

2nd Edition

UNDERSTANDING PERSON-CENTRED CARE

FOR NURSING ASSOCIATES

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Chapter

2

Acute and long-term care

NMC STANDARDS OF PROFICIENCY FOR NURSING ASSOCIATES

This chapter will address the following platforms and proficiencies:

Platform 3: Provide and monitor care

At the point of registration, the nursing associate will be able to:

- 3.1 demonstrate an understanding of human development from conception to death, to enable delivery of person-centred safe and effective care
- 3.3 recognise and apply knowledge of commonly encountered mental, physical, behavioural and cognitive health conditions when delivering care
- 3.5 work in partnership with people, to encourage shared decision making, in order to support individuals, their families and carers to manage their own care when appropriate
- 3.7 demonstrate and apply an understanding of how and when to escalate to the appropriate professional for expert help and advice
- 3.11 demonstrate the ability to recognise when a person's condition has improved or deteriorated by undertaking health monitoring. Interpret, promptly respond, share findings and escalate as needed
- 3.12 demonstrate the knowledge and skills required to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain
- 3.19 demonstrate an understanding of co-morbidities and the demands of meeting people's holistic needs when prioritising care

Chapter aims

After reading this chapter, you will be able to:

- use a systematic assessment method to recognise the different needs of patients with acute and long-term conditions;
- identify patients' needs across their lifespan;

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- describe person-centred care in relation to the four fields of nursing;
- develop the varied interpersonal skills needed to provide person-centred care for patients with acute and long-term conditions alongside registered nurses.

Introduction

As a nursing associate, you have a broad scope of practice that can be implemented to meet the needs of patients in any setting. Importantly, you need to be able to care for people across their lifespan and in the context of all four fields of nursing: adult, paediatric, mental health and learning disability. In other words, nursing associates are generalist practitioners, which makes them unique in comparison to the four fields of nursing and the multidisciplinary team (MDT). This chapter will provide you with the tools that you need to provide person-centred care in a wide variety of clinical environments for a very diverse patient population. You will be able to achieve the aims of this chapter by engaging with the learning features found throughout, including activities, case studies and 'Understanding the theory' boxes. You will be able to find outline answers at the end of the chapter, as well as an annotated list of further reading and a list of useful websites. Patient diversity was discussed in Chapter 1, and one key learning point was that nursing associates need to be able to provide person-centred care because each patient is different. There are too many conditions that patients could have to list, but they can be identified as either an **acute condition** or a **long-term condition** ('long-term' is also known as 'chronic').

What does acute mean, however? How long does a condition need to last before it is identified as a long-term condition? In short, an acute condition is a sudden deterioration in the patient's health, physically or psychologically, that is usually reversible if the appropriate treatment is provided. In comparison, a long-term condition is a physical or psychological condition that has no cure. A long-term condition may improve over time, remain stable or become progressively worse. If a long-term condition suddenly deteriorates, it is known as an exacerbation. In other words, an exacerbation of a long-term condition then becomes an acute condition. Diabetes is a relevant example.

Diabetes is a long-term condition that affects a patient's ability to produce the hormone insulin from the pancreas to control glucose levels in their blood. Type 2 diabetes is the most common type of diabetes in the United Kingdom, usually caused by poor lifestyle choices (particularly an unbalanced diet, sedentary lifestyle and/or smoking). Type 1 diabetes is a **hereditary** condition, usually diagnosed in childhood. For type 1 diabetes, patients need insulin injections, or they can wear an insulin-releasing patch that ensures their glucose levels are controlled. Patients with type 2 diabetes may be able to manage their diabetes with a balanced diet and regular exercise. Some patients with type 2 diabetes, however, may be prescribed a medicine called metformin or they may also need insulin (NICE, 2019). As you can see, diabetes is a long-term condition with multiple subcategories that require different interventions of care. If a patient's diabetes becomes unstable, however, they may have a hypoglycaemic attack. This is when the capillary blood glucose (CBG) level drops below 4.0 mmol/L. This is very serious because the patient's **metabolism** will not function correctly. If a hypoglycaemic attack is not treated with a

source of simple glucose (e.g. a sugary drink) followed by complex carbohydrates that break down into sugar slowly (e.g. toast), the patient could become unconscious, which will lead to a diabetes-induced coma. A hypoglycaemic attack is known as an acute condition. The following case study illustrates a real-life example of how a patient can have both acute and long-term conditions.

Case study: Alice

Alice is a 58-year-old business manager in a large technology company. She has worked for the company for nearly 20 years and is a senior member of staff with many responsibilities. Three years ago, she was diagnosed with a cardiac condition called angina. Her cardiologist explained that angina is the narrowing of the coronary arteries that supply oxygenated blood to the heart muscle (**myocardium**). The narrowing of the arteries is caused by atheroma, the gradual buildup of fatty deposits in the artery walls. She explains to her cardiologist that she often eats takeaway food for both lunch and dinner because it is convenient and allows her more time to work, rather than cooking. Her cardiologist explains that the chest pain she has been experiencing is caused by insufficient blood flow to her heart when her blood pressure is raised due to exercise or stress. Alice is concerned by her diagnosis, but the cardiologist reassures her that if she makes positive lifestyle choices with her diet and starts to do regular exercise, she will be able to control her angina.

Alice decides to change her diet. She starts to prepare nutritious meals for lunch and cook homemade food for dinner, and on Fridays she goes out to a restaurant with her partner as an end-of-week treat. Her workload, however, starts to become unmanageable. She does her best to meet the company directors' expectations but starts to have episodes of severe chest pain again. On one occasion, the pain is so intense that her colleague calls an ambulance and Alice is brought to her local A&E department. Her vital signs are measured by the nursing associate and she is reviewed by the medical registrar. The medical registrar diagnoses Alice with an angina attack and prescribes a medication called glyceryl trinitrate (GTN) that stops the chest pain.

Alice is referred back to her cardiologist for a review. The cardiologist explains that an angina attack is an acute condition that can be managed by administering GTN. The correct method is to spray the medication twice under the tongue so that it is quickly absorbed into the bloodstream. Alice learns that the GTN relaxes the smooth muscle cells in her coronary arteries, causing them to dilate and allow oxygenated blood to flow to the myocardium more easily, thus stopping the pain. The cardiologist explains that an angina attack is an exacerbation of her long-term condition, angina. The cardiologist recommends that Alice books an appointment with her workplace's occupational health department for support on how to reduce her workload so that she is not constantly stressed. This will reduce the risk of her having an angina attack, providing she continues with the positive lifestyle changes she has already made.

Alice's case study demonstrates that a patient can have both acute and long-term conditions. Acute and long-term conditions change over time as a result of many influencing factors. In Chapter 8, you will read about how you can provide person-centred health promotion to help patients manage their long-term conditions, but for now complete Activity 2.1 to consolidate your understanding of acute and long-term conditions.

Activity 2.1 Reflection

The patients you care for often have many co-morbidities that can include both acute and long-term conditions (e.g. Alice in the previous case study had angina and chronic stress). The next time you are in clinical practice caring for a patient, identify (in your head) which of their conditions are acute and which are long-term. Think about the differences in the care they may need for each of these conditions. Have a reflective discussion afterwards with your supervisor or the registered nurse you are working with to check your thoughts.

As this activity is based on your own reflection, there is no outline answer provided at the end of the chapter.

Whether a patient you are caring for has an acute or long-term condition, you will need to complete an assessment to establish what their health and social care needs are. Remember, patients often have complex health and social care needs – that is, some patients may have physical and psychosocial needs. As a result, your assessment must be thorough, and it goes without saying that you cannot overlook or miss anything that is potentially significant. To reduce the risk of this happening, you need to use a systematic patient assessment tool; a step-by-step guide when assessing patients that will help you to identify what their health and social care needs are. Remember that as a nursing associate, you should always provide person-centred care, which includes all aspects of patients' health and social care needs. In other words, you should provide holistic person-centred care. The next section looks at some of the assessment tools that you can use in your clinical practice.

Systematic patient assessments

There are many assessment tools that you can use in your clinical practice. Some are used in specific clinical environments, whereas others are generic. The nursing process is a tool that can be applied to any patient, in any clinical environment, at any stage of their lifespan. Considering that you will be working with patients across their lifespan and in any of the four fields of nursing, the nursing process is very useful for you to have awareness of because it is generalisable. In other words, the nursing process can be used as your guide, which can be of great support to you if you are working in a new clinical area and are unsure what you are expected to be doing. To learn more about the nursing process, read the following box.

Understanding the theory: the nursing process

According to Howatson-Jones et al. (2015), the nursing process has five stages. You can use the nursing process to guide you through the caring process of any patient. The nursing process does not tell you specifically what to do, but it does provide high-level guidance to your practice. The steps below have been adapted for nursing associates, based on Howatson-Jones et al.'s (2015) nursing process. These can be reassuring if you are working in a new area that is unfamiliar to you.

1. Assessment

In the assessment stage, you can use a patient assessment tool to help you establish what the patient's needs are. This is the stage when you gather all the information about the patient's condition and situation. Your main role here is to identify any red flags (signs of deterioration) and what care needs the patient has, as well as being ready to communicate this succinctly to a registered nurse.

2. Patient goals

Nursing associates do not provide a diagnosis, but you can identify what the patient's primary concerns are. Another way to describe this stage of the nursing process is that you are identifying the patient's goals in relation to their health and wellbeing. They may have an immediate need, such as pain relief, or a more long-term goal, such as being able to walk independently after having a stroke. Always remember to escalate any concerns outside of your scope of practice to the appropriately qualified practitioner – check the *Standards of Proficiency for Nursing Associates* if you are unsure (NMC, 2018a). It is highly likely that there will be more than one goal, especially as health needs can become complex across the lifespan, hence why you need to complete a thorough holistic assessment. Remember that there may be other health and social care concerns that the patient is not aware of themselves. For example, a patient who is living with severe additional learning needs may not completely understand how unwell they are. If so, consider alternative communication methods to establish patient goals. To find out more, read the section on SMART goals later in the chapter.

3. Planning

After your assessment and establishing the patient's goals, you need to plan what you are going to do to meet the patient's needs. This may be something you, as a nursing associate, will do, or you will make a referral to another member of the MDT. If there is more than one goal, you need to put them into priority order. Later in this chapter, you will read about the A-G assessment tool, which can help you with prioritising. Remember to include in your plan a time frame for implementation and evaluation, which will be recorded in the patient's care plan. You will read about care plans later in this chapter too.

4. Implementation

This is the stage where you and other members of the MDT will put the plan into action. By doing so, you will be supporting the patient to achieve the goals that you identified in the second stage. Remember to adhere to the principles of person-centred care, as discussed in Chapter 1.

5. Evaluation

After all implementation steps have been completed, the final stage of the nursing process is to evaluate if the patient's goals have been achieved. If they have, great – the patient is likely to be transferred to another service or discharged. There will be times, however, when the patient's goals have not been achieved for some reason. The patient (and you) may feel frustrated by this, but remember that there are some circumstances which are out of our control. The important thing to remember at this stage is that the nursing process is cyclic, meaning you can restart at any point, at any time. It may be that the implemented care did

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not work for this patient on this occasion, and so a new assessment, nursing diagnosis and plan need to take place.

The nursing process only has five stages, which has great benefits because you do not need to spend a long time remembering a complicated formula. Although the nursing process is simple and easy to remember, using it as a framework to your clinical practice will provide you with guidance to provide person-centred care for a patient. Furthermore, the nursing process is flexible, allowing you to stop and restart at any stage. The next time you go into clinical practice, try to identify what happens for a patient at each stage of the nursing process and compare this with another patient's care. You will be able to see that the nursing process is a tool that can be applied to all clinical environments for any patient.

Case study: Oliwia

Oliwia is a mother who gave birth 7 days ago. Her baby is healthy, and Oliwia is also physically well; however, she has been feeling more down than usual. Oliwia was seen at home by a nursing associate working in a health visitor service. During the visit, Oliwia was asked by the nursing associate how she was feeling. Oliwia explained that she was glad her baby was healthy, but she wanted to know if she should be concerned about her low moods. The nursing associate explained that postnatal depression is common and can affect 1 in 10 women in the United Kingdom, usually during the first two weeks after birth. The nursing associate used the nursing process to guide their clinical practice.

1. Assessment – The nursing associate noted that Oliwia explained she was experiencing low moods, which could suggest postnatal depression.
2. Patient goals – Oliwia wanted to know if she should be concerned about her low moods.
3. Planning – The nursing associate arranged for Oliwia to see her GP for a formal diagnosis and possible treatment options.
4. Implementation – The nursing associate made this appointment for Oliwia during the visit and providing some additional patient education material about mental health and wellbeing after giving birth.
5. Evaluation – The nursing associate asked if Oliwia was satisfied with the care that was provided, and Oliwia explained she felt glad that she was supported to make an appointment with her GP for further investigation.

In this case study, you can see that the nursing associate has used the nursing process as a guide to their practice. The nursing process did not tell them what to do but guided their decision making to ensure the health and social care needs of the patient were met. This case study also demonstrates that the nursing process can be used when a patient's needs are not physical – rather, in this case study, Oliwia's needs were related to her mental health.

Whenever you care for a patient, you will subconsciously complete the first stage of the nursing process (i.e., assessment). Whether you are revisiting a patient or meeting them for the first time, you will often gain a first impression of their health and wellbeing. Have you ever looked at someone and suddenly thought, "They do not look very well at all"? This is your clinical

intuition, or first impression. It is likely that you are already able to identify your clinical intuition because there are some easily identifiable signs and symptoms to look out for when gaining a first impression of how well or unwell a patient is. Complete Activity 2.2 to help you recognise the potential stages of the thought process that you are using in your clinical intuition.

Activity 2.2 Reflection

When first meeting a patient, even if you have met them before, using your clinical intuition can help you to identify if the patient is acutely unwell or in pain, or has a different immediate care need. This activity lists four topics of different signs and symptoms that you can observe when initially meeting a patient. You may already subconsciously assess these, but reflecting on them can help you to consolidate your practice. To help you remember them, the observations have been listed as 'A to D'. You could complete this A-D assessment before moving on to the more familiar A-G assessment, which is discussed later in this chapter. The only equipment that you need for an A-D assessment is your basic observation and communication skills.

1. Appearance

Imagine that you are approaching a patient, either in a hospital or in their own home. At this stage, take note of how they appear. Make sure that you assess their appearance objectively, not subjectively. Describing a patient's appearance as 'scruffy' could have many different interpretations, or even be hurtful, whereas describing their appearance as 'partially dressed and unshaven' is objective. You may notice that the patient's colour is different: cyanosis (blue), flushed (red), jaundiced (yellow) or mottled (patchy colours). Be careful not to start describing their behaviour until the next stage.

2. Behaviour

As you get closer to the patient, observe their behaviour. An important question to ask yourself is, 'Is this behaviour expected and appropriate for this patient?' If the patient is acting out of character, this could be a sign that something is wrong. If you have never met the patient before, assessing their behaviour is more challenging, but you can use your intuition and common sense. For example, it is typically unusual for an elderly patient to swear at you before you have introduced yourself (although there may be exceptions, of course!). Unexpected behaviour could be a sign of an underlying acute or chronic condition, such as delirium. If you are still unsure, move on to the next stage to establish more information.

3. Communication

You are now likely to be next to the patient, so you need to introduce yourself. The best way to do this is by continuing the legacy of Dr Kate Granger, a consultant geriatrician who had cancer. During her treatment, she noticed that she did not know many of the healthcare staff's names, so she started a campaign called #hellomynameis (Granger, 2013). Dr Granger advocated that all health and social care staff should introduce themselves using 'Hello, my name is ...' so that every patient knew who was looking after them. Her legacy has spread around the world and has unquestionably improved standards of care. At this stage of your initial assessment, you can also shake the patient's hand (providing you maintain infection control precautions). By doing this, you will be able to assess the patient's warmth, strength and coordination, as well as helping to build a rapport between you and the patient.

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4. Demeanour

The final stage of your initial assessment is an assessment of the patient's demeanour. You have now spent around 30 seconds gathering important information, so you will be able to identify any first impression concerns. The patient may have told you, 'I am in a lot of pain', which is evidently a high priority; however, some patients may not want to be a nuisance, and will avoid saying they are in pain, but their actions may tell you otherwise. Lastly, this is a perfect opportunity for you to ask the patient what their main concern is and what they would like you to do. Asking this question demonstrates that you are putting their concerns at the centre of your care, and hence you are demonstrating person-centred care.

The next time you are in clinical practice, see if you can identify if you are observing these items, or whether you have observed something else with a patient you are caring for. Discuss your reflection with your supervisor or line manager the next time you meet with them. Remember that your initial assessment using your clinical intuition, such as the observations listed in this activity, will inform the next part of the nursing process. If you are concerned by something or recognise that a patient is acutely unwell, call for help from your supervisor or another nearby registered practitioner to help you.

As this activity is based on your own reflection, there is no outline answer provided at the end of the chapter.

Completing an initial assessment, such as the A-D assessment in Activity 2.2, in clinical practice will inform the nursing process and your next assessment. Linking back to the nursing process, you need to choose an appropriate assessment tool in order for you to identify the patient's goals. Remember, patient goals may differ depending on their lifespan and which of the four fields of nursing you are working in. There are many assessment tools that you can use, but your trust may advocate a particular one.

A reliable and transferable tool is the A-G assessment. It is important to note that each NHS trust may have different policies and clinical guidance. For example, London NHS trusts usually use an A-G assessment tool (but there may be exceptions), whereas NHS trusts outside of London and pre-hospital care providers usually use an A-E assessment tool. Furthermore, each letter of the acronym may have slightly different meanings, so you will need to check this. This is not a case of right or wrong, but making sure that your practice adheres to the policy of the trust you are working in. In this book, the A-G assessment tool is referred to, but remember to check which version to use when you are next in clinical practice. Read the following box to find out more.

Understanding the theory: A-G assessment tool and National Early Warning Score 2 (NEWS2)

Here are two assessment tools that can be used together. The A-G assessment, based on the A-E guidance from the Resuscitation Council UK (2015a), is a systematic tool that you can use to do a top-to-toe assessment of an adult patient. The NEWS2 tool is a physiological assessment that – when combined with the A-G assessment – provides a complete holistic assessment of the patient (RCP, 2017). Remember to gain informed consent from the patient

before you begin (for more information about informed consent, see Chapter 3). See, also, alternative assessment tools for paediatric, mental health and learning disability services.

1. Airway

If the patient has spoken to you during your initial assessment, you know that their airway is clear and patent (unobstructed). If, however, they are coughing, holding their throat or chest, flushed, and unable to speak to you in full sentences, they may have a partially or fully obstructed airway. This is very severe, and you need to act immediately. See the annotated further reading section at the end of the chapter for guidance on how to treat choking. If their airway is clear and patent, you can move on to the breathing assessment.

2. Breathing (NEWS2: Respiratory rate and peripheral oxygen saturation percentage)

First, you need to complete a respiratory assessment. For 15 initial seconds, you need to observe and take note of any respiratory noises, use of accessory muscles, shallow or deep inhalation, unequal chest expansion or irregular breathing rhythms. After this, you need to count how many breaths the patient has during one full minute (a breath in and out counts as one breath). In total, your respiratory assessment should take 1 minute and 15 seconds. A word of caution: do not be tempted to cut these times short and multiply up (e.g. counting how many breaths in 30 seconds and doubling the number). It is imperative that you complete a full 1 minute and 15 seconds assessment because if a patient is going to deteriorate, the first vital sign calculated as part of NEWS2 is the respiratory rate, or what you observe in the first 15 seconds. You may see alternative practices where you work, but you are accountable for your own practice.

Next you need to measure the peripheral oxygen saturation percentage (SpO₂). You need to place a clean saturation probe on one of the patient's fingers and leave it there for approximately 10–15 seconds. Remember to ensure that the patient has warm hands and is not wearing nail varnish, as this prevents the saturation probe from working (ask permission to remove the nail varnish, or as a last resort place the probe on a toe or the pinna – top – of the patient's ear). According to the Royal College of Physicians, the SpO₂ should be 96 per cent or greater (RCP, 2017). Check your local trust's policy because some trusts choose to adhere to the British Thoracic Society's guidance of 94–98 per cent (British Thoracic Society, 2017). If the patient's SpO₂ is less than their target percentage, they may need to have oxygen administered. Check your local trust's policy for guidance on target values, particularly for patients with chronic obstructive pulmonary disease, and at what percentage you need to start emergency oxygen therapy at 15 litres per minute via a non-rebreather mask.

Now that you have measured two NEWS2 vital signs, it is recommended that you correctly record them on the NEWS2 chart so that you do not forget them (see the annotated further reading section at the end of the chapter).

3. Circulation (NEWS2: blood pressure and pulse rate)

There are three things you need to measure in the circulation section of the A-G assessment: blood pressure, pulse assessment and target fluid balance. Many trusts use a machine to automatically calculate blood pressure. The NMC *Standards of Proficiency for Nursing Associates* states that you must be able to use a manual

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sphygmomanometer (sphyg for short) to measure a patient's blood pressure, so you will need to ensure that you remain competent using each method. For both machines and sphygs, make sure that you use the correct size of cuff for the patient you are caring for. Sphyg cuffs come in paediatric to extra-large sizes; see the manufacturer's guidance of the sphyg you are using to make sure that you size it correctly. Remember to record these measurements on the NEWS2 chart.

The patient's pulse rate may be displayed on the automatic blood pressure machine. However, this number does not inform you about the strength and regularity of the pulse; the only way to assess these is by doing a manual pulse assessment. Place three fingers on the radial pulse for 15 seconds to establish the strength and regularity of the pulse, then count the pulse rate for 60 seconds.

To calculate the target fluid balance for the patient, you need to know their age and weight. Use these values in the equations below to establish the target fluid input and output:

1. Input

- Aged 59 years or younger: $35 \text{ ml} \times \text{total weight (kg)} = \text{target fluid (ml) input in 24 hours}$
- Aged 60 years or older: $30 \text{ ml} \times \text{total weight (kg)} = \text{target fluid (ml) input in 24 hours}$

2. Output

- All adult ages: $0.5 \text{ ml} \times \text{total weight (kg)} \times 24 \text{ hours} = \text{total fluid (ml) output in 24 hours}$

3. Paediatric fluid balance

- Infants and children need different amounts of fluid and excrete different amounts of fluid, depending on their age and weight. These values differ slightly between each trust and local authority, so make sure that you check your local trust's policy and/or guidance.

4. Dysfunction (NEWS2: Level of responsiveness)

In the dysfunction stage (also known as disability), there are six assessments that you need to make, which are summarised below. First, you need to assess the patient's responsiveness using another acronym, 'ACVPU':

Alert

Confused

Voice

Pain

Unresponsive

If the patient is alert, they will be looking at you and orientated to the correct time, place and person (e.g. who you are). If they are talking to you but not orientated to time, place or person, they are confused. In the event that they do not engage in conversation, you need to check their response to your voice by giving them a simple command such as, 'Open your eyes'. If they do not carry out your command, test their response to pain by squeezing

their shoulder muscle (trapezium) with your thumb and fingers. This is the only way that anyone can assess a patient's response to pain – never attempt any others. Always remember 'squeeze the trapeze' when assessing response to pain. If the patient does not respond to any of the above, they are classed as unresponsive and you need to call for help from a nurse or doctor immediately. Remember to record your findings on the NEWS2 chart.

If the patient is diabetic or you observe hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) signs or symptoms, you need to measure their CBG level. See the annotated further reading section at the end of the chapter for more information on what is considered a safe CBG level.

If the patient is in pain, you need to assess this thoroughly. There are many pain assessment tools, but you could use the initialism 'PQRST' to help you:

Provoke and Palliate

Quality

Radiate

Severity

Time

These are questions that you can ask the patient about their pain, such as 'What makes the pain worse?' (provoke) and 'What makes the pain better?' (palliate). Ask the patient to describe what their pain feels like (quality). Do not ask leading questions here, but rather open questions, such as 'Describe to me what your pain feels like.' The next question might be 'Does your pain spread anywhere?' (radiate). You need to measure how bad the pain is, so you might ask, 'On a scale of zero to three, zero being no pain at all and three being the worst pain you have ever experienced, where would you rate your pain?' The 0–3 scale aligns with the World Health Organization's pain scale ladder, which is particularly useful for patients living with cancer (WHO, 2019); however, your trust may use a 0–10 pain scale, so remember to check their policy.

Pain is a common symptom of constipation, which many patients suffer from across their lifespan. You can use the Bristol stool chart, adapted by the Central and North West London NHS Foundation Trust (2015), to help you identify what type of stool the patient last had.

The medications the patient is taking may be affecting their bowels, so you need to ask questions such as:

1. What medications have you been prescribed?
2. Which medications have you continued to take?
3. Are you taking any over-the-counter or homoeopathic medication?
4. Do you use any recreational drugs?

Remember to escalate these findings to the prescriber, pharmacist or registered nurse you are working with.

Lastly, you need to assess how mobile the patient is and if this has recently changed. Remember to ask if they have a fear of falling or have had a fall in the last six months (for guidance on caring for patients at risk of falling, see the annotated further reading section at the end of the chapter).

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5. Exposure (NEWS2: Temperature)

The last vital sign to measure in the A-G assessment is the patient's temperature. According to NEWS2, the patient's temperature should be between 36.1 and 38.0°C (RCP, 2017). A higher temperature than this is known as hyperthermia and a lower temperature is known as hypothermia.

The last few things to assess are the integrity of the patient's skin (look for pressure sores, wounds, rashes or discolouration), checking if they have any allergies (you could do this during your initial assessment when first meeting the patient), asking if they have been eating normally for them or if there have been any changes and lastly any other tests or investigations that the patient may need (e.g. an X-ray for a broken wrist). Remember to objectively record the findings in the patient's care plan or assessment record.

6. Family and friends

Lastly, you need to complete a quick social care assessment. Identify who the patient's next of kin or main point of contact is and offer to contact them (if the patient would like you to). If appropriate, discuss with the patient if they have an existing package of social care at home or if they think they need one. This will inform the process of discharge planning.

7. Goals

You are now at the end of your A-G assessment. It is time to calculate the total NEWS2 score (for more information on using this tool, see the annotated further reading section at the end of the chapter) and identify the patient's goals. Each goal needs to be recorded in the patient's care plan, which you will read about later in this chapter, and each goal needs to meet the following requirements:

Specific

Measurable

Achievable

Realistic

Timely

You can see that the first letter of each requirement spells 'SMART'. Remembering this acronym and using it as a checklist when identifying the patient's goals will ensure that you are adhering to the principles of person-centred care.

An example of an alternative tool is the paediatric early warning score (PEWS) (NHS England, 2023). Even though you may not be primarily working in a paediatric environment, as a nursing associate your scope of practice includes young people. So, it is important to note that you need to adjust the assessment tool you use that is appropriate for the patient you are caring for. Once you have completed your A-D and A-G assessments (or suitable alternative assessment tool), you may need to hand over the patient's care to someone else or escalate their condition because they are about to clinically or psychologically deteriorate. There is one more acronym, 'SBAR', which is very useful for keeping your handover or escalation succinct, as well as ensuring that you communicate effectively.

Understanding the theory: situation, background, assessment, recommendation (SBAR)

One of your aims as a nursing associate when caring for a patient is to recognise if a patient is about to deteriorate, or to react promptly if they have already started to become acutely unwell. The deterioration may be a new acute illness or an **exacerbation** of a long-term condition. In either scenario, you will complete A-D and A-G assessments. Linking back to the nursing process, you have now completed the assessment, planning and nursing diagnosis stages. You now need to implement your plan, which for any deteriorating patient is to escalate to a senior member of nursing or medical staff (this may be the ambulance service, if you are working in the community or in a learning disability school).

In the heat of the moment, your stress levels are likely to be raised, and it is very easy to rush your communication in this situation. Using a systematic tool such as 'SBAR' will support you to communicate effectively and efficiently, proven by Müller et al.'s (2018) **systematic review**, which investigated the impact of using 'SBAR' to communicate among healthcare staff. The information below is based on Table 1 in Müller et al. (2018, p. 2).

1. Situation

Whether you are speaking on the phone or in person, if your colleague does not know you, make sure that you introduce yourself using the principles of #hellomynameis. Identify which patient you are escalating or handing over by stating their name. Now state the patient's predominant concern in a short sentence. It may sound something like, 'Mrs Gibson is having severe abdominal pain'. Keeping this sentence short will capture your colleague's attention; you need them to hear about the important information you have just gathered during your assessment.

2. Background

Next your colleague needs to know the patient's background. You only need to state the relevant past medical history and recent events that led to the current situation. Similarly, keep this section short so your key message does not get lost in surplus information. You may say something like, 'Mrs Gibson was brought to A&E because of the pain and she has not urinated for 10–12 hours. Her relevant past medical history is that she has insulin-dependent type 2 diabetes'.

3. Assessment

Now is the time to share the important information you have gathered during your A-D and A-G assessments. Just as before, only share relevant information. In other words, you do not need to tell your colleague every vital sign that you have recorded on the NEWS2 chart. Simply state the overall NEWS2 score and which vital signs are a concern. For example, you might say, 'Mrs Gibson's respiratory rate is 22 breaths per minute, her pulse rate is 140 beats per minute, and her temperature is 38.5 °C. This makes the overall NEWS2 score 6. Her blood pressure does not score on NEWS2 because it is 180/90 mmHg. However, because she is diabetic, her target systolic blood pressure should be 135 mmHg or lower, so she is **hypertensive too**'.

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4. Recommendation

If you have a clinical impression, you can say this now. You might state, 'I think she has urinary sepsis'. It is equally acceptable to say that you are not sure what is wrong with the patient you are caring for; saying that you do not know what is wrong will further encourage your colleague to help you. You now need to ask your colleague to come with you to see that patient. State a realistic time frame of when you think your colleague needs to see the patient, such as, 'I would like you to see the patient within the next 30 minutes, please'. It is important to note that a different time frame may be needed, depending on which of the four fields of nursing you are working within. If the patient is critically unwell like Mrs Gibson, you may need to be professionally assertive and say, 'I would like you to come with me now to see Mrs Gibson, please, because I am very concerned'. Before you end the conversation, ask your colleague, 'Is there anything more I can do now?'

So far in this chapter, you have read about four tools you can use in clinical practice that can help you care for patients with acute or long-term conditions. In relation to the implementation stage of the nursing process, read Annex B of the *Standards of Proficiency for Nursing Associates* for a list of procedures within your scope of practice (NMC, 2018a). Next you will read about providing person-centred care across the lifespan and within the context of the four fields nursing.

Person-centred care across the lifespan

It has been emphasised many times in this book so far that the differences between people are something to celebrate, but there is one thing that unites everyone: we all experience the same stages of the lifespan. You will read about each stage of the lifespan throughout the next sections of this chapter (adapted from Armstrong, 2019). Reading the following box will provide you with an overview of the human lifespan.

Understanding the theory: the human lifespan

Pregnancy

The term of pregnancy is approximately nine months from conception to birth. The care of pregnant women is an interesting topic, and there are many textbooks to inform your knowledge. A salient point here is that your duty of care is to the woman, first and foremost. This poses an ethical debate; you could have a discussion about the laws surrounding the care of pregnant women with your supervisor or senior colleague if you are going to work in a maternity environment. Remember not to identify a pregnant woman as a patient – it is perfectly healthy to be pregnant.

Birth

Your role as a nursing associate in relation to the birth of a child is to support the MDT (particularly the midwife), as well as the mother and her family. Your A-D and A-G assessment skills will be vitally important here, including your skills at measuring vital signs using NEWS2. If a birth is complex, the child will be transferred to a paediatric unit after birth, whereas the mother will be cared for in an adult nursing environment. If at all possible, mother and baby will be kept in the same clinical environment to help with bonding.

Infancy

The age of an infant is approximately 0–3 years, but this age range may differ depending on what literature you read. One of the most important care needs of an infant is to monitor their growth and development. Each local trust will have a policy on how this is measured, but every tool is a holistic assessment of growth and development. If you have been signed off as competent in your trust to complete these assessments, you are likely to be working in the community assisting a home visiting team; however, you could be working in an inpatient paediatric assessment unit.

Childhood

Childhood is from approximately the age of three until puberty. These are pertinent developmental years, both physically and psychologically. Great Ormond Street Hospital in London is the national hospital for the specialised care of children. Visit their website for more information about the acute and long-term conditions that they specialise in: www.gosh.nhs.uk

Adolescence

Another phrase for adolescence is 'teenage years'. It is difficult to put an exact age on when puberty begins because each child is different. The physical health of adolescence has been well documented; however, historically, the mental health of adolescence was overlooked. Thankfully, in modern practice, adolescent mental health is taken more seriously.

Early adulthood

Early adulthood can be when many young people gain their first independence from their parents or guardians, but never presume that this is the case. Patient education during this stage of the lifespan is very important, particularly on how to maintain health and wellbeing.

Midlife

The importance of patient education continues in midlife. Maintaining a healthy work-life balance is significant for patients' physical and psychological health. Due to poor lifestyle choices, this is the stage of life when some long-term conditions may start to present themselves. Diabetes was discussed earlier in this chapter; people who are overweight and aged 40 years or older are at high risk of gaining type 2 diabetes.

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Late adulthood

It is during this stage of the lifespan that people may choose to retire. As patients become older, particularly in the modern age when we are living longer, multiple long-term conditions may be diagnosed. With advances in healthcare, many people can continue to live a very active and healthy life in late adulthood.

Elderly

People who are elderly (approximately 80 years of age or older) can similarly be very healthy and active if they maintain positive lifestyle choices and good health and wellbeing habits. In some cases, however, people living with many co-morbidities may have complex care needs to manage their physical and psychological health.

End-of-life care

End-of-life care is defined as the last 12 months of a patient's life. This can be difficult to determine, and hence end-of-life care is a clinical specialism. You may hear the term 'palliative care' in reference to caring for someone who is dying, although palliative care is defined as managing a long-term condition. End-of-life care can last for more than six months, so it is a long-term condition, but remember that the term 'palliative care' may be in reference to another long-term condition.

Now that you have read about the stages of the lifespan and have had some suggestions of what care a patient may need at each stage, complete Activity 2.3 to put your learning into context.

Activity 2.3 Reflection

The next time you are in clinical practice, discuss with your supervisor or line manager which stage of the lifespan a patient may be in. Do not use their age as an indicator; the more important things to observe here are their care needs. By being able to identify the patient's care needs, you will more accurately and confidently be able to provide person-centred care.

As this activity is based on your own reflection, there is no outline answer provided at the end of the chapter.

The different needs that patients have at each stage of their lifespan can be met within the context of the four fields of nursing. As a nursing associate, you are a generalist practitioner, so your clinical knowledge and skills will transcend all four fields of nursing. If in practice, however, you need to get some more advice about how to care for a patient with a particular need, speak to a practitioner who specialises in one of these fields. By doing this, you are demonstrating that you are working within your scope of practice and linking other members of the MDT together to provide person-centred care for the patient in your care.

Person-centred care in the four fields of nursing

The nursing profession is currently separated into four specialised fields: adult, paediatric, mental health and learning disability. The rationale behind having four specialisms is that since nursing students' education is so in-depth, they choose to study a course that focuses on one of the four fields of nursing. Having a deeper understanding of one field of nursing enables practitioners to strengthen their knowledge and skills, thus better understanding patients' needs. There are some generic topics to study that are applicable to all four fields of nursing; however, the remainder of undergraduate nurses' training is bespoke to their chosen field of nursing.

Although nurses have a specialism, every nurse must adhere to *The Code* (NMC, 2018b), just like nursing associates. Fundamentally, all nurses are expected to be competent at providing basic nursing care. Within their respective specialisms, however, nurses will have more specific knowledge and skills that they can use to care for patients with particular needs. For example, all nurses have a basic understanding of how to communicate with someone that is living with depression. A mental health nurse, however, has significantly more knowledge and understanding about how to complete a mental health assessment for someone living with depression, as well as what care they may need.

How does this relate to you as a nursing associate? Nurses have a specific scope of practice within their chosen field of nursing. Nursing associates are, as previously mentioned, generalist practitioners. This does not mean that nursing associates are miniature nurses. This is impossible because you are a different practitioner, with your own professional registration. In other words, you are not registered with the NMC as a 'miniature nurse'. Nursing associates' scope of practice is to provide fundamental care from not just one field of nursing, but all four.

Your training as a nursing associate gives you exposure to all four fields of nursing, both academically and in clinical practice. (However, your learning does not stop at the end of your apprenticeship. To find out more about how to keep up to date with the future of providing person-centred care, see Chapter 8.) As a fully qualified and registered nursing associate, you will be able to use your knowledge and experience to support nurses and the MDT while working independently to meet the needs of the patients in your care. You must always work within your scope of practice, so make sure that you read and continually familiarise yourself with the *Standards of Proficiency for Nursing Associates* (NMC, 2018a).

Person-centred care plans

Care plans are formal records of a patient's previous assessments and treatments, as well as instructions on what their current care needs are. Care plans are needed as a communication tool between practitioners and support workers in the MDT. A care plan can be used to evidentially measure if the patient is getting better or deteriorating, as well as determining if their condition remains the same. A care plan is also a legal record of what care has been provided for the patient by the healthcare service; this is important to protect the safety of the patient, as well as the professionals looking after them. Although nursing associates do not write care plans, it is within your scope of practice to evaluate them, as well as suggesting changes or updates to the registered nurse that you are working alongside. This could involve suggestions on how a patient with additional learning needs can access the health and social care services they need. There are often many challenges, and as a nursing associate you can be their advocate. You must consider all documentation in your clinical practice to be legal documents. Accurate and evidence-based record-keeping is hence considered a vital skill for a nursing associate. In Chapter 5, we will discuss inclusivity in person-centred care. A care plan

is bespoke to an individual patient, so your ability to be inclusive when reading and evaluating care plans is paramount to maintaining person-centred care. The Royal College of Nursing (RCN) has published guidance on the principles of good record-keeping, which is freely available for you to download (RCN, 2017). Use this guidance to complete Activity 2.4.

Activity 2.4 Reflection

For this activity, you can use any word-processing software, your email account or a pen and notebook. To practise objective record-keeping, write down the following:

1. *A record of what happened today.* This record could be about your day at university, in clinical practice or what you did on a day off. You need to ensure that you are writing objectively (i.e. only write down the facts of what happened). You may wish to record your feelings or interpretations in a separate paragraph, but make sure to keep the first paragraph focused on facts. Remember to maintain confidentiality if you are writing about clinical practice.
2. *A plan of what you would like to achieve tomorrow.* Your plan for tomorrow should be listed in order of priority, and each point must meet all components of a SMART goal (see earlier in this chapter). Make sure that you consider what a realistic list of targets would be for tomorrow; achieving three goals in total is much more satisfying than achieving three goals out of ten that you have written down.

You could focus this activity on your studying to help you maintain focus, or you could use it as a reflective tool to help you continue to learn from clinical practice. This activity can be a single exercise, or you may choose to continue it over an extended period of time if you find it a useful exercise.

As this activity is based on your own reflection, there is no outline answer provided at the end of the chapter.

A key question to ask yourself about any of your record-keeping in clinical practice is, 'Does my care plan evaluation remain focused on providing person-centred care?' If the answer is yes, then you have written a good care plan. Linking back to the nursing process at the beginning of the chapter, the next stage after planning is to implement care. For this stage, nursing associates must have very good interpersonal skills and communication techniques.

Interpersonal skills and communication techniques for person-centred care

In the chapter so far, you may have recognised that the patients you care for each have their own backgrounds, conditions and healthcare needs. As a result, you need to be able to frequently adapt and develop your interpersonal skills and communication techniques to be able to efficiently build a rapport with patients. You need to earn their trust before you will be able to provide the best quality person-centred care. This requires extensive and consistent practice, but reading this section will point you in the right direction.

Being **interpersonal** in health and social care can be defined as establishing professional relationships between people, as well as using appropriate communication and building connections with them. To be interpersonal is significantly important for nursing associates because you need to earn patients' trust. Achieving this will encourage patients to feel relaxed, as well as being forthcoming about their acute and long-term conditions. When patients are relaxed enough to be honest about their health, you will be able to complete a thorough holistic assessment, as well as monitoring their health and evaluating the outcomes. From reading this chapter so far, it will be clear to you that a rigorous assessment is vital to ensure that patients' acute and long-term conditions are cared for appropriately.

So, how do you ensure that your practice is interpersonal? There is no rulebook on interpersonal skills, but it is likely that you already use them on a daily basis.

You may have lived experience of caring for someone in your family or friendship circle who has mental health or additional learning needs. Reflecting on your own experiences can help to inform your clinical practice to ensure patients with health and social care needs in all four fields of nursing receive person-centred care. Thus, becoming more self-aware of your interpersonal skills will enable you to enhance these skills in practice.

According to Mind Tools (2019b), to have interpersonal skills requires **emotional intelligence**, as well as being able to recognise other people's emotions by their expressions, mannerisms and tone of voice. You are then able to adjust your communication with patients to build a connection with them. For example, if a patient appears upset but does not vocalise it, you can demonstrate empathy by acknowledging that they appear upset and asking if there is anything you can do for them. Once a patient starts to trust you, you need to consolidate this trust by using **active listening**. Actively listening means that you demonstrate your understanding of what a patient is telling you; repeating what they have said in your own words may do this, or you could simply state that you understand their point of view (providing you do understand!). If you are unsure what their key message is, show that you are trying to understand by saying something like, 'I am not sure what you mean; could you explain it in a different way?' With this in mind, you clearly need to have **bespoke communication** skills to be able to provide interpersonal person-centred care. Think carefully about how you are communicating and question if there is a more appropriate method. You may need to use picture cards, ask the patient to write down what they are saying or request an interpreter. Effective communication between patients and practitioners is imperative, similar to communication within the MDT.

As discussed earlier in the chapter, documentation and record-keeping is one communication technique that nursing associates need to be masters of. Remember that you are a link between all practitioners in the MDT; therefore, your documentation and record-keeping must be immaculate so that all of your colleagues can read the important information you have gathered about a patient. Professionals in the MDT, however, are not the only people you need to be able to communicate with. As discussed in Chapter 1, the NHS serves the public. Patients are considered the most important members of the MDT, because without them there is no NHS. In the annotated further reading section at the end of the chapter, there is suggested guidance for you on record-keeping.

Chapter summary

There is a lot of content in this chapter, which is representative of the knowledge required to understand person-centred care of acute and long-term conditions. As previously noted, reading this chapter provides you with the tools to use in clinical practice to care for patients

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with acute and long-term conditions. It is impossible to include intricate details on how to care for each acute and long-term condition, but you will now be able to recognise differences between the two, as well as what stage of the lifespan a patient is in. The nursing process is applicable to all acute and long-term conditions, so you can use this as a guide for providing person-centred care. Remember to practise using the assessment tools discussed in this chapter and seek feedback from your supervisor or line manager, as well as keeping yourself up to date with new developments in evidence-based practice and the interpersonal skills you need.

Activities: Brief outline answers

All of the activities in this chapter are based on your own reflection, so there are no outline answers.

Annotated further reading

Flaherty, C. and Taylor, M. (2022) *Assessing and Managing the Acutely Ill Patient for Nursing Associates*. London: SAGE.

This book is part of the Understanding Nursing Associate Practice series and is an excellent resource for learning the knowledge and skills you need to assess acutely ill patients. Each chapter uses a case study to demonstrate the role and scope of practice for a nursing associate, so this book is grounded in the clinical environments that nursing associates work in. You will also learn about evidence-based practice, which builds on the content included in this book.

NHS England (2023) *National paediatric early warning system (PEWS) observation and escalation charts*. Available at: www.england.nhs.uk/publication/national-pews-observation-and-escalation-charts/

This web page provides all the PEWS observation and escalation charts, which are useful to use when working with children. Even if you are not primarily working in paediatric services, you may need to care for a child, such as in mental health learning disability services.

Resuscitation Council UK (2021) *Choking*. Available at: www.resus.org.uk/choking/

Read this guidance on choking to know the process of how to treat someone who has a partially or fully obstructed airway. You can find the adult and paediatric guidelines via this link.

Royal College of Nursing (RCN) (2023) *Record Keeping: The Facts*. Available at: www.rcn.org.uk/Professional-Development/publications/rcn-record-keeping-uk-pub-011-016

You can use this fact sheet about documentation and record-keeping to self-assess the standard of your documentation. The RCN has published additional articles about other principles of documentation, which you can search for on its website.

Useful websites

American Institute for Learning and Human Development – The 12 Stages of Life: www.institute4learning.com/resources/articles/the-12-stages-of-life/

This web page provides more information about Armstrong's (2019) work on the stages of the lifespan.

Mind Tools: www.mindtools.com

Visit this website for more information on interpersonal skills and communication techniques.

National Institute for Health and Care Excellence (NICE) Guidance: www.nice.org.uk/guidance

NICE produces evidence-based guidance for clinical practitioners, which is published in relation to conditions and diseases. The guidelines are reviewed and updated; therefore, they are a very useful supplement to the clinical policies of the area you work in. NICE guidance includes the care of acute and long-term conditions.