



Reports from Winners of Foundation of Nursing Studies Awards 2002

Changing Eye Care Practice: Evidence Based Eye Care on an Adult Intensive Care Unit

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Background

40% of intensive care (ICU) patients have superficial keratopathy during their admission (Parkin and Cook, 2000). Ineffective or inappropriate care of this condition can lead to complications that may affect vision. Data from a retrospective audit of 68 patient records in the ICU during January – April 2003, demonstrated that the frequency of eye care treatment for sedated and ventilated patients varied significantly. These findings support those of other studies which suggest that eye care techniques vary widely and are largely based on nurses' beliefs and values established by traditional practice (Laight, 1995).

Aims and objectives of the project

This project aimed to introduce an algorithm/guideline to guide eye care practice, assessment and documentation (Suresh et al., 2000). It was anticipated that the outcomes of this approach would be:

- improvements in the standard of eye care for critically ill patients in ICU
- improved education of staff who would then perform a procedure integrating research into clinical practice

Method

Published literature and evidence from a telephone survey of 10 hospitals in London relating to eye care practices was collected. A two-step framework for evidence-based healthcare devised by McInnes et al. (2001) informed the implementation strategy.

Step 1: Education

Meetings were held to discuss and reflect on the applicability of the evidence gathered to link it with expert opinion and clinical experience. Staff then developed a standard and audit tool for eye care (Royal College of Nursing, 1990). Copies of the standard and guideline were made available at each bed-space and staff were asked for their comments.

Step 2: Implementation

A computer presentation and teaching pack were developed and information was given to staff regarding documentation and instructions on how to perform and document eye care assessment and treatment appropriately. The project nurse and teaching sister provided the nurses with additional support and education during the introductory period of the guideline.

In June 2003, three months after the implementation of the eye care guideline, practice was audited.

Results

81% of nurses had received training and 78% had completed the eye care competency. 74% could state the resources available to assist them with eye care. Both nurses and doctors demonstrated a high level of knowledge relating to the effects of ICU and procedures on eye integrity. More nurses could state the frequency for eye assessment for an awake patient compared to the sedated and ventilated patient (69% versus 53%). Only 50% of nurses could state the treatment recommended in the guideline although the documentation demonstrated the correct treatments were administered in 67% of cases. It was observed that eye care treatment was performed using a clean non-touch technique (93%).

98% of nurses could state the descriptive documentation required for eye assessment. 69% of eye assessments for an awake patient were completed a minimum of once per shift, and 59% of eye assessments for sedated and ventilated patients were completed four hourly, in accordance with the guideline. All staff audited knew how to report and document eye abnormalities (100%). At the time of the audit, 6% of patient records/documentation reported an eye abnormality. No patients needed referral to an Ophthalmologist. The eyes of 98% of the patients audited were clean, moist and free from signs of inflammation and infection.

Discussion

The results demonstrated a general high level of compliance with the new eye care guideline. The main findings were that there was significant variation in the knowledge and documentation of the frequency for eye assessments for the awake and sedated and ventilated patients. These results suggest that the staff were utilising the guidelines at the bed space to assist them in performing assessment and choosing the correct treatment but were, as yet, unable to recount the procedure verbally.

As a result of the introduction of the new guideline for eye care, we anticipate that there will be a sustained improvement in the standard of eye care for critically ill patients in our ICU. Audit results have been disseminated to staff on the unit and the criteria that achieved poor results have been highlighted and discussed. A second audit has been planned for June 2004.

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FOLDS

Top Notch: A Practical Approach to Hair Loss in Women with Cancer

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Background

Alopecia is a distressing and often overlooked side effect of chemotherapy, yet it remains one of the most frequently encountered side-effects of treatment and is experienced as one of the side effects with the most impact (Batchelor, 2001). Women who experience alopecia have reported lower self-esteem, poorer body image and reduced quality of life when compared with women with cancer who retain their hair (Williams et al., 1999; Batchelor, 2001; McGarvey et al., 2001).

Although the toxic effects of chemotherapy on the hair are almost always reversible, there is a delay of several weeks before regrowth begins. Giving patients information about hair loss and teaching self-care strategies can have a positive impact on well-being (Batchelor, 2001).

Aims of the project

This project aimed to improve patient care by developing a service at Ardgowan Hospice that could offer support and practical techniques to women affected by hair loss. It was anticipated that this service would be self-funding once an initial stock of scarves was purchased and staff training completed.

Processes

The project involved establishing a team of nurses and volunteers that had received training:

- in the practical techniques of scarf tying and wearing hats to address hair loss
- to raise their awareness of the psychological impact of hair loss
- to enhance their skills in communication and listening

The latter was very important as the project was designed to allow women and men the opportunity to talk about how they felt about their hair loss in a supportive environment.

Patients are offered individual appointments. They are given the opportunity to practice the scarf tying techniques and time to air their feelings about their hair loss and any other issues important to them. Carers are also able to access the service to increase their involvement, ease their sense of helplessness and help their relative where required.

The first ten patients to use the service were involved in an audit to ascertain if the service had met their needs at this stage. The results of a short questionnaire allowed us to re-evaluate the whole project and take a closer look at how the service could be provided. The main issue arising from the feedback from patients related to the environment in which the service was provided. The patients felt this was too clinical and not as comfortable as it could be.

Outcomes

The following progress has been achieved:

- In response to their feedback about the environment, patients have been asked to give ideas about ways in which it could be improved
- These ideas have been taken to management who have agreed in principal to fund the redecoration of the room although negotiations have been ongoing for several months
- An initial stock of scarves has been purchased and these are sold at a reasonable price to cover outlay
- Staff training is ongoing, as new staff will be taught the skills where appropriate

Challenges

The main challenge was to try and recruit staff for training from all departments within the hospice. However, in the end this did not prove to be a very useful strategy. The staff were only allowed to carry out sessions within their normal working day and as all departments have experienced staff shortages, it has been impossible for most of them to offer any time to the project. Currently, the Living with Cancer team are able to offer a service without resource implications, but it is hoped that more staff will be trained in the near future.

Future developments

- The service will be re-launched during February/ March 2004 making much greater use of publicity
- A new audit will be undertaken by the summer of 2004 to ensure the service continues to meet the expressed needs of the patients
- The service will be offered to a wide geographic area by means of an out-reach programme and a home visit service for patients too distressed to attend the building

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FOLDS

A Nurse Led Clinic for Faecal Incontinence

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Background

Faecal incontinence is a distressing condition, which often has a negative impact on everyday living and quality of life (Rothbarth et al., 2001). It has been defined as the inappropriate passage of faeces (Royal College of Physicians, 1995) and many studies have estimated the incidence within the total population of 1-2%. Treatment options for faecal incontinence within Northern Ireland have been fragmented and mainstay treatment has been dependent on surgery and constipating drugs.

Aims and objectives of the project

The overall aim of the project was to develop a nurse led clinic within a designated colorectal unit and to provide effective conservative management and treatment for patients with faecal incontinence. Conservative treatments incorporate various approaches under the umbrella term of biofeedback. This includes patient assessment, support and information, dietary advice and medication, pelvic floor exercises and behaviour modification. The objectives of the project therefore were to:

- Ensure accurate assessment
- Provide support and information
- Improve symptom management
- Improve quality of life
- Audit efficacy of treatment

Development of clinic

Prior to development of the nurse led clinic, a comprehensive literature review was undertaken. A multi-professional project team was identified and a twelve-month project plan and framework to meet our objectives was devised.

Acquisition of equipment

A budget was allocated facilitating the purchase of rectal manometry and biofeedback equipment. Manometry is a technique that aids accurate investigation and determines future management by measuring the strength of anal sphincters, degree of sensation felt within the rectum and the ano rectal inhibitory reflex. Biofeedback allows patient visualisation of sphincter contraction through computer imagery and is a technique used to complement pelvic floor exercises.

Training needs

A training programme for the colorectal nurses was devised including both theoretical and experiential learning and incorporating clinical placements in specialist units. A short course in bowel continence was undertaken by one of the colorectal nurses.

Development of documentation

Using information collected from the literature and other colorectal units, a range of documentation was developed including patient information leaflets, assessment tools, protocols and outcome measures.

Challenges

The development of the new service has posed many obstacles. The key problems have revolved around the purchase and sterilisation of the equipment and training in the effective utilisation of the equipment. Difficulties with technical support proved frustrating and led to a delay in meeting the project timescale.

To ensure clinical practice was of a high standard the colorectal nurses needed to gain both theoretical knowledge and clinical experience in a short space of time. This proved difficult while maintaining the existing colorectal service but is an ongoing essential aspect to the provision of high quality patient care.

Outcomes

The development of this new service will have benefits for patients and health professionals both within the hospital and community settings. Research has demonstrated that up to 70% of patients have reported benefit or cure following a programme of biofeedback (Norton and Chelvanayagam, 2001). The provision of direct support and information by a specialist nurse has also been shown to be a significant factor in facilitating a positive outcome (Pager et al., 2002).

Health professionals now have a resource for advice and information coupled with a cost effective programme of care for patients.

Conclusion

The project has successfully established a nurse led service within a multiprofessional framework for patients with faecal incontinence. The referral rate has been considerable and already there has been the need to create a waiting list. As the service has not yet been widely advertised, however, there may be Trust wide implications in relation to staffing levels.

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FONDS

Consistency in Care – Developing Inpatient Services for People with Borderline Personality Disorders

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Background

It is widely known that clients with borderline personality disorder (BPD) present mental health services with difficulties (Jones, 2002). The associated maladaptive behaviours are problematic for inpatient staff to manage both professionally and personally. BPD characteristics are not curable within an acute ward and reluctance in accepting this underpins frustrations and negativity in care providers (O'Brien, 1998). The level of complaints received from clients with BPD indicates that such issues taint their inpatient experience.

The core problem identified is the lack of any robust model or approach to care. This can result in inconsistency in care, which causes distress, confusion and dissatisfaction for both staff and client groups. Individual staff responses to care are intrinsically linked to team splitting in relation to this client group (Tredget, 2001). This is detrimental to both clients and staff and creates non-therapeutic environments that exacerbate rather than alleviate client distress. It is essential for staff to receive appropriate education, support and supervision to facilitate the building of cohesive and productive teams in order to provide adequate care to clients with BPD (O'Brien, 1998).

Aim of the project

This project aimed to develop a consistent, evidence-based approach to caring for clients with BPD.

Project plan

Four phases of the project were identified.

1. Pre-planning

To include the collection of baseline data through focus groups, examination of case notes, complaints and ward comparisons and the agreement of a project plan.

2. Planning

To include a review of the literature, identification of best practices and working with project consultants; the formulation of an action plan and development of practice guidelines.

3. Implementation

Agreement of changes to care and implementation of these practices.

Qualitative evaluation to commence alongside implementation and new changes to be agreed and implemented as a result.

4. Evaluation

A formal evaluation to be undertaken using data from ongoing evaluations and recollecting data as in phase 1. Standards to be set as a result.

Central to the project was the creation of a core project team of interested professionals. This included ward based nursing and occupational therapy staff, medical and community team representatives and a Senior Research Fellow from the RCN Institute. The emphasis was placed on improving practice in practice. A fortnightly forum was established to identify key activities and the project leader and project facilitator were available to support staff to achieve these. The core team consulted widely with other interested parties. These included members of the psychology and psychotherapy teams and service user councils, networks and groups.

Progress and challenges

The project has faced many challenges, particularly relating to a huge turnover in staff and vacancies in key leadership roles.

Although a literature search has been completed, a resource file has been developed and data collection has started, the project has not progressed as far as had been expected. Fortnightly forum meetings were held for about six months, however, they were not always well attended and at times, staff seemed reluctant to contribute.

There are many barriers to change. Although staff are not satisfied with the current approach to care for clients with BPD, the impetus for change has diminished. Several factors have contributed to this including staff changes and also a reduction in the number of inpatients with BPD over recent months.

Future plans

The Director of Nursing has set leading the project as a priority for the new ward manager who will be in post shortly. A project steering group has been created to support the ward manager in this work. We look forward to moving ahead with the project plan over the coming months.

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FOKIS

Epidural/Intrathecal Analgesia in the Hospice/Community Setting

Project team:

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Background

The many logistical and technical complications associated with facilitating access to spinal analgesia in the hospice and community setting have historically created a barrier to the provision of this method of pain relief. The NHS Modernisation Agency, Cancer Services Collaboration (CSC, 2002) aims to reduce unnecessary restrictions on access to care and ensure that the patient receives the best care, in the best place by the best person. The facilitation of adequate pain relief in the patient's home epitomises this philosophy.

Aims of the project

This project involved nursing, pharmaceutical and medical staff working in partnership across acute, community and independent organisational boundaries in order to enable appropriate patients to receive spinal analgesia in their home.

Processes

In order to achieve this a support framework and multi-disciplinary professional network were developed. This has involved:

- Mapping a patient pathway
- Developing patient information
- Developing a guideline
- Developing staff competencies, an assessment programme and training days
- Developing support information and documentation

All relevant documentation has been published within a clinical support folder. According to Richardson (1999) well presented, colourful and professionally prepared documentation is likely to promote acceptance of and compliance to clinical guidelines. A printing company has therefore produced the folders with funding that was provided by The Foundation of Nursing Studies Award and sponsorship from the hospice and PCT sectors.

Outcomes

Short term

- Clinical Support Folders have been distributed to partaking hospitals, hospices, PCT's and GP Surgeries

within the project area

- A competence and assessment programme has been initiated with staff from PCT's, hospices and the hospital jointly facilitating training days
- Appropriate patients have successfully followed the patient pathway and safely received effective spinal analgesia in the hospice and home setting

Long term

It is anticipated that this initiative will contribute towards meeting national standards in relation to:

- Shifting the Balance of Power, Department of Health (2001)
 - Organisational barriers have been removed and the focus of patient care is shifted from acute hospital services to primary care
- Cancer Services Collaboration, The Modernisation Agency (2002)
 - Reducing unnecessary restrictions on access to care
 - The patient receives the best care, in the best place by the best person
- Manual of Cancer Services Assessment Standards (2001)
 - The establishment of networks and strategies between palliative care and specialist pain services

Challenges

Working across organisational and professional boundaries creates various barriers to change. The project took place soon after an acute Trust merger, PCT's were in their infancy and hospices were undergoing legislative influences. Approval bodies and systems were diverse in their requirements and key personnel were frequently moving posts. Health care professionals had to commit to the project by taking time out from their busy clinical environment. All these issues slowed the process considerably. The project team however, overcame these challenges with persistence, enthusiasm and a shared vision. Multi-professional working relationships harnessed the skills of the individuals who built an effective team and in collaboration were able to successfully implement this project.

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FOCUS

Leading the Way in Neuro Ophthalmology

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Background

Approximately 38,000 patients in the UK suffer from incapacitating dystonias for which there are no cures. A proportion of these patients suffer from a condition known as Blepharospasm. This condition is distinguished by uncontrollable blinking, spasms and or sustained contraction of the eyelids. This condition is often life altering not least because it can cause functional blindness and social isolation. These patients need timely support and quick access to medical/nursing intervention.

Interventions include the injection of botulinum toxin into the eyelids which provides symptomatic relief, however, the timing of the need for repeat treatments is not always predictable. As the majority of patients are never discharged, clinics must accommodate an increasingly large number of patients. Consequently, patients can find access to the clinics difficult and often need the injection before their planned clinic date. It was recognised, that although well intentioned, the service at the Royal Victoria Infirmary seemed to meet the needs of the organisation rather than the patient.

Aims of the project

The project aimed to establish a rapid access Nurse-Led Service offering repeat botulinum toxin injections to run in parallel with existing twice monthly consultants clinics. Patients would also be able to contact named nurse practitioners for information regarding their condition, treatment and available support groups.

The concept of nurse-led clinics has been highlighted and endorsed in key governmental papers (DoH, 1999; 2000). They have been found to be highly effective and popular with patients and professionals alike. It was anticipated that this approach would enable highly competent ophthalmic nurses to extend their roles, making better use of their knowledge and skills (DoH, 1999) and making the service more accessible and responsive to the needs of patients.

Project outline

The consultant ophthalmologist discussed ideas on training and clinic organisation with the medical and nursing staff from several botulinum toxin clinics around the country. Multi-disciplinary meetings between the nursing and medical staff in the clinic were arranged to formalise a training programme including visits to the local general dystonia clinic and another regional botulinum toxin clinic. A process for self-audit and reflective practice was devised and a core knowledge base identified.

During November and December 2003, an audit of patients' views on access and information was performed using an anonymous questionnaire. It was done at this time because the nurses were still in training and the clinic was primarily doctor led.

At this stage the patients were introduced to the nurses and the proposed new nurse-led, rapid access clinic was explained to them. This enabled the patients and carers to have involvement in how this would be developed. 32 patients were able to complete the questionnaire. The audit showed that:

- 74% of patients were interested in using the nurse-led clinic in the future
- the information given out about botulinum toxin treatment was well understood
- patients would value more information on support groups

Outcomes

Due to staff changes, the current nurse practitioners continue to perform botulinum toxin injections under consultant supervision. Over the next few months it is anticipated that they will be fully trained and the nurse-led clinic will run in parallel with the consultant service to allow access according to patient request for those with unpredictable treatment needs. Information on how to access the nurse led clinics will be given to all patients. When the patient feels that they are ready for further treatment they will contact the nurse who will arrange to see them for treatment within 2 weeks. The nurses currently offer information on treatment and patient support groups to all patients and there is an extended range of leaflets and written information for patients.

Until the nurse practitioners are fully trained, an interim measure to improve patient access has been introduced. Patients are offered the choice of either a specific follow up date or to contact the consultant's secretary themselves when they need repeat injections, the consultant then adds them to the next clinic list which is usually within two to three weeks. Approximately 50% of patients have chosen to contact the clinic when they feel they need re-treatment, and have informally said that they appreciate the extra degree of control this gives them over the management of their symptoms and the flexibility they gain over fitting their appointments around their lives and those of their carers and relatives. Some patients are choosing to have injections less often under this system as they know they can wait until their symptoms warrant treatment rather than trying to plan ahead.

Patients are now getting to know the nurse practitioners personally and are asking them more questions about their treatment and condition. As a result, the nurses are obtaining information from diverse sources (such as other departments, other dystonia nurses, the botulinum toxin pharmaceutical representative, patient support groups and the literature) to answer queries from individual patients. With the use of reflective practice and clinical supervision, the nurses are developing an enthusiastic approach with good multi-disciplinary links which is advantageous both to the patients and staff.

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FOLIOS

Working in Partnership with Gypsy/Travelling Families

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Background

General findings suggest that gypsy travellers have poorer health status and higher mortality rates compared to that of the general population (Van Cleemput, 2000). They are more likely to live in unhealthy conditions and use the healthcare services less than the population as a whole (Hawes, 1997). There is a high illiteracy rate amongst this ethnic minority group which severely limits the effects of 'wordy' health promotion booklets, yet it appears that currently health promotion material aimed specifically at the travelling community is scarce.

Aim of the project

This project aimed to work in partnership with twelve travelling families who have pre school children living on a trailer site within the East Howle area of County Durham to produce an effective health resource that was accessible and pertinent to travelling parents and children regardless of their literacy skills.

Project outline

The project leader, a local health visitor, worked with the travellers to gain their opinion of the limited resources that were available to meet their specific health needs. Parents explained that the literature was confusing and usually not understood due to their limited literacy skills. They expressed a need to produce their own resource. Travellers agreed with the evidence-based literature that highlighted diet, play, safety, interaction, dental health, uptake of child surveillance and limited literacy skills as specific health issues pertaining to traveller culture.

A safe, compact and robust health promotion picture board book has been produced. The book uses photographs of children and parents taken within or around travellers' trailers and at the child health clinic. The photographs were taken by the project leader and a family worker at the request of the travellers as they are highly suspicious of outside agencies. Many photographs were taken to ensure that all the parents and children who wanted to be involved were included. This required many visits which strengthened the relationship between the project leader and families. Travellers requested one sentence per page and simple repetitive text was used throughout.

Each family received two copies of the resource and an audio tape to aid literacy.

Evaluation

A qualitative evaluation consisting of one to one and small group discussions was undertaken involving eight of the families (the remaining four families had moved off site) to determine the effectiveness of the resource. The following questions were considered:

- Has the resource been useful/user friendly?

- Has the use of books/toys increased within the home since the introduction of the resource?
- Has there been any interest in literacy skills programmes?
- What improvements can be made in terms of health service provision for travellers within the locality?

The parents see the resource as something to be proud of and kept away in a cupboard in case of damage rather than something to be read or looked at with the children. However, many other positive outcomes have developed as a result of this initiative.

There appears to be a more positive attitude towards dental health and travellers have requested that a mobile dental unit visit the site. They have also asked for a permanent building on site to provide health services such as a health visitor drop in session and a parenting group. Options to fund these facilities are currently being explored. A mobile unit is to be set up on the site, two days per week, to offer library services and support the development of literacy skills. A Sure Start equipment package has been adapted for use in the trailer. The families have been greatly encouraged by their involvement in the project and the travellers, health visitor and Sure Start are now in the early stages of a further project to highlight the needs of trailer and site safety.

Since developing the resource, over a hundred orders have been received from interested parties. A questionnaire has recently been sent to these groups and individuals and the feedback about the resource has been positive.

Challenges

The initial challenges presented by this project related to time scales and increased work load. There were many repeat visits to families to obtain images and processing was time consuming. Some of the families who wanted to be involved were travelling and it was difficult to ensure all were included. By raising awareness of health issues, travellers have become more willing to express their views about the provision of on site health care provision and indeed these expressed health needs are now presenting new challenges for the health and social care services.

Conclusion

Developing the health resource has enabled the health visitor and others to work in partnership with the travelling families. By listening to their expressed needs and incorporating a strong evidence base, a bottom up approach has allowed the health visiting service to drive forward the public health agenda by attempting to tackle the inequalities in health service provision which exist within this ethnic minority group.

References

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A Voluntary Sector Help Desk

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Background

Users of mental health services have been campaigning for greater participation and involvement in service development and delivery for a long time and such involvement is supported by the National Service Framework (NSF) for Wales (2002). This project was developed from an idea put forward by a mental health service user who thought that access for in-patients to services provided by the voluntary sector could be improved and presented an ideal opportunity to put Key Action 7 of the NSF into practice. Discussions with the Manic Depression Fellowship (MDF) resulted in the pilot of a 'Help Desk' in a Patients' Resource Centre, manned by service user volunteers and supported by nurses from the rehabilitation service and acute service.

Aims of the project

In line with Standards 1 – 3 of the NSF the aims were to:

- Promote the involvement of service users and carers in mainstream service provision
- Promote the social inclusion of service users, their families and carers
- Promote positive choices in the self-management of mental illnesses
- Improve access to the support available from voluntary sector providers
- Give users and carers hope of positive outcomes

Setting up the Help Desk

Initially, discussions were held with the Development and Information Manager and volunteers from the MDF Wales and a number of presentations were given to the local Clinical Governance Forum. This enabled many key issues to be explored and informed the development of a protocol to guide the involvement of service user volunteers.

It was agreed that the volunteers would be based in the Patients' Resource Centre for two hours once a week and would also visit patients on the wards where appropriate. All wards and other relevant areas received a visit to explain the purpose of the project as well as publicity posters and information leaflets. Link Nurses were identified on some of the wards to support the volunteers in identifying who may benefit from the service.

Outcomes

Over the first ten months, 68 contacts with the Help Desk were recorded. Although a more 'in-depth' analysis of these contacts would be desirable, this was not possible within the existing funding and human resources. Since the project's inception, Hafal Cardiff (Hafal, meaning equal in Welsh, formerly the National Schizophrenia Fellowship), the Depression Alliance Cymru and Cardiff Mind have joined the Help Desk.

Challenges

As with many new initiatives, the project has faced challenges:

- The MDF volunteers commented that they sometimes felt unsupported by their own organisation and found it particularly difficult to sustain their enthusiasm for attending every week during periods when there are not many patients in hospital requiring support. As a result, paid workers from MDF now cover the Help Desk on alternate weeks.
- The Link Nurses on the wards have encountered difficulties in being available every week because they all work on busy acute wards.
- Barriers presented by the culture within the hospital. Some ward-based staff deny any knowledge of the existence of the Help Desk, others know that the voluntary organisations come to the hospital but misinterpret their involvement. Efforts to raise the profile of the Help Desk continue with presentations being made during staff induction programmes and at other staff meetings.

Conclusion

This report has demonstrated how service user volunteers have been successfully involved in a project to improve the access of mental health service users to the support available from the voluntary sector. The key benefits and learning points from the project are outlined in Box 1.

Box 1. Key benefits of the project

- The service user volunteers gained confidence which has helped them to find new directions in their lives and to move-on to other activities
- Involving service users in all aspects of the project from planning to delivery has meant that it addressed a need that was previously unmet
- Nursing staff have gained new perspectives about the help and support available from non-statutory organisations
- Working alongside service users has been a very positive experience and has educated nursing staff about the importance of encouraging the self-management of mental health conditions

Key learning points from the project

- User involvement can sometimes be seen as tokenistic. Nursing staff have a large part to play in actively encouraging meaningful user involvement
- Planning new projects with agreed protocols, guidelines and timescales is vital if they are to succeed
- Successful projects take a lot of time, determination and effort to establish
- The support of senior staff is of vital importance at all stages but especially if difficulties arise

References

Welsh Assembly Government (2002) *Adult Mental Health Services: A National Service Framework for Wales*.