certain specialised areas. The range of work done by HCAs is likely to increase to include other investigations such as audiometry, pulmonary function tests, electro-cardiography and simple dressings.

Currently within the practice setting, the job outline of a HCA may involve some ofthe following components:

Preparing treatment rooms and general ward areas for the safe delivery of patient care
Assisting patients' to achieve activities of daily living (ADL) as planned by the registered nurse.

- Taking and recording blood pressure - as requested by doctors or nurses.
- Testing urine specimens using appropriate equipment and recording results.
- Maintaining stocks of examination instruments and specimen collection materials.
- Maintaining stock levels and stock rotation as agreed with the registered nurses.
- Maintaining and ordering drugs, instruments and clinical supplies.
- Cleaning, autoclaving and correctly storing instruments.
- Perform ECG's as required.
- Performing venepuncture for patients if agreed as part of the HCA's role and contract.
- Ensuring that specimens brought in by patients or taken by doctors or

nurses are ready for collection by pathology service.
- Performing other clinical tasks as trained and agreed, to meet the needs of the practice setting.

Qualifications and Training

There are no national minimum entry requirements, but HCAs will generally be expected to have a good general education and perhaps previous voluntary experience in a caring role. Training mainly takes place on the job and can be supported by day release study courses. New recruits to the HCA role are trained in areas such as hygiene, health and safety, personal care, and communication with patients, and may also be taught how to measure and record temperature, pulse, respiration and weight.

HCAs normally have the opportunity to undertake a locally developed competency programme or a Scottish Vocational Qualification (SVQ) in Health and Social Care up to Level 3. Obtaining SVQ at Level 2 will enable the person to be given more clinical responsibility, while SVQ at Level 3 will allow the HCA to undertake a broad range of clinical activities without the direct supervision of a qualified nurse and may meet the minimum educational entry requirements at some Universities for entry to a nurse education programme. Some NHS Boards will employ HCAs attaining SVQ level 3 as 'Senior Healthcare Assistants' where the role demands a higher level of responsibility than a Healthcare Assistant.

NHS Boards wishing HCAs to undertake SVQs need to use the services of an approved local SVQ assessment centre. Some NHS Boards employ registered nurses as SVQ assessors whilst others use assessors from approved assessment centres such as local Colleges. Nurse assessors are required to gain the SVQ Assessor Award.

It is important that the HCA is valued as an integral member of the healthcare team. A mentor from the practice setting should be appointed to support the development of the HCA. Induction and foundation training should be provided within the first six weeks based on national standards established by Skills for Health (www.skillsforhealth.org.uk)

3.6 Health Care Students

◆ The Higher National Certificate (HNC) Health Care Student programme was an initiative launched by the then Scottish Executive Health Department in 2003. This development aimed to provide Healthcare Assistants within NHS employment with an opportunity to complete a one year nationally recognized education programme. On successful completion of the

programme the student is permitted to enter Year 2 of a Nursing Diploma/ Degree programme at a local University. Should the healthcare student decide not to proceed to University then they could remain within their current employment. The initiative is only available to HCAs wishing to follow a career in Adult or Mental Health Nursing.

A major incentive for HCAs to consider this opportunity is that they remain salaried for the one year of the HNC programme, and on registration with the NMC they are guaranteed employment as a qualified nurse within the NHS.

Aims of the HNC Healthcare Award

All HNCs have broad aims that allow candidates to:

- Develop transferable skills, including Core Skills,
- Develop personal effectiveness
- Develop critical thinking skills
- Progress through the levels of the SCQF framework and into first or second year of the Higher Education progamme
- Progression within a variety of health care settings to the level of Senior Health Care Assistant

The HNC programme equates with the first year of the Nursing Diploma /Degree programme (known as the Common Foundation Programme).

The HNC Health Care programme also has four Units which are common to this award and the HNC in Allied Health Professions, thus allowing candidates flexibility in their eventual choice of health career.

Target groups

The HNC Health Care aims to attract candidates who wish to:

- Pursue a career in health care as a Care Support Worker
- Gain entry to the Nursing Degree/ Diploma Programme
- Obtain a recognised qualification to undertake diploma or degree studies in health studies, health sciences or health promotion
- Go on to further study having completed a General Scottish Vocational Qualification (GSVQ) at level 3 or Scottish Group Award at Intermediate level 2 or Higher levels in Care or related areas
- Gain underpinning knowledge for the SVQs in Health and Social Care

3.7 What is the HNC programme like?

◆ The HNC Health Care programme is designed to allow candidates to join the Nursing Degree/Diploma programme and should allow progression into either 1st or 2nd year of the programme. The entry point is dependant upon the agreement with the University and on

the candidate completing 760 hours placement experience during the HNC programme. To achieve this number of practice hours the Health Care Student must spend 3 days per week in their practice placement. While this is not a requirement of the award, it is a strong recommendation of NHS Education for Scotland (NES) where articulation agreements exist between Colleges and Universities.

A mentor will be allocated to each Health Care student within the practice placement to facilitate and support the achievement of the required clinical competencies. A College lecturer liaises with the Health Care student within the practice placement to provide learner and mentor support and monitor the development of the clinical competencies.

Throughout the HNC programme Health Care students wear the same uniform as a University Nursing Student so they may be hard for you to identify. During your exchange visit, look out for their distinctive identity badge which identifies them as 'Health Care Student'. Numbers of health care assistants following this pathway are low, (approximately 30 per year in our local area of Tayside and Fife) but you may bump into one or two of them during your time in Scotland.

The nature of this award allows candidates to demonstrate their ability to work as part of a team and to work within a multidisciplinary environment. Furthermore, it enables them to relate theory to practice and to reflect on the skills required to become a registered nurse within the health care service.

Candidates should be able to develop skills which allow them to work with a variety of patients/clients/individuals in different health care settings and to practice in a non-discriminatory way. This award allows candidates to gain knowledge of the current legislation relating to health care, the policies and procedures in their placements and to critically evaluate their care of others.

Candidates will also be able to gain knowledge of health promotion throughout the award and use it to enhance their care of patients/clients/individuals to encourage prevention of ill health and promote healthy living strategies in general. The units of this award are outlined page 33.

Students will normally gain all the required clinical competencies of the HNC programme within their existing workplace. Occasionally, it may be necessary for Health Care students to undertake a practice placement out with their existing workplace to achieve any competencies which may not have been available.

HNC HEALTH CARE – FRAMEWORK, Mandatory Units

UNIT TITLE	CREDIT VALUE	SCQF* LEVEL
Physiology for Health Care Professionals	1.5	7
Physiology of the Reproductive System	0.5	6
Principles of Health Care Practice	1.0	7
Health Care Policy	1.0	7
Psychology and Sociology in Health Care	1.0	7
Health Care Practice Experience	4.0	7
Calculations and Practical Techniques in Health Care	1.0	7
Positive Health Care for Individuals	1.0	7
Health Care: Graded Unit	1.0	7

There are no Optional Units for this award. * SCQF = Scottish Credit and Qualifications Framework

The outcomes for the HNC Health Care programme are outlined below:

OUTCOME 1
Demonstrate an awareness of the principles of professional and ethical practice when caring for patients / clients.

Knowledge and/or Skills (K/S)
- Discuss in an informed manner, the implications of professional regulation
- Demonstrate an awareness of the relevant codes of professional conduct
- Demonstrate an awareness of, and apply, ethical principles to health care practice
- Demonstrate an awareness of legislation relevant to health care practice

OUTCOME 2
Develop and Maintain Professional Caring Relationship with Patients/Client

Knowledge and / or Skills (K/S)
- Know methods of, barriers to and boundaries of effective communication and interpersonal skills in the professional caring relationship.
- Demonstrate sensitivity in interaction with and provision of information to patients / clients.
- Maintenance of patient / client privacy, dignity and confidentiality.
- Demonstrate the importance of promoting equity in patient / client care by contributing to care in a fair and anti-discriminatory way.
- Recognise the effect of one's own values on relationships with patients / clients.

OUTCOME 3
Demonstrate skills in the delivery of care through participation in holistic care provision to meet the needs of patients / clients

The candidate is required to demonstrate to demonstrate knowledge, skills and understanding of the full care delivery process. The details of the knowledge and skills required in each of the areas of assessment, planning and evaluation of care, as well as when to refer a patient/ client on, are outlined below.
- Assessment, Planning, Implementation, Evaluation and Referral
- Be aware of assessment strategies to guide collection of data for assessing patients/ clients and use assessment tools under guidance.
- Discuss the prioritisation of care needs.
- Be aware of the need to re-assess patients/clients.
- Identify care needs based on the assessment of a client/patient.

- Participate in the negotiation and agreement of the care plan with the patient/ client and significant others, under the supervision of a registered practitioner.
- Inform patients/clients about intended actions respecting their right to participate in decision about care.
- Maintaining dignity.
- Privacy and confidentiality.
- Effective communication and observational skills including listening.
- Taking physiological measurements.
- Safety and health, including moving and handling and infection, control, essential first aid and emergency procedures.
- Administration of medicines.
- Emotional, physical and personal care including meeting the need for comfort, nutrition and personal hygiene.
- Demonstrating an awareness of the need to regularly assess a patient's/ client's response to health care intervention.
- Providing for a supervising registered practitioner, evaluative commentary and information on the care provided based on personal observations and actions.
- Contributing to the documentation of the outcomes of the care interventions.
- Demonstrating the ability to discuss and accept care decisions.
- Accurately recording observations made and communicating these to the relevant members of the health and social care teams.
- Recognise and acknowledge the limitations of their abilities.
- Demonstrate an understanding of when to defer to the registered practitioner.
- Demonstrate an ability to accept responsibility for their own actions and decisions.
- Identify examples of the use of evidence in planning care interventions.
- Reflect on their own practice and seek advice and support from a registered practitioner where necessary.

OUTCOME 4
Participate in inter-professional teamwork for the purposes of integrative care provision

Knowledge and/or skills (K/S)
- Understand and implement health and safety principles and policies
- Recognise and report situations which are potentially unsafe for patients/clients, self and others
- Identify the roles of the members of the health and social care team
- Work within the health and social care team to maintain and enhance integrated care

3.8 Employment opportunities

◆ The knowledge, skills and competencies achieved by candidates who successfully complete their HNC Health Care should enable them to secure employment in a variety of health care areas, including the statutory, voluntary or private sectors, as Health Care Assistant or Senior Health Care Assistant/Support Worker.

Below are some advertisements of local employment opportunities which are currently available to individuals having achieved such educational programme.

Health Advisor Assistant	
Grade:	Indicative Band 3
Salary: (pro rata where appropriate)	£14,388 - £17,219 pro rata
Type:	Part Time
Hours:	Call, Service Co-ordinator on 01382 ******
Location:	GUM Clinic, Local Acute Adult Hospital
Contract:	Permanent
Closing Date:	02/05/2008
Description:	Dundee CHP, GUM Clinic, Local Acute Hospital, Health Advisor Assistant – Indicative Band 3* [Salary Scale : £14,388 - £17,219 (pro rata) per annum] We require an individual to work within the Health Advising Team in Genito-Urinary Medicine Clinic at Local Acute Hospital. You must have experience working in a caring environment/role or a recognised qualification in healthcare (SVQ 3 or HNC Health Care) Informal Enquiries to Service Co-ordinator, Ryehill Health Centre, Dundee, 01382 ****** Hours of work are 25 per week. To request an application pack please: (0845 *** **** (24 Hour Recruitment Line) Please quote reference number - P/FM/61

Nursing Auxiliaries	Grade: Band 2
Salary: (pro rata where appropriate)	£12,481 - £ 15,485
Type:	Full Time
Hours:	Call Recruitment Line on 0845 ** 000 **
Location:	LOCAL Hospital
Contract:	Permanent
Duration:	
Closing Date:	09/06/2008
Description:	We are looking for enthusiastic Nursing Auxiliaries to work as team members within the Assessment and Rehabilitation Wards, LOCAL Hospital. You will deliver quality and individualised care under the supervision of a registered nurse, report to the registered nurse changes in patients' conditions and any other relevant information. You will have experience of working as part of a team with good communication skills. You should have the ability to relate to older people in a caring and compassionate manner. These posts are to provide rotational cover for wards 4,5,6,7 & 8 and will require alternate weekend working. This flexibility will allow you to gain valuable experience throughout the Elderly and Rehabilitation Service. Full training will be given and a comprehensive orientation programme will prepare you for your duties. Informal enquiries to: Speciality Development Manager.
Additional Info (how to apply):	To request an application pack please 0845 ** 00 ** * (24 Hour Recruitment Line) or email: recruitment.tayside@nhs.net (quoting the job reference number in the subject box).
For further information:	Call Recruitment Line on 0845 ** 00 **

Healthcare Assistant	
Grade:	Band 2
Salary: (pro rata where appropriate)	£12,481 - £15,485
Type:	Part Time
Hours:	30
Location:	Medicine & Cardiovascular Ward 4 Local Acute Hospital Dundee
Contract:	Permanent
Duration:	
Closing Date:	02/06/2008
Description:	You must have experience working in a caring environment/role or a recognised qualification in healthcare (SVQ 2 or 3) as well as an ability to work with people and as part of a multidisciplinary team Informal enquiries to Senior Charge Nurse, telephone 01382 660111
Additional Info (how to apply):	To request an application pack please telephone 0845 000 0*** (24hr) recruitment line or email recruitment.tayside@nhs.net quoting the appropriate job reference in the subject box.
For further information:	Call …….. on 01382 660111 ext ***** or *****

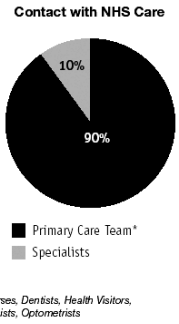
Local Nursing Home Vacancy	
Care Assistant	
CARE Assistants required for care home in Dundee area, we are looking for enthusiastic and dedicated staff to work as part of our friendly team providing 24-hour care. S/NVQ Level 2 in Care qualification would be advantageous but not essential as full in-house training will be given.	
For an application form please contact the Administration Department on 01382 ******.	
Registered	02-06-2008
Expires	03-06-2008
Job-ID	(328978317)
Job location	United Kingdom - Scotland - Angus
Job type	Full-time
Job categories	Health Services, Social Services
Position	Care Assistant, Care Worker, Carer
Education	S/NVQ Level 2 in Care
Skills - Some experience Healthcare (Health Services)	
Home nursing (Health Services)	
Intensive care (Health Services)	
Nursing (Health Services)	
Patient care (Health Services)	
Languages English	Excellent (written and spoken

Bottom of Form

4. The Organisation of the Healthcare Service in Scotland

◆ For most people contact with the NHS begins and ends in primary care. The professionals who provide these services are in every community: General Practitioners, nurses, health visitors, community pharmacists, optometrists, dentists, physiotherapists, occupational therapists, podiatrists and speech and language therapists and dieticians.

These community healthcare professionals manage 90% of patient contacts with the health service, co-ordinating diagnosis, treatment and care and ensuring that more of these services are provided as close to home as possible. They also have an expanding role in improving health, by helping patients to take more responsibility for actively managing their own health. Access to the hospital system of care is achieved via the General Practitioner (GP). During your exchange visit you will undertake your practice placement experience in a hospital setting but remember that the majority of adults are cared for within their local community.



The Patients' Journey

The process of gaining access to hospital treatment may vary for each individual depending on the type of treatment required, but generally the following steps apply:

GP Referral

All UK residents are required to register with a GP. Should the individual become unwell they should initially arrange to meet with their GP and discuss their health issue. The GP may decide that referral to a hospital specialist, known as a 'Consultant', is required and if so the GP will discuss the reasons for referral with the patient and gain their consent. The GP will usually write to the hospital requesting an appointment for the patient with the specialist at a hospital outpatient clinic.

Outpatient Consultation

The purpose of the initial outpatient consultation is to meet the Consultant who will review the GP's referral and recommend to the patient how they plan to proceed. In a limited number of cases the consultant may decide to admit the patient immediately for inpatient care and treatment.

Health Questionnaire
If the Consultant decides that further treatment is required as in inpatient but at a later date, the patient returns home and may be sent a Health Questionnaire prior to receiving an appointment date for the planned treatment. They are asked to complete and return the questionnaire as soon as possible. This is exactly what happened to Mr Fraser in Case Study 1.

Pre-Admission Assessment
Once the hospital receives and reviews the Health Questionnaire, the patient may be required to attend a pre-assessment clinic prior to coming in for their treatment. Alternatively, they may receive a pre-assessment telephone call from a nurse requesting some health details.

Appointment Date
Once the pre-admission assessment is completed, whether by telephone or by attending a clinic, an appointment date will be arranged and the patient receives a letter detailing the time and date of their planned admission to hospital. This letter provides information on their treatment, including how to prepare for this appointment and what they should bring with them to hospital.

Date of Treatment
On the day of admission to hospital the patient will be given further information regarding the treatment and is asked to give consent for the proposed treatment. This consent must be given in writing and is filed in the patient's case notes.

After treatment and discharge from Hospital
After treatment the patient's progress will be monitored closely. When they are well enough and feel able to return home, the Consultant will discharge them from hospital and the patient will be given individual advice about the recovery period at home.

Follow-up appointment (if required)
If the Consultant decides that a follow-up appointment is needed, the patient will either be given their next appointment date on the day of discharge, or it may be sent to them via post. If they have any concerns about their progress before this appointment, they are advised to telephone the hospital and ask for advice.

At the follow-up appointment the patient will be able to discuss how they feel with their consultant at this time and the consultant will decide whether further progress checks are needed in the future.

Flowchart summarising – 'The Patients' Journey'

5. The National Characteristics of the Healthcare System

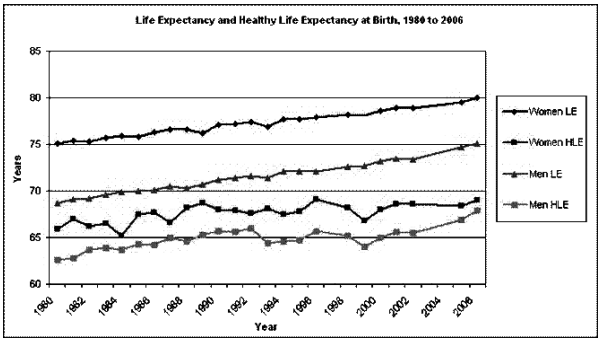
Life Expectancy and Healthy Life Expectancy

Life expectancy is the term used to describe the number of years that a person can expect to live on average. It is a single statistical measure used to assess the health of a population by monitoring its public health, health inequalities and the outcomes of health service interventions. It therefore provides vital information that informs the allocation of resources.

Life expectancy at birth for Scots has improved in recent years. Monitoring of this measure shows a continuing positive trend and a slight narrowing of the gap between males and females to under 5.0 years in 2006.

Examine the graph below and follow the 'LE' line to reveal males in Scotland now have life expectancy at birth of 75.1 years compared with 80.0 years for females. Whilst the Scottish Government are pleased with this improvement, life expectancy in Scotland remains low compared with most Western European countries. This presents many challenges for the future.

It is not just living longer that is important. Quality of life and healthy life expectancy (HLE) is essential. The graph below reveals that HLE has also increased in Scotland but at a slower rate than the increase in overall life expectancy. HLE is a measure based on a combination of life expectancy and self-assessed health (SAH). Notice from the graph that the gap between life expectancy and healthy life expectancy is greater for women than for men, suggesting that women spend more years of life in poor health.



Source: NHS Information Services Division (ISD Scotland)

5.1 The Most Common Diseases in Scotland

◆ The gradual increase in overall life expectancy in Scotland is in part due to improvements in both lifestyle and healthcare provision. These improvements have impacted by reducing premature mortality from Scotland's three big killers: cancer, coronary heart disease (CHD) and stroke.

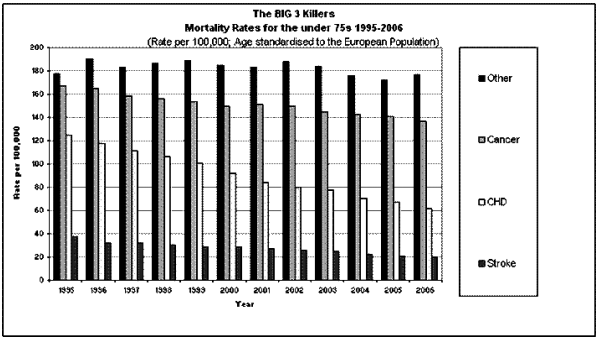
The overall mortality rate for the under 75s dropped from 507 per 100,000 in 1995 to 396 in 2006. This reduction in the mortality rate was largely due to a reduction on deaths caused by cancer, CHD and stroke. Combining these improved rates represents a fall from 329 per 100,000 in 1995 to 219 per 100,000 in 2006. This equates with a reduction from 65% of all deaths in 1995 to 55% in 2006.

Cancers

- In 2007, approximately 15,000 people died from cancer in Scotland. The most commom cancer deaths are due to cancers of the lung (4115), colorectal (1539), breast (1067) and prostate (793).
- The mortality rates for these four major cancers are generlly decreasing with the exception for lung cancer in females.

Taking all cancers combined, age-standardised cancer mortality rates have decreased by about 7% between 1997 and 2007, with a greater decrease in males than in females (11% and 5% decreases, respectively)

Taking all cancers combined, the rate of cancer mortality (standardised to the European standard population) in the under 75 year olds has decreased by 19% since 1995.



Note: Rates are European Age-Standardised Rates (EASR) per 100,000 population aged under 75 years.
Source: NHS (ISD Scotland)

The Scottish Government has a target to reduce the cancer mortality rate in this age group by 20% between 1995 and 2010.

Coronary Heart Disease
Coronary Heart Disease, also known as Ischaemic Heart Disease, is a major cause of death in Scotland. In 2006 it accounted for 9,532 deaths within a population of approximately 5 million people. Scotland has one of the highest death rates from CHD in the western world. This fact is attributed to high rates of smoking, poor diet and deprivation within certain areas. The prevention and treatment of CHD is a major focus of the work of NHS Scotland.

In the year ending 31 March 2007:
- NHS hospitals had 47,924 hospital discharges for CHD, of which 15,884 were patients having experienced an Acute Myocardial Infarction (AMI) also known as heart attack.
- CHD discharges represented around 4% of all acute hospital discharges.

NHS Scotland carried out 2,121 Coronary Artery Bypass Grafts (CABG), 5,779 angioplasties and 16,516 angiographies (for year ending 31 March 2007).

Treatment of CHD in Scotland places a major strain on NHS funding in Scotland.

Stroke (Cerebrovascular Accident)
Stroke (i.e. a cerebrovascular thrombosis or haemorrhage) is the third most common cause of death in Scotland and is a major cause of impairment and disability. It is estimated that approximately people 15.000 will suffer a stroke each year in Scotland. More than 1 in 5 strokes occur are in someone under 65 years of age. NHS hospital care of these individuals accounts for 7% of NHS bed usage and 5% of the entire NHS funding budget. Scotland has an estimated 100,000 stroke survivors.

5.2 Legislation and Funding of the Healthcare System in Scotland

◆ Modern Day healthcare in the United Kingdom is provided free to residents at the point of need. This 'National Health Service' (NHS) was set up in 1948 in an attempt to improve the health of the nation by encouraging United Kingdom (UK) residents to seek medical attention without the worry of having to pay for medical consultation or treatment. The architect of the NHS was a man called Aneurin Bevin, a Welshman. In 1945, towards the end of World War II, he was appointed as UK government Minister of Health and was charged with the responsibility of developing

a national health service. Three years later the NHS was born.

Prior to the development of this system, healthcare was a luxury not everyone could afford. Before the introduction of the NHS access to a doctor was free to those workers on lower pay, but this level of healthcare did not extend to their wives or children, nor did it cover other workers or people with a better standard of living. Hospitals used to charge for services, though sometimes poorer people would be reimbursed. Even so, it meant paying for service in the first place and those who couldn't afford the initial cost would avoid going to hospital when treatment was recommended. As a result of this system of charging, the health of the nation suffered. Furthermore, older people who were no longer able to look after themselves also fared badly. Many older adults ended their lives in what was known as the 'workhouse' where they did unpaid work in return for food and shelter.

The need for a more responsive, accessible and egalitarian health service was obvious and the National Health Service (Scotland) Act 1947 set about to provide such a service. Services available before the creation of the NHS were just the same as afterwards; no new hospitals were built nor were hundreds of new doctors employed. What was different was that the poor could now access healthcare free of charge from the 'cradle to the grave'. This was one of the most important founding principles of the National Health Service.

The NHS is funded through general taxation of the working population. There is also a small private healthcare system in the United Kingdom where individuals may choose to pay for private healthcare either through insurance or when they use its services.

The current National Health Service in Scotland is derived from one of the original three national health systems created in the United Kingdom after 1948. However, in 1998 the Scottish people voted in favour of establishing a devolved Scottish parliament separate from the central United Kingdom Government. This new Scottish government has legislative powers and is able to make certain localised decisions on issues directly affecting the Scottish population. The NHS Scotland is now a separate system from that of England Wales and Northern Ireland. Healthcare policy and funding is presently the responsibility of the Scottish Government achieved via the Scottish Government's Health Department.

The NHS Reform Bill (2003) was introduced by the Scottish Government to reform the structure of the NHS and bring it up to date. Its aim was introduce a number of changes in the structure of the NHS by decentralising

it and giving more power to healthcare staff.

There are significant differences in how the NHS works between the partner countries of the United Kingdom. This handbook deals only with Scotland.

How the NHS works

Minister for Health and Community Care
This is the government minister responsible for the NHS in Scotland, answerable to the Scottish Government for its performance.

Scottish Government Health Department
The NHS in Scotland is managed by the Scottish Government Health Department. Its role includes:

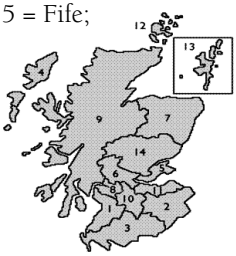
- Setting national objectives and policies on health
- Holding NHS Scotland accountable for its performance against these national objectives
- Intervening when serious problems arise that cannot be resolved locally

Primary and secondary health services
Health services in Scotland are divided into 'primary' and 'secondary' care services.

- Primary care covers everyday health services such as GP's surgeries, dentists and opticians. It accounts for over 90% of patient contact within the NHS
- Secondary care refers to specialised services such as hospitals, ambulances and mental health provision

Health Boards
Under the NHS Reform Bill all healthcare is now delivered by 14 regional NHS boards and eight 'special health boards'. These are identified on the following diagram.

1 = Ayrshire and Arran; 2 = Borders;
3= Dumfries and Galloway;
4 = Western Isles; 5 = Fife;
6 = Forth Valley;
7 = Grampian;
8 = Glasgow;
9 = Highland and Argyll;
10 = Lanarkshire;
11 = Lothian;
12 = Orkney;
13 = Shetland; 14 = Tayside



The NHS boards decide what primary and secondary health services their area needs. This used to be the direct responsibility of various local health 'trusts'. However, these trusts were abolished in April 2004 and their responsibilities have been taken over by the NHS boards.

If you are undertaking your exchange practice placement through Dundee College you will be located within Tayside Health Board.
Each NHS board is run by its own board of governors, made up of

senior medical staff and lay people. They have a duty to encourage public involvement and are accountable to the Scottish Government. NHS board responsibilities also include:

- Developing and implementing health plans to address the needs of Allocating resources and funding to local health services
- Assessing and managing the performance of the local NHS services
- Promoting health improvement programmes

NHS Tayside is the local board that is responsible for the provision of healthcare services in the area in which you will undertake your placement exchange.

Local Health Boards are supported by a number of non-geographical Special Health Boards including:

- NHS Health Scotland provides information and services relating to public health and health education and helps develop strategies for improving public health
- NHS Quality Improvement Scotland (QIS) is responsible for improving the quality of healthcare in Scotland
- Scottish Ambulance Service is the single public emergency ambulance service in Scotland
- The Golden Jubilee National Hospital is a special NHS Board in Scotland with the purpose of reducing waiting times using a single modern hospital located on the west coast near Glasgow
- The State Hospitals Board for Scotland is responsible for providing high security services for mentally disordered offenders and others who pose a high risk to themselves or others.
- 'NHS 24' is a special Health Board which runs a 24 hour telephone helpline serving Scotland. This telephone service aims to assess symptomatic callers and provide advice on access to services. Nurses also advise on how to manage an episode of illness at home. Health Information Advisors can provide information on a wide range of medical conditions, treatments, medicines and NHS services and can provide guidance on NHS policy and procedures.
- NHS Education for Scotland are responsible for training and e-library
- NHS National Services Scotland provides central support services for geographical NHS boards. It was formerly known as the Common Services Agency.

Primary care: 'Community health partnerships' (CHPs) exist to provide primary care under the NHS Reform Bill. Although they are technically part of NHS boards they have control of their own budget and medical staff form part of their management structure. The CHPs are responsible for providing services that the public can access directly such as:

- General Practitioners (GP's – family doctor)
- Dentists

- Pharmacists
- Community nursing
- Opticians

Secondary care: The NHS boards and several national special health boards are responsible for providing secondary care:

- 'Acute services', the specialised healthcare which is available from hospitals and outpatient clinics, are provided directly by NHS boards.
- Community care, such as care for the elderly in care homes and their own homes, and the long-term care of people with mental health problems, is also provided by NHS boards working with local authorities. In Scotland there is free personal and nursing care for the elderly – this is not the case in England and Wales!

The health of the population is seen as a major challenge in Scotland as there are high levels of obesity, cancer and heart disease. The overall trend is very much on public health awareness, understanding Scotland's particular health issues and developing health improvement programmes to tackle them.

How the private sector and the NHS work together

The private sector in Scotland is relatively small and because of the rural nature of Scotland, its coverage is limited. However, the policy of the Scottish Government is that where the private sector provides a value-for-money alternative to NHS care, it may be used to reduce NHS waiting times. The private sector works with the NHS in Scotland in a number of ways.

Outsourcing treatments: Parts of the NHS use private healthcare companies to help them provide more treatment to more people and to help reduce waiting lists.

Private finance initiatives (PFI): The government is building more hospitals using private money. PFI is a way of funding major public building projects and involves private companies contracted for about 30 years to design, build and manage these large new projects. The building is leased by the health board from the private company for this period while the government pays back the building cost with interest. Because the payment can be spread over time the government has been able to start an extensive building programme. Generally speaking the Scottish public are in opposition of the involvement of private financing of their beloved National Health Service.

The private healthcare sector

There are a number of ways for people to access private healthcare.

Private health insurance: One of the largest private healthcare companies in the UK is called 'BUPA'. Membership of health insurance schemes offered by

BUPA accounts for a large proportion of private health treatment in the UK. Many employers are now offering membership of such schemes as an incentive to employees. Individuals or companies pay a monthly or annual premium to such companies.

Secondary care in the private sector: Secondary care, which refers to more specialised health treatment such as hospitals, mental health provision and care for the elderly, is especially well served by the private sector. While people may be registered with an NHS GP the private sector is often used for secondary care such as:

- Diagnostic tests for certain conditions
- One-off specialist treatment, such as visiting a dermatologist
- Specific operations in a private hospital
- Non-essential treatment such as cosmetic surgery
- Treatment for addiction or rehabilitation

The private healthcare sector does not have the same structures of accountability as the NHS. The private healthcare system does reflect the NHS in that it provides GPs consultations, nursing homes, ambulances, hospitals and consultation with medical specialists, but it does not have to follow national treatment guidelines and health plans. More importantly, it does not have responsibility for the health of the wider local community, only for its paying clients.

5.3 Regulation and Quality of Healthcare

Providing guidance on medical treatment

The Scottish Medicines Consortium provides advice to NHS boards about all newly-licensed medicines, new versions of existing medicine and any new information about established medicines.

Monitoring healthcare standards

NHS Quality Improvement Scotland (QIS) is the special health board responsible for improving the quality of healthcare in Scotland. It sets standards and monitors NHS performance against these standards. Its role includes:

- Issuing advice and guidance on good clinical practice and service improvements
- Issuing advice and guidance on medical devices and technologies
- Learning lessons about patient safety from adverse events
- Collecting and publishing clinical performance data

The need to provide high quality evidence-based care is imperative to NHS Scotland. Nationally developed guidelines provide a 'state of the science' for a particular disease or treatment and provide concrete examples of

how clinically effective and patient focused care should be provided. These National guidelines must be adapted to reflect local circumstances and cannot be put into practice without local analysis and application. Nurses need to continue developing skills of critical reflection on practice and the use of existing knowledge to inform strong clinical judgements. The range of professional guidelines available to nurses is increasing particularly relating to up to date practice and clinical governance. Clinical guidance and protocols are available from the Scottish Intercollegiate Guidance Network (SIGN) which was established to generate and distribute guidelines based on the best available evidence (www.sign.ac.uk). The Cochrane library (www.cochrane.co.uk) provides systematic reviews on a range of health care literature with he aim of providing practitioners with sound evidence upon which to base practice. Policies and protocols authorise nurses to practice utilising the most up-to-date knowledge and thus it is important that they are familiar with those relating to their practice area.

Monitoring social care standards

The Scottish Commission for the Regulation of Care (located within Dundee) is the body responsible for regulating the quality of all adult, child and independent healthcare services in Scotland. Its role is to:

- Provide information to the public about care services
- Report to the Scottish Government on care services
- Inspect all care services covered by the Regulation of Care (Scotland) Act 2001
- Deal with complaints made about the services it regulates
- Take legal action when some services fail to improve

The 'Scottish Social Services Council' is another authority that exists to raise standards in social work and social care, mainly by regulating the social services workforce, its education and training.

Health education and improvement

Most of the responsibility for educating and improving the health of the public lies with the NHS boards, and they also work with local authorities. 'NHS Health Scotland' is a special health board whose role is to develop strategies for improving public health. Its role will include:

- Collecting and analysing information on health improvement
- Developing new health improvement policies and programmes
- Reviewing international, national and local strategies aimed at health improvement in Scotland

Investigating complaints

The Scottish Public Services Ombudsman is completely independent of the NHS and the government and investigates complaints about the NHS and private healthcare providers if the treatment was funded by the NHS.

Regulating of medical and nursing professionals

The Council for the Regulation of Healthcare Professionals is the umbrella body answerable to the UK Parliament, which represents the regulatory councils for nurses, doctors, pharmacists, opticians, osteopaths and chiropractors. It promotes good practice in the regulation of healthcare professions. The General Medical Council (GMC) has a role in protecting public health and can take action against doctors where there has been a serious professional misconduct. The Nursing and Midwifery Council (NMC) is the regulatory body for nurses and midwives in the UK. The NMC publishes the Code of Professional Conduct as identified in Section 3.

5.4 Challenges for the Future

NHS Performance Targets

In December 2004, the Minister for Health and Community Care launched a major policy paper on NHS targets and performance called "Fair to All, Personal to Each". This gives details of NHS targets to the end of 2007 and beyond.

NHS Scotland's performance is managed to ensure that we can:

- Improve the quality and effectiveness of services to patients
- Put patients and their needs at the centre of service development
- Achieve greater consistency in healthcare provision across Scotland
- Improve health and reduce inequalities
- Promote partnerships between patients and professionals who care for them
- Promote the integration of the different parts of the NHSiS and provide seamless services
- Increase accountability of the NHS, and the amount of information available to the public and patients
- Promote partnerships between the NHS in Scotland and other organisations whose work can help improve health and quality or services.

To support this work a Local Delivery Plan sets out a delivery agreement between the Scottish Government Health Department and each NHS area Board, based on the key Ministerial targets. Local Delivery Plans reflect the key objectives, targets and measures that reflect Ministers' priorities for the Health portfolio. The key objectives are as follows:

Health Improvement Targets for 2007

- Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including: coronary heart disease, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.
- Reduce rate of smoking among adults (16-64 age group) in all social classes to 29%: target date 2010. Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men, and of 14 units to 11% of women: target date 2010.
- 50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week.

Access Targets for 2007

- Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours from April 2004.
- No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.
- By the end of 2005 no patient will wait longer than 6 months from GP referral to an out-patient appointment, reducing to 18 weeks from 31 December 2007.
- By end 2007 no patient will wait more than 4 hours from arrival to discharge or transfer for accident and emergency treatment.
- By end of 2007 the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.
- By end of 2007 the maximum wait for admission to a specialist unit for hip surgery, following a fracture, will be 24 hours.
- The maximum wait from urgent referral to treatment for all cancers is two months; women who have breast cancer and need urgent treatment will get it within one month where appropriate.
- By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent and no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment.
- By the end of 2007 patients will wait no more than 9 weeks for any MRI or CT scans and other key diagnostic tests.
- To respond to 75% of Category A (Emergency) calls within 8 minutes in 2007/08 (mainland Health Boards only).

Treatment Targets for 2007

- The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced by 50% from April 2006 to April 2007 and to zero by April 2008. Additionally, the number of patients delayed in short-stay beds will be reduced by 50% from April 2006 to April 2007, and to zero in April 2008.
- By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008.
- Cervical screening target 80%: ongoing.
- QIS clinical governance and risk management standards improving.
- To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010.

Efficiency Targets for 2007

- NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement; meet their cash efficiency target.
- NHS Boards to achieve time-releasing savings including an increase in consultant productivity by 1% pa over the next 3 years and a sickness absence rate of 4% by 31 March 2008.
- Universal utilisation of CHI (Community Health Index).

6. What is European Health Policy Like?

6.1. Background

◆ **European Union's recent general health policy lines** were set out in 2002 with the concept of a **Europe of Health** in 2002. Work was undertaken on addressing health threats, including the creation of a **European Centre for Disease Prevention and Control** (**ECDC**) (2004), developing cross-border co-operation between health systems and tackling health determinants. The Community's **health information system** provides a key mechanism underpinning the development of health policy. This development work has already resulted for example in European health insurance card.

Naturally work and efforts in promotion of health had taken place during previous years. One significant effort being programme of **Community health monitoring programme (1997-2002)**. The aim of the programme was to produce a health monitoring system to monitor the health status in the Community, facilitate the planning, monitoring and evaluation of Community programmes and to provide member states with information to make comparisons and to support their national policies.

Before existing Programme of Community Action in the Field of Public Health was drawn lot of previous work and programmes had been carried out. Development of health indicators (Programme of Community action on health monitoring) has resulted in European Community Health Indicators (ECHI). Other programmes have been e.g. pollution related diseases programme, the cancer programme, the drugs prevention programme and rare diseases programme. Previously carried out work has resulted in following programme.

Aim has been on prevention and finding joint indicators and monitoring systems to facilitate comparison of health status and determinants effecting it.

6.2. Present situation

Programme of Community action in the field of public health (2003-2008)

The Council and Parliament set in 2002 as overall aim "**to protect human health and improve public health**" and as **general objectives**:

A. to improve information and knowledge for the development of public health; that is to be reached by e.g. following measures:

- developing and operating a sustainable **health monitoring system to establish comparable**

quantitative and qualitative indicators at Community level … concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health;

- developing an **information system for the early warning, detection and surveillance of health threats**, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases;
- improving the **system for the transfer and sharing of information and health data** including public access and by improving analysis of **health policy developments** and of other Community policies and activities.

B. to enhance the capability of responding rapidly and in a coordinated fashion to threats to health; that is to be reached by following types of measures:

- enhancing the capacity to **tackle communicable diseases** by supporting the further implementation of Decision No 2119/98/EC on the ***Community network*** **on the epidemiological surveillance and control of communicable diseases**;
- supporting the network's operation in relation to common investigations, training, continuous assessment, quality assurance
- developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable **disease threats, including gender-specific health threats and rare diseases**
- exchanging information concerning strategies in order to **counter health threats from physical, chemical or biological sources in emergency situations**
- exchanging information on **vaccination and immunisation strategies**;
- enhancing the **safety and quality of organs and substances of human origin, including blood, blood components and blood precursors**
- implementing vigilance networks for human products, such **as blood, blood components and blood precursors**;
- developing strategies for **reducing antibiotic resistance**.

C. to promote health and prevent disease through addressing health determinants **across all policies and activities**; that is to be reached by following types of measures:

- preparing and implementing strategies and measures, including those related to public awareness, on **life-style related health**

determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;
- analysing the situation and **developing strategies on social and economic health determinants**, in order to identify and **combat inequalities in health and to assess the impact of social and economic factors on health**;
- analysing the situation and developing strategies on **health determinants related to the environment**
- analysing the situation and exchange information **on genetic determinants and the use of genetic screening**;
- developing methods to evaluate quality and efficiency of health promotion strategies and measures;
- encouraging relevant training activities related to the above measures.

6.3. Future

Programme for Community Action in the Field of Health 2007-2013

The new Community Action in the field of Health sets three broad objectives. These objectives align future health action with the overall Community objectives of prosperity, solidarity and security. This will help to create synergies with other Community programmes and policies – which is inevitable as health issues and their origins derive from existing environment, society and economy. It is to form a continuum for predecessing programme 2003-3008. The objectives of new programme are to:

1. Improve citizens' health security
- to protect citizens against health threats including working to develop EU and Member State capacity to respond to threats
- to cover actions such as those in the field of patient safety, injuries and accidents, and community legislation on blood, tissues and cells and in relation to the International Health Regulation.

2. Promote health for prosperity and solidarity
- to foster healthy active ageing and to help bridge inequalities, with a particular emphasis on the newer Member States.
- to incorporate action to foster cooperation between health systems on cross-border issues such as patient mobility and health professionals.
- to cover action on health determinants such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

3. Generate and disseminate health knowledge

- to exchange knowledge and best practice in areas where the Community can provide genuine added-value in bringing together expertise from different countries, e.g. rare diseases and cross-border issues related to cooperation between health systems
- to cover key issues of common interest to all Member States such as mental health.
- to expand EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens in a user-friendly manner, such as the health portal.

Despite being reduced in scope compared to the original proposal, the modified Programme proposal is broad enough to be able to accommodate key health issues as well as those which may arise unexpectedly and need urgent attention.

7. References

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On Chapter 6:

Amended proposal for a DECISION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL establishing a second Programme of Community action in the field of Health. Brussels, 24.5.2006/ COM(2006) 234 final/ 2004/0042 A (COD))

http://ec.europa.eu/health/ph_overview/pgm2007_2013_en.htm

http://ec.europa.eu/health/ph_programme/programme_en.htm

Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008))

The WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth" WHO, Copenhagen, Bled 19 November 2007

Useful websites

http://www.cochrane.co.uk

http://www.icn.ch

http://www.isd.scotland.org

http://www.nursingworld.org

http://www.scotland.gov.uk

http://www.sign.ac.uk

http://www.skillsforhealth.org.uk

8. Glossary of Terms

Adult Nurse – A registered nurse who nurses adult patients

Bay – Area within a hospital ward where beds are located

Body Mass Index (BMI) – A health index based on the ratio of weight to height

Community Health Index (CHI) – A unique numeric identifier, allocated to each patient on first registration with the healthcare system, based on birth date and gender

Consultant – A senior specialist doctor

Holistic – Considering the physical, psychological, sociological and spiritual

General Practitioner (GP) – A doctor based within a community health centre (family doctor)

Medicine round – A specified time when medication is dispensed to patients

Mentor – A guide or supervisor during a learning experience

Programme – A period of educational study

Porter – Member of the healthcare team who transports patients

Shift – Period of time spent on duty within the work place

Theatre pack – Bedding folded into a special pack for use post-operatively

Ward – An area within a hospital where patients reside

Ward round – A time when the healthcare team go round the ward to review patient progress

Vital Signs – Measurement of the patient's physiological status e.g. pulse, temperature and blood pressure

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