In 2006, just short of 7,325 babies were born in the Hospital. The Hospital is situated in the heart of Dublin within 30 minutes of Dublin Airport and convenient to bus and rail services. The Hospital is committed to the recruitment, development and retention of the highest calibre of staff, in order to provide the best quality health care to all of its patients. A midwife working in the Hospital has the opportunity to practice normal midwifery as well as experience a wide complexity of pregnancy related conditions.

Recent additions to our services is an integrated model of Community and Hospital care facilitating the DOMINO and Early Transfer Home models of care. A number of community based antenatal clinics already exist and plans are advanced to introduce “midwife-led” booking and review community clinics.

The Hospital also has a wide range of specialty pregnancy clinics including:

- teenage pregnancy
- diabetic
- cardiac
- metabolic
- a range of paediatric and gynaecology clinics.

A range of day care facilities, which include maternal and fetal assessment, is available. The ultrasound department facilitates a full range of pregnancy and gynaecology assessment. An early pregnancy unit is designed to minimise the distress of women and their partners, who experience pregnancy loss. A full range of maternity impatient services is available including a Delivery Unit of 9 individual rooms with a 5 bed ward for induction of labour. The 36 cot Neonatal Unit is a tertiary referral centre and is part of a national neonatal transport system. This unit was opened in 2002 and offers the highest standard of facilities and care in the country.

Opportunities for midwives to engage in both in-house and external education programmes exist - The School of Midwifery is linked to the University of Dublin, Trinity College. A Clinical Skills Facilitator is employed with the specific remit of working with newly qualified or newly appointed midwives to support their development within the hospital.

The Rotunda Hospital

Founded in 1745, The Rotunda Hospital is the oldest maternity hospital in Ireland. With a complement of 189 beds and approximately 8,500 staff, the Hospital is a provider of a comprehensive range of specialist services in the treatment, education and care of mothers and babies - a public voluntary Hospital whose mission is to achieve the optimal health and well-being of the women and infants for whom it is responsible.

Currently there are vacancies for MIDWIVES who wish to work either full or part-time in all areas of the Rotunda Hospital.

• Advice on employment terms and conditions is available on request.
• application forms and job descriptions may be downloaded from www.loadzajobs.ie or www.hospitaljobs.ie and are also available upon request from the Human Resources Department on 0035318171714 or at hr@rotunda.ie.

If you would like to know more about the hospital please visit our website on www.rotunda.ie

Please Quote Reference Number: Vac. Ref. 2007/39

Various opportunities on page 53
NURSES WANTED. MUST HAVE A HEAD FOR HEIGHTS.

As a nurse you're used to dealing with emergencies. As a military nurse you'll be an expert in Aeromedical Evacuation, as well as working alongside NHS staff in the acute or primary care environment. Talking of which, if you have a secondary qualification in A&E, ITU or theatre you could be eligible for an £8,000 welcome cheque.

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(please ensure cheques are made payable to Strathayr Publishing).
Diabetes UK is extremely concerned that specialist diabetes teams, staff and budgets are being cut. In a report launched, the charity is calling for action to be taken now as the loss of skills in specialist services has already impacted on the quality of care for people with diabetes. More than one in four (29 per cent) specialist healthcare professionals reported funding cuts to the diabetes team in the last 12 months, 18 per cent said posts have been made redundant and 43 per cent said vacant posts have been frozen.

The Cuts in Diabetes Specialist Services report, launched at the Diabetes UK Annual Professional Conference, in Glasgow, asked Diabetes Specialist Nurses (DSN) if and how funding cuts have affected services. Results also reveal how specialist skills are being devalued despite the fact that they are key in ensuring high quality integrated care. One in three (32 per cent) said that specialist posts had been downgraded as a result of the agenda for change, in addition to 18 per cent reporting downgrading to make cost savings. A further 34 per cent said specific diabetes services such as drop in clinics were no longer being provided. The high response rate from England is likely to indicate that service reductions are more significant here than in Scotland, Northern Ireland and Wales.

Professional development and education for specialist healthcare professionals have also been affected with 45 per cent reporting reduced investment. In addition, 40 per cent said their requests for study leave had been denied and that time for this had been reduced.

June James, DSN and Vice Chair of Diabetes UK Professional Advisory Council, said: “Specialists have an essential role to play both in caring for people with complex health needs and providing training, expertise and support for the whole local diabetes community. High quality integrated care relies on the skills and expertise of specialist teams to support everyone working in diabetes. People with diabetes deserve the best quality care healthcare professionals can provide. How can this possibly be achieved when investment in staffing levels and our ongoing education and training are cut?”

The report reveals the impact on people with diabetes. Over half (55 per cent) of specialist healthcare professionals reported that they spent less time with patients and there were increased delays to see DSNs and consultant diabetologists due to the redeployment onto general wards. In addition, 39 per cent reported increased waiting times for patients’ annual reviews.

As a direct result, one in three healthcare professionals reported an increase in hospital admissions. In addition, one in four said there was an increase in emergency admissions, many of which could have been avoided if patients had been able to see a member of the diabetes specialist team.

Douglas Smallwood, Chief Executive at Diabetes UK, said: “It is absolutely appalling that specialist diabetes services are being reduced. The skills of these teams are vital in supporting people with diabetes and those providing local services. People have needlessly been admitted to hospital with complications that could have been avoided. Decision makers have to end such short sighted cost savings and invest in specialist care to deliver patient centred care. With over two million people diagnosed with diabetes in the UK and prevalence increasing at a worrying rate, action has to be taken now. The potential long term impact of cuts, in terms of human cost and burden on NHS resources, is frightening.”

The survey was distributed to 484 DSNs, of which 162 responded to the questionnaire. The response rate for each nation: 77 per cent for England, 10 per cent for Northern Ireland, 10 per cent for Scotland and three per cent for Wales.
New standards in the field of smoking cessation are introduced with the launch of The Baby CO, a revolutionary new breath monitor for pregnant smokers that not only measures the mother’s carbon monoxide levels but also, for the first time, the CO levels of the unborn foetus.

Designed and manufactured by UK based Micro Medical, global leaders in the design and manufacture of respiratory and cardiovascular devices, The Baby CO, is an innovative new product which acts as a shocking incentive to pregnant smokers to stop harming their unborn babies. Its creation is the result of clinical studies carried out in Paris that revealed quantities of carbon monoxide in the placental blood stream of pregnant smokers.

The Baby CO is a hand held unit that works by measuring the components of a single breath. The device measures the alveolar carbon monoxide in parts per million (PPM) concentrations of the mother. From this measurement, the amount of carbon monoxide in the foetus is derived and represented as foetal Carboxyhaemoglobin (%FCOHB). Both results are instantly displayed on a large liquid crystal display along with three light indicators ranging from red to specify danger levels when an alarm sounds and a picture of a baby appears, down to green for healthy.

Small, lightweight and moulded from high impact ABS for durability, The Baby CO is ergonomically designed with a textured hand-grip for easy and reassuring use. The unit comes complete with all accessories including a hard shell carry case, sample cardboard mouthpieces, one way plastic mouthpiece adaptor, calibration adaptor, calibration tool, 9V PP3 battery and operating manual. Additional disposable mouthpieces are available in boxes 250 or an easy to use dispenser box of 50.

Micro Medical has trialled prototypes of The Baby CO in 14 countries worldwide with remarkable results.

Mary O’Connor, a midwife specialising in smoking cessation in pregnancy, based in the Isle of Man, says: “I have been using The Baby CO since November 2006 and am finding it to be a highly motivational tool in helping pregnant women give up smoking. When the women see the level of harm they are inflicting on their babies combined with the emotive image of the baby, which appears, they are incentivised to try to reduce this. As a result of using The Baby CO on the Isle of Man we are now going to test all pregnant women for levels of carbon monoxide, not just smokers, as passive smoking can have an equally harming effect on the babies.”

Launching The Baby CO, Micro Medical’s International Sales & Marketing Manager, Martin Marsh, says: “We are excited about bringing this new technology to market which will have a life changing effect on our future generations. The feedback from our prototype groups has been astounding with one midwife reporting a quit rate amongst pregnant smokers of over 60% in just one month. ‘The Baby CO represents a significant move forward in the field of smoking cessation in pregnant women.’ Amanda Sandford, Research Manager for ASH says: “We welcome the launch of the Baby CO as a device which brings to women’s attention the immediate impact that smoking has on their unborn child and increases their chances of quitting as a result.”

Measuring breath carbon monoxide is an established technique used in smoking cessation clinics worldwide. Micro Medical is the leader in this sector and has produced in excess of 30,000 breath carbon monoxide monitors distributed to over 50 countries. The Baby CO is the gold standard in CO breath testing and is the most advanced system currently available today.

For further information on The Baby CO contact Micro Medical on telephone 01634 893500 or www.micromedical.co.uk.

Case Study Trial of The Baby CO:

Conducted by Mary O’Connor, Midwife specialising in smoking cessation in pregnancy, based in the Isle of Man

8-week trial period (14 November 2006 to 15 January 2007)

• 48 women referred
• 38 started the programme
• 2 cancelled
• 8 did not turn up
• 18 validated quits and these women continue to be smoke free
• Between 15 January and first week of February 2007, 6 further women have quit and 2 others have reduced their smoking
Funding for NHS Boards will go up by over six per cent next year as NHS Scotland’s annual budget reaches more than £10 billion, it was announced today.

The allocations will see Scotland’s 14 area health Boards and eight special NHS Boards receive around £7.8 billion in 2007-08. The figures mean the overall health budget for next year is more than double the amount spent on health in 1999.

Health Minister Andy Kerr said:
“Today’s announcement highlights the unprecedented levels of investment we are making in improving Scotland’s health. Next year we’ll be spending over £2,000 per head on health, compared to less than £1,000 in 1999.”

“Of course, investing the money is one thing - but we’re also making sure it’s bringing real benefits to patients. For example, in 2005-06 NHS Scotland performed over 70 per cent more knee-joint replacement operations than in 1998-99. Over the same period, the number of angioplasties undertaken has increased by 151%.”

“These trends are set to continue. The growing investment in our NHS is leading to a quicker service, and shorter waits for treatment. We’ve also seen significant reductions in deaths from our biggest killers, cancer, heart disease and stroke, and record numbers of staff. Now we want to go even further.”

“We’re already on track to meet even lower waiting times targets. Tough new targets on diagnostics and A&E waits are also being introduced. All at a time of fundamental change in the way we deliver healthcare.

“We’re no longer waiting for people to get ill, then rushing them to hospital for urgent treatment. Instead, we’re doing more than ever before to encourage people to lead healthy lives, and spotting and dealing with poor health before it can develop into something more serious. When people do need treatment, we’re delivering more of it closer to home in their local communities.”

“Today’s announcement of allocations significantly above the rate of inflation to NHS Boards across the country will allow them to take that forward. I firmly believe it will mean significant long term benefits to the health of our nation.”

Background
• The revenue allocations for area Boards announced today are calculated using the Arbuthnott formula. The formula takes account of the population in the NHS Board area, the age of the population, gender, level of deprivation and the proportion of population living in remote and rural areas. NHS Boards receive funding based on their need using the Arbuthnott formula.
• In 2007-08 total £7.8 billion was allocated (6.4%), all have received a standard increase of 6 per cent, with those boards currently below their Arbuthnott formula target allocation receiving more. See table for a breakdown of each NHS board’s allocation.

The total health budget for 2007-08 is £10.26 billion, including £7.79 billion for territorial and special health boards plus another £2.28 billion to be distributed to other areas such as Capital spending, IT and Primary Medical Services. Another £188 million will go on Health Improvement and other health services.

Last year saw significant increases in productivity. NHS Scotland carried out nearly 6,500 hip replacements (up 13 per cent year on year); 5,252 knee replacements (up 19 per cent year on year); 5,500 angioplasty heart operations (up 21 per cent year on year); over 29,000 cataract operations (inpatient and outpatient, up 14 per cent year on year); saw 4.5 million outpatients attendances; 1.4 million new A&E attendances; over half a million attendances at nurse-led clinics; issued 77.3 million prescriptions; carried out 775,000 inpatient and day case principle operations.

Allocations to Special Health Boards for 2007-08 are as follows:

<table>
<thead>
<tr>
<th>Allocation £m</th>
<th>Increase £m</th>
<th>Increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS National Services Scotland</td>
<td>236.3</td>
<td>11.8</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>350.5</td>
<td>19.8</td>
</tr>
<tr>
<td>State Hospital</td>
<td>32.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>177.8</td>
<td>10.1</td>
</tr>
<tr>
<td>NHS Quality Improvement Scotland</td>
<td>15.7</td>
<td>0.5</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>16.8</td>
<td>0.6</td>
</tr>
<tr>
<td>NHS 24</td>
<td>51.7</td>
<td>2.9</td>
</tr>
<tr>
<td>National Waiting Times Centre</td>
<td>38.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>920.3</td>
<td>49.8</td>
</tr>
</tbody>
</table>

A leading midwife has expressed doubts over Sir Richard Branson’s plan to set up a blood bank reaped from umbilical cords, in order to use them for stem cell therapy in the future.

Sue Jacob of the Royal College of Midwives said that midwives are too busy during birth to worry about collecting umbilical cords.

Stem cells are capable of regenerating new bone marrow, which make them crucial for treating blood cancers and immune disorders.

Speaking on BBC One’s Six O’clock News, Ms Jacob said: “You have got the third stage of the labour where there is quite a high risk of some of the mothers bleeding so you want to concentrate on her and this is just additional.”

However, speaking on the same programme, Sir Richard contended that most births are quite straightforward and collecting the umbilical cords would not pose a problem.
New surgery for Kincaidston

NHS Ayrshire & Arran is pleased to announce plans to replace the existing GP surgery premises at Cornhill by a new, purpose-built health care facility at the edge of Kincaidston next to Dalmellington Road, Ayr.

Space at the existing surgery at Cornhill has become limited as the practice has continued to develop services for patients. Clinical accommodation for the practice and community nursing staff is severely constrained with no scope for future service development in the existing building.

The new development would create additional consulting rooms, a state-of-the-art, fully equipped treatment / multi-purpose room for minor surgery services and office space for the community nursing staff.

Joanne Atkinson, General Manager South Ayrshire Community Health Partnership commented: “This new surgery would allow more community services to be provided for the people of Kincaidston and the surrounding area. This will include minor surgery, so fewer people will be referred to the hospital for treatment.”

The development is evidence of close partnership working between NHS Ayrshire & Arran and South Ayrshire Council to improving health in the local community.

Councillor Gibson T. Macdonald, the Leader of South Ayrshire Council said: “The appropriate planning permission will need to be gained for the proposed new surgery before it can be progressed. However, a new surgery would provide space that could be used by social workers when they are working in the area, to meet a range of client groups. The space could also be used for direct work with service users, or liaison with health colleagues, so it could provide flexibly for more local and integrated work between Health and Social Work staff.”

In 2005 NHS Ayrshire & Arran selected Sapphire Primary Care Developments as the preferred developer to deliver the new premises for Dr David Stevenson and Dr Alisha Dosumu.

Subject to planning consent, work will start on the site in summer 2007 with work being completed by the end of the year.

Introducing the Safer Patients Initiative

NHS Ayrshire & Arran has been selected to take part in a major UK initiative to work on ways of making patient care safer. We received £130,000 in December 2006 to support the programme until September 2008.

The Ayr Hospital will be the initial focus of the study with all improvements shared across the whole organisation and the same process being mirrored at Dumfries and Galloway Royal Infirmary.

We will work in partnership with NHS Dumfries & Galloway to improve patient safety and will receive support from patient safety experts at the US-based Institute for Healthcare Improvement (IHI). We are one of ten hospital partnerships that have been successful through a highly competitive UK-wide selection process to take part in this patient safety initiative.

Research from across the world estimates that approximately one in ten patients can experience unnecessary harm or suffering due to mistakes that happen in hospitals. Such mistakes cost the NHS vast amounts of money each year. This initiative will test our ways of making care safer within the organisation and staff will look at ways to improve medical records, the management of transfers and communication between hospitals and staff teams, in support of patient care.

Dr Bob Masterton, Executive Medical Director, comments: “This is a fantastic opportunity for both NHS Ayrshire & Arran and NHS Dumfries & Galloway. It will help promote shared learning between the organisations and benefit our patients in the long term.”

“Over the next two years we will work closely with our partners not only to build on existing knowledge, but to put in place new systems and procedures to further improve patient safety.

Best Foot Forward

Sharon Gardner is putting her best foot forward and running the Fort William Marathon in April to raise money for Ayrshire Maternity Unit’s Neonatal Unit.

Sharon, from Kilbimie, is running the 26 miles to show her appreciation to the unit’s staff for looking after her premature daughter in 2006. Sharon’s daughter Lauren spent ten weeks between March and June last year in the neonatal unit at Ayrshire Central Hospital and she wants to say a big thank you to the staff.

If you would like to help Sharon raise as much money as possible for the unit, please contact her on 01505 681852 or GrdnrShrn@aol.com.

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ISLAND NURSE WINS UNIVERSITY AWARD

A Lewis nurse, Rachel Kennedy (23) from Barvas -- who took a year off her training to nurse her fiancée who was paralysed in a car accident has scooped a prestigious award from the University of Stirling in recognition of her level of commitment and achievement in nursing.

Out of 300 graduates she was chosen to receive this year’s R G Bomont Award for Recognition of Clinical Excellence. She is the first nurse based in the Western Isles to receive the award.

Rachel, a student in the 2003 Adult Nursing Programme based at the Western Isles campus of the University of Stirling, received her award yesterday (Monday) at the campus in Stornoway. She completed her training in September, and now works as a staff nurse in Medical Ward 2 in Western Isles NHS Hospital.

Rachel said: ‘Prior to commencing my final year of the course my fiancé Sandy Macleod was involved in a serious car accident. Unfortunately he sustained traumatic injuries to his back. It was a difficult and trying time for the family. I took time away from the course in order to be with Sandy, as he required specialist care and rehabilitation in a mainland hospital in Glasgow. He spent 9 months in the spinal unit and I remained with him in Glasgow until we came home together.

‘My personal tutor Gill kept in touch regularly and encouraged and supported my return to do my final year in 2005. I had a renewed determination and motivation to complete the course. I looked back on the year that I spent with Sandy in hospital as a life changing experience but also positively as a learning curve in my life. This encouraged me to carry on and give it my all to the nursing profession.’

The RG Bomont Award is presented annually to the student who has demonstrated a high level of commitment and achievement during their clinical placements as a student. The fact that Rachel has won the award is not only a boost for her, but also for the Western Isles campus and her fellow students.

Her fiancé Sandy (24) said: ‘I am very proud of Rachel and what she has achieved. We hope to marry next year but we haven’t fixed a date yet.’

GET IN GEAR FOR MAGGIE’S MONSTER BIKE & HIKE

Mud, sweat and gears are part of the monstrous challenge that lies ahead at one of this year’s biggest outdoor charity events, Maggie’s Monster Bike & Hike 2007, which takes place across 73 miles of stunning Highland scenery during 24 hours on the weekend of 5th and 6th May.

In its fourth year, Maggie’s Monster Bike & Hike takes place along the Great Glen Way in the Scottish Highlands and challenges participants to firstly bike 30 miles cross country from Fort William to Fort Augustus and then hike 8 (bronze), 22 (silver) or 43 (gold) miles – all non-stop and within 24 hours.

Starting under the shadow of Ben Nevis, participants will be rewarded with some of Scotland’s most awe-inspiring scenery along the way, including views across Loch Ness, the famous Caledonian Canal and the historic Urquhart Castle as well as passing by several imposing Munros, before reaching the Gold finish line in Inverness.

All the funds raised from the event will go to Maggie’s Cancer Caring Centres to help support and grow the charity’s programme of emotional and psychological support and practical information offered to people with cancer and their family and friends.

Maggie’s Centres Head of Fundraising, Marie McQuade, said: “This is an exhilarating event which allows participants to choose their challenge and take themselves to their own limit, whilst helping us to continue to support the thousands of people affected by cancer who visit our Centres annually.

“Each year it’s amazing to experience the feeling of team spirit as everyone encourages each other to have a fun and make it to their chosen finish line. It takes a great deal of determination to take part in this event but by all accounts it’s hugely rewarding both physically and mentally.”

You can take part in Monster Bike & Hike as an individual or corporate team, with as little as two members, as long as you commit to raising £400 each for Maggie’s Centres.

A new relay option has also been introduced this year, which means participants in groups of four can share the challenge and the fundraising. For the relay option, team members complete an individual stage before handing over to their next team mate until the final member reaches the Gold finish. The team fundraising target is £1,000.

In the last three years, Maggie’s Monster Bike & Hike, which is sponsored this year by Inverness based manufacturers, LifeScan, leading construction group, HOCHTIEF, and financial services company, Aegon, has helped to raise £1.7 million to continue and grow Maggie’s network of Centres in the UK.

This year, Maggie’s Centres is celebrating a decade of support through its five existing Centres in Scotland as well as its programme in Oxford. In addition to the London Centre which is currently being built, a further six Centres are planned throughout the UK in the next four years.

For further information on the Maggie’s Monster Bike & Hike visit www.maggiescentres.org/monster, email dee@maggiescentres.org or call 0141 341 5669.

NEW MULTI-FACETED SUPPORT SERVICE IS LAUNCHED FOR NEWLY DIAGNOSED PATIENTS WITH ULCERATIVE COLITIS TAKING MESALAZINE

A new patient support service is being launched at the British Society of Gastroenterology (BSG) annual meeting. The service is for newly diagnosed patients with ulcerative colitis (UC), who have been prescribed mesalazine treatment.

The service called “Everyday-Living” is designed to supplement the treatment patients currently receive from their healthcare professionals, enhance the patient experience and ultimately to improve their well-being. It aims to help patients better understand their condition and provide education to them on the long-term management of UC.

As with most chronic conditions, compliance is a major problem in UC. Research suggests that up to 60 per cent of UC patients do not take their medication as prescribed and putting them at increased risk of relapse and surgery.

“Everyday-Living” is tailored to your newly diagnosed UC patients because it has many different but complementary components including:

• A telephone support service
• Intermittent letters and disease awareness leaflets
• Quarterly lifestyle magazines
• Dedicated patient website

Allison Nightingale, IBD Nurse Specialist, Addenbrooke’s NHS Foundation Trust, Cambridge said, “This will be a very valuable resource, particularly for those patients that do not have access to an inflammatory bowel disease (IBD) nurse specialist.”

After recommendation from their gastroenterologist or IBD nurse newly diagnosed UC patients on mesalazine treatment can sign-up for the service by completing a registration form or calling a free phone number.

The new support service supported by Procter & Gamble Pharmaceuticals will be monitored and its impact on patient behaviour and well-being evaluated on an ongoing basis.

References

www.scottishirishhealthcare.com
New report says poverty and social exclusion increases risk of mental illness in young people with learning disabilities

A new report from the Foundation for People with Learning Disabilities and Lancaster University has found that children with learning disabilities are six times more likely to have a diagnosable psychiatric disorder than other children in Britain.

According to The Mental Health of Children and Adolescents with Learning Disabilities in Britain, the increased risk of mental illness is not always caused by a young person’s learning disability, but instead because of exposure to greater poverty and social exclusion than experienced by non-disabled children.

The report, based on the experiences of over 18,000 children aged between 5 and 15 years old**, says that one in three (33 per cent) children with learning disabilities are likely to have a mother with mental health needs and nearly half are living in poverty (47 per cent). Young people with learning disabilities also have fewer friends than other children living in Britain and are more likely to suffer abuse and be involved in serious accidents.

Eric Emerson, the report’s author, says: “It is no surprise that children with learning disabilities experience higher rates of mental illness when they are much more likely to be exposed to poverty, social exclusion and challenging family environments than their non-disabled peers. If the mental health of young people with learning disabilities is to be improved, the Government must take steps to address the social circumstances under which this vulnerable group is living.”

While the report found that children with learning disabilities are at an increased risk of mental illness than other children in Britain, nearly half (44 per cent) of the families surveyed said they did not receive sufficient help from medical professionals, social workers or mental health services.

Alison Giraud-Saunders, Co-Director of the Foundation for People with Learning Disabilities, says: “The Foundation is currently working with Child and Adolescent Mental Health Services to ensure that those with learning disabilities get the support they need. But services still have a long way to go - we need schools, primary care, local communities and Child and Adolescent Mental Health Services to work together to prevent mental ill-health and support this vulnerable group.”

Read the report, The Mental Health of Children and Adolescents with Learning Disabilities in Britain, at www.learningdisabilities.org.uk

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• 2nd May 2007
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Fax 0141 201 0674
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Tel: +44 (0) 141 221 6362

• 2nd - 4th May 2007
Welcome to EWMA GLASGOW 2007
Evidence, Consensus and Driving the Agenda forward
The conference gives the participants an opportunity to benefit from high level of scientific presentations, exchange data and evaluate clinical practice. The conference will be held in Glasgow at the Scottish Exhibition and Congress Centre, which is located on the banks of the River Clyde. The participants will therefore not only benefit from the scientific aspects of the conference but also from the beautiful and central location of the conference.
For contact details and booking:
www.ewma.org/ewma007

• 4th May 2007
MANAGEMENT OF ACUTE UPPER AND LOWER gastrointestinal BLOOD LOSS
‘Life Lessons: Insights into Grief & Loss in Palliative Care’
Venue:
HILTON GROSVENOR HOTEL,
GROSVENOR STREET, EDINBURGH
Time:
09.30 - 16.45
For further information please contact:
Mrs Lesley Forsyth, SIGN Executive, 28 Thistle Street,
Edinburgh EH2 1EN
Tel: 0131 718 5109/5090
Fax: 0131 718 5114
email: lesley.forsyth@nhs.net
www.sign.ac.uk

• 5th & 6th May 2007
Maggie’s Monster Bike & Hike 2007
Mud, sweat and gears are part of the monstrous challenge that lies ahead at one of this year’s biggest outdoor charity events.
In its fourth year, Maggie’s Monster Bike & Hike takes place along the Great Glen Way in the Scottish Highlands and challenges participants to firstly bike 30 miles cross country from Fort William to Fort Augustus and then hike 8 (bronze), 22 (silver) or 43 (gold) miles – all non-stop and within 24 hours.
All the funds raised from the event will go to Maggie’s Cancer Caring Centres to help support and grow the charity’s programme of emotional and psychological support and practical information offered to people with cancer and their family and friends.
For further information on the Maggie’s Monster Bike & Hike visit www.maggiescentres.org/monster, email dee@maggiescentres.org or call 0141 341 5669.

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A unique event encompassing an eclectic mix of conventional and complementary practitioners, public and corporate bodies.
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Thu 10th 09.30 - 16.30
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• 16th May 2007
Physicians Assistant Anaesthesia Project Event
Venue:
The Lister, Hill Square, Edinburgh
One day event.
For more information contact:
claire.morrison@nes.scot.nhs.uk
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Scottish Irish Healthcare has recently appointed Charlie Blee as Clinical Editor and a new Editorial Board has been assembled. Meet the team!

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CEO Charles Blee Training Ltd.
Charlie graduated with a BSc in Social Sciences and Nursing Studies from the University of Edinburgh in 1984 and spent much of his clinical career as a senior nurse in Cardiac Care and Medical High Dependency. He is now CEO of Charles Blee Training Ltd who deliver onsite and online clinical updates to healthcare staff across the UK and beyond.

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Assistant Clinical Editor
Clinical Nurse Specialist in Liaison Psychiatry, Tayside Health Board
Scott undertook his RMN training in Dundee, qualifying in 1991. Since that time he has worked in acute, long-term, rehab and supported accommodation. He was appointed Clinical Nurse Specialist in Liaison Psychiatry in 1996. Scott has also completed an MSc in cognitive and behavioural psychotherapy.

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After a period of 7 years as senior Staff Nurse in Coronary Care Michael was appointed Resuscitation Training Officer in Forth Valley Acute Hospitals NHS Trust. He has since moved to Ayrshire where he is lead Resuscitation Training Officer at Ayrshire & Arran NHS Trust. Michael is a Resuscitation Council (UK) approved Advanced Life Support Instructor and ALS course Director. He is also the lead Resuscitation Advisor and Lecturer to Charles Blee Training Ltd delivering updates across he UK.

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Kirsten spent much of her early clinical career as Staff Nurse in Coronary Care and Medical High Dependency. She was among the first Nurses in the UK to undertake the role of nurse initiated coronary thrombolysis. Kirsten now works as a Hospital at Night Practitioner at Fife Acute Hospitals NHS Trust.

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Jamie Ramsay RN (Adult) BSc DipHE PGDip ALS(I) APLS(I)
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Sheenagh qualified in 1975 and is currently a Moving & Handling of People Specialist undertaking assessment, training and a number of speaking appointments at National Conferences. She is one of the co-authors of ‘The Guide to the handling of People’ 5th edition. Sheenagh is an active member of the National Back Exchange and was vice chair of the National Executive 1998 – 2001.

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Jamie Ramsay RN (Adult) BSc DipHE PGDip ALS(I) APLS(I)
Emergency Nurse Practitioner, Pontypridd & Rhondda NHS Trust
Jamie has spent his career working in the Accident & Emergency environment. He has held Staff Nurse, Deputy Charge Nurse and Charge Nurse Positions before moving onto his current position as an Emergency Nurse Practitioner. He has specific interests in resuscitation, minor injuries and development of emergency care systems.

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Introduction

Castledine (2005) asserts that the most important skill that a nurse must acquire is the ability to accurately and completely assess any patient in any situation. What happens in practice however is rarely the systematic approach advocated by the nursing process. There are many possible reasons for this including lack of time, inadequate knowledge and, unfortunately, lack of motivation or interest. None of these are acceptable reasons for not assessing patients/clients appropriately; assessment is vital as the first step in any patient or care setting. Without comprehensive assessment the worst case scenario might be the death of a patient with many other negative physical, psychological, social or cultural outcomes along the continuum.

For the nurse, the outcome may be allegations of professional misconduct and/or breach of employment contract leading to dismissal, or involvement in the litigation process. The first of two papers will explore the meaning of wound assessment and its application to the management of patients with wounds. The second paper will explore the process of wound assessment in relation to best practice in patient management.

Competence

The healthcare practitioner must be deemed competent before conducting any assessment. Competence is defined as ‘the knowledge, skills and values essential in carrying out one’s role’ (Oermann, 1998) or, less grandly, as the ability to carry out a task. The basic competencies needed for assessing a patient with a wound are those involving all of the senses plus knowledge and experience. Therefore, assessment is not just a task that can be delegated to a health care assistant or student nurse as they would not be in a position of competence to carry out a thorough assessment. The first level nurse is the person who has been educated to a level where assessment means observing, identifying significant findings and making links with what is known about the patient and their current situation and his/her personal knowledge and experience. Due to the organisation of practice placement experience and lack of focus on wounds in the pre-registration programme, many students will not have actually seen a wound until their third year of training. This begs the question ‘what happens when they qualify?’ Self-reflection is essential as the developmental process through which individuals assess their own skills and knowledge necessary to manage wounds to an acceptable and appropriate standard.

What do we mean by assessment?

At the broader level, nursing assessment is the gathering of information about a patient’s physiological, psychological, sociological, and spiritual status (Wikipedia, 2006). Collins, Hampton and White (2002) define assessment as information obtained via observation, questioning, physical examination and clinical investigations in order to establish a baseline for planning intervention. So, it is a problem-solving approach used every day and almost subconsciously by many experienced nurses who may consider it to be so fundamental to organising care that there is a danger that they may overlook the need to define and explain how it is done. The concept of assessment came to the fore with nursing process in the late 1970s where it leads to the construction, implementation and evaluation of a patient care plan that reflects the patients nursing problems and patient goals. Nursing problems as distinct from medical problems; which was a new way of thinking at the time and a long-overdue move away from, but complementary to, the traditional medical model approach to care. Among the many advantages associated with comprehensive patient assessment, Castledine (2005) suggests that the time taken can be rewarded in that it can save the nurse unnecessary time and effort in certain nursing tasks and procedures by identifying tasks that can be delegated. Identifying patient ability to self-help can also contribute to their well-being and rehabilitation by building on them as well as reducing nursing workload.

Patients with wounds

The advantage for nurses of patients with wounds is that, for the most part, they can be seen. However, seeing is not everything; it is not only direct visual observational skills that are used but also the special senses of hearing, touch and smell combined with subjective observations. What the patient reports can substantially influence the way in which the care plan is devised and the outcome of care. Wound assessment is only one part of the total patient assessment which will include assessment of, for example, level of mobility, degree of dependence, nutritional status, the presence or absence of concurrent illness such as diabetes, anaemia, carcinoma, cardiovascular or peripheral vascular disease, mental state and attitude to having a wound, to mention a few.

Recognition of those factors that will delay or indeed promote the healing process should also direct patient and wound management. Problems associated with a person’s physical or psychological state that are known to impede healing should be identified and dealt with as far as possible.

Contrary to the belief of many nurses, successful wound healing is totally dependent upon the innate ability of the individual to heal, not on which dressing is used. Regular patient and wound assessment will provide baseline data from which treatment decisions are made, however, many wounds heal in spite of professional input rather than as a result of conscientious assessment and high quality management.

Basic requirements for healing

There must be adequate supplies of appropriate types of nutrients, oxygen and other elements available and deliverable for cell metabolism and effective waste product removal in the body for a wound to heal at the optimal rate. Healing is a complicated, poorly understood systemic process which will be affected by systemic influences (Waldrop & Doughty, 2000). The systemic disease processes that adversely affect metabolism and are likely to delay or prevent wound healing are many and varied which precludes categorisation. However, they can be roughly separated into those disorders that affect the delivery of oxygen to cells and those that affect cell nutrition and metabolism. The former include anaemia, arteriosclerosis, cardiovascular disorders, peripheral vascular disease, respiratory disorders where either adequate oxygen is prevented from entering the body as in chronic obstructive airways disease or is prevented from reaching the cells by arteriosclerotic arteries.

Diabetes

Diabetes affects cell metabolism both directly and indirectly through the cellular metabolic effects of the disease and its associated vascular complications. The complex interplay between diabetic neuropathy, microvascular disease and macrovascular disease (leading to plaques and calcification) renders the diabetic patient not only to impaired wound healing but also the increased risk of injury.

Immune, inflammatory diseases and jaundice

The spectrum of systemic immune and inflammatory disorders place the patient in a challenging situation for healing due to the lack of cellular capacity for dealing with the demands placed on the body particularly in the early stages of healing (inflammatory phase). There is some controversy regarding the effect of the presence of jaundice on healing. Grande, Garcia-Valdecasas, Fuster, Visa and Pera (1990) found a significant difference in wound dehiscence in jaundiced patients compared with non-jaundiced patients linked with low rates of collagen synthesis. Conversely, an earlier study found no causative connection between jaundice and wound breakdown (Armstrong, Dixon, Duffy, Elton and Davies, 1984).

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Nutrition
Reynolds (2002) stresses that nutrition is vital to health and wellbeing while Todorovic (2002) makes significant links and gives guidance on the importance of the holistic approach to healing and nutrition. Pinchcofsky-Devin (1994) reiterates the need for adequate supplies of accessible nutrients for healing and that malnutrition results in weak, poor-quality scars. There is evidence of the need for protein supplementation in the presence of a large wound to prevent protein-energy malnutrition but patient assessment will provide a baseline of information about eating habits and the quality of the patient’s diet prior to their contact with health care services. The effects of pre-hospital malnutrition or undernutrition will potentially undermine the best medical and nursing efforts if not detected and managed appropriately at an early stage.

Nutritional assessment
Nutritional assessment starts with looking at the patient’s physical appearance for signs of weight loss before discussing their food and fluid intake and attitude to nutritious eating. This will be supplemented by anthropometric tests (weight and body mass index) and a wide range of blood estimations of key elements such as plasma proteins (Anderson, 2005). The aim being to reduce the possibility of avoidable healing complications however, there remains controversy and lack of sound evidence regarding the need for certain dietary elements for example, zinc, which is essential for the production of enzymes (McLaren, 1992). Anecdotal evidence points to impaired healing in states of zinc deficiency. Iron deficiency impairs healing through its effect on collagen synthesis. Anderson (2005) provides an excellent review of nutrition and healing stressing the need for assessment as an important nursing responsibility for alerting other health care professionals to actual and potential problems. There are a number of nutritional assessment tools available that have been developed to quantify nutritional status. These include the Burton Score (Russell, Taylor, Brewitt, Ireland, Reynolds, 1998), the Mini Nutritional Assessment (MNA) for elderly people in the community (Guigoz, Vellas & Garry, 2002) and the Malnutrition Universal Screening Tool (MUST) (British Association for Parenteral and Enteral Nutrition [BAPEN], 2003). Unfortunately, any assessment tool is only as good as the people who use it and Cartwright (2002) highlighted problems firstly, with nurses’ lack of awareness of the importance of nutritional status and secondly, their interpretation of the results of the assessment, hindering care planning.

In addition to good nutrition, adequate fluid intake plays a significant part in normal cell metabolism, normal blood flow and skin hydration, and therefore healing (Mcllwaine, 2003).

Aging
The age of the patient is significant; children heal more quickly and produce stronger scar tissue than the elderly, who may be suffering from a multiplicity of medical conditions and taking medications that interfere with healing. The aging process produces irreversible changes in skin, underlying tissue and blood vessels that make a person both more vulnerable to injury and less able to cope with healing. For example, wound dehiscence is up to 3 times more likely in people over 60 years of age (Davis, Dunkley, Harden et al, 1992). Bond (1998) identified that factors such as long-standing chronic disease, drugs, anxiety, depression, and radiotherapy, will impair appetite and affect healing. It must, however, be remembered that it is not possible to heal all wounds, so the aim will be palliation of symptoms and improved quality of life for the patient with a wound that is unlikely to heal.

Smoking
Smokers and non-smokers regularly exposed to cigarette smoke (Siana, Frankild & Gottrup, 1992) are adversely affected by the nicotine and carbon monoxide they contain. Among other effects, carbon monoxide binds to haemoglobin in place of oxygen significantly reducing the amount of circulating oxygen for cell metabolism which can impede healing (Silverstein, 1992). The nicotine absorbed from cigarette smoking causes the peripheral blood flow to be reduced by at least 50% for more than an hour after smoking just one cigarette (Siana et al, 1992). Nicotine also increases platelet adhesiveness increasing the risk of vascular occlusion and tissue ischaemia. Problems associated with inhibition of epithelialisation and scarring have been identified. However, more research is needed to elicit the direct effect of nicotine on wound healing.

Medication
Steroids and anti-inflammatory medications interfere with the normal immune response reducing the inflammatory response, masking signs of infection, suppressing fibroblast and collagen synthesis and slowing healing down (Morris & Malt, 1994). Cytotoxic medications prolong healing by interfering with cell proliferation and causing immunosuppression leading to increased infection risk. Sedatives and tranquillisers have the potential to reduce patients’ movements, circulation and metabolic function, and reduce their ability to sense and react to stimuli such as excessive pressure or heat. Blood circulation and oxygenation to the periphery is reduced leading to reduced healing and increased tissue breakdown. Stress, anxiety and sleep disturbance

Psychological problems such as stress and anxiety adversely affect the normal functioning of the immune system (Maier & Laudenslager, 1985) leading to sleep disturbance. The body needs time to repair and regenerate (anabolism) during sleep and it has been suggested that healing is promoted by rest and sleep (Adam & Oswald, 1987). Older people are elderly with multiple pathology and receiving poly-pharmacy, it is not surprising that wound healing is complicated. The importance of knowing about the patient, their medical history, current and previous medications, their current health status and overall mental and physical well-being while Todorovic (2002) makes significant links and gives guidance on the importance of the holistic approach to healing and nutrition. Pinchcofsky-Devin (1994) reiterates the need for adequate supplies of accessible nutrients for healing and that malnutrition results in weak, poor-quality scars. There is evidence of the need for protein supplementation in the presence of a large wound to prevent protein-energy malnutrition but patient assessment will provide a baseline of information about eating habits and the quality of the patient’s diet prior to their contact with health care services. The effects of pre-hospital malnutrition or undernutrition will potentially undermine the best medical and nursing efforts if not detected and managed appropriately at an early stage.

Conclusion
This article has only touched briefly on the myriad patient factors that can potentially impinge on the healing of wounds. When we consider that, by far, the patients treated with chronic wounds, in particular, are elderly with multiple pathology and receiving poly-pharmacy, it is not surprising that wound healing is complicated. The importance of knowing about the patient, their medical history, current and previous medications, their current health status and overall mental and physical well-being while Todorovic (2002) makes significant links and gives guidance on the importance of the holistic approach to healing and nutrition. Pinchcofsky-Devin (1994) reiterates the need for adequate supplies of accessible nutrients for healing and that malnutrition results in weak, poor-quality scars. There is evidence of the need for protein supplementation in the presence of a large wound to prevent protein-energy malnutrition but patient assessment will provide a baseline of information about eating habits and the quality of the patient’s diet prior to their contact with health care services. The effects of pre-hospital malnutrition or undernutrition will potentially undermine the best medical and nursing efforts if not detected and managed appropriately at an early stage.

Well developed patient assessment skills do not just appear as nurses undergo training but evolve over time and are crucial to high quality care. The next stage of the assessment process is to analyse the findings and document them accurately. These baseline assessment findings will inform patient care interventions and should be updated at each interaction change or more relevant information emerges – this is a dynamic process.

References
Guigoz Y (2000) The ‘been there, done that attitude’ of British Journal of Nursing. 14:20. 1103

Wound Care & Treatment
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Environmental Disinfection and Cleaning

Over the last few years, hospital infection outbreaks caused by such organisms as Clostridium difficile, Acinetobacter, M.R.S.A. and Norovirus have highlighted the need for cleaner, properly disinfected hospital wards. In response to the rising costs and increasing numbers of deaths due to health-care acquired infection (H.C.A.I.), a number of prominent politicians, the National Press and, most important of all, various patient safety groups have justifiably called for better cleaning practice in our health care facilities throughout Great Britain.

Unfortunately the reality of the situation is that the process of properly cleaning and then disinfecting the hospital environment is time consuming and labour intensive.

Disinfection is needed to kill harmful micro-organisms

Under normal circumstances cleaning (the removal of dirt, soiling and some associated micro-organisms using soap or detergent and water) is sufficient for every-day use in the average hospital; however when the above-mentioned infections are present, disinfection (which actually kills the harmful micro-organisms) is needed as well as the cleaning process.

To perform this ‘disinfection clean’ properly it is essential to clean the area thoroughly first to remove all traces of dirt, grease etc., where micro-organisms may be concealed. Then the area needs to be washed with clean fresh water to remove any soap or detergent residues that will otherwise inactivate the disinfectant and render it unable to kill the bacteria and viruses. The final stage is to wash the area thoroughly with the disinfectant solution.

Three-stage process creates more pressures

This three-stage process needs to be performed regularly during outbreak situations or once after an infected patient has left a side room or treatment area and before a new patient takes up residence. Unfortunately it is rarely done properly due to the pressures put on ward staff to make beds available quickly and domestic staff being under-manning. A further complication can be that during outbreaks of norovirus, which causes quite violent ‘gastric flu’-type symptoms, many staff are infected as well’ creating an even heavier burden of work on the remaining personnel.

New technology has provided the answer

New technology has now provided a simple and effective answer to the above problem. Chlor-Clean tablets have been developed using special surfactant (or cleaning agent) that will actually work with the chlorine disinfectant that is bound into the same tablet. Thus, once the Chlor-Clean tablet has been dissolved in one litre of water the resultant solution will both clean and disinfect the environment in one go, reducing cleaning time but, at the same time, providing effective disinfection of the area.

Chlor-Clean has proved its effectiveness in many hospitals during the outbreak of norovirus that have been sweeping up and down the country over the last three or four years and more recently it has become part of the regime used by those hospitals that have been successful in significantly reducing their Clostridium Difficile infections, including the particularly virulent 027 strain.

The product is simple and pleasant to use. Chlor-Clean tablets have been formulated to work in cold water thus reducing the chlorine smell in use whilst still retaining the effective cleaning action of the surfactant. The manufacturers provide a diluter to make it easy for domestic staff to obtain the correct dilution of 1,000 p.p.m. available chlorine with surfactant action and this vessel doubles as a mixing container. Once made up the solution will last for up to 24 hours provided the cap is screwed tightly and the diluter is stored away from heat sources such as windows or radiators.

Chlor-Clean is manufactured by Guest Medical of Edenbridge, who have been long established as manufacturers of chlorine disinfection products such as Haz-Tabs, Haz-Tabs granules and the Biohazard Spills Kits. Their distributor in Scotland is Inverclyde Biologicals, who are based in Bellshill, telephone 01698 749 368.
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Specific learning objectives for this section:
By the end of this section the reader should be able to:
- Describe and demonstrate the correct technique for hand decontamination including preparation
- Identify the different hand decontamination agents and hand drying methods that are available
- Identify some of the reasons for non-compliance with hand hygiene

Introduction
Hand hygiene is the single most important intervention in the control of cross-infection as most cross-infection in health care occurs by transfer on staff hands (ICNA 2002). It is therefore essential that all staff who come into contact with patients fully understand the role that the hands play in the spread of infection and the importance of good hand hygiene practice.

The occasions when hands should be decontaminated are many and include:
- After going to the toilet
- Before preparing food
- When hands are visibly soiled or grossly contaminated with dirt or organic material
- After glove removal
- After dealing with contaminated laundry or clinical waste
- Before aseptic procedures
- Before any episode of direct patient contact and after any contact that may result in contamination
- On arrival at work and before leaving work

Preparation for hand decontamination
Before decontaminating hands, clinical staff need to consider the following general principles:
- Removing wrist watches and stoned rings as they can harbour micro-organisms (Trick et al 2003) and inhibit a good hand washing technique. Stoned rings can also tear gloves (Jacobson et al 1985)
- Ensuring that cuts and abrasions are covered with a waterproof dressing
- Ensuring nails are short as most microbes on the hands are found around and underneath the fingernails
- Not wearing false nails or nail varnish. False nails can harbour more microbes (Heddewick et al 2000) and prevent vigorous hand hygiene. Nail varnish can be chipped increasing bacterial counts (Winslow 1997)
- The use of nail brushes is not routinely recommended as the bristles can cause abrasions which can increase bacterial counts on hands (Gould 1994) and nail brushes can quickly become contaminated.

Hand washing technique
When washing hands, the following sequence should be followed to minimise the risk of skin irritation and easy transfer of micro-organisms:
- Hand should be wet first under running water
- One shot of soap should be applied
- All areas of the hands should be washed
- The soap should be fully rinsed off
- Hands should be thoroughly dried

To ensure that all areas of the hands are washed, the six step technique is recommended. This technique was developed from research which found that certain areas of the hands are commonly missed during routine hand washing (Ayliffe et al 1978). The technique, if followed correctly, ensures that all areas of the hands are washed.

The Microbiology of the Hands
There are two main types of microbes which are present on the hands:
- Resident micro-organisms or resident flora are those which live deep within the epidermis of the skin on the hands. They are difficult to transfer to other people but are also not easily removed from the hands by washing. This however, does not generally present a problem as they do not generally present a risk in routine procedures. They are more of a risk in invasive procedures such as surgery.
- Transient micro-organisms or transient flora are those microbes found on the surface of the skin which are readily picked up by contact with people, the environment and so on. They are readily transferred to others but are also easily removed from the hands. These are the microbes that cause the most problems in clinical procedures.

These microbes are an important factor in deciding what type of hand hygiene and product is required in particular situations.

Routine Hand Hygiene
This is the type of hand hygiene which takes place in most care situations. It removes transient micro-organisms from the hands and is carried out using the six step technique, takes around 10-15 seconds and generally involves the use of liquid soap. This is called routine social hand hygiene. Prior to aseptic procedures such as wound dressings and insertion of a urinary catheter, an antiseptic solution may be used – this is known as routine hygienic hand hygiene. Routine hand hygiene can also be carried out using one application of an alcohol hand rub which should cover all areas of the hands as with the hand washing technique.

Surgical Hand Hygiene
This generally takes place prior to surgical procedures and significantly reduces resident micro-organisms in addition to removing transients. It generally takes around 2 minutes and involves the use of an aqueous antiseptic solution. It can also be carried out using 2 applications of alcohol hand rub depending on local policies.

Hand Decontamination Agents
When deciding which of the following hand washing agents to use the practitioner must consider the need to remove transient and/or resident hand flora.
1. Bar soap – this is not generally recommended for use in clinical practice
2. Liquid soap – this is recommended for routine social hand hygiene to remove transient micro-organisms from the hands
3. Aqueous antiseptics – these can be used for routine hygienic hand decontamination prior to aseptic procedures or for surgical hand hygiene prior to surgical procedures. There are several products available which generally contain one of three antiseptics (Chlorhexidine Gluconate, Iodophors or Triclosan)
4. Alcohol products – these can be used as an alternative to hand washing if the hands are not physically dirty. This might include situations where access to facilities is limited, such as in community nursing, and in situations where hands need to be decontaminated multiple times in a short space of time. The Normal Patient Safety Group has produced work on the use of hand rubs and it is now a requirement that alcohol hand rubs be available at the point of care such as at the patient’s bed side. This is in the hope that compliance with hand hygiene can be improved. Alcohol products do not have residual activity on the hands unless an antiseptic such as triclosan or chlorhexidine is added. Alcohol hand rubs are available in both liquid and gel forms.

Hand Decontamination Agents

<table>
<thead>
<tr>
<th>Step</th>
<th>Technique</th>
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<tbody>
<tr>
<td>1.</td>
<td>Palm to palm</td>
</tr>
<tr>
<td>2.</td>
<td>Right palm over left dorsum and left palm over right dorsum</td>
</tr>
<tr>
<td>3.</td>
<td>Palm to palm fingers interlaced</td>
</tr>
<tr>
<td>4.</td>
<td>Backs of fingers to opposing palms with fingers interlocked</td>
</tr>
<tr>
<td>5.</td>
<td>Rotational rubbing of right thumb clasped in left palm and vice versa</td>
</tr>
<tr>
<td>6.</td>
<td>Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa</td>
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Non-compliance with hand hygiene

Despite hand hygiene being a simple method of reducing infection and cross-infection, compliance can be low. In one observational study, Feather et al. (2000) reported a rate of compliance with hand hygiene of 8.5% in medical students. Many reasons have been reported for this poor compliance including:

- Poor facilities
- Cost
- Time and workload
- Lack of education, training and policies
- Lack of role models and poor management support
- Poor risk perception i.e. staff not perceiving any risk
- Interference with activities e.g. skin irritation from repeated washing leading to reluctance to decontaminate hands

It is clear, then, that improving compliance with hand hygiene is not just about education or improving facilities but is a multi-faceted issue. The use of alcohol hand rubs has addressed some issues but others remain a challenge.

Hand Hygiene Facilities

One of the main reasons for non-compliance with hand hygiene is a problem with facilities which may either not be available or may be inadequate (Harris et al. 2000, Nelsing et al. 1997). Proper facilities are therefore required in clinical areas to improve levels of compliance. These include separate hand basins with elbow operated mixer taps (or non-touch or knee operated), wall mounted soap dispensers with cartridge refills, paper towels in wall mounted dispensers and a foot operated waste bin.

Work based activities

- Identify five areas / actions within your working environment which could lead to hand contamination.
- Locate the areas within your workplace where facilities are provided to decontaminate your hands correctly and assess whether they meet all your facility requirements.
- Identify the hand hygiene materials and skin cleansing products that are available in your workplace such as soap, paper towels, alcohol hand rubs and moisteners.

References


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Take the course.

Infection Control

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A programme of education and training on the decontamination of medical devices, designed for primary care staff, is now free and online throughout NHS Scotland.

Register at www.decontamination.scot.nhs.uk

www.scottishirishhealthcare.com 27

One pair of these scissors is contaminated with micro-organisms. The other is not.
Greenbridge Environmental Control Ltd was contacted by the South West Ambulance Service in November 2006 about concerns over the levels of cleanliness within their ambulances.

This is a brief introduction detailing the processes involved with the deep clean of an ambulance with the Activ8 Vapourization Fluid and the test certificate from the Health Protection Agency dated 21st November, 2006.

The tests were carried out inside an ‘in service’ vehicle with no exposure to the outside elements with nothing being removed from the ambulance prior to the swabbing or disinfecting. In order to not contaminate any swabs, non-powdered latex gloves were worn by all operatives and replaced after every swab. Thirty One before and after swabs were taken from various areas.

### Method of Swabbing Prior to Vaporization

The swabs were provided by the Bristol office of the Health Protection Agency and were the standard 10cm swabs. The swabbing areas were pre-determined and involved a cross section of the ambulance ranging from the floor to the glove box.

Please refer to the test certificate dated 13/11/2006. The worst contaminated areas are the floor (No. 27) where there are 13,000,000 colonies pre-clean and the fixed chair (No. 16) where 5,500,000 colonies were found.
Method of Vaporization

The machine used was a ‘fog master junior 2400’ with a capacity of 1 litre of fluid. This is a hand held device that is mains power (240v) operated. Other than a paper mask no other personal protective equipment was required. All cupboards inside the vehicle were opened; all lights were turned off and all doors and windows were closed.

The ‘fog’ filled the ambulance within 4 – 5 minutes and the machine was then turned off, with the operator removing himself from the vehicle leaving the ‘mist’ inside the vehicle. The cabin of the vehicle then received the same application allowing the mist to enter the glove box and side compartments. The application within the cabin took just 2 minutes. After 15 minutes the doors and windows were opened to allow any remaining fog to escape.

After Vaporization cell swabs

The same format was repeated for the after vaporization cell swabs as the ‘before swabs’. Swabs were taken from the same places as the ‘before swabs’ were taken from. Again these swabs were taken to the laboratory within a 2 hour period for testing.

Result

As you will see the results are for the most part astonishing. 13,000,000 cells from the floor came down to <200. There are areas such as the CO2 bag and the glove box where insufficient product was used.

Conclusion

An ambulance can be sanitized in just 15 minutes using locally trained staff allowing the ambulance staff more time on the road and better protection against infection.
Automatic behaviour and the way that they respond to situations. It could be to help them to feel better, to give them a sense of control, to feed their emotions. Messages about food and so it is not surprising that they use it at times. Some people were given food as a treat or a reward. The sorts of food that were included were sweets, biscuits, cakes, ice cream, bread and butter. At the doctors and dentists they used to give out boiled sweets if you had been a good and healthy eater. Some people overeat because there are people starving in the world. Others are driven to eat because they are in pain. The physiological and psychological impact on people’s lives. This includes coronary heart disease, diabetes, kidney failure, osteoarthritis and high blood pressure, some cancers and reduced life expectancy. The psychological consequences of the relationship between eating and self esteem is that anxiety to clinical depression and a higher risk of suicide; these are often made worse by bullying, prejudice and social stigma. People on some medications particularly for mental illness are vulnerable to weight gain sometimes of several stone and this can be problematic as it may affect both physical and mental well being. Usually the focus of interventions for people who are overweight and obese centre around the eat less and exercise more message. Many people find themselves on a dieting treadmill and have a list of foods that they have been told they should or ought to eat, the good foods and a list of foods that they have been told they shouldn’t or mustn’t eat, the bad foods. This leads to a culture of guilt and deprivation. If a person is eating the “good foods” they feel deprived and if they are eating the “bad foods” they feel guilty. The challenge is how to break this negative cycle.

If a person presents as obese and the weight is seen as the problem the obvious solution may be to address the weight. If however the weight is seen as a symptom of problematic eating behaviours then the challenge is how to address the behaviour.

It is important to think about the reasons why people overeat and what purpose this behaviour is serving. People identify that they overeat for a variety of reasons such as stress, boredom, happiness, hunger, loneliness, habit, availability, addiction, comfort, distraction, low self esteem, lack of self confidence, reward, rebellion, to be sociable, to celebrate …and many others.

There are a multitude of reasons, very few or none of them having anything to do with physical hunger. Sometimes food is there as a treat or a reward and the significance that it carries for us can be traced back to childhood messages. Some children are told to, “Eat everything on your plate because there are people starving in the world”. Others are told that, “it is polite to always leave something on your plate”. Some people were given food as a treat or a reward. The sorts of food that often give instant gratification, highly refined carbohydrates like sweets, biscuits, cakes, ice cream, bread and butter. At the doctors and dentists they used to give out boiled sweets if you had been a “good” boy or girl. So an injection which hurt would be followed by a lovely sweet taste, which served two purposes. To reward the behaviour and to distract from the pain so that the message that stayed with them was that the sweet had made it better. People often have mixed messages about food, and when they experience obesity there is a clear, not surprising that they use it at times to feed emotions. The behaviours that people develop serve a purpose at the time, this could be to help them to feel better; to give them a sense of control, to control them, to help them to avoid difficult situations and to give them some comfort or something else. They then become part of their “automatic” behaviour and the way that they respond to situations.

If a person overeats in response to stressful situations a stress management programme would be a more proactive solution than a diet sheet. If relationship difficulties are the problem and a person is overeating to comfort themselves in situations when they feel unable to put forward their point of view assertiveness skills may help.

For many people the weight is a symptom of the way that they are managing their lives. Using a life management approach to weight management can be empowering. It is a way of helping people to take control of their lives and allows them to define what it means to them. Building up a range of personal development skills such as assertiveness, planning, problem solving, confidence building, understanding the difference between wants and needs, what motivates them and other areas enables people to take personal responsibility and to make informed choices.

People’s eating behaviours differ some have eaten a little too much most days and over time have become obese. Eating 1 _ digestive biscuits a day beyond a body’s energy needs leads to a weight gain over a year of 10 lbs. With this pattern a healthy weight person becomes obese in about 4 years. A reduction in activity levels can over a period of time have the same effect. Other people have become obese by eating hundreds, maybe thousands of extra Calories some days and so gain weight quickly. The differences don’t just fall into different eating or exercise patterns. Psychological and educational differences strongly influence a person’s behaviour. Other variables include age of onset of obesity, health profile and family environment.

Twenty years ago, anorexia was treated as a matter of under eating and the first line treatment was force feeding, it is now recognised that it is a serious and complex illness that requires psychological as well as physiological input. Obesity rather than being just a matter of too much food and not enough exercise is a complex, multifaceted problem and there is no one or all solution for all people. Developing their eating behaviours because of a variety of different reasons. We need to develop a range of strategies, treatments and support to combat this.

Cognitive Behavioural Therapy (CBT) is widely recognised as an effective way of identifying the connections between how we think, how we feel and how we behave. Its effectiveness in working with sufferers of a range of eating disorders has been well documented in psychiatric literature. However, whilst eating disorders such as anorexia nervosa and bulimia nervosa are acknowledged by psychiatrists and psychologists as eating disorders, obesity is regarded as a medical condition. The reasons for this are varied and treatment for obesity is rarely a part of the psychiatric services. There is evidence to suggest that people who are morbidly obese are more likely to suffer from depression and also that between 25% and 40% would suffer with binge eating disorder. It could therefore be argued that the development of a binge eating disorder unites obesity with anorexia nervosa and bulimia nervosa through characteristic values and attitudes pertaining to shape and weight. In essence, suffers of these conditions are likely to experience overvalued ideas of their self-worth in terms of their shape and weight which impact on how they think, feel and behave. An example of this may be seen when considering the following values and beliefs:

- I must be thin because to be thin is to be successful, attractive and happy.
- I must avoid being fat because to be fat is to be a failure, unattractive and unhappy.
- Self-control is a good because it is a sign of strength and discipline.
- Self-indulgence is bad because it is a sign of weakness and indiscipline.

Such beliefs and attitudes will inevitably impact on the individual’s feelings and behaviour. Typically, a failure to control weight and shape through over eating (control loss) may manifest itself in terms of depression, anxiety and social avoidance. Sufferers are likely to reinforce negative self-regard and low self-esteem through a perceived sense of hopelessness at having failed to achieve a sense of control. Were they to notice two people laughing and whispering to each other as they walked by, the likely negative thought…”They were probably saying I looked unattractive”, is likely to deflate and sadden. Ironically, it is common for negative emotions such as sadness and boredom.
to influence eating habits resulting in a maintenance cycle where the sufferer feels trapped. Interventions should be considered in terms of examining the nature and personal significance of these thoughts and the impact they have on the individual’s lifestyle. In effect, showing that it is possible to control weight and shape through more controlled eating would demonstrate a capability to exert control over other aspects of the individual’s life. To achieve this, sufferers need to focus not only on changing dietary habits or other behaviours they need to change their attitudes and values to shape and weight.

Some Useful Cognitive Behavioural Therapy Interventions

- Identifying the nature and scale of the problem as seen by the sufferer.
- Examination of attitudes to obesity, Thoughts, Feelings and Behaviour therein.
- Identifying and challenging negative thinking styles (distorted beliefs).
- Understanding the impact of methods of weight control (diet/ exercise).

Depression, anxiety and other interpersonal issues common with chronic obesity, such as social avoidance, are usually not in themselves a focus for therapy as they often respond positively to the sufferer’s enhanced control over eating habits and consequence weight control.

The Obesity Awareness & Solutions Trust (TOAST) represents people whose lives are affected by obesity. They have a range of supportive services including an active website and a Help and Information service which is available for the price of a local call 0845 045 0225 or by email obesity.helpline@toast-uk.org.uk. They are also an accredited training centre with a range of programmes that use elements of Cognitive Behaviour Therapy and are designed to inform professionals and people who are overweight and obese, they offer courses such as a 12 week Life and Weight Management Programme and Obesity Awareness & Diversity. For more information contact Louise Diss on louise.diss@toast-uk.org.uk or 01279 866010.

( ) The House of Commons Health Select Committee on Obesity 27th May 2004

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Fundamental Aspects of Children’s Nursing Procedures

Edited by Alan Glasper and Gillian Prudhoe


This book has been edited and written by children’s nurses for children’s nurses in practice. The clear and straightforward descriptions of clinical procedures will be an excellent resource for nursing students and newly qualified staff nurses in their everyday working lives within the child field of practice.

The complexities of caring for sick children and their families requires nurses who are fully conversant with the special needs of this client group and the initial chapter details these crucial considerations which encompass risk assessment, consent and safeguarding.

The book is structured to give the reader maximal clarity and simplicity and each chapter is structured around the what, how and why of children’s nursing procedures. Additionally helpful exercise activities will help readers practice and hone their skills within the safety of the skills laboratory. The step-by-step approach takes the reader through a logical series of steps designed to provide the knowledge which underpins the skill and the practicalities of actually carrying it out.

Readers will find the sections on the equipment need to carry out the skill and what actions to take pre and post procedure particularly helpful. As the complexities of children’s nursing procedures grow year on year this timely book supplemented with important information pertinent to the skill in question will prove an invaluable handbook for nurses working in contemporary children’s nursing settings.

Alan Glasper is professor of children’s nursing and Gillian Prudhoe is a lecturer in children’s nursing at the University of Southampton

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Bullies don’t like it if you disarm them, and take away their weapons. I’ve seen them protest over the past few days, as they’ve reeled at the news of the obesity gene.

It proves that obesity is a much more complex issue than the sanctimonious preachers would have society believe. There is something that many people are born with which predisposes them to put on weight, and struggle to take it off given a food-rich and exercise-poor lifestyle. In other words the sort of environment we have today in the Western world. Even Japan now has an obesity problem. 23 million are dangerously overweight and for the first time in its history, Japan is seeing Type 2 diabetes. This epidemic coincides with a sea change in dietary habits and an explosion of fast food outlets, from Krispy Kreme doughnuts to McDonalds, Burger King and Cold Stone Creamery, serving ice cream mixed with fruits nuts and biscuits!

The newly discovered obesity gene is not an excuse for fat and it changes nothing about what we do. But, in the words of the scientist who discovered it, Professor Mark McCarthy, it does help explain why some people struggle so hard. While the thinners do not, while we all live virtually the same lifestyle.

Now this, you would think, would lead to a better understanding and more compassion from the rest of society. But not a bit of it! The bullies have been moaning that this will make the obese even more lazy and glutonous.

As patron of TOAST, The Obesity Awareness and Solutions Trust, I get called up by TV and radio stations when they want to debate the obesity issue. So, as you can imagine, the past week or so has been very busy! But I think the publics hostility to the concept of an obesity gene surprised even the presenters of the various TV and radio programmes on which I appeared.

Listeners rang in to say it’s a pity the news wasn’t hushed up. Give fat people an excuse said one, and they’ll just stuff their faces with even more cream cakes and chocolate.

I made a plea for tolerance and understanding, and still many listeners spoke about fat people as though they were a lower form of life, and deserving of only contempt and ridicule.

Fat people say they try to exercise, said one particularly nasty man, but you see them in the gym. They’re the ones standing around looking pathetic, or propping up the coffee bar, filling their faces with biscuits. He forgot to mention that there were no doubt, lots of slim people eating and drinking at the coffee bar, or nattering in corners. Does that make them lazy and stupid? No, just the fat ones.

To me, that’s why the gene discovery is such a breakthrough. Not because it provides an excuse, or a reason to give up the fight. It does not. But it should help explain, for those prepared to listen, that we are all complex individuals, who respond to the same environment in different ways.

Sure, if you locked us all up in a room and starved us all, we would lose weight. But at different rates, and with varying effects upon our health. And that’s the problem. We are all trying to be fit and slim in an environment which is more toxic to some than others.

One obesity specialist I know in Melbourne, Australia, calls it the thrift gene. If you’ve got it, you make the very most of every calorie you eat, and your body is super-efficient at storing it as fat, and not letting go.

In cave-man days, those with the thrift gene would have survived better than those without. It would have been a positive asset! Nowadays, when food is plentiful and junk food abundant, those with the thrift gene get fat, says Dr John Dixon. Obese people are not blameworthy, they are the victims of our modern culture.

Yet Dr Dixon stresses that, by the time his patients get to his clinic, they are already badly damaged by societies attitude, and this makes their problem even harder to beat. Fatties are so used to being abused and name-called, that they deprecate themselves.

You can even see it in the user names of the members of my weight loss support website, FatHappens.com. Although it’s done in fun, members give themselves horrible nicknames. Many admit it reveals an underlying despair.

I asked them recently what was the worst thing about being fat. Try and read these without feeling for their humiliation:

• I can’t shave my legs properly
• When on a camel ride on holiday with my boyfriend (that poor camel) they had to put sand bags at my boyfriend’s side to balance the weight out.
• Being told (after collecting sponsor money) that I wouldn’t be able to make a tandem parachute jump because I was too heavy.
• Being told by a “friend”, it’s a shame you’re so fat, because you have a really pretty face.
• On seeing every other woman they’ve ever met.
• Promising every morning you’ll be “good” at dieting and weeping every night that you weren’t.

Fat people are human beings. Why is that such a difficult message to get across? I think that so-called ordinary people take their lead from the media and it’s those attitudes which must change first. There’s a long way to go, however. Just witness the recent reporting of fat child stories in the press.

The coverage of young Connor McCreadie made me quite sick. His sin to be grossly overweight, over 14 stones at the age of just 8. Clearly a desperate situation but one with obviously complex causes, and needing an holistic solution. His mum, terrified that social services might take him into care, appealed to the media for help and got a barrel load of blame. The same media that until recently advertised crisps, chocolate and Pot Noodles to kids and squealed when that right and revenue was taken away from them.

We all know the media loves a good headline but obese people make great pictures, too. So young Connor was told to take his clothes off, for the gawping public to tut-tut at his folds of flesh. His pitiable image was adorned with tag lines such as the child with a man-size gut or the lard-arsed little one.

We were also told how many folds of fat he has around his middle, how many sausages he eats for breakfast, how many beds he’s broken and how many lavatory seats he’s cracked just by sitting on them!

Connors story was closely followed by that of a nine year old girl, Samantha Hanes, whose size 18 frame was pictured atop a mountain of junk food and cigarettes. Her words of the scientist who discovered it, Professor Mark McCarthy, it does help explain why some people struggle so hard. While the thinners do not, while we all live virtually the same lifestyle.

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• Getting wedged between your chair and the lecture table and not being able to move until everyone had left the room.
• Splitting a pair of jeans I was trying on in a shop.
• Getting stuck in a swing in the park.
• Needing an extension belt for aeroplanes.
• Being asked to pay for two airline seats.
• Having a friends dining chair collapse underneath me.
• Going to the doctor with a rash/infection underneath the arm strap.
• I broke the lateral trainer at the gym.
• Having blood pressure taken - and the arm strap is too small.
• I can’t shave my legs properly.
• On a camel ride on holiday with my boyfriend (that poor camel) they had to put sand bags at my boyfriends side to balance the weight out.
• Being told (after collecting sponsor money) that I wouldn’t be able to make a tandem parachute jump because I was too heavy.
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WHO BENEFITS FROM SAFE MANUAL HANDLING?

Author: Sheenagh Orchard RN RNT Cert Ed (FE) DN (Lond), Moving & Handling Consultant

Safe manual handling and manual handling training is often seen as ‘an evil necessity’ and at the least as a ‘tedious’ aspect of general health and safety in the workplace. It can be costly to maintain the training, provide the equipment and support and monitor staff. There is also the cost of time in removing staff from their work to undergo training. While this can be matched against the potential costs of not implementing safe handling such as: compensation claims, negligence claims and staff replacement costs, these rarely convince staff and management sufficiently that they actively pursue training and equipment provision.

A benefit must be seen by individuals if there is to be a change in working culture and attitudes and often the benefit is not adequately highlighted. What is more is that the training of staff is often not properly understood by the staff or the client/patient. The added benefit is that while the patient/client needs are met more safely staff also will be using postures and management that are more ‘back friendly’ thus reducing the incidence of musculoskeletal injury.

The desire of carers is to deliver ‘Quality of Care’ which promotes physical, mental and social wellbeing of the patient/client and this needs to be achieved with ‘Quality of Work’ which promotes the physical, mental and social wellbeing of the carer.

To achieve both Quality of Care and Quality of Work needs careful assessment of each individual situation. Balanced-decisions must be made in order not to compromise patient/client or carer. This is not always easy and often necessitates a multi-disciplinary approach to the assessment which includes input from the patient/client and/or other involved parties.

It can be seen that in most circumstances improvement of Quality of Care is immediately reflected in improved Quality of Work and vice versa. This reinforces the argument for change of practice as both the staff and the patient/client benefit. For example, the introduction of electric profile beds for patients/clients with reduced lying to sitting ability eliminates musculoskeletal stress of manual moves from the carer and allows the patient/client to sit up with a slower, more comfortable position change as well as more secure head support. There are also the added benefits for some patients/clients of sitting up as and when they wish rather than waiting for a carer. For the carer it removes an unnecessary handling activity releasing them for other care activities. Care and cost benefits can be seen from such an intervention.

Used thoughtfully equipment can promote physical ability – for example if a patient/client is regaining sitting ability an electric profile bed can be used to improve function by gradually increasing how far back they are reclined, prior to the sit, encouraging and developing the patient/clients own muscular function to sit.

Manual interventions will always have some degree of potential risk particularly where there is a close match between the body mass index of carer and patient/client, or where the physical/behavioural aspects of the patient/client significantly influence the handling activity. The safest (and most comfortable!) option is to remove the need for manual manoeuvres by introduction of suitable equipment.

All equipment must be:

- assessed as suitable for the patient/client and situation
- used by staff who are trained in its use
- used according to the manufacturers instructions
- safe for that activity – correctly maintained and checked - and clean!

Where manual interventions are retained all options to reduce the risks to a reasonable level must be considered. Account must be taken of factors relating to the skill of the staff. Training in itself will only reduce risks as part of an ergonomic strategy for safe handling. There will remain the dilemma that in order to maintain risk reduction staff must be:

- Trained to a sufficiently repeatable level of competency
- Able to apply the training in the workplace
  - Supervised sufficiently to ensure they apply safe practice
  - Able to repeat or practice the skill regularly enough after training to ensure skill retention.

Repeating skills frequently enough to maintain a high standard of skill in itself can pose a risk – consider the balance of risk between sufficient repetition to be competent and the fact that the more you do it the more exposed you are to risk. Sometimes the exposure to risk during training cannot be justified when compared to the infrequency of meeting the actual handling situation in the workplace. For example, staff can be trained how to control a falling person but the risks during training, both to simulated carer and simulated patient/client, are significant and indeed have occurred during training sessions. When you analyse how often the workforce in a specific setting are exposed to this potential situation it may be seen that it potentially occurs annually or less - the risks of training and maintaining skill in controlling a fall thus greatly exceed the risks of being exposed to a possible ‘real’ situation as a less skilled carer. Most carers ‘find’ the person ‘fallen’ and are much less likely to be in a position where they could control a fall. Training should, therefore, focus on management of ‘falls’ rather than management of ‘falling’.

There will be some settings where controlling the falling person is a regular occurrence and if this is the case then training may be less risky than no training. The risks during training then must be managed by basic strategies such as:

- Working on a gym mat
- Breaking the controlled fall down into its component parts and teaching them stage by stage
- Ensuring partners are confident in each other
- Supervising one pair at a time not a whole group
- The trainer giving some additional control by holding a handling belt

Use of equipment and good training are essential component parts of establishing safe handling practice in the workplace. They must be used in conjunction with comprehensive risk assessment, risk management and safe systems of work if they are to improve the Quality of Care and Quality of Work to the level most of us seek. There is no ‘quick fix’ to this it requires ongoing commitment by staff, management and to a degree of the patient/client themselves and safe handling should be seen not as an entity in itself but as part of our holistic approach to healthcare.

The Guide to the Handling of People - 5th edition - BackCare (ISBN 0-9530582-9-8) has now been available for two years - how is it affecting practice? The book was reviewed in April 2005 by Professor D.A. Stubbs.
MOVING AND HANDLING INFORMATION UPDATE

Professorial Research Fellow at The Robens Centre for Health Ergonomics of which the following is an extract:

“The contents of the book should enable and encourage all practitioners to critically appraise and develop their own practice within a safer systems framework in the absence of which the editor notes that ‘safer handling practice will not flourish’. The reviewer totally endorses this view and highly commends the editor, editorial team, contributors, evidence review panels, external reviewers and all the collaborating and sponsoring bodies for a job very well done and I have no hesitation in very strongly recommending The Guide to the Handling of People, 5th Edition.”

Practitioners who have spoken to me over the last two years have all unfailingly said that they are finding the information in the book beneficial both in broadening their knowledge and assessment skills and also in helping them to analyse, for themselves, working practice.

This is good to hear as we should be less ‘prescriptive’ in our safe handling management, rather we should be basing assessed outcomes on principles with an evidence-base.

This enables us to make balanced decisions while using the legal framework which requires us to work from an ‘assessment base’ to make decisions on how to reduce the risks of handling activities. The reduction of risk must apply to both staff safety and client safety – reduction of risk being taken ‘so far as is reasonably practicable’. There can never be a guarantee of absolute safety and it is important that staff and clients are aware of:

• the risks that remain,
• how to evaluate the remaining risks and
• the need for reporting or seeking advice when applicable.

A key aim in the safe handling of people is to encourage as much independent movement from that person as possible. Assessment prior to moving a person should identify what they can do without assistance and then what level of assistance needs to be given to meet the needs of the person. It is from assessment, therefore, that we should be identifying moving and handling management not from a list of proposed techniques. The Guide to the Handling of People 5th edition is one of the tools that we can use to lead us to make sound decisions based on evidence.

Certainly the 5th edition (HOPS as it is colloquially referred to) gives us the tools to analyse practice. It is clear in the publication that all possible working practice is not described within its pages, rather a range of suitable practice with the benefits, risk and precautions of each. Practitioners have taken this a step forward and are beginning to analyse other practice using the same framework. An example of this was published in the November 2006 issue of ‘The Column’ the quarterly journal of National Back Exchange. Here a panel from the Yorkshire group examined a range of sitting to standing transfers that had not been considered in HOPS. These were analysed using the same format as the analysis in HOPS and risks and precautions identified so that other practitioners can use this information to decide whether a method would be potentially suitable in their own situation.

It is good to see that HOPS has not only given additional information and guidance to practitioners but also initiated debate and further analysis of practice.

Two other publications currently available for those working in the field of Moving and Handling are the 2006 editions of Risk Management Guidance 1 and Manual Handling Guidance 3 both available from the College of Occupational Therapists.

Hopefully practitioners in the field of Moving and Handling of People will not only find all of the above publications available and useful but they also may be inspired to do their own studies and research to develop practice even further.
A lot of serious attention is being given to GI (Glycaemic Index) at the moment. Half the academic world is busily researching whether it matters for slimming (or for health) while the other half is trying to find a way of measuring it reliably and discussing how it should be used. Pity they didn’t complete this work to confirm the theory before selling it so hard to the public!

So what on earth does it actually mean? Well, it’s quite simple really and all comes down to deviance. No, not what you’re thinking! This is about the deviation of your blood glucose level from its background level. Let’s start in the morning, when you haven’t eaten since last night. The level of glucose in the blood is nice and steady but not zero. If it were zero, you’d be dead, because it is glucose in the blood that keeps the brain working. Overnight, the body uses its stores of glucose (in the liver as glycogen) to top up the blood level to keep it steady. Next you have a nice healthy carbohydrate-rich breakfast. Soon the level of glucose in the blood begins to rise. The Glycaemic Index is a measure of how quickly it rises.

So a high Glycaemic Index food such as white bread will cause a rapid rise in blood glucose and a lower GI food, such as a bagel, will lead to a slower rise. And so foods can be put into different groups according to whether they cause a rapid rise, a middling one or a slow one. The only problem is that classifying foods in this way is rather like measuring the acceleration of a Ferrari driven by a formula one driver and comparing it with a Skoda driven by me. Actually it’s worse. Think what it would be like if they were both towing caravans. Certainly, the cars will make a difference but other factors will make the comparison between the performance of the two cars a bit difficult to notice.

Here’s why. Different people react differently to exactly the same amount of the same carbohydrate food. In addition, give the same food to one person on different occasions and their blood glucose rise will be different. Sure, there is a difference between the foods but it matters as much in real life as the cars driven by an expert and by a clod, when both are loaded down with a caravan.

The real problem with all this attention to small changes in the rate of increase of blood glucose level after eating different carbohydrate foods is that it is making people nervous about these foods. Perhaps a little reassurance is in order! Carbohydrates are an essential part of a healthy diet. Without adequate carbohydrate, the body goes into “emergency mode” to keep the brain supplied with the glucose it needs to function. And of course, as every athlete knows, the muscles don’t work too well either.

So what is happening when you eat some carbohydrate? Is the rise in blood glucose something to worry about? And do “slow carbohydrates” really give you energy for longer? Well, when you drink a sports drink containing glucose, for example, the glucose is taken into the body fairly quickly. The body reacts by releasing insulin to tell the liver and muscles to take the glucose out of the blood stream and use it (mostly to put into store as glycogen). In fact, most of the glucose from the drink will be taken up into the liver and never be seen in the blood in the arms and legs, feet and hands (which is where the blood levels are measured). In a healthy individual, the rise in blood glucose level is quite small and things quickly return to normal. No harm done!

If a more slowly digested carbohydrate source, such as porridge, is eaten, much the same happens, only first the starch in the porridge is broken down to glucose. With some starches (but not all) this takes a little while, so the blood glucose level is slower to rise and doesn’t get as high. And it will take a bit longer to return back to normal. But again, most of the glucose is taken up before it ever appears for measuring in a finger tip prick of blood.
Most carbohydrate foods are converted to glucose one way or another. And glucose in the blood means an insulin response that will tell the body to remove the glucose from the bloodstream and make use of it, either as a fuel for energy immediately or as a store of energy for later. Incidentally, this store will only be as the carbohydrate store glycogen. Very little will be stored as fat even if you are over eating a bit.

One important exception is fructose. This sugar is found, along with ordinary sugar (sucrose) and some glucose, in most fruits. It is different in that it doesn’t give rise to very much glucose in the blood, so its insulin response is low too. So the GI of fructose is very low. As a result, common sugar (sucrose), which is made up of half glucose and half fructose, has a moderately low GI. Not many people seem to know that!

Do low GI foods really give you energy for longer? Not unless there is something very wrong with you! What people forget is that the glucose seen in the bloodstream after eating a carbohydrate food is only part of the story. A small amount of the carbohydrate eaten will be used as fuel immediately but the rest will be stored for later (unless you are running a marathon, in which case the body wisely uses all it can straight away). And because of the need to keep a steady glucose supply going to the brain, the stored carbohydrate will be released as, and when, it is needed. What matters most is how much carbohydrate you eat, not what type it is.

Some people get a much bigger rise in blood glucose after eating carbohydrate foods than others. This is a particular issue for people with diabetes, of course, but is also seen (to a lesser extent) in people who are “insulin resistant” – meaning their body doesn’t respond normally to insulin. This is quite common in people who are overweight and unfit.

If you want to reduce the rise in blood glucose after eating carbohydrate, the most important thing is to improve your body’s response to insulin. The most effective trick for doing this is to exercise (obviously check with your doctor if you suspect you have any medical restrictions on what exercise you can do). Exercise improves fitness, and fitness improves insulin response. It will also help you lose weight if you have unwanted fat to shed. Interestingly, exercise also improves the body’s uptake of glucose in another way that is independent of insulin, so you benefit even more.

Another trick is the obvious one – eat smaller amounts of carbohydrate at each eating occasion! A less obvious fact is that what you eat with the carbohydrate food can slow its uptake into the body. This is why eating meals is better than snacking, simply because the meals will contain a variety of foods, all of which will be digested together. But whatever you do, keep eating carbohydrate. The daily menu should contain more carbohydrates than anything else. Even diabetes sufferers are now advised to base their eating habits around carbs.

OK but what are the GIs of different foods? The enthusiast’s web site will give you all the numbers, if you really want them: http://www.glycemicindex.com/

But here are a few facts to make you blink!

- Glucose is high GI
- But sucrose is moderate GI (as the fructose in it is very low).
- Many breakfast cereals have high GI but adding sugar to them lowers it.
- White bread is very high but so is wholemeal bread.
- Baked potato and freshly boiled or mashed potato are high GI.
- There are a limited range of low GI foods. These include many fruits (because some of their carbs are fructose) but few staple starchy foods.
- Some pasta, granary and rye bread and baked beans are low GI.

A reasonable rule of thumb is to mix your choices of carbs. It isn’t very practical to live on fruit, pasta, rye bread and baked beans.

What about slimming the GI way? This is very controversial, partly because it is so impractical. Choosing low carbohydrate foods all the time is tricky and boring. If you stick with it, will it work? Experts disagree on this too, so it’s up to you if you want to try it. But most important of all is that a carbohydrate rich diet is the recommended diet for health and weight control. Overeating anything leads to weight gain and experiments have shown that people are less likely to overeat if they have a carbohydrate rich diet. Fat rich diets are the most likely to lead to weight gain. And sugar is useful as part of a carbohydrate-rich diet for both health and weight control.
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Abstract: In the second article of this series, we will be discussing the different types of Diabetes Mellitus (DM) and the clinical presentation of both Type 1 and Type 2 DM. As previously identified in Article 1, Type 1 DM accounts for approximately 5-10% of all patients diagnosed, with the majority of patients presenting with Type 2 DM.

Type 1 - Insulin Dependent Diabetes Mellitus
Type 1 DM occurs as a result of the progressive destruction of beta-cells (β-cells) in the islets of Langerhans within the pancreas, which, in turn, leads to insulin deficiency. These underlying pathophysiological changes occur over a prolonged period of time, with symptoms of the condition only appearing once 80-85% of all β-cells have been destroyed. The only treatment option for a Type 1 patient is insulin replacement, with sub-cutaneous injections remaining by far the most favoured method of delivering same (treatment options will be discussed in more detail in the fourth article of this series). Continuous subcutaneous infusion of insulin via pumps and inhaled insulin are alternative methods, albeit far less common, with both now being recommended by NICE and the Scottish Medicines Consortium for those patients with very specific problems/issues relating to their diabetic control and insulin administration.

β-cell destruction would appear to be an autoimmune reaction, which is thought to be triggered by a variety of environmental factors, i.e. viral infection; prolonged period of ill-health; ingestion of certain toxins; dramatic change in life circumstances. These individuals are also thought to have a genetic predisposition to developing the condition and, frequently, there will be a close member of family already diagnosed with DM. In studies of identical twins, there was found to be a 50% chance of the second child developing the condition when one twin had already been diagnosed.

Pancreatic changes are confined to the β-cells, with other cells in the islets of Langerhans being unaffected. The triggering event leads to an inflammatory reaction referred to as insulitis. This autoimmune response leads to the formation of autoantibodies - islet cell antibodies (ICA). ICAs can be detected before the symptoms of Type 1 DM become apparent, but usually disappear within months of the diagnosis.

As this autoimmune reaction continues, the initial phase of insulin secretion after the ingestion of food disappears and peak insulin responses begin to decline. Blood glucose levels invariably remain normal throughout this stage. The symptoms of DM only become apparent once the total mass of β-cells remaining is insufficient to sustain normoglycaemia. Cell destruction can continue for many years following diagnosis.

Type 2 - Non-insulin Dependent Diabetes Mellitus
Type 2 DM is characterised by a combination of reduced insulin sensitivity (insulin resistance) and impaired β-cell function. Many Type 2 patients will initially be commenced on a healthy diet and lifestyle management programme. Inevitably, however, the vast majority of these patients will go on to require oral medications and, now more commonly, a combination of insulin and tablets to improve their glycaemic control (treatment options will be discussed in more detail in the fourth article of this series).

The onset of Type 2 tends to much slower than in the case of Type 1, and significant hyperglycaemia can be present for up to 10 years before a formal diagnosis is made. It is therefore not uncommon for Type 2 patients to already have both microvascular and macrovascular complications present at the point of diagnosis (complications will be discussed in more detail in the third article of this series).

Insulin resistance (IR) reduces the biological effect of insulin on the body, although the exact cause for this is unclear. There is, however, an established link between obesity (esp. abdominal) and IR which can, in some cases, be partially reversed if the patient loses a significant amount of weight.

IR causes increased levels of insulin to be circulating within the system (hyperinsulinaemia), yet blood glucose levels remain elevated. IR is commonly associated with hypertension, microalbumin and dyslipidaemia, resulting in an obvious increased risk of micro- and macrovascular complications. IR is also thought to be connected to impaired vasorelaxation and restricted blood flow.

Reduced β-cell function in Type 2 patients is, again, not fully understood. Insulin insufficiency is less severe than in Type 1 patients, with blood insulin levels high enough to prevent ketosis. Thus, the usual insulin level tends to either fall well below normal when patients become severely hyperglycaemic, which is usually when the introduction of insulin treatment is required.

Genetic predisposition to developing Type 2 DM is an established fact, with studies of identical twins showing concordance rates of almost 100%. The prevalence of Type 2 DM among close relatives is much higher than in the general population - there is a family history of DM in up to 30% of patients newly diagnosed with the condition.

Environmental factors include obesity (about 65-70% of Type 2 patients are clinically obese); reduced physical activity; higher intake of calories, refined carbohydrates and fats (although the influence of diet is thought to be affected by the other environmental factors); and certain drugs, such as beta-blockers, corticosteroids, thiazides and loop diuretics, are known to exacerbate insulin resistance and interfere with insulin secretion.

Maturity-Onset Diabetes in the Young (MODY)
MODY is an early onset form of Type 2 DM. Strict diagnostic criteria include a diagnosis before the age of 25 years; no requirement for insulin therapy 5 years after diagnosis; previous familial history spanning several generations.

MODY is essentially due to β-cell defect i.e. reduced insulin secretion in response to specific blood glucose levels. In contrast to the more common form of Type 2 DM, there is no significant insulin resistance.

Gestational Diabetes Mellitus (GDM)
This particular diagnosis is restricted to pregnant women whose glucose intolerance is first detected during the stages of pregnancy. It does not apply to known diabetic women who then become pregnant.

Diagnosis is usually made following an oral glucose tolerance test, with the same criteria as for the general population. Frequently GDM is not detected until the later stages of the pregnancy, with blood glucose levels often returning to normal (without treatment) following the delivery of the foetus.

It is, however, accepted that the development of GDM can significantly increase the risk of developing Type 2 DM in later life. Avoiding obesity and increasing physical activity can reduce this risk.

Treatment of GDM consists of an adapted dietary intake and often insulin therapy, as the use of oral hypoglycaemic agents during pregnancy is contraindicated.

Other causes of DM
DM secondary to certain genetic syndromes and medical conditions, or drug-induced will account for 1-5% of all cases diagnosed. Examples include acromegaly, Cushing’s syndrome, phaeochromocytoma, chronic pancreatitis and pancreatocyst, certain carcinomas, haemochromatosis, and prolonged use of steroid medications, for example in the case of chronic pulmonary disease and organ transplantation.
**Clinical Presentation of Type 1**
Type 1 DM usually occurs in younger people i.e. < 35-40 years, with a peak incidence during puberty and teenage years. Symptoms have a relatively sudden onset, invariably including:

- excessive thirst (polydypsia) and frequency of micturition (polyuria)
- fatigue and general malaise
- weight loss
- blurred vision
- muscular cramps (particularly in the legs)
- candida infections and balanitis
- nausea and vomiting
- if remaining undetected, diabetic ketoacidosis

Ketonuria and evidence of acidosis are usually present at the diagnosis of Type 1 DM, with prolonged hyperglycaemia resulting in ketoacidosis (DKA) and dehydration. If untreated, DKA can lead to coma and impaired cardiac and renal function. Rarely, undiagnosed DKA can result in death.

**Clinical Presentation of Type 2**
Type 2 DM occurs most frequently in people over the age of 40 years, with the peak incidence at 60+ years. However, as discussed in Article 1, the increasing incidence of obesity in younger age-groups has resulted in the prevalence of Type 2 DM in those under the age of 40, and even in childhood, becoming more common. Symptoms tend to occur much more slowly, and often patients will be diagnosed through routine blood and urine tests. Symptoms can still include:

- polydypsia and polyuria, though not as acute
- chronic fatigue
- some weight loss and visual disturbance can also occur
- persistent ‘minor’ ailments and ill-health i.e. colds; skin irritations; thrush infections

NB Patients are often diagnosed secondary to other conditions i.e. investigations/ presence of macrovascular complications, or by an optician during routine eye examination.

References

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Anticoagulant Therapy

Anticoagulant therapy refers to a group of drugs that are given to prevent clot formation (thrombosis) within the heart and blood vessels. These drugs may be administered orally, by subcutaneous injection or by intravenous infusion. In this edition we will look at the anticoagulants Heparin and Warfarin.

Charlie Bloe (Clinical Editor)

Heparin

Heparin is a naturally occurring anticoagulant. It was originally isolated from liver cell nuclei under the name Hepar. Hepar is Greek for liver. Hepar has a rapid onset and is therefore the drug of choice when initiating anticoagulation therapy and where rapid anticoagulation is required. It has a half life of approx. 1 hour and so has a short duration of action. Heparin is often referred to as being standard or unfractionated to distinguish it from the longer acting low molecular weight heparins. (LMWH)

Uses

Prophylaxis of thrombosis and where anticoagulation is necessary:

- Deep vein thrombosis (DVT)
- Pulmonary Embolism (PE)
- Acute Coronary Syndrome (ACS)

Mode of action

Mode of action acts by binding to antithrombin III which is an inhibitor of thrombin. Heparin potentiates this effect. Antithrombin III also inhibits other coagulation factors involved in the clotting process, notably factor Xa which results in less fibrin formation and reduced incidence of thrombosis.

Dosage

Heparin cannot be administered orally and must be injected either intravenously or subcutaneously.

DVT and pulmonary embolism: A loading dose of 5000 – 10,000 iu is given by slow intravenous bolus followed by an IV infusion of 20,000 – 40,000 iu over 24 hours. The aPTT is used to measure the clotting status and is measured 6 hours after commencing the IV infusion and after any changes to the infusion. The dose is adjusted to maintain the aPTT within the required range.

Side effects:

- Heparin-induced thrombocytopenia (dangerously low platelet levels) This side effect is less common with low molecular weight heparin but may still occur. Particularly if the dosage is greater than one week in duration. Platelet levels are checked if therapy is continued for more than 5 days.
- Hyperkalaemia (elevated potassium levels) This is due to inhibition of aldosterone secretion by heparin.
- Haemorrhage
- Skin necrosis
- Chloracne – after prolonged use
- Alopoeia (rare)

Haemorrhage:

As Heparin has a relatively short duration of action its effects are quickly terminated by stopping the infusion. The administration of protamine sulphate may be sufficient to control bleeding. If bleeding continues the effect of Heparin may be reversed by the administration of protamine.

Contraindications:

- Haemophilia and bleeding disorders
- Severe hypertension
- Recent cerebral haemorrhage
- Peptic ulcer

Low Molecular Weight Heparins (LMWH)

These drugs include dalteparin, enoxaparin (clexane) and tinzaparin.

They are given subcutaneously and target anti factor Xa activity rather than antithrombin III. They have a longer duration of action than unfractionated heparin and are considered as convenient as they only require a once daily subcutaneous dose.

Monitoring of aPTT is not necessary as the effect of LMWH is targeted and is sensitive to alterations in factor Xa

LMWH are now widely used to prevent deep vein thrombosis in medical and surgical patients and in the treatment of DVT and pulmonary embolus. These drugs are also used in the management of acute coronary syndrome.

Warfarin:

This drug is a derivative of coumarin (found naturally in many plants) and was originally developed as a rat poison.

Mode of action:

Warfarin works primarily by inhibiting the synthesis of clotting factors dependent on Vitamin K: II, VII, IX and X.

The anticoagulant effect takes at least 72 hours to develop and so heparin is usually commenced at the same time if a more immediate effect is required.

Indications:

- Prevention of thrombus in atrial fibrillation
- Artificial heart valves
- Pre cardioversion anticoagulation
- Antithrombotic therapy
- Cardiomyopathy

Dose:

Warfarin is administered orally. Tablets are available in 1mg (brown), 3mg (blue) and 5mg (pink) tablets. It has a long half life and need only be administered once daily. Starting doses are usually between 5 – 10 mg daily and effective target INR range (typically 2.0 – 3.0 for most indications) Daily maintenance dose is usually 3 – 9 mg daily.

Warfarin should be given at the same time each day. The INR is checked daily initially and the dose adjusted accordingly.

Contraindications:

- Hypersensitivity; history of cardiac failure (NYHA stages I to IV), diarrhoea, hypothyroidism, severe hypertension, diabetes, renal disease, severe liver disease. It is contraindicated in people who are dependent on Vitamin K: II, VII, IX and X.
- Peptic ulcer
- Severe hypertension
- Thickened blood
- Haemophilia and bleeding disorders
- Pregnancy & lactation
- Oral anticoagulant or reducing the dose of warfarin.
- Oestrogenic hormones (found naturally in many plants) and was originally developed as a rat poison.

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Lactic acidosis

Rare reports of hepatocellular dysfunction. Therapy should not be initiated in patients with increased baseline ALT levels (>2.5xULN), or other evidence of liver disease. Liver enzymes should be checked prior to therapy initiation and periodically thereafter based on clinical judgement. Discontinue if jaundice is observed. Erythrocyte disorders Report of new or worsening haemolytic anaemia with rosiglitazone. Common:

- Renal oedema
- Cardiac failure
- Oedema
- Low molecular weight heparin

Fluid retention & cardiac failure Rosiglitazone can cause dose-related fluid retention that may rarely be associated with rapid & excessive weight gain, & may exacerbate or precipitate heart failure in patients with signs of cardiac decompensation or deterioration in cardiac status. Heart failure reported more frequently when history of heart failure, elderly, or mild or moderate renal failure, or when used in combination with a sulphonylurea or insulin. Cardiac failure was more common in patients with significant peripheral oedema. The use of rosiglitazone in triple therapy with a sulphonylurea is associated with increased risk of fluid retention. Increased monitoring is recommended and dose reduction of the sulphonylurea may be considered. Coadministration of insulin is particularly recommended if AVANDAMET is used in combination with insulin.

Monitoring of liver function Rare reports of hepatocellular dysfunction. Therapy should not be initiated in patients with increased baseline ALT levels (>2.5xULN), or other evidence of liver disease. Liver enzymes should be checked prior to therapy initiation and periodically thereafter based on clinical judgement. Discontinue if jaundice is observed. Erythrocyte disorders Report of new or worsening haemolytic anaemia with rosiglitazone. Common:

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Monitoring of liver function

Rare reports of hepatocellular dysfunction. Therapy should not be initiated in patients with increased baseline ALT levels (>2.5xULN), or other evidence of liver disease. Liver enzymes should be checked prior to therapy initiation and periodically thereafter based on clinical judgement. Discontinue if jaundice is observed. Erythrocyte disorders Report of new or worsening haemolytic anaemia with rosiglitazone. Common:

- Renal oedema
- Cardiac failure
- Oedema
- Low molecular weight heparin

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  - Improve β-cell function¹–⁶
  - Achieve and maintain glycaemic control¹–⁶

*When at maximal tolerated dose.
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Cow & Gate has upgraded its milk formula for children and infants with Cows' Milk Protein Allergy (CMPA) to include prebiotics. The newly upgraded formula, Cow & Gate Pepti, now the only extensively hydrolysed whey formula which contains prebiotics. Prebiotics are oligosaccharides which are also found in breastmilk, which support a baby’s natural immune system. Latest advice from the Chief Medical Officer recommends that extensively hydrolysed formulas are the most appropriate option for infants suffering from CMPA.

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• Patients taking Fleet® Phospho-soda® (sodium phosphate), or Sodium Picosulfate with Magnesium citrate (Picolax®) are required to fast for the whole day before they take the preparation, whereas those taking MOVIPREP® are able to eat until the evening before their colonoscopy, which results in less disruption to their personal and working life, allowing the patient to carry on with normal life/work the day before the colonoscopy.

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Deep Venous Thrombosis

Author: Dr Greig Ferguson, MD, DSc, BN (Hons), RN, BSc (Hons), ATLS, ALS, EPLS

INTRODUCTION
Deep Venous Thrombosis or DVT’s are not acutely life threatening per se however they can be complicated by pulmonary embolism (PE), a serious condition that led to over 100,000 deaths in an 8-year period in the United Kingdom and it is estimated that at least 60,000 a year can be attributed to DVT (1). In most cases, PE is caused by a DVT between one in three and one in four cases of DVT (2). Venous thrombosis can form anywhere in the venous system. However, DVT and PE are the most common manifestations of venous thrombosis.

RISK FACTORS
There are a number of factors that increase a person’s risk of developing a venous thrombosis. At least one risk factor can be identified in over 80 percent of patients who develop a venous thrombosis. An increased risk of developing a blood clot is sometimes referred to as a “thrombophilia” or a hypercoagulable disorder (3,4).

- Previous surgery (especially orthopaedic surgery and neurosurgery)
- Obesity
- Pregnancy (Hypercoagulable state)
- Use of certain medications (e.g., Oral Contraceptive Pill, HRT)
- Immobilisation or prolonged bed rest
- Heart failure
- Elevated blood levels of homocystine
- Certain disorders of the blood, such as polycythaemia vera
- Kidney problems, such as nephrotic syndrome
- Antiphospholipid antibodies (antibodies that affect the clotting process).
- A previous episode of a clot in the leg (deep vein thrombosis) or PE.

Smoking and increased age may also increase the risk of venous thromboembolism, but it is not clear what role these factors play.

SIGNS AND SYMPTOMS
There are signs and symptoms of DVT and PE; these may be caused by the thrombus, or maybe related to another condition. In most cases, testing is needed to determine if a clot is present (2,3). Deep vein thrombosis—classic symptoms of DVT include swelling, pain, warmth and discolouration in the involved leg however this pain occurs in 50% of patients and is entirely non-specific. Pain can occur on dorsiflexion of the foot (Homan’s sign) (4). Homan’s sign is described as discomfort in the calf muscles on forced dorsiflexion of the foot with the knee straight has been a time-honoured sign of DVT. However, this sign is present in less than one third of patients with confirmed DVT. The Homan’s sign is found in more than 50% of patients without DVT and therefore is very non-specific (4).

Pulmonary embolism - The most common symptoms of pulmonary embolism are difficulty breathing, chest pain while taking a deep breath, cough and coughing up blood.

The most common physical findings are an increased rate of breathing, abnormal lung sounds heard with respiration and a rapid heart rate (4,5).

If a part or all of the blood clot breaks off from the site where it was created, it can travel through the venous system. This clot can limit blood flow through the vein, causing swelling and pain. Most commonly, venous thrombosis occurs in the “deep veins” in the legs, thighs, or pelvis. When this occurs, it is called a deep vein thrombosis, or DVT.

DVT — Tests used to establish a diagnosis of DVT may include compression ultrasonography, contrast venography, magnetic resonance imaging (MRI), computerised tomography (CT scan) and a blood test called D-dimer.

D-dimer — D-dimer is a substance that is often found to be elevated in the blood of people with venous thromboembolism or PE. It can be used to eliminate the possibility of deep venous thrombosis. If the D-dimer test is negative and the patient is thought to be at low probability of DVT or PE on the Wells score, DVT or PE are unlikely and further testing may not be needed (6).

TREATMENT
The treatment of deep vein thrombosis and pulmonary embolism is similar in DVT, the main goal of treatment is to prevent a PE (7). Other goals of treatment include prevention of further clot extension, prevention of a recurrence of thrombosis, and the prevention of complications, such as the postphlebitic syndrome and chronic blood pressure on the vessels between the heart and lungs (pulmonary hypertension).

The mainstay of treatment for venous thrombosis is anticoagulation (11,12). Other treatments may include thrombolytic therapy or inferior vena cava interruption. If a reversible risk factor, such as immobility, exists in a particular patient, the clinician may opt to treat the patient until the risk factor is resolved.

- Patients with a first episode of venous thrombosis without an apparent cause should be treated for a minimum of six months.
- Patients who have recurrent venous thrombosis should be treated for a minimum of 12 months.

Treatment may be continued indefinitely in patients with three or more episodes of venous thrombosis and in patients with a risk factor that cannot be reversed (8).

PREVENTION
Surgical patients — Certain high-risk patients undergoing surgery (especially orthopaedic surgery and cancer surgery) may be given anticoagulants to decrease the risk of blood clots. Anticoagulants may also be given to women at high risk for venous thrombosis during and after pregnancy (9).

In surgical patients with a moderate to low risk of blood clots, other preventive measures may be used. For example, some surgical patients are fitted with inflatable compression devices that are worn around the legs and periodically filled with air; these exert gentle pressure to improve circulation and help prevent clots (10). Low risk and some moderate risk patients may be asked to wear graduated compression stockings. For all patients, walking as soon as possible after surgery can decrease the risk of a blood clot.

REFERENCES & FURTHER READING

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Australian Migration

Nurses are in desperate shortage in Australia. This is undeniable. It really is an employee’s market and the nursing recruitment companies are competing to entice overseas skilled nurses to use their services for the purposes of finding employment in Australia. Whilst this is one option that nurses can utilize, it’s worth looking at the pros and cons of all options that nurses have on offer.

The fastest way to Australia as a nurse is usually the work permit known as a 457 visa. At the very least it’s a guaranteed job and it can take as little as a few weeks to be processed but the hidden catch is that the visa is “tied” to one employer. This can make life restricted especially if there are circumstances which make working life uncomfortable. Take for example a situation where your boss is difficult to deal with or the hospital is not what you expected. You have to be realistic and accept that even in the lucky country, there will be bad bosses and not so great places of work. Moving jobs on a 457 can be difficult, time consuming and expensive!

Where a change in employer is to take place, a fresh 457 application needs to be lodged and the new job can not be commenced until the new visa is approved. In some cases sponsored employees feel their bargaining position in the workplace is reduced given the necessity to hold on to a job in order to hold on to the visa. However, there are potential tax benefits that 457 visa holders can take advantage of as well as the speed at which you can exchange rainy weekends for the sunshine and beaches!

The other option for nurses is to consider being independent and having the ability to move from employer to employer. This involves applying for permanent residency on the skilled migration path. Many nurses under 45 will qualify for permanent residency and in such cases the visa holder can still opt to use a nursing recruitment company to land that first job before you even leave home.

In order to apply for the skilled migration visa a general applicant must satisfy the minimum requirements. These are:

- Under 45
- Competent English
- Have a skill on the Skilled Occupation List
- Have recent work experience in a skilled occupation

In order to prove your skill as a nurse a skill assessment needs to be obtained from the Australian Nursing and Midwifery Council. Further details can be found at www.anmc.org.au.

The real benefit that derives from an independent application is the freedom at which a permanent resident can change employers. Other benefits that go with permanent residency are of course the health and education benefits, the first home owner’s grant and the pathway to becoming a citizen of the greatest country in the world.

A permanent residency application is also processed with priority such that a recent approval for a nurse from Scotland took less than 6 months. With this sort of time frame in mind it makes the independent process worth serious thought.

Australian Migration & Visa Lawyers are specialists in all areas of migration and visas to Australia. With over 20 staff worldwide (including our new Dublin office) we can provide the degree of professionalism and expertise that many thousands of successful clients are happy to attest to. Visit our web site www.australianmigrations.com and go online for a free personal assessment or email any questions you may have to info@australianmigrations.com

www.scottishirishhealthcare.com 49
Australia’s strong economic performance over the last decade is clearly seen through its economic growth, low inflation, low unemployment and low interest rates. The Australian economy is open and competitive, aided by a dynamic private sector and a skilled, flexible workforce.

The Australian Government seeks skilled workers & professionals to fill shortages created by the growing Australian economy. 97,500 work rights visas will be made available between July 2006-June 2007, allowing skilled workers to work and live in Australia. Over 150,000 jobs are advertised each week, and the current unemployment rate at its lowest level in 10 years. Australian Government statistics confirm 89% of Skilled Visa holders gain employment within 6 months.

Australia is often referred to as “The Lucky Country”, with its spacious surroundings, high standard of living, excellent health and education systems, temperate climate, wide and varied landscape, political and economic stability, and a general quality of life envied by many around the world.

There are six states and two territories in Australia. Each have a nurse regulatory authority which maintains its own register of qualified nurses. Each nurse must be registered or enrolled in the state or territory in which they intend to practice.

There are two levels of nurse in Australia: registered and enrolled nurses. Registered nurses are educated in degree level courses at universities. Enrolled nurses are primarily educated through advanced certificate or diploma level courses in colleges of technical and further education.

**Australia welcomes Nurses.**

Australia has become the number one destination for nurses wanting to work abroad. Hospitals in Australia offer better working conditions and greater emphasis on patient care.

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The appeal of Australia is evident in the large number of people who migrate under the Department of Immigration and Citizenship (DIAC) Migration Program every year. Over 100,000 people will migrate to Australia every year for the next four years, further enhancing the existing multicultural population.

Despite being the sixth largest country in the world, Australia has a lot of space but not many people. It has the lowest population density in the world - only 2.5 people per square kilometre - a far cry from the packed cities of other countries! Aussie lifestyle is arguably the finest in the world and is the number one reason that most people flock to its sandy shores to live and work.

Australia’s not a place where you stand on the sidelines and simply watch - there is so much on offer for you to see, do, and experience.

There are mutual recognition laws in Australia which provide recognition of registration across state boundaries. Therefore a nurse registered in one state may apply for registration in another state under mutual recognition.

Overseas educated nurses must be able to speak English for working in Australia. Nurses from countries where English is not the first language are required to complete and pass either the Occupational English Test (OET) for Nurses or the International English Language Testing System (IELTS).
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*Offers subject to Nurses Board of Victoria, Queensland, New South Wales and Western Australian registration boards.

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The Hospital also has a wide range of specialty pregnancy clinics including:

- teenage pregnancy
- diabetic
- cardiac
- metabolic and
- a range of paediatric and gynaecology clinics.

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8. Kilkenny

This is your opportunity to make a difference and join our professional team, dedicated to the delivery of the highest standards of care to our residents.

The following vacancies are currently open within each of our 11 Homes:

Clinical Nurse Managers – Swords, Do. Dublin
Senior Nurses – Swords, Co. Dublin, Croom Co. Limerick, Kilmarnock, Kells Co. Meath
Nurses – All Locations

Should you wish to apply for any of our current vacancies, please submit your CV to:

HR Manager,
Mowlam Healthcare,
Barrow House,
Michael St.
Limerick
Email: recruitment@mowlamhealthcare.com

Share in our Success story

Occupational Health Opportunities

Inventive Solutions/Refer2Us are part of the Healthcare At Home Group a nationwide supplier of healthcare services. We are developing our bank and permanent nursing resources in the area of Occupational Health and as such are looking for experienced OHN or nurses that have OH experience to register their interest with us for forthcoming contracts. Experience in the Rail/Public Sector/Police and local government would be of an advantage.

These are exciting positions for Nurses to gain experience of working in a travelling capacity across a range of contracts Nationwide. Salary negotiable but an excellent package is available for the right candidate. Exciting career path, prospects and development.

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- Health surveillance
- Management referrals

Prevention and Promotion:
- Workplace visits/assessments and advice
- Health Promotion
- Management referrals
- Occupational Therapy

Rehabilitation:
- Full time and part time will be considered. All discussions we have with you are in total confidence

For further information on these positions and to find out how we can work towards successfully placing you in a new position contact Louisa Antrobus on 08451298582 from 8am to 5.30pm or email a CV to: enquiries@inventive-solutions.co.uk - quoting ref. ScotOH04/07.

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• Medical/Oncology
• Orthopaedics
• Endoscopy
• Podiatry
• Midwifery

You must be RGN qualified and have significant experience in your speciality.

For more information and to apply please visit www.jobsataramco.com/newyou or send your CV to nurseCV@aramco.nl
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Careers in Healthcare
CARDIO THORACIC NURSES, GALWAY UNIVERSITY HOSPITALS, IRELAND

CARDIO THORACIC NURSES

Cardio Thoracic Unit
Staff Nurses required for:
■ Theatre/Anaesthetics/Scrub
■ ICU
■ HDU
■ Ward

Following the completion of our new state-of-the-art cardio thoracic unit at Galway University Hospitals, vacancies now exist for Staff Nurses. Based in Galway city centre, the new facility is fully equipped, with procedures already underway. The unit has a full range of resources provided by 2 Consultant Cardio Thoracic Surgeons and a full complement of Doctors and Health and Social Care Professionals. We are now seeking additional Staff Nurses to complete the service. If you have ever considered working in a centrally located hospital in the West, then we would like to hear from you.

Informal enquiries welcomed. Please contact:
Ms. Marie Cloonan, Clinical Nurse Manager 3, Cardio Thoracic Unit, Galway University Hospitals, Ireland.
Tel: +353 (0)91 544582 or +353 (0)91 544038
Email: marie.cloonan@mailn.hse.ie

For further information or to apply online, freephone 0800 056 9710 or go to www.careersinhealthcare.ie

www.careersinhealthcare.ie

www.scottishirishhealthcare.com
Cork University Maternity Hospital (CUMH) is located on the campus of Cork University Hospital. It is an amalgamation of maternity services for the whole of Cork into one comprehensive hospital, creating a much more centralised maternity service for Cork and surrounding regions. With the huge investment and planning that has taken place, Maternity Hospital staff will benefit from working with extensive facilities including 12 delivery rooms, water pool room, day services, out-patient facilities and much more.

The building, a flagship for the services the Hospital provides, covers some 13,000 square meters, over six storeys, with underground parking facilities. In total, there are 118 maternity beds, 26 gynaecology beds and a 6-bedded high dependency unit, along with the neonatal intensive and special care unit, which has 46 cots, and is one of the biggest in Europe. In addition, the National Epidemiology Unit is located at CUMH, which will collect statistics on all births in Ireland.

To make the Service provided by the Hospital as ground-breaking as the facilities, Cork University Maternity Hospital is now seeking applications for the following permanent positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Reference</th>
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<tr>
<td>ASSISTANT DIRECTOR OF MIDWIFERY</td>
<td>REF: N2407</td>
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<tr>
<td>CLINICAL MIDWIFE MANAGER 2 (Ante-Natal and Post-Natal)</td>
<td>REF: N19407</td>
</tr>
<tr>
<td>MIDWIVES</td>
<td>REF: N18407</td>
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</tbody>
</table>

For more information and job descriptions and to apply online, please log onto [www.careersinhealthcare.ie](http://www.careersinhealthcare.ie). We are an equal opportunities employer.

CUMH staff will not only have a state-of-the-art facility to look forward to, they will also have an opportunity to work with a highly-motivated, enthusiastic team providing the highest standard of care. Staff will also benefit from defined career paths, ongoing training and development as well as family-friendly work practices. The Cork University Hospital campus is well served by a public bus transport service.
New Zealand offers unique opportunities for registered nurses to practice in a diverse range of nursing practice areas, in a variety of settings. New Zealand's health system is comprehensive and modern and is renowned for the quality of its health professionals. Since 2000, registered nurses in New Zealand are educated in a three year Bachelor of Nursing degree. The role of the nurse practitioner has recently been introduced in New Zealand's health and disability system, offering for the first time a clear clinical career pathway for nurses in clinical practice.

Registered nurses who have gained their registration in countries other than New Zealand need to apply to the Nursing Council of New Zealand before being able to practice as a registered nurse in New Zealand.

The Nursing Council of New Zealand is the statutory authority governing the practice of nurses and midwives in New Zealand and sets and monitors standards in the interests of public safety.

The Nursing Council assesses each applicant on an individual basis and does not operate a system of reciprocal registration or enrolment except for Australian applicants who meet the requirements of the Trans-Tasman Mutual Recognition Act (1988).

Principle considerations for registrations are:
• The applicant has undertaken a nursing programme that is similar in all specified content and length to the equivalent programme in New Zealand, and is able to meet the competencies for registration
• The applicant has practised as a nurse within the past five years
• The applicant has supplied the Nursing Council with evidence obtained within the past two years of ability to speak and write in the English language when English is not the applicants first language. Tests recognised by the Nursing Council are CGNFS, IELTS, OET, or as part of a competency programme
• Applicants who do not meet the requirements for nursing registration may be required to undergo further experience with instruction through a Department of Nursing within a New Zealand educational institution. The applicant is responsible for negotiating the arrangements for the experience and instruction and for informing the Nursing Council about those arrangements.

New Zealand offers a great climate with a diverse and sophisticated society. There are just over four million New Zealanders, and every single one is either an immigrant or descended from one. English is the main written and spoken language in New Zealand – with a number of different accents!
New Zealand needs skilled people to drive its development. Its relatively small population and low unemployment means specialist talent and skills are always welcome and encouraged. The presence of communities with experience and skills from around the world strengthens New Zealand.

Registered Mental Health Nurse?
Let your career take off...

If you’ve recently graduated as a Registered Mental Health Nurse, or you’re soon to, the ideal place to enjoy a great career and lifestyle is in New Zealand!

There are just so many upsides to making a move down under – you’ll work at the leading edge of mental health (both community and in-patient services) with modern facilities and best of all, a supportive fun team. And the lifestyle? It’s one of the best in the world. Whether it’s the great nightlife, shopping and cafes, the golden sand beaches or the abundant leisure pursuits, you’ll find all you could ask for in and around Auckland – New Zealand’s largest city.

A move to join us will be the making of you, both professionally and personally. To make it even easier senior members of our team will be conducting interviews in Glasgow, June 2007. So email your CV to Melanie at MBurn@adhb.govt.nz to arrange a chat about your future in New Zealand and the assistance we provide. For more info about our Mental Health Service visit: www.mentalhealthjobs.co.nz

Jump on a plane to New Zealand

New Zealand’s economy has grown by more than 25% since 1999. During this time, real income per capita rose by just under 19%. New Zealand offers sophisticated urban living, with fine restaurants and a vibrant arts scene. Most New Zealanders live within half an hour of the coast.
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Scottish Nurse May edition vacancies BW $2219.34

Nursing Opportunities

Our needs are always changing but we often have vacancies in the following areas. Applicants need to be, or be eligible to become, registered in New Zealand in their particular field, and preferably with some years experience.

- Theatre
- Paediatrics
- Mental Health
- Midwifery
- Maternity
- Surgical
- Critical Care/Medical
- Rural and Public Health
- Practice Nurse

The West Coast DHB offers a supportive environment with competitive remuneration, flexible working hours and opportunity for internal and external training. Working and living on “the coast” offers a unique lifestyle. The spectacular native forests, mountain rivers, lakes and seacoast offer outstanding recreational opportunities such as fishing, skiing, tramping, kayaking and mountain biking.

Working and living on “the Coast” offers a unique lifestyle, that truly reflects the New Zealand way of life.

The West Coast DHB

for more information on careers, lifestyle and opportunities please visit www.westcoastdhb.org.nz/careers

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We are an expanding intensive care unit specialising in Cardiothoracic and Vascular surgery. We offer extensive critical care therapies and also lead the country in providing transplant and ECMO services.

Our personalised orientation programme is the beginning of your journey into this exciting and highly fulfilling nursing career.

We have full time and part time positions available. Join our dynamic Intensive Care Unit now!

Call Marianne Smit on +64 9 638 0364 or email mariannes@adhb.govt.nz anytime for more information and a position description.

Reference No: 010896. To apply online, please go to www.aucklandhealthcareers.co.nz

www.scottishnursingservices.com
David Bohan-Shaw has spent twice as much of his life as a Registered Nurse in New Zealand than he has in his native London, so he feels well qualified to say it’s been well worth the move. Now a New Zealand citizen, he has worked six years in Auckland’s Middlemore hospital, three in the Emergency Department (ED) and three in ICU. He and his wife decided to immigrate for a better lifestyle and to escape the violence David experienced daily in London emergency medicine.

“We were subject to a lot of verbal abuse and there were quite a few occasions when we got ‘sorted’ – punched, pushed, chased,” he says.

“I'm very happy here – I have no intention of going back.”

Don’t come over thinking the grass is greener on the other side,” he says. You have to take the rough with the smooth and I reckon the smooth over here outweighs the rough. It’s not perfect but it’s more than good.”

“Whereas, in three years [in Middlemore’s ED], I was shouted at twice, maybe three times. One patient actually came back to apologise.”

However, even though patients attending the ED were more chilled out and his professional life more satisfying, Bohan-Shaw eventually felt it was time to move on.

Since joining the ICU three years ago, he has never looked back. The chances for professional development are excellent and the way shifts are arranged he says is “fantastic.”

“Back in the UK, I used to do eight-hour shifts and I could work eight or nine, sometimes ten days on and then I’d have two days off,” he says.

“Over here, we do twelve-hour shifts and we only work three or four days on. We work thirteen days a month and you get a hell of lot more time off. And that is so beneficial, especially if the weather’s good or you’ve got something planned.”

“We get great support from our manager and we’re encouraged to do extra study. We have an ICU fund that pays for us to go on conferences – and that can be national or international. I never got the opportunity to do that in the UK.”

Settling into Auckland took some time but house buying turned out to be easier than in the UK.

“Buying a house was a lot different from the UK – it was a lot quicker,” says Bohan-Shaw.

“Houses were fairly cheap and we got a good house in a good area for a good price.”

“Shopping was a bit of a mission when we first got here, but we soon got used to that. Because we’re vegetarians, we found it difficult to buy the food we used to eat at home.”

Although he says the public transport system in Auckland is generally poor, Bohan-Shaw’s house is in an area that is well serviced by trains.

“I walk 12 minutes to Ellerslie, jump on the train and that takes me to work in 11 minutes,” he says. Initially, he and his wife found making new friends difficult.

“You find yourself always gyrating towards the other ex-pats. Back home we had the pub culture and we just don’t have that here.”

“We have a small circle of friends we see now. You have to join clubs. We go to an Irish bar and do the pub quiz and I’ve taken up martial arts. And having a baby helps.”

Overall, he says the whole adventure has been “a really good move”.

“I have a much better lifestyle over here and the weather is a huge factor. It’s just more enjoyable. You actually get a summer – not just two or three days of sun then more rain.”

His advice to anyone considering following in his footsteps is simple: “be realistic”.

“Don’t come over thinking the grass is greener on the other side,” he says.

To apply online please visit www.aucklandhealthcareers.co.nz
Cappagh National Orthopaedic Hospital

Cappagh National Orthopaedic Hospital has 160 beds and is the major centre for orthopaedic surgery in the country. The Hospital is a tertiary referral centre for the treatment of complex orthopaedic problems including major joint replacement surgery, revision joint surgery, foot and upper limb surgery, primary bone tumours, spinal surgery, sports injuries and paediatric orthopaedic surgery.

Applications are invited from suitable candidates who are registered or eligible to register in the division of the live register of Nurses kept by An Bord Altranais for the positions of:

**CLINICAL NURSE MANAGER 3**
Theatre
(Mon-Fri)

Cappagh National Orthopaedic Hospital is currently undergoing a major capital development programme, which will lead to the creation of four new world class, state of the art Theatres enabling clinicians to deliver optimum patient care to the highest quality and standards. Join us in this exciting new stage of our development and be at the forefront of change and innovation.

We want to recruit a motivated Clinical Nurse Manager with excellent leadership ability to deputise and support the Assistant Director of Nursing, maintaining standards of excellence and ensuring that service delivery meets the needs of patients in the Theatre area.

Experience at Clinical Nurse Manager level is essential as well as confident change management skills, energy and enthusiasm.

- Have a minimum of five years post-registration experience in an acute hospital setting
- A recognised post registration qualification relevant to the specialist area is essential.
- A management qualification is desirable

**STAFF NURSES**
Theatre

Interested applicants should:
- Have a minimum of five years post-registration experience in an acute hospital setting
- A recognised post registration qualification relevant to the specialist area is essential.
- A management qualification is desirable

Applications are invited from suitably qualified candidates.

**CLINICAL NURSE MANAGER 2**
Theatre

Interested applicants should:
- Have a minimum of five years post-registration experience in an acute hospital setting
- A recognised post registration qualification relevant to the specialist area is essential.
- A management qualification is desirable

**CLINICAL FACILITATOR**
Theatre
(Mon-Fri)

Interested applicants should:
- Have a minimum of five years post-registration experience in an acute hospital setting
- A recognised post registration qualification relevant to the specialist area is essential.
- Experience in mentorship, preceptorship, teaching and assessing is desirable

Informal enquiries for the above posts to: Ms Kathy O’Sullivan, Acting Director of Nursing, Tel: (01)8341211

Cappagh National Orthopaedic Hospital offers:
- Group Health Insurance Schemes
- Subsidised staff restaurant
- Ample free car parking
- Excellent opportunities for professional development in a friendly and supportive environment
- Continuing support for on-going education and regular in-service education
- Easy access from Dublin City Centre, the Greater Dublin and South Meath areas
- Accommodation on site may be provided on a short term basis

Interested candidates should forward a letter of application together with four copies of their Curriculum Vitae and the names of three referees to:
Ms Kathy O’Sullivan, Acting Director of Nursing, Cappagh National Orthopaedic Hospital, Finglas, Dublin 11, Ireland.

Closing Date: 5pm on Friday 4th May 2007.

Shortlisting will take place.
Pay and conditions as per Department of Health & Children guidelines.
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