The challenges of health care provision in a multicultural society.
Content

The challenges of health care provision in a multicultural society ................................................................. 3
Angela Merrington
School of Nursing and Midwifery
University of Tasmania

Midwifery-led models of care ................................................................. 12
Kate Wilde
Graduate Diploma of Midwifery, First Year
School of Nursing and Midwifery
UTAS

Horizontal Violence in Midwifery ........................................................... 21
Melissa Carins
Graduate Diploma of Midwifery, First Year
School of Nursing and Midwifery
UTAS

Changing the Perspective – The Challenges faced by all Nurses as Forensic Nurses ........................................... 30
Rhiannon Golder
Bachelor of Nursing, Year 3
School of Nursing and Midwifery
UTAS

Supportive Care Clinical Enquiry ............................................................. 38
Sharise Larosa
Bachelor of Nursing, Year 2
School of Nursing and Midwifery
UTAS
The challenges of health care provision in a multicultural society

Angela Merrington,
CNA 309 Professional Issues in Nursing Practice,
2005 Student Online Conference,
School of Nursing and Midwifery

Abstract

Australia is privileged to be a multicultural society, and while the country has been immeasurably enriched by multiculturalism, the health care system has been challenged to meet the ongoing and increasing needs of the diverse population (National Health and Medical Research Council, 2005: p4). As culture is vital to the provision of holistic and individualised care, it is imperative that culturally competent health care be available to all Australians (Cortis, 2003: p62). To provide culturally competent health care, while endeavouring to meet Australian Nursing Council (ANC) Competencies, nurses face many challenges (Blackford, 2005: p29). This paper will address the challenges of communication between patients and nurses, and the solutions required to overcome the existing barriers.

Nursing and the challenges of a diverse population

In the 60 years following World War II, Australia’s post-war immigration program has brought over 5 million immigrants and refugees from more than 200 countries to a new life in Australia (Cameron-Traub, 2000: p236)(Australian Institute of Health and Welfare, 1997: p1). Many of these settlers come from non-English speaking and diverse cultural backgrounds and endured many hardships while endeavouring to adjust to a new language and way of life (Cameron-Traub, 2000: p237). In the 1970s, a multicultural policy was developed by the Federal Government supporting the right of Australians from all backgrounds to maintain, within the law, their cultural heritage, religion and language (Cameron-Traub, 2000: p237-238). In 1996, the term ‘people of culturally and linguistically diverse backgrounds (CALDB)’ was created to support the multiculturalism policy (Blackford, 2005: p29). Culture consists of the beliefs, way of life, philosophy, habits, behaviour and values that determine the sense of identity, self-worth and belonging to a particular group of individuals (Cortis, 2003: p55). Culture also affects the provision of health promotion, illness prevention and treatment and social roles and expectations that the patient healthcare provider encounters (Cortis, 2003: p55-56). It must be appreciated and understood that culture is not static, but rather, dynamic (Cortis, 2003: p57).
It is the right of all Australians to be provided with appropriate health care (National Health and Medical Research Council, 2005: p2). Although Medicare provides equitable access to health care services, people from ‘CALDB’ still experience barriers because cultural and language differences are not adequately addressed (National Health Strategy, 1993: p9). The inability to speak English should not be a barrier to accessing equity in health care (Khunti & Samani, 2003: p479). Despite information leaflets being published in various languages, verbal communication is still required between patient and nurse to describe symptoms and anxieties, and also for diagnostic and treatment information to be explained (National Health Strategy, 1993: p9).

Although the multicultural policy aims to include and support the rights of all Australians, requiring that each other’s cultural differences be accepted and respected (Blackford, 2005: p29), this has created a challenge for nurses as mainstream services have remained monocultural with health care also reflecting a biomedical western ideology (Omeri, 1996: p20). Under the domain of Professional and Ethical Practice, ANC competency element 2.1 requires the nurse to ‘practice in accordance with the professional code of ethics’. In doing so he or she accepts individuals and provides care regardless of factors including culture, race and religion (Australian Nursing Council, 2000: p7). Part of the vision of the National Health and Medical Research Council (NHMRC) is that the ‘quality of life, health and wellbeing of citizens from linguistically and culturally diverse backgrounds are improved and the social exclusion of individuals, families and communities is reduced’ (National Health and Medical Research Council, 2005: p2).

Nursing, and the entire health care team, is faced with many difficult, but fulfilling, challenges in meeting patient needs, while endeavouring to provide appropriate and culturally competent health care to these immigrants (National Health and Medical Research Council: 2005: p4). ANC Competency 3.5 provides for the spiritual, emotional and cultural needs of individuals (Australian Nursing Council, 2000: p10). Cultural competence is a combination of behaviour, attitudes and policies, carried out by professionals to work effectively in cross-cultural situations to improve health and wellbeing by integrating culture into the delivery of health care services (Cross et al, 1989 cited in National Health and Medical Research Council, 2005: p6).

Research shows that to meet these challenges, nurses require ongoing professional development to increase their cultural awareness, knowledge and skill (Cortis, 2003: p63). Cultural awareness is the
ability to be sensitive to the values, beliefs and practices of the patient’s culture (Cortis, 2003: p57). Cultural knowledge is understanding specific physical, biological and physiological differences among people of ‘CALDB’ (Purnell & Paulanka, 1998 cited in Cortis, 2003: p57). Providing healthcare in a multicultural society requires nurses to have a knowledge of similarities and differences as well as recognising inequalities in health care (Cortis, 2003: p57). It is important that nurses understand problems and discrimination that Australians of ‘CALDB’ face in society (Cortis, 2003: p57). Cultural skill is the ability to sensitively conduct a cultural assessment which should be integrated into every nursing assessment for all patients, as culture is an integral part of a patient’s life (Cortis, 2003: p57&62). ANC Competency 2.1 states that the nurse must carry out assessments while remaining sensitive to the individual’s needs (Australian Nursing Council, 2000: p7). Cultural diversity or potential barriers to health care may not always be obvious to the nurse (Cortis, 2003: p57).

A major challenge for nurses in a culturally diverse society is communication, which is a vital component when providing health care (Symanski-Sanders, ‘undated’: p2). Under the domain of enabling, competency element 12.1 states that the nurse must communicate using formal and informal channels of communication and using an interpreter where appropriate (Australian Nursing Council, 2000: p23). Language, verbal and non-verbal behaviour, touch and silence are all forms of communication (Tate, 2003: p214). Misinterpretation of language often occurs as some words have different meanings in other cultures (Schaafsma et al., 2003: p186). Evidence shows that language differences are the most likely major barrier to the provision of culturally competent health care (Tate, 2003: p214).

To communicate effectively the sender must convey the message clear enough to be heard and understood by the receiver (Tate, 2003: p214). Language is more than just understanding the meaning of words (Riley, 2004: p57). Important aspects of verbal communication are tone and volume, the meaning of which can vary in different cultures. Thai people are quiet natured because talking too much indicates stupidity, while Cubans are proud to speak their language loudly as they love to socialize (Riley, 2004: p57). The willingness to share thoughts and feelings is also determined by culture. Europeans are happy to discuss their emotions, while Asians are reluctant to display their feelings. It is vital that nurses understand these aspects (Riley, 2004: p57).
Body language appears to be unimportant until the amount of information we communicate without using words is realized (Tate, 2003: p214). In Western culture, eye contact is expected when communicating with another person, while in Hispanic culture, respect is shown by looking downwards, as eye contact indicates arrogance and is only maintained with peers of the same gender (Tate, 2003: p214). Asians and Native Americans consider eye contact to be offensive (Luckman, 2000 cited in Riley, 2004: p59), while Muslim Arab women are only permitted eye contact with a male if that person is their husband (Riley, 2004: p59). Culture also determines the acceptability of touch. In Arab and Hispanic culture, certain parts of the female body may not be touched or examined by male healthcare professionals (Andrews & Boyle, 1999 cited in Riley, 2004: p58). Cultures also vary in degrees of closeness in personal space (Riley, 2004: p58).

Recent studies have determined that there is continued evidence of inequity among Australians of ‘CALDB’ frequently due to communication barriers (Blackford, 2005: p30). The lack of common language between patient and nurse can result in inadequate assessment leading to ineffective care, delayed recovery and discharge, misunderstanding of treatment, re-admission and poor health outcomes (Blackford, 2005: p30). Cultural differences can also influence the presentation and behaviour of patients (Khunti & Samani, 2003: p479), resulting in their admission to hospital unaware of the treatment to be received, which may be contrary to their cultural beliefs, or being sent home with a serious condition undiagnosed (National Health Strategy, 1993: p12). ANC competency element 3.4 states that respect for individuals in terms of their culture and social context must be demonstrated and the rights of others to their opinions must be respected (Australian Nursing Council, 2000: p10).

Serious legal implications can occur through the misunderstanding of communication. Although relatives and friends can often assist with communication, the issue of patient confidentiality may be breached and sensitive issues / decisions may cause family conflict (Mailhot, 1997: p48). ANC competency 2.4 states that ‘Discussions concerning individuals… are restricted to relevant members of the health care team’ (Australian Nursing Council, 2000: p8). When legislation requires that informed consent be obtained, it is preferred that the services of a medical interpreter, who is familiar with the patient’s language and culture, be used (Mailhot, 1997: p48). ANC competency 12.1 states that the nurse should use an interpreter when required (Australian Nursing Council, 2000: p23). This creates a challenge for nurses as many health care facilities do not provide
interpreters (Blackford, 2005: p30). If health care professionals do not communicate understandably and sufficiently with patients of ‘CALDB’, freely and voluntarily given consent for procedures or treatment will not be obtained which will result in the tort of assault (Forrester & Griffiths, 2005: p129). Failure to respect the patient’s wishes could result in the lodgement of a claim for battery or assault (National Health Strategy, 1993: p19). A claim for negligence may also be lodged if the patient suffers damages as a result of care / treatment (Forrester & Griffiths, 2005: p83).


Essential to meeting the communication challenges faced by nurses is transcultural nursing, which was founded in 1974 by Madeline Leininger at the University of Washington School of Nursing (University of Washington, 2005: p2).

‘Transcultural nursing goes beyond cultural sensitivity and diversity by allowing nurses to discover cultural care knowledge in order to develop nursing practices suitable to meet the nursing care needs of diverse groups in relevant, responsible and meaningful ways’ (Omeri & Cameron-Traub, 1996: p15).

Although transcultural nursing has been strongly supported by the Royal College of Nursing in Australia (Leininger, 1996: p9), and courses are available at the Royal Melbourne Institute of Technology (RMIT, 2005: p1), there has been considerable educational resistance, limited support in Universities and health care facilities, and a lack of funds preventing transcultural nursing from being effective in Australia (Leininger, 1996: p10).

‘As technology becomes an increasingly important part of healthcare, the essence of human caring becomes the most valued aspect of nursing. The diversity of populations and the uniqueness of the caring phenomenon in these diverse practice...

Although Australia is improving the health care response to Australians of ‘CALDB’ by developing policies at Federal and State levels, many strategies in place are still not meeting the needs of nurses, who are endeavouring to meet ANC Competencies (National Health and Medical Research Council, 2005: p4). There needs to be more emphasis on ensuring that nurse education reflects the diversity of our multicultural population and health care system (Commonwealth Department of Education, Science and Training, 2005: p2). Nurses have a responsibility to care for all people by identifying their needs and ensuring that they have the resources, skills and knowledge to provide culturally competent health care to all Australians.

‘When we are able to provide equity in care, the social, financial and health benefits are enormous: improved health outcomes for people of CALDB; increased efficiency of clinical and support staff; and greater client satisfaction with services’ (Blackford, 2005: p31).
The challenges of health care provision in a multicultural society.  

Angela Merrington

References


The challenges of health care provision in a multicultural society.  

Angela Merrington


Mailhot, C., 1997, ‘Culture and Consent’, Nursing Management, 28 (3) 48P.


Tate, D., 2003, ‘Cultural awareness: Bridging the gap between caregivers and Hispanic patients’,

Midwifery-led models of care

Kate Wilde,
Graduate Diploma of Midwifery, First year
School of Nursing and Midwifery

Abstract

Pregnant women are faced with an overwhelming array of options for their pregnancy, birth and postnatal care. However, while there may be many options, how can a woman choose which one is appropriate for her? This essay presents an overview of the different models of care available to women and then focuses on two specific ones, caseload midwifery and homebirth. First, the models of care are briefly outlined and the midwifery-led models of care are highlighted. Then, caseload midwifery and homebirthing are critically analysed, including definitions of each, the effects of these models of care on women and the advantages and disadvantages of each for women and midwives according to midwifery research. There are many consequences of a woman's choice of model of care and it could be the subject of more midwifery research to discover why women choose a specific model of care and how they would evaluate the outcome of that decision. However, this assignment aims to give only a brief survey of the caseload midwifery and homebirth models of care.

There are many models of care to choose from. The options vary between public and private care with a general practitioner (GP), obstetrician or midwife as the primary carer. At the Royal Hobart
Hospital (RHH), the options given to women on booking in are share care with a GP, the Know Your Midwife (KYM) scheme, the Birth Centre, the midwives clinic, and an obstetrician if there are complications with the pregnancy (RHH Maternity Unit 2006, p. 1). There are two distinct cultures in caring for women throughout pregnancy: the midwifery view that pregnancy and birth are low-risk natural events requiring guidance, support, counselling and medical intervention only as needed, and the obstetric view that birth is a potentially high-risk situation requiring technological back-up. Midwives operate under a wellness model while obstetricians under an illness model (Reibel 2004, p. 329). The World Health Organisation (WHO) states that midwives are the most appropriate primary careers for women during pregnancy and childbirth as these are normal biological processes where most women will achieve successful outcomes if given support and patience. These conflicting philosophies on pregnancy and birth affect the models of care available to women today and also how women choose their preferred model of care (Armstrong 2005, p. 13; Forrest 2006, p. 4; Halliday et al. 1999, pp. 19-21).

Women need quality, evidence-based information on various models of care to enable them to make informed choices during their pregnancy (Australian Health Workforce Advisory Committee 2002, p. 26). The Who Usually Delivers Whom And Where Report (WUDWAW) (Halliday et al. 1999, p. 33) found that the most frequently used model of care is specialist private obstetrician care. Western countries place trust in more medicalised models of care (Reibel 2004, p. 329). Only 0.1 percent of women chose to have a midwife in private practice (MIPP) and 0.7 percent of women chose the caseload midwifery model of care for their antenatal and intrapartum care (Halliday et al. 1999, p. 24). This research clearly demonstrates that Australian women prefer the private and medicalised models of care. However, as a midwife-to-be, I am interested in the midwifery-led models of care where women and midwives are the powerplayers and how these models of care can best serve the needs of women.

Caseload midwifery is an example of a midwifery-led model of care. The philosophy in caseload midwifery is that a midwife enters into a professional partnership with the pregnant woman. This allows for equality, shared responsibility, informed choices, empowerment, individual negotiation and self-fulfillment for both the woman and the midwife. The care is woman-centred, pregnancy and birth are viewed as normal and healthy life events and continuity of care is ensured by having one primary midwife as the main caregiver (Forrest 2006, pp. 2-7). Usually, a midwife works with
Midwifery-led models of care.  

K Wilde

Nuritinga Issue 7, November 2006  3

© Copyright School of Nursing & Midwifery, & Individual Authors

a woman and has one or two midwives who act as “back-up” midwives for the primary caregiver and also meet the woman once or twice antenatally. The primary midwife meets the client six to eight times antenatally, referring the woman for doctor visits in weeks twelve to sixteen, thirty-six and after forty weeks (Johnson et al. 2005, p. 22). One of the three midwives known to the woman will be present for the intrapartum period. And postnatally, discharge within twenty-four hours is encouraged and the primary midwife does home visits for the first ten days and then up to six weeks postpartum as needed. This increases maternal independence and confidence while still having the guidance of a midwife on hand (Forrest 2006, pp. 11-12).

A full-time caseload is forty births per midwife per year plus back-up cases too. The caseload midwives work in collaboration with GPs, obstetricians, specialist obstetricians, child health nurses, drug and alcohol services, social workers and other relevant health professionals to provide a “seamless” service throughout the woman's antenatal, intrapartum and postnatal periods. Epidurals, inductions, episiotomies and other medical interventions are not first-line options in caseload midwifery and women are transferred to a tertiary hospital if these services are required (Tracy et al. 2005, p. 336). Forrest (2006, p. 13) states that Northwest Private Hospital already has the caseload midwifery model of care. She has presented a proposal to the Tasmanian State Government for implementation of caseload midwifery on a statewide basis. Midwives are covered by indemnity insurance within the public hospital system with this model of care, an important aspect to care that is lacking in the homebirth model at present (Tracy et al. 2005, p. 337).

Homebirth is another midwifery-led model of care available to women. It shares the caseload philosophy that childbirth is a normal part of life, not an illness, and that it is important to develop a rapport between woman and their midwives (Having a Baby in Victoria website, viewed 4 April 2006). Midwives in private practice (MIPP) work outside the hospital and assist women with uncomplicated pregnancies to birth at home. All of the antenatal, intrapartum and postnatal care is provided by one independent midwife, with one or two back-up midwives. The MIPP is on-call for labour and birth. Midwives in private practice work in collaboration with obstetricians, GPs and other health professionals and accompany the women to the hospital if there are any complications with the pregnancy or birth (Australian Health Workforce Advisory Committee 2002, p. 31; Maternity Care Options website, viewed 4 April 2006). Hospital is the most common place for Australian women to give birth, but studies in the United Kingdom, United States, Netherlands, Switzerland and New Zealand show that planned homebirth by a qualified MIPP is as safe as a
hospital birth (Janssen et al. 2002, p. 315). Any woman with complications is transferred to a hospital. Consequently, the maternal and neonatal mortality and morbidity outcomes are higher in hospital due to higher intervention rates (Reibel 2004, p. 333). Cases that are ineligible for homebirthing are multiple pregnancies, breech presentation, bleeding during pregnancy or labour, pre-eclampsia, birth before thirty-seven weeks, birth after forty-one weeks, placenta problems and baby distress in labour (Homebirth website, viewed 21 April 2006). While homebirth is not a common model of care used in Australia, there is sufficient demand for homebirth to guarantee that it will remain a service that women will continue to utilise and MIPPs will continue to provide.

The caseload midwifery model of care gets positive reports from women. Women have higher satisfaction levels with their antenatal care and level of preparedness for birth and motherhood. Maternal outcomes of caseload care compared to standard hospital care demonstrate lower inductions, lower episiotomies, lower medical interventions and higher requests for pethidine. This last fact may reflect the strong rapport between the midwife and woman and the woman feeling comfortable enough to ask for pain relief or the midwife being more intuitive about the woman’s pain relief needs. Infant outcomes are similar to standard hospital care (Johnson et al. 2005, pp. 22-26). Women have commented they felt more in control in labour and labour was a more positive experience with a known midwife in attendance (Flint & Poulengeris 1988, p. 1). Less conflicting advice from different caregivers, lower unnecessary admissions to hospital, reduced length of stay in hospital, lower anxiety and pain levels are all benefits associated with the caseload midwifery model of care (Swan 1993, p. 59). When I described the caseload midwifery model of care to a mothers group, every mother was excited about an option that involved a one-to-one relationship with a known midwife during the pregnancy, labour, birth and postnatally. They asked when this model of care would be available to women in Hobart and Tasmania (Birth and Beyond, attended 24 April 2006). The caseload midwifery model of care offers many improvements to the standard hospital care conventionally offered to women.

The homebirth model of care struggles to prove that it is a safe option for women and babies in the face of a strongly medicalised view of childbirth in Australian society. In the 1970's and 1980's, the hospital was considered the only safe place to give birth, and many people still believe this. There is mounting evidence that for low-risk pregnancies, there is no significant difference in clinical outcomes between homebirths and hospital births (Huisman 2003, p. 72). Many women have their first child in hospital and have a positive experience. Some women, in contrast, feel disrespected,
dismayed, scared, uninformed and disregarded by hospital staff, doctors and midwives alike (Birth and Beyond, attended 24 April 2006; Craven 2005, pp. 204-205). These are the women who may choose homebirth for successive births. A MIPP attends all the antenatal care of each woman and monitors for complications. If there are no complications, homebirth is a safe, empowering, affirming and amazing life event. Women find the environment more supportive, and therefore easier to birth in, empowering, women are in control of the situation, it is private, only people known to the woman are present and invited, there is a lower risk of infection, and women have an empowering start to motherhood (Huisman 2003, p. 72; Network News 2001, p. 2). Due to the birth taking place at home, women are free to express themselves in their own style and they do not have the threat or fear of medical intervention looming over them (Homebirth Australia website, viewed 21 April 2006). If complications do arise, the MIPP transfers their woman to hospital care. The most common complications are foetal distress and maternal bleeding. The key seems to be knowing when to move to hospital prior to an emergency situation developing (Bastian et al. 1998, p. 387; Reichert 2002, p. 70). This is where the rapport established by a homebirth midwife is crucial to a woman's care.

Midwives also report advantages to the caseload model of care. They act as independent and autonomous practitioners and are responsible for their own caseload of women. Higher levels of job satisfaction and more opportunity to develop and utilise midwifery skills are advantages as this model of care moves away from the current fragmented and compartmentalised service offered to women today. Midwives learn from their colleagues and relationships between doctors and midwives involve more understanding and appreciation for their differing roles (Stock 1994, pp. 33-35). This is opposed to midwives trying to carve out a profession in the shadow of obstetric dominance. Midwives expand their scope of practice to include health education and counselling, in accordance with the WHO definition of a midwife, with programs on immunisation, safe sex, family planning and preconceptual care (Swan 1993, p. 61). The caseload model of care has many benefits to offer midwives.

With homebirthing, midwives also can practice in their own style, work autonomously and collaborate professionally with other health service providers as appropriate to each individual client (Network News 2001, p. 2). Women and midwives have a personal one-to-one relationship and there are no rushed appointments or feeling part of a production line of childbearing women, a comment made at a mother's group (Birth and Beyond, attended 24 April 2006; Reichert 2002, p. 70).
Midwifery-led models of care.  

70). Women usually interview several MIPPs and can choose the one they feel most comfortable with (Homebirth website, viewed 21 April 2006). However, due to the lack of knowledge about homebirth, there are not many MIPP's to choose from. In Hobart, there are four. As homebirth becomes more accepted and more people learn about the advantages of homebirth, this may become a more popular and accessible option for women.

Naturally, there are some disadvantages to midwifery-led models of care. Caseload midwifery demands more flexibility from midwives as they are responsible for the “total care” of their clients, antenatally, intrapartum and postnatally. They are on-call and the frequency and length of these shifts can be draining. Some midwives find it hard to “switch off” from work when they are at home due to being on-call. The many on-call hours can lead to high burnout rates. Not all midwives are able to commit to this style of midwifery. Stock (1994, p. 34) found that younger midwives were more supportive than older ones of the integrated team care approach. Perhaps this is due to older midwives having more commitments outside work or being accustomed to the more compartmentalised model of care. One midwife in Stock's study stated that she would not be able to handle the caseload without a supportive family and partner. With the great improvement in continuity of care that the caseload midwifery model of care offers, challenges still remain for midwives.

Midwives in private practice find challenges within the homebirthing model of care also. Many MIPPs must maintain work outside their homebirthing to stay financially solvent. They are constantly battling against public and professional misconceptions and fear about homebirth. There is low peer support, professional isolation and the constant fear of jeopardising their professional status if anything goes wrong with a homebirth. Deregulation and loss of career are constant insecurities in the current climate of social, political and professional hostility toward homebirthing (Homebirth Australia website, viewed 21 April 2006). The policy that evidences this hostility clearly is the battle for MIPPs to have professional indemnity insurance. In 2001, the government revoked MIPPs' indemnity. The Northern Territory, South Australia and Western Australia now offer subsidised indemnity to MIPPs through their health departments (Australian Nursing Journal February 2005, p. 5). In Tasmania, no government-subsidised indemnity insurance is available to MIPPs. A midwife has the duty to inform her client of this on their initial consultation and then the relationship is entered into with clear knowledge of this fact. Clearly, the “underground” status of the homebirth model of care serves only to further call into question and stigmatise the women and
midwives who operate within this model. However, women will continue to choose planned
homebirths and their midwives will continue to practice their skills because there is a need in the
community for this option.

In conclusion, women are faced with a multitude of choices of maternity care when they become
pregnant. These models of care vary from public to private, home or hospital, and obstetrician-led
or midwifery-led care. There are problems commonly encountered by women and midwives with
the models of care available today and one solution is the development and implementation of
midwifery-led models of care. Two specific examples of these, caseload midwifery and homebirth,
are defined and the effects on women, advantages and disadvantages to both women and midwives
are critically analysed. The maternity care system in Australia currently is not satisfying its
consumers or health care providers. Lesser-known models of care, such as caseload midwifery and
homebirth, are being suggested as ways to increase satisfaction and continuity of care for women
and their midwives.
References


Birth & beyond 2006, mother's group, Hobart Women's Health Centre, attended fortnightly.


Huisman, G 2003, 'Why GPs are safe to suggest homebirth', *GP*, June, 72.


Reibel, T 2004, 'Normal birth: A thing of the past or the new future for primary health care?','

© Copyright School of Nursing & Midwifery, & Individual Authors

Royal Hobart Hospital 2006, Antenatal care pamphlet for booking-in, Midwives clinic.


Abstract

This paper examines the issue of horizontal violence in midwifery. Horizontal violence is becoming a more widely acknowledged phenomenon within the midwifery profession. This paper discusses many of the facets of horizontal violence within midwifery, and looks at the most appropriate methods to deal with horizontal violence.

Horizontal violence is a serious issue within midwifery. This assignment looks at this issue using a critical perspective. It discusses what horizontal violence is, why it occurs in midwifery, who are the victims of horizontal violence within midwifery, how horizontal violence is perpetrated, what it means for the profession, and what individuals and managers can do to deal with and reduce the incidence of horizontal violence. Through this discussion the underlying assumptions, power players and key stakeholders within the issue of horizontal violence will be identified. Horizontal violence in many forms has been present in midwifery for many years. Historically it has been seen as a means of socialising students and new staff members into the work culture. However, horizontal violence is now an identified phenomenon within midwifery that is having a negative impact on the profession.

Horizontal violence is “hostile and aggressive behaviour by individual or group members towards another member or groups of members of the larger group” (Duffy 1995, cited in Hastie 2000). It has also been described as inter-group conflict, and it may be overt or covert (Leap 1997, p. 689). Horizontal violence aims to mould, shape and dictate the behaviour and practises of those within a workplace. It acts to socialise new members into the workplace culture (Hastie 2000). The existing group within a workplace perceives anyone new and different as change, which is threatening and may damage their power base (Hastie 1996). The Australian College of Midwives Inc. (ACMI) recognises that within the midwifery culture horizontal violence is widespread and believes it is unacceptable and destructive (ACMI 2002). Freshwater (2000, p.484) states that horizontal violence within nursing is increasing. Historically, horizontal violence has been seen as a rite of passage into midwifery. Comments such as “this is how people were to me when I was learning”
Horizontal violence is most often seen in environments where conditions are stressful and workers have limited control over their work (Robertson 2004, p. 40). This is often the case with hospital-based midwifery. Midwives are dominated by the medical model of pregnancy and childbirth (Harcombe 1999, cited in Robertson 2004, p. 40) and by a patriarchal system managed by doctors, administrators, and nurse managers (Farrel 1997, cited in Freshwater 2000, p. 482). This patriarchal hierarchy is both a power player in the issue of horizontal violence in midwifery and one of the key stakeholders. Midwives have no power in decision-making and have no autonomy within their workplace, and are left feeling oppressed/powerless (Hastie 2000). Unable to direct their dissatisfaction and frustration at the cause, midwives direct it toward each other (Leap 1997, p. 689). Perpetrators within a workplace can also see themselves as responsible for policing the behaviour of others, especially those who are seen as being slightly deviant, to force them to conform (Kirkham 1999, p. 733).

Victims of horizontal violence can experience a wide range of physical and psychological symptoms. Horizontal violence can also have an impact on the victim’s employment, the way he/she works, and on the team within which the violence is occurring. All of these effects can be progressive if not addressed (Hastie 2000). Midwives subjected to horizontal violence in their workplace can experience symptoms including sleep disorders, elevated blood pressure, low self esteem, eating disorders, nervous conditions, apathy, depression, disconnectedness, impaired personal relationships and even suicide (Griffin 2004, p. 258). Hastie (1996) describes one 25 year old midwife who took her own life and in her suicide note implied the reason for her suicide was the inability to change the situation in her workplace, which she found intolerable. This midwife identified that practices in her workplace needed changing, but was made to conform to existing practices through the use of horizontal violence by other midwives. She was depressed, disillusioned and frustrated by the way the midwifery profession treated women – both midwives and mothers.
Horizontal violence can also have effects on the workplace as a whole and on the employment of individuals who are subjected to it. Wright (1996, cited in Begley 2001, p. 226) states that horizontal violence can lead to a breakdown in the cohesiveness of a work team. For the individual, they may remove themselves from the workplace (either through sick leave or by resigning) (Hastie, 2000) and some midwives even choose to leave the profession altogether (Turnbull 1995, Wheeler 1998, Quire 1999, cited in McKenna et al. 2003, p. 91).

Student midwives appear to be particularly vulnerable to horizontal violence, affecting their future in the profession. Some choose not to complete their education program, or leave midwifery once their program is completed (New South Wales Midwives Association 2001, p. 4). Thompson (2000, cited in New South Wales Midwives Association 2001, p. 4) writes of one student midwife who described her clinical practice year as ‘horrendous’ because of the patronising and rude manner in which she was spoken to by the qualified midwives. In a survey conducted by the NSW Health Department (2000, cited in New South Wales Midwives Association 2001, p. 4), horizontal violence was identified as contributing to an unsatisfactory clinical experience for student midwives and contributed to midwifery students leaving their education program.

Within the midwifery profession those most often subjected to horizontal violence are those with the least power – students, newly registered midwives, and midwives who are new to the workplace (Griffin 2004, p. 258). Bosanquet (2002, p. 302) describes that in the United Kingdom, in order to gain qualification and continue to practise, students must be “good girls” and “know their place”. They must conform to the culture of the workplace, and alter their behaviour and practise to conform to the workplace goal and routine (Bosanquet 2002, p. 302). In a study of student midwives in Ireland, Begley (2001, p. 225) states that most students described an unwelcoming atmosphere, and that at least initially most staff were unhelpful, and that some senior staff often put students down and belittled them, frequently in the presence of others. Marson (1982), Wubbels & Levy (1993) and Fretwell (1983, cited in Begley 2001, p. 225) state that in these unfriendly environments, students do not learn as well as those who had a good rapport with qualified midwives and felt safe to ask questions. For newly qualified midwives, ‘leaders’ in the workplace are aware that they have no prior experience as qualified midwives, and thus have areas of knowledge deficit, which makes their work more subject to scrutinising and micro-management (Griffin 2004, p. 258). This horizontal violence stops new midwives from...
asking questions and seeking confirmation of the knowledge they do have. It prevents them from ‘fitting-in’ and from gaining the knowledge-building that is required for competent practise (Sternberg & Horvath 1999, cited in Griffin 2004, p. 258).

Horizontal violence is displayed in behaviours or actions that seek to control and dominate the victim, and to limit their free speech and their right to have and express their own opinion (Hastie, 2000). The perpetrators of horizontal violence usually have an elitist attitude regarding their work area, education and level of experience (Hastie, 2000). Horizontal violence is usually non-physical in nature, but occasionally becomes physical in actions including shoving, hitting and throwing objects (Hastie, 2000). In her study of student midwives, Begley (2001, p. 225) describes an example of this type of physical violence where a student stated that she was grabbed by the arm by a staff nurse and pulled out of a delivery room after she had not prepared medications appropriately for a doctor to administer.

The usually type of horizontal violence, non-physical violence, can take a number of forms – behaviour, body language/actions, and spoken (or not spoken) words. These horizontal violence behaviours can include sabotage, infighting, scapegoating, backstabbing, undermining, failure to respect privacy, failure to keep confidences, lack of openness, unwillingness to help out, lack of support, discourtesy, derisiveness, lack of cohesiveness, intimidation, dismissing, and fault-finding (Leap 1997, p. 689; Hastie 2000). An example of this fault-finding and undermining is described by Begley (2001, p. 225) in her study of student midwives. One student describes how she had a horrible day - she was working with a midwife who became flustered with everything and persisted in correcting the smallest of things the student did in front of the couple with whom the student was working (Begley 2001, p. 225). Another student in this study describes the experience of fault-finding – she was instructed by a midwife not to bath a baby in a particular way as this was not how this midwife bathed babies, and not to start making the beds until after second break, as this was what this particular midwife did (Begley 2001, p. 227). This is also an example of the way that horizontal violence seeks to disallow people to express their own opinions and make their own choices (Hastie 2000).

Horizontal violence can also take the form of actions or body language. This can include belittling gestures such as rolling eyes, folding arms, raising eyebrows, and turning away (McCall 1996,
Farrel, 1997, Leap, 1997, cited in Griffin 2004, p. 258). One student in Begley’s (2001, p. 225) study describes how she found some of the older midwives to be very unkind and stated that when she met them in the corridor they would not even acknowledge her – they would look through her and not even smile.

Horizontal violence can also be carried out in spoken (or unspoken) words. This may take the form of comments that devalue, freezing out of conversations/silent treatment, name calling, threatening, put-downs, and dismissing (Hastie 2000). An example of this verbal dismissing was described by Hastie (1996), who talks of a young midwife who, when she attempted to improve practices and care in her workplace was told “what would you know you’re only a new graduate” and “we’ve been doing it this way for x amount of years”. (Hastie 1996). This type of horizontal violence also includes belittling, the use of sarcasm and intimidation (Hastie, 2000). In Begley (2001, p. 225), one midwifery student described how her tutor was very sarcastic and how she was afraid to ask a question because she felt intimidated. This student believed that if the question was a ‘stupid’ one, then the tutor would laugh at her. All of these types of horizontal violence and hostility seem to escalate when the level of enthusiasm of the victim or challenge of existing practices increases (Hastie, 1996).

Nobody benefits when horizontal violence occurs in a workplace. For the profession of midwifery, horizontal violence can have a very detrimental effect. With some student midwives leaving the profession because of the impact that horizontal violence has had on them (New South Wales Midwives Association 2001, p. 4), there will be a decline in the number of new midwives coming through to replace those that are retiring. This could potentially lead to some birthing women not having access to a midwife for their care. Also, one of the goals of midwifery care is to empower the birthing women, but midwives will be unable to do this if they themselves continue to work in a disempowering culture and are not empowered (Kirkham 1999, p. 735).

Midwifery as a profession has an obligation to decrease horizontal violence within the workplace. Individuals subjected to horizontal violence can help to do this by naming the problem, both to management and the perpetrator (Hastie, 2000). Confronting the perpetrator is often regarded as the first step in the resolution of horizontal violence (Robertson 2004, p. 40). Although this can be quite difficult (Robertson 2004, p. 40), it often results in the resolution of horizontal violence.
behaviour (Hastie, 2000). Victims should also break their silence and raise the issue at staff meetings, and ask about the institutions policy for dealing with horizontal violence in the workplace (Hastie 2000). Individuals who are subjected to horizontal violence behaviour should also ensure they practice self care behaviours, e.g. get counselling; have massages, practise relaxation (Hastie 2000).

Employers and management have a duty of care under the Occupational Health and Safety Act (1989) to provide a safe working environment (ANF ACT Branch 2005). This includes taking all reasonable and practicable steps to lessen horizontal violence (ANF ACT Branch 2005). In order to manage horizontal violence in midwifery, management must first gain an understanding of what horizontal violence is and what are its causes (Hastie 2000). Whilst horizontal violence is occurring in a workplace management must create an environment were staff feel safe to report incidences of horizontal violence (McKenna et al. 2003, p. 95), and there must be an effective system for incident reporting (McKenna et al. 2003, p. 96). These reports must be analysed and action taken to prevent the same situation arising again (McKenna et al. 2003, p. 96). The workplace culture that views horizontal violence as acceptable must be addressed (ACMI 2002).

To prevent horizontal violence from occurring, management need to produce a statement outlining appropriate/desired workplace behaviours and attitudes and display this statement prominently around the workplace (ACMI 2002). Managers need to be seen to support and encourage students, new staff and staff generally to foster an attitude of accepting behaviour (Hastie 2000). Managers need to encourage midwifery staff autonomy and initiative and monitor staff morale (Hastie 2000).

As previously stated, horizontal violence occurs in midwifery because midwives as a group are oppressed and have no autonomy in their workplace. Therefore, the key to reducing horizontal violence is to develop models of midwifery care that allows midwives to practice autonomously, have positive professional collaboration and be involved in decision-making (Leap 1997, p. 689). This will help increase self-esteem and breakdown the hierarchies within midwifery (Leap 1997, p. 689). Brodie (1996 cited in Leap 1997, p. 689) demonstrated that midwives who work in models of care that have close collaboration with women (e.g. homebirth, caseload, team midwifery) see the women as their priority and their allegiance is shifted away from their work institution or professional group (Leap 1997, p. 689).
Education also plays an important role in reducing horizontal violence in the workplace. This must start as education in undergraduate programs and graduate year programs about what horizontal violence is and how to deal with it (McKenna et al. 2003, p. 96). For newly registered nurses and midwives understanding how horizontal violence is practised can allow them to view the behaviour in the appropriate context (Griffin 2004, p. 262). Education programs should also be developed within workplaces on the subject of horizontal violence (ACMI 2002), which should include how to deal with being victimised (Hastie 2000).

Horizontal violence is widespread within the midwifery profession, and it can have serious and long-lasting effects on the victims, their families and the workplace. If horizontal violence continues within midwifery, those that the profession needs most, enthusiastic students and new graduates with up to date knowledge and current information on midwifery care, will continue to leave the profession. If no action is taken and these people leave the profession, then it may lead to the situation that not all birthing women will have access to a midwife. If the culture of horizontal violence within midwifery is to be changed, then both victims and management must take action. One way to change this culture is to give midwives more autonomy in their practise, thus preventing the feeling of oppression.
References


Australian College of Midwives Inc. 2002, ACMI Philosophy and Position Statements-Horizontal Violence in Midwifery, Canberra.


McKenna, BG, Smith, NA, Poole, SJ & Coverdale JH 2003, ‘Horizontal violence: experiences of
90-96.

New South Wales Midwives Association 2001, Senate Inquiry into Nursing and Midwifery,
Retrieved May 3, 2006, from
<www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2002-
04/nursing/submissions/sub891.doc>

Robertson, J 2004, ‘Changing a culture of horizontal violence’, The Practising Midwife, vol. 7,
no.2, pp. 40-41.
Changing the Perspective – The Challenges faced by all Nurses as Forensic Nurses

Rhiannon Golder,
Bachelor of Nursing, Year 3,
School of Nursing and Midwifery

Abstract

In Australia, Forensic nursing has traditionally been viewed as an area of health care limited to custodial care, or custodial psychiatric care (Saunders, 2000:49). This paper will seek to broaden this view, by examining new research that is expanding the definition of forensic nursing. Several issues have been identified impacting on forensic nursing: forensic nursing in a violent society (Australian Nursing Journal, 2005:5), a lack of awareness among nurses that they actually offer forensic care (Saunders, 200:49), and pertinent ethical dilemmas (Martin, 2001:27). Relevant competencies from the Australian Nursing and Midwifery Council’s ‘National Competency Standards for the Registered Nurse’ will be identified as a resource for managing these issues.

Methodology

As this paper is written in and for the Australian context, material relevant to forensic nursing here in Australia has been utilised where possible, with consideration given to literature from the United States where forensic nursing has been developed to a larger extent.

Forensic Nursing Defined

The definition of forensic nursing centres on the health care response to crime or civil injustice, and involves many aspects of care offered by nurses, and is not limited to the pathologic investigation of death, as is frequently misunderstood (International Association of Forensic Nurses, 1998; Forrester and Griffiths, 2005:44). It is caring for the illnesses or injuries of victims and perpetrators, in many environments within the health system, from emergency departments to courts to the custodial system (IAFN, 1998). Obtaining samples of bodily fluids, describing wounds, physical assessments, interpreting behaviour, patient advocacy, and documenting all the above while maintaining evidence procedures are all duties of forensic care (Stevens, 2004: 54). The essential duty of care is to meet patients’ needs, while developing a degree of critical awareness, to recognise and process evidence where it exists (Saunders, 2000:49). Power adds to the scope of potential practice by stating that nurses have an important role to play in preventing cyclical patterns of violence, as part of a health promotion framework (2004:21.) While 1/5 of Australian women suffer domestic violence in their lifetime, this aspect of forensic care is vital (Bowie, 1998; Power, 2004:22). Forensic nursing was identified as a specialty in the early 1990’s, however the width of potential
nursing practice within it indicates that can vary more upon context than just the definition of a specialty (IAFN, 1998; Stevens, 2004:54)

**Forensic Nursing in a Violent Society**

Violence is the causal factor for the majority of patients receiving forensic care in Australia, with 50% of workers experiencing verbal or physical abuse from members of the public (Bowie, 1998). As nurses care for victims of violence, they become part of the above statistic, as they suffer some of the highest rates of workplace violence of all – 1/3 Queensland nurses have been assaulted, in what has been described as an “‘endemic’” problem; rural and remote nurses have reported sexual assaults and homicides; this explains why nurses were the second highest workers compensation claimants for violence-related incidents (Australian Nursing Journal, 2005:5; Graycar, 2003; Harulow, 2000:27).

These figures apply to all nurses, perhaps even more so to those offering forensic nursing care in the non-stereotyped roles discussed in this paper, as one nurse stated they felt safer working within the custodial system than in previous employment in accident and emergency departments (Witham, 2000:19). The Australian Nursing Journal describes a senior staff member of a rural emergency department who documented 46 violent incidents over four-months during a pilot study in 1998 (Harulow, 2000:29). As awareness of nurses’ forensic role increases, it is foreseeable that instrumental violence could increase as people employ violence and intimidation in attempts to manipulate outcomes (Bowie, 1998).

The ANMC Competencies contain several elements relating to violence in the nursing workplace: recognising the need for caring for self, identifying and responding to unsafe practice, acting to ensure the dignity and integrity or individuals/groups, responding effectively to unexpected situations, and finally recognising and maintaining relationships with members of the health care team (2000:6,13, 21-22, 25-26). These standards could be criticised for the apparent focus on the individual nurse, contributing to a victim-blaming culture, noted by Professor Megan Jane-Johnstone to be prevalent (Harulow, 2000:28). These competencies however apply to nurses at a managerial level who are required to ensure safe outcomes, recognise the rights of their workers to dignity and integrity in the health care setting, support their staff in caring for patients and collaborating as a team (ANMC, 2000:6, 9, 21-22, 25-26). Introducing patient codes of behaviour,
making security more visible, violence intervention training, increased staff and OH&S legislation change have also been suggested as ways of reducing violence in the health care setting (Bowie, 1998; Graycar, 2003; Harulow, 2000:28; Mayhew, 2000)

Lack of Recognition

This second issue identified in literature is that nurses already fill a forensic role to some extent, but lack the full awareness of this to be able to make a more formal contribution (Saunders, 2000:50). Specht, Singer and Henry have found that nursing documentation is of inadequate standard, despite the emphasis placed upon it (2005:21).

This paper seeks to increase the knowledge of the more general population of nurses, to recognise the skills they already have, so as to make a more effective means of care a realistic path for the future.

Evans and Wells found that custodial or custodial psychiatric nurses were alone in recognising the forensic responsibility they had (1999:4). However, the definition of forensic nursing is clearly quite broad and involves skills undertaken by most nurses – blood samples, urinalysis, wound assessments, blood alcohol levels, psychiatric assessments, risk assessments, identification of emotional trauma, and the documentation of all the above (Potter, 2004: 2; Australian Nursing and Midwifery Council, 2000:3). The expanding field of forensic custodial nursing within Australia is increasing in awareness of forensic nursing, according to the Australian Nursing Journal (2000:19), however we would like to raise the point in this paper that it may simply emphasise the already prevalent misconception of the separateness of forensic nursing from ‘regular’ nursing.

The ANMC’s ‘National Competency Standards for the Registered Nurse’ detail professional requirements under the domain of ‘Professional and Ethical Practice’ which covers the need for understanding of legislation, adherence to the law, fulfilling of the duty of care, and accurate documentation of patients and the care offered to them (ANMC, 2000:5). Professional associations such as the IAFN hold a significant role in promoting forensic nursing, in education and research (IAFN, 1998). The competencies relating to professional development and assessment can be fulfilled when information from these resources in put into practice and shared with others (ANMC, 2000:13-15)
Ethical Dilemmas

Seedhouse has described Nursing as an ethical endeavour because its core aims are issues of potentiating human well being, namely, of improving health, assisting in recovery from illness and supporting in death (1998, 45; Henderson, 1969 in Chiarella, 2002:15). Some research has proposed that forensic nurses may especially face ethical difficulties as they are forced “to consider illness, crime, morality, treatment, containment and possibly punishment” (Burnard 1992 in Martin, 2001:25). This statement is made in the context of custodial psychiatry, however it is my opinion in this paper that this may be true for nurses in general, and any specificities relating to forensic nursing can be applied to a nurse in any area caring for perpetrators of crime or negligence. Particular conflicts arising for the nurse may include the need for patient advocacy – how to advocate for perpetrators of rape; confidentiality – how to protect patients from their abusive next-of-kin; the allocation of healthcare resources – should guilty parties receive equal health care as their victims. Mark Beltchev, a forensic custodial nurse in Victoria touches on these conflicts: “…I prefer not to know what they [detainees] are in [custody] for…and that way you treat everyone the same.’” (Witham, 2000:19). The scope of this paper is not to investigate these dilemmas specifically, but to raise them as issues of probable concern faced by nurses caring for forensic patients.

The primary means of resolving moral conflict for nurses is through reflection on ethical resources, such as the ANMC Code below, and also through engagement with colleagues in supportive environments, such as a new website offered to Australian Nurses for the discussion of issues related to nursing (Seedhouse, 1998: 43; ANJ, 2005:39). The ANMC has developed a Code of Ethics alongside the National Competency Standards as a means for examining ethical conflicts. The code contains six value statements, four of which that are particularly relevant here: respect for individuals needs, and upholding quality care for all, heedless of ‘any ground’ for exclusion, honouring of individuals’ choices, and the use of professional judgement in maintaining confidentiality (Johnstone, 1999). The Competency Standards uphold these by legally requiring that the nurse follow these values when engaging in ethical debate and in practice, ensuring confidentiality for clients and acting to ensure the rights of individuals/groups are not compromised (2000:7-9). These requirements and guidelines define the nurses’ role, but also provide a framework from which to examine practice, as an aid in providing competent care, forensic included (Johnstone, 1999).
Forensic nursing is growing as a specialty in the United States, and greater awareness of nursing forensics is growing here in Australia. Whilst not seeking to criticise the development of forensic nursing as a specialty, this paper has highlighted some particularly relevant professional issues from the Australian context, that apply to most nurses as they apply forensic skills that are often not recognised, and often expose them to violence and ethical dilemmas. In summary, for forensic nursing to develop as a specialty, the forensic potential of nurses must be recognised and barriers to its implementation critically approached for resolution.
References


Nuritinga Issue 7, November 2006

© Copyright School of Nursing & Midwifery, & Individual Authors


Nuritinga Issue 7, November 2006


Supportive Care Clinical Enquiry

Sharise Larosa,
Bachelor of Nursing, Second Year
School of Nursing and Midwifery

Abstract

Vascular Dementia is a progressive syndrome arising from cerebrovascular disease causing a disturbance in the flow of blood to the brain. This underlying pathophysiology manifests as difficulties with cognition, memory loss, language, executive function and psychological impairments. This paper will examine the experience of caring for Ivy (pseudonym), an 82 year old lady diagnosed with vascular dementia residing in a Launceston aged care facility. The discussion will explore the psychosocial aspects, pathophysiology, pharmacology and medical interventions surrounding vascular dementia and Ivy’s care.

Supportive Care Clinical Enquiry

Vascular Dementia (VaD) is a progressive syndrome arising from cerebrovascular disease causing a disturbance in the flow of blood to the brain. This underlying pathophysiology manifests as difficulties with cognition, memory loss, language, executive function and psychological impairments. As such, VaD is a debilitating condition resulting in an individual’s inability to maintain activities of daily living, social relationships and responsibilities. This paper will examine the experience of caring for Ivy (pseudonym), an 82 year old lady diagnosed with VaD residing in a Launceston aged care facility. The contents of this discussion are not intended to be a comprehensive chronology of care or a description of the multiple co-morbidities she experiences; but rather an exploration of the psychosocial aspects, pathophysiology, pharmacology and medical interventions surrounding VaD and Ivy’s care. The paper will conclude with a description and rationale of nursing management focused on the most pertinent care provided to maintain her emotional health, physical health, personal care and dignity.

When I first saw Ivy I was unaware of her diagnosis or that she was one of the residents whose care I would be assigned to. She was sitting in a corner next to her walker quietly absorbed in her large print book, oblivious to the conversations and events around her. Her manner revealed a picture of detached calm, her affect appeared flat and she conveyed a sense of apathy towards her surroundings. I would never have guessed that Ivy has dementia or that her care needs place her in the category of level two bordering on level one; meaning that she is highly dependent on staff for even the most basic care. As Ivy experiences cognitive and communication difficulties related to her VaD, information regarding her
psychosocial circumstances was obtained from sparse conversations with her, the facility’s records and a brief conversation with her daughter. I obtained consent for this paper from both Ivy and her daughter due to the fact that Ivy is currently considered legally incompetent to consent.

Ivy was diagnosed with VaD twelve years ago when she started to experience concentration difficulties and inability to organize and complete tasks. During a conversation with her daughter I learned that she was quite accepting of her diagnosis, read widely on the topic of VaD and visited many aged care facilities in anticipation of an impending admission. With the help of her doctor Ivy managed to reduce many of the factors that contribute to the development of VaD; she quit smoking, exercised regularly, amended her diet and managed to reduce her cholesterol. At the time of diagnosis Ivy resided in Launceston alone after moving from a rural farming community upon the death of her husband. As time went by she became incapable of attending to the things she placed value on such as her children and grandchildren, gardening, exercise and charitable work. Her daughter believes it was Ivy’s inability to cope with social situations and her belief that she was rapidly loosing her dignity that lead to depression and withdrawal from the family. At this point her doctor and family intervened and Ivy moved into residential care.

Ivy’s children and grandchildren visit her regularly and are very happy with the care she receives within the facility. The daughter I spoke with is a registered nurse (RN) who visits regularly to participate in diversional activities and is closely involved in Ivy’s care. She is greatly relieved that Ivy no longer experiences the debilitative depression she once did. More than anything, she is grateful that Ivy is yet to display any of the overt behavioural disturbances so often associated with dementia; despite the cognitive difficulties Ivy experiences the family is not presented with the picture of someone they do not know when they visit.

The exact subtype of VaD Ivy suffers from is not known. There are many subtypes of VaD; each with a slightly different pathophysiological basis and often a definitive diagnosis can only be made with post-mortem studies (Adams, 1997). However blood vessel occlusion is recognised as the predominant cause of all VaD and it is usually a result of atherosclerotic growth (Kumar & Clark, 2006). Atherosclerosis begins with an inflammatory response after vascular endothelial cell damage. Smoking, hypertension and hyperlipidaemia are some of the risk factors for endothelial damage and atherosclerosis (McCance & Huether, 2002) present in Ivy’s history. During the inflammatory response macrophages adhere to the endothelium and engulf low-density lipoprotein (LDL) circulating in the blood (McCance & Huether, 2002). A fatty streak is formed on the artery wall and smooth muscle cells proliferate and produce
collagen which forms a plaque covering the streak (McCance & Huether, 2002). Over time the smooth muscle cells die and are replaced by scar tissue and calcium salts (Marieb, 2004).

As a result of this process Ivy’s blood vessels would be hardened and narrowed reducing the flow of blood to brain tissue. As the plaque continues to develop it may rupture initiating platelet aggregation resulting in thromboembolism (McCance & Huether, 2002). In VaD atherosclerosis or thromboembolism results in ischemia and as brain tissue is hypoperfused it may lead to multiple infarcts, lesions and atrophy (Gustavo, Roman, 2003b). The cumulative affects of the hypoperfusion and infarcts contribute to the progressive nature of VaD (Peretz, Cummings, 1988) In Ivy’s case this is manifested in step-like deterioration as each ischemic event occurs.

White matter lesions are a common feature of VaD; they are due to neuronal demyelination and glial cell proliferation, and it is the extent and location of such lesions that are believed to produce mental changes (Strub, 2003). White matter is a collection of axons connecting cortical cells (O’Sullivan et al., 2001) so for Ivy the disruption of these neural pathways disconnects assorted areas of the brain resulting in cognitive decline. Additionally, damage to a very specific brain area can also produce focal deficits (Peretz & Cummings, 1988); this is evidenced by Ivy’s history of Jacksonian seizures isolated to her left leg. Such seizures usually emanate from a lesion to the motor cortex of the brain and are not followed by lasting neurological deficits (Duus, 1983).

Subcortical infarctions are responsible for memory deficits (Duus, 1983) so it may be that Ivy’s problems with short term memory result from occlusion of subcortical vessels. It is also believed that lesions disrupting subcortical pathways are responsible for the loss of executive function so common with VaD (Roman, 2003a). Ivy experiences a severe progressive loss of executive control as she has difficulty with goal directed planning, execution as well as behavioural and emotional supervision. This manifests as difficulties with activities such as dressing, personal care, activities of daily living, eating, mobilisation and toileting (Roman, 2003a); Ivy experiences all such difficulties. Her disorganised thoughts and emotions are consistent with emotional supervision difficulties. Such disorganisation is evident in the confusion and frustration she feels as she tries to communicate, as well as her previous history of depression, tendency towards apathy and flat affect.

It is believed that ischaemia caused by lesions is responsible for the acetylcholine deficits associated with VaD (Roman, 2003a). Cholinergic nerves are associated with cognitive and intellectual function, memory formation and motor control (Galbraith, Bullock, Manias, 2000). Therefore pharmacological
treatment of VaD sometimes involves acetylcholinesterase inhibitors (Brandt, 2001) to decrease the breakdown of acetylcholine in order to reduce cholinergic deficits (Australian Medicines Handbook Contributors, 2004). However, on consultation with Ivy’s doctor I learned that he has based her treatment around treating the risk factors for vascular abnormalities which contribute to the development and progression of VaD. Therefore over the past years Ivy has ceased to smoke, her diet has been altered to such a point that she no longer has hyperlipidaemia and she continues to receive pharmacological treatment for hypertension.

To treat Ivy’s hypertension she is prescribed 40 mg of frusemide daily. This loop diuretic inhibits sodium, potassium and water reabsorption in the ascending limb of the loop of Henle within the kidney nephron, thereby increasing diuresis (Tiziani, 2002). For Ivy this reduces blood volume as fluid leaves the vascular compartment; therefore total peripheral resistance is lowered subsequently reducing her systemic blood pressure. Hypertension increases thromboembolism risk and small vessel brain infarction which contribute to white matter abnormalities associated with VaD (Strub, 2003). Diuretic treatment is therefore important for Ivy because lowering her blood pressure reduces the chance of events leading to cerebral hypoperfusion which is the hallmark of VaD.

Loop diuretics inhibit potassium reabsorption potentially exposing an individual to hypokalaemia (Bryant et al., 2003) which adversely affects nerve and muscle transmission (Tiziani, 2002). This may induce arrhythmia, fatigue, paralysis, confusion, shallow respiration or cramp (Crisp & Taylor, 2005). Therefore to prevent hypokalaemia Ivy takes a 600mg slow release potassium chloride supplement daily to replace potassium lost due to the frusemide.

Ivy has been prescribed oxybutynin to treat her urge incontinence (UI); she experiences nocturnal enuresis therefore she takes 5mg nocte to reduce nightly incontinent episodes. Acetylcholine facilitates detrusor contraction leading to micturition (Bryant et. al., 2003). The anticholinergic oxybutynin blocks acetylcholine binding at receptor sites on the detrusor muscle, reducing bladder contractility (Pharmacy Guild of Australia, 2004). Ivy’s bladder will contract less frequently, allowing more complete filling which reduces the frequency she voids at night facilitating a comfortable and dryer sleep. Anticholinergics potentially cause a number of adverse effects, especially in the elderly who are often very sensitive to them (Bryant et al., 2003). These adverse effects include dry eyes and mouth and constipation. Confusion and impaired cognition (AMH, 2004) are two effects that can be particularly detrimental to those with dementia. Therefore while caring for Ivy I regularly monitored for such adverse effects.
On consultation with Ivy’s doctor I learned that since commencing oxybutynin she is often constipated. Therefore she has been prescribed 2 daily coloxyl and senna 50mg/80mg tablets as well as microlax enema PRN when the coloxyl and senna is ineffective. The active ingredient in coloxyl is the faecal softening agent docusate (AMH, 2004). Docusate’s emollient action breaks surface tension allowing water and fat to penetrate faeces; it also stimulates water secretion into the bowel (Bryant et al., 2003). Senna is a stimulant laxative which increases water and electrolyte secretion into the colon (AMH, 2004) and promotes peristalsis by stimulating colonic nerves (Bryant et al., 2003). For Ivy the net affect of coloxyl and senna is a softened stool and increased peristalsis making defecation easier and more regular. While caring for Ivy I monitored her bowel actions, maintained her bowel chart and assessed the need for a microlax enema. Microlax contains an emollient with a similar action to senna; it also contains sorbitol, an osmotic laxative (Tiziani, 2002). Sorbitol exerts an osmotic effect within the bowel which draws fluid into the lumen (Bryant et al., 2003). This distension stimulates peristaltic movement and Ivy defecates within 5-30 minutes after administration.

As Ivy has a long history of urinary tract infection (UTI) she takes 100mg of nitrofurantoin daily as a long term prophylactic measure against infection. It is a broad spectrum antibiotic, sensitive to a range of gram positive and negative bacteria responsible for lower UTIs (Australian Medicines Handbook, 2004). Nitrofurantoin interferes with bacterial protein, DNA, RNA and cell wall synthesis ultimately leading to bacterial death (Bryant et al., 2003). This means bacterial growth sensitive to nitrofurantoin within Ivy’s urinary tract will be inhibited reducing the likelihood of infection.

Due to the recurrent and asymptomatic nature of Ivy’s UTI history, every quarter her doctor orders a midstream urine sample to be sent to pathology. In the laboratory the specimen is examined under the microscope, cultured and any pathogens are tested for antibiotic sensitivity (Lee & Bishop, 2002). The culture and microscopic examination allows a clinical picture to be built surrounding the presence of red, white and epithelial cells, as well as casts and bacteria indicative of infection. The sensitivity test determines the bacterial sensitivity to drug treatment (Gray, 2005). The pathology report allows Ivy’s doctor to confirm infection and choose an antibiotic capable of destroying the bacteria responsible for the infection. In the past Ivy’s infections were usually a result of Escherichia coli. This bacterium is a natural bowel flora and commonly causes UTI in elderly women due to proximity of the anus to the urethral opening and inadequate flushing of bacteria from the urethra due to incontinence (Crisp & Taylor, 2005).
When Ivy first started displaying symptoms consistent with Dementia her doctor ordered a non-contrast computed tomography (CT) scan. CT imaging coupled with health history, cognitive assessment, mental and physical examination allows physicians to distinguish between VaD and Alzheimer’s disease (O’Brien & Barber, 2000). A CT scan consists of an x-ray beam which revolves around the person; detectors measure the beam’s penetration amount and a computer analyses the findings to construct a cross-sectional image (Brown, 2004). Findings on Ivy’s scan consistent with VaD include pronounced periventricular white matter lucency, enlarged ventricles as well as carotid and vertebral artery calcification. White matter lucency is indicative of chronic ischaemia associated with lesions and the calcification provides evidence of advanced vascular disease (Roman, 2003b). The diagnosis of VaD would then have allowed the doctor to educate Ivy and plan pharmacological treatment to minimise the progression of the disease and manage her symptoms. Likewise a diagnosis allows nursing staff to provide appropriate care and understand the likely progression of Ivy’s physical and mental status.

The RNs at Ivy’s age care facility have developed a comprehensive nursing plan which is reviewed and altered according to Ivy’s care needs on a regular basis. Care plans identify goals and provide strategies and an evaluation process to ensure that people receive safe and optimal care (Sox, not dated). As such I consistently consulted Ivy’s care plan over the course of my placement and documented care I provided and relevant events in her resident notes, bowel charts, medication charts and observational charts. Any documentation was then countersigned by an RN. Documentation is important because it provides a way to communicate information to staff, ensures continuity of care, displays accountability, assists quality assurance and allows funding to be maintained (Crisp & Taylor, 2005).

Ivy’s care plan indicates that her communication is impaired due to deficits in cognition, eyesight and short term memory loss. In the initial days of caring for Ivy I sensed that she felt uncomfortable in my presence; she withdrew, seemed unwilling to converse and appeared apathetic. Such behaviour is common in VaD (Adams, 1997); people withdraw because they are unable to understand and therefore cope with a situation that is unfamiliar (Gorman, Raines, Sultan, 2002). I worked very hard to develop a trusting rapport with Ivy by utilising therapeutic communication skills in order to display empathy and kindness. I was mindful to include Ivy in all aspects of her care by explaining what I wished to do and asking for her consent. I was aware of the non-verbal cues and information I was displaying and attempted to provide a supportive stress free environment. According to best practice, I spoke calmly and slowly in short sentences and was mindful to appreciate and acknowledge Ivy as a valued human being (Anderson, 1995). However she still remained apathetical in a distant, smiling kind of way. I was
able to gain Ivy’s trust and communication between us eventually improved as she ceased to withdraw quite as much, and caring for her became an easier and enjoyable experience.

Ivy’s withdrawal from social situations has been ongoing since her admission to this aged care facility. Her doctor believes that she no longer suffers from depression; however she displays many characteristics consistent with depression. These characteristics include withdrawal, tendency towards weight loss, apathy and loss of pleasure in the things she previously found enjoyable (Gorman et al., 2002). Due to problems with cognition I was unable to complete a geriatric depression scale with Ivy so I sought instead to provide for her emotional needs and encourage socialisation. As emotional status is based heavily on one feeling validated as a person with a history and social connections (Lin, Dai, Hwang, 2003) I implemented reminiscence therapy into Ivy’s day. We spoke about things she remembers and values from the past such as life on the farm and her connection with nature; I read her a contribution she made to a book about the people in her local area, and we sat in the garden and enjoyed the sunshine. As our rapport developed I was able to encourage Ivy’s participation in activities organised by the diversional therapist and conversations with residents around the home.

During this placement I assisted Ivy with her personal care needs. I was mindful at all times to maintain her dignity and fostered independence (Godkin & Godkin, 2004) by encouraging her to perform the few tasks of which she is capable for herself. Personal hygiene is essential for a person’s safety, physical and emotional wellbeing; it also provides an opportunity to assess skin and mucosal integument (Crisp & Taylor, 2005). Due to functional and executive planning deficits associated with dementia the nursing care needed to maintain Ivy’s personal hygiene is extensive. Care provided for Ivy therefore included showering, oral care, perineal care, hair care and assessment of integument including feet. The assessment of integument is extremely important when caring for the elderly as their epithelium is often thinner, looses elasticity and healing is often slow due to multiple co-morbidities; this predisposes the elderly to tears, bruising and ulcers (Jarvis, 2004). Additionally people with dementia can not always isolate pain and discomfort or express this to caregivers (Volicer & Hurley, 2003). Therefore I thoroughly assessed Ivy’s skin daily while bathing her and provided measures to maintain integrity such as proper drying, cornstarch to her abdominal folds and sorbelene to dry skin on her arms and legs.

Maintaining a dry perineal area free of urine and faeces is essential to maintaining comfort, dignity and skin integrity (Crisp & Taylor, 2005). I therefore ensured that Ivy’s perineal care was performed meticulously and with sensitivity to the very private nature of this care. In order to discourage microbial colonisation often responsible for UTI, I attempted to keep Ivy dry, free from faeces and wiped from
front to back (Gulanick et al., 1990). In order to keep Ivy dry I toileted her soon after meals and administration of her diuretic and every two hours in between. I was mindful to monitor her behaviour for fidgeting or non-verbal cues suggesting the need to urinate or defecate; each day I asked her about pain on urination indicative of UTI.

Each week Ivy has a set of observations performed; blood pressure, pulse, respirations and temperature. Vital sign measurements are indicative of circulatory, respiratory, neural and endocrine effectiveness; alterations in these observations result from changes to physiological or psychological functioning (Crisp & Taylor, 2005). As such, each week I compared the results to previous findings in order to determine if they were within an acceptable range or if there was any changes warranting further investigation. Monitoring vital signs regularly is essential considering Ivy’s history of UTI and the risk of cerebrovascular accidents associated with VaD.

In conclusion, VaD is a debilitative syndrome that leaves people requiring increasingly extensive amounts of care as it progress. People caring for those with VaD need to provide care that maintains the individual’s comfort and dignity, validating them as a human being with a rich history and personal identity. During this placement I learned that identifying the needs of a person with VaD requires one to have comprehensive knowledge of the pathophysiology, pharmacology and psychosocial circumstances surrounding the individual. Only then can we provide care in such a way as to optimise that individual’s health and well-being and maintain their quality of life.
References


Bryant, B., Knights, K., Salerno, E., 2003, Pharmacology for Health Professionals, Elsevier Australia, Marrickville, Australia.


Jarvis, C., 2004, Physical Examination and Health Assessment, Elsevier Science, USA.


