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Discuss and critique how the body may be problematic and how nurses may accommodate and respond to these issues.

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Abstract

This essay will explore the view that the body becomes problematic in nursing due to the dominance of the biomedical model and its representations of the body. This model effectively renders much of the work that nurses do with the body invisible. The characteristics of the biomedical model and its representations of the body will be described. The central role of the body in nursing will be established and a contemporary concept of gender discussed. I will then briefly describe the historical construction of nursing and medicine that I believe has produced the gendered and hierarchical workplace that presently exists. Cartesian dualism and the development of a dominant discourse that defines the body scientifically will be examined in greater detail. My personal experiences both as a nurse in a neonatal intensive care unit and an experience as a patient in a neurosurgical unit will be examined in the light of these issues.

The biomedical model of medicine is characterised by an institutionalised, scientific, and technologically directed approach and is derived from the positivistic philosophy of Descartes (Turner 1987: 214). The body is represented as a machine and disease is seen as a mechanical problem (Parker 1997:11). The biomedical model is also focused on cure, not care and seeks to control 'dysfunctions of the body-physical by controlling the cellular molecular level' (Watson 1999:132). While this paradigm has had success and 'led to diagnostic and therapeutic advances of stunning effectiveness' (Cassell 1992:237) it has ignored the personalised and subjective experience of embodiment.

I write from a perspective that supports the view that the body is central to nursing (Parker, 1997: 11, Fassett & Gallagher, 1998: 15, Holmes, 1994: 111) and is more than just flesh and blood, being produced as much through historical and cultural processes as biological processes (Parker, 1997: 21, Fassett & Gallagher 1998: 14, Grosz, 1994: 20, Turner, 1992: 47). I also support 'the perspective that considers gender to be one of the most important means by which the world is structured. This gendered structure grants men and women unequal opportunities, unequal access to resources and different social statuses' (Harrington and Kunkel, 1996: 8).

Connell (1987: 139) argues that 'collectivities, institutions and historical processes' are also gendered, and this understanding can be applied to the construction of nursing and medicine. The institutionalisation of women's role as caregivers can be traced to the rise of Christianity and its appropriation of Greek philosophical ideals regarding 'the superiority of the spirit over the inferiority of the body' (Colliere 1984: 99). By the 13 th Century hospital orders had developed, with nuns providing patient care, while at the same time women's knowledge of healing outside of
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the church was declared pagan' (Colliere 1984: 99). A gendered hierarchy that allowed women to nurse under the control of men and punished women who chose to preserve their own knowledge was clearly visible. Punishment extended to death in the witch-hunts of 14th to 18th Centuries (Colliere 1984: 99). This gendered hierarchy continued into modernity.

Colliere maintains that a moral and a technical perspective determined the modern training of the nurse and care of the body became so overwhelmed by procedures and treatments that it became invisible within a task oriented environment. (Colliere 1984:102-103). Caring for the body subsequently became part of a moral identity rather than work (Reverby, 1987: 5). This perspective influenced my experience as a nurse training in the 1970's. Following medical orders and collecting data for doctors were visible and important parts of my work. Care of the body was assigned the title of 'basic nursing care' and the term basic was seen to mean 'simple' rather than 'essential' or 'fundamental' (Lawler 1991: 31). Caring for the body therefore became part of my feminine identity, shaping the stereotypes of 'ministering angel' and 'Doctors handmaiden' (Bridges 1989: 851-2) rather than being central to my work as a nurse. These stereotypes also supported the existing gendered division of labour.

While historically the church had defined the body, and nurses owed their allegiance and devotion to God, in modernity science and the biomedical model define the body, and nurses owe their allegiance and devotion to the Doctor. While women are no longer are burnt as witches 'medical knowledge is legitimated as superior to subjective observation, intuition and the skilled practical knowledge acquired over time by the nurse' (Street, 1992:157). Nursing, and care of the body, have over time become strongly associated with femininity, while science, and medicine, have been constructed using masculine images (Lumb, Strube 1992: 87, Emden 1995:31). Wilshire (1989: 94-95) points out that culturally we extol things perceived of as male and degrade those things perceived of as female, and supports Connell's (1987: 139) view that it is not only individuals that are gendered. The historical construction of nursing has produced a gendered hierarchy that functions regardless of the gender of individual nurses and doctors and values medical and scientific knowledge at the expense of all other forms of knowledge.

"This prevailing attitude affected my experience as a nurse on a daily basis. Perhaps its biggest effect was that I internalised these attitudes and thought of my colleagues and myself as 'just' nurses. I was taught to believe that part of the role of a good nurse was obedience and subservience to medical staff and to their assessment of any situation. At the same time close contact with patients meant I was aware of an expanding knowledge base being developed from my practice. This was often at odds with the bio-medical model and its understandings of the body and was difficult to verbalise. Any knowledge gained through the practice of nursing was gendered knowledge and could therefore be legitimately devalued as 'feminine'." (Carr 2000)

Western philosophical thought is characterised by dichotomous thinking and leads to hierarchies that assign advantage to one of the polarised terms (Grosz 1994: 3). The mind/body separation of Cartesian dualism is an example of this type of thinking and has been a powerful influence on perceptions of the body. Holmes (1994: 105) states Cartesian dualism has 'delineated the realm of scientific enquiry, and of rationalist understanding, as being concerned with the physical and not the spiritual or psychological aspects of persons'. This has meant that the body has increasingly become a thing to be studied and the experience of embodiment is ignored (Madjar 1997:55).
As a nurse I often felt as if I was working in two worlds, the patient's and the Doctor's. As Lawler states (1991: 34) 'one cannot simply nurse the body in the bed' and I found it was impossible to focus only on the medically defined problem and provide effective care. How a person defined their illness and their body could not be ignored. Their lived, embodied experiences of health could not be ignored. But they were! While the concept of embodiment was not recognised I, and other nurses, were daily working with its reality. The body I worked with was not the one in textbooks, neatly divided into body and mind. Body and mind were inextricably linked. Scheper-Hughes and Lock (1987: 10, 30) point out that even when we begin to question the notions of Cartesian dualism we are often left without a vocabulary to voice our concerns.

Martin (in Turner 1992: 51) points out while we are able to acknowledge that the language used by medicine in previous centuries is a 'symbolic representation of social ideas', modern language is seen to be an accurate description of the natural world. Language is, however, recognized to have the power to shape our understandings of the world and to inform practice (Bruni 1995: 173, Turner 1992: 52) and this extends to our understanding of the body and our role as nurses in caring for bodies (Parker 1997: 11). Foucault (in Turner 1992:52-54) argued that understandings are created by the dominant epistemology of any given time. This ability to create reality is also linked to power (Turner 1992: 52-54) and Glass (1998: 122) reminds us with Delaclour's words, 'nursing has been constructed by powerful discourses including those of medicine and gender, in which our society's dominant ideologies are enshrined'.

In what way does this make the body problematic in nursing? The body in modernity has been created by the dominant scientific discourse of modern medicine (Parker 1997: 24, Foucault in Fassett and Gallagher 1998:14) and as Silverman (in Fassett & Gallagher 1998: 22) describes it 'discursive bodies lean upon and mould real bodies' Until recently alternative ways of describing or knowing the body had been silenced or marginalised (Gray & Pratt: 173,) and I believe that nursing is one of these alternative ways of knowing the body. However it may be that the invisibility of care of the body, and of nursing, in the dominant scientific discourse has been a double-edged sword. While it has meant that our work has been unacknowledged and assigned little value it may have also created a space for this different way of knowing the body to grow and develop unimpeded. Since Merleau-Ponty in 1962 (Turner 1992: 43) nurses have been writing of their knowledge of the body and embodiment and the recent proliferation of papers dealing with these issues could be seen to support this view. The challenge I see, as a nurse, is to take this conceptual and subjective view of the body and build its legitimacy in both the professional and public spheres.

My experience is that this way of knowing the body is sometimes accepted and respected but on an informal basis only. 'As a neonatal intensive care nurse there were huge amounts of observations to be recorded every hour. Many of these could be recorded without ever paying any attention to the baby; it was possible to simply look at the appropriate machines. As I gained experience I learnt that while all the observations could appear normal sometimes a baby just did not look right. Over time I learnt to trust this assessment and I saw other nurses doing the same. Although there was no way to adequately express my concerns, due to their experiential and subjective nature, I learnt that if I reported my concerns to an experienced doctor they were acted on. Just as my experience informed me, the doctor's experience was that this was valuable information. This was never recorded anywhere, only what was found was recorded' (Carr 2000)
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The biomedical model of the body may dominate health care at the moment but this dominance is not total and nurses can choose to resist this dominance. I believe that as language constitutes knowledge and is linked to power nurses could use language to promote their knowledge of the body. If we can develop a discourse that adequately describes not only what we do, but also why we do it, we could challenge this dominance and allow a different model of the body to emerge.

The difficulty of working as care givers in an environment focused on cure also makes the body problematic in nursing. Parker (1997: 16, 22) sees cure and care as 'conflicting temporalities, one directed to the present time, the other towards the future. They can also be understood as competing ideologies of health care.' I have already established that medicine and nursing are gendered and cure and care are similarly gendered. This gendering leads to care of the body being invisible and devalued in a system that is focused on cure. In such a system the experience of embodiment and even the body as a whole can become lost. Cassell (1992: 237) tells us how the trend towards molecularisation in modern medicine has created a situation where pain is no longer understood in terms of human suffering but as the biology of nerve transmission. The embodied experience of pain is of no interest. For nurses, focused on care, the experience of pain is what matters. How an individual manages pain, what it means to them and how it affects their life are what matters. If these two ways of understanding the experience of pain were equally valued I believe the patient would be well served, but as Cassell points out 'medical science and disease theory naturally deal with clinical events by reaching for molecular explanations even when they provide no insight into the clinical situation'.

I will end this discussion by recounting a personal experience illustrating the importance of the work of nurses in caring for the body.

'After an operation to have a meningioma removed a nurse with warm towels came to wash me. I was tired, scared, and unable to speak, although the words were in my head. For the first time in hospital the whole of me was noticed, not just my tumour. Although I.V. lines, cannulas, drains, catheters and other pieces of plastic and steel had to be negotiated I was central to this experience. Warm towels helped me feel what was different about my body, helped me to find my body again. I stopped being scared because of warm towels'. (Carr 2000)

A sponge is the most basic of nursing tasks, and yet in terms of my embodied experience of illness and hospitalisation it was significant. While this sponge was significant to me, the biomedical model would not have even noted its occurrence.

This paper demonstrates the ways the biomedical model, and its representations of the body, have created a situation where much of the work nurses do, and knowledge gained through this work, is made invisible or worthless. I have established the centrality of the body to nursing and the important role that gender has played in the construction of nursing. The way in which Cartesian dualism has restricted modern understandings of the body has been noted. The discourse of the biomedical model and its role in maintaining the dominance of this perspective has been explored. I have discussed the possibility of resistance through the use of another discourse that recognises the experience of embodiment, and knowledge gained through working with embodied beings. The conflict between cure and care is also recognised. I have used my experiences as a nurse throughout this paper and have recalled one experience as a patient. While the dominant bio-medical model
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presently ignores the experience of embodiment I believe, like Cassell, (1992: 241) 'We are of a piece. Persons can accomplish nothing, see, hear and touch nothing, know nothing and think nothing in which their bodies do not take part'.

References


Grey G and Pratt R 1995 Scholarship in the Discipline of Nursing Churchilll Livingstone, Sydney


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Is it really just a uniform 'nurse'?

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Abstract

Every time I looked up I noticed I was the only person not wearing a uniform - I felt so powerless. The other students all looked the same, they were a group, and I was different. I was alone. [As] the class began, the lecturers immediately began to discuss the significance of professionalism and how we looked and behaved affected our professionalism. They also discussed the significance of first impressions and how first impressions can never be taken away. So, by not wearing my uniform was I automatically presumed to be unprofessional and had I ruined my first impressions? But more importantly what does all this mean to clients? (Ladd, 2000, Journal).

The nursing uniform is a form of nonverbal communication (Meade 1980, 147). Nursing uniforms are often the first points of any contact between a nurse and a client (Leventon 1989, 64). The moment a nurse walks into a room and a client visualizes them they will immediately notice their uniform (Leventon 1989, 64). Attached to this nursing uniform are not only a substantial history but also a multitude of stereotypical images, some of which are positive and some of which are negative (Nightingale 1983, 22). This can both enhance and impede the role of the nurse as well as having a significant affect on the therapeutic relationship between the nurse and the client (Nightingale 1983, 22; Mangum, Garrison, Lind & Gill Hilton 1997, 39). Consequently the issue of nursing uniforms has and will continue to be a highly debated issue about whether nurses should or should not wear uniforms (Smith 1990, 32). However, central to any discussion should be consideration of the views and opinions of the client (Mangum, Garrison, Lind & Gill-Hilton 1997, 39).

Nursing uniforms, as nonverbal communicators, have the capacity to convey many different messages to clients, both positive and negative (Tiffany 1987, 40). A nursing uniform can convey stability and confidence to the observer - when everything around a client is changing, namely their health, there is confidence in recognizing a nursing uniform, and knowing exactly what that uniform represents (Mangum, Garrison, Lind & Gill-Hilton 1997, 39-40). A nursing uniform can also convey feelings of calmness in the observer - that the uniform wearer will nurture and protect them (Kaler, Levy & Schall 1989, 85). A nursing uniform can also convey the image of 'sex object' - perpetuated by media depictions of nurses as being predominantly unintelligent, immoral women (Kaler, Levy & Schall 1989, 85-89). This can best be exemplified by a male client who recently asked me where my short skirt was; he clearly felt this was an integral part of the care I was about to provide him. A nursing uniform can also stipulate 'boundaries' - '[she/he] would take your pulse [and] give you a pill' a client stated on viewing a nurse in a traditional uniform (Tiffany 1987, 40: Rowland 1994, 35).
So where do these beliefs and impressions come from? Effectively, through the process of socialization (Robinson 1987, 115). From an early age a child is taught what a nurse looks like and what 'she' does, by institutions like their family, media, and school (Brennan, Scully, Tarbuck & Young 1995, 36). All of these representations are derived from historical interpretation (Heywood-Jones 1980, 105). For example, centuries ago the first people to provide health care were nuns and monks who were often attired in their 'orderâs' uniforms, projecting an image of purity (Heywood-Jones 1980, 105). The military nurses provided nursing and its uniforms with an image of order and strength (Tiffany 1995, 40). However, the early Victorian era presented nurses' as 'promiscuous, slovenly and dishonest' (Tiffany 1995, 40). This was later rectified by Nightingale's nurses' who were both 'clean' and 'neat' (Tiffany 1995, 40). Consequently, all of these historical representations and perceptions of nurses have culminated in stereotypes that today include the nurse as the 'angel', the nurse as the 'battleaxe' and the nurse as the 'handmaiden' (Sparrow 1987, 41). The nursing uniform has therefore become a symbol representing all of these images. When a client sees a nurse in a uniform all prior knowledge and experience allows that client to categorize, to pass judgment and to respond to an individual nurse's perceived competence and professionalism based on their uniform (Tiffany 1987, 40; Mangum, Garrison, Lind & Gill-Hilton 1997, 40).

As a result of these prior beliefs and values there are several reasons why many clients prefer nurses to wear uniforms (Brennan, Scully, Tarbuck & Young 1995, 36). Firstly, it makes nurses easily identifiable, to answer questions, to provide assistance and to assist in emergencies. Clients believe that by recognizing the uniform they automatically know the knowledge and skills of the wearer (Brennan, Scully, Tarbuck & Young 1995, 35). Often, clients who I have never met before will sing out 'nurse' or 'sister' with the expectation that I can and will help them. However a study by Hawkey and Clarke (1990) found that clients who had stated that uniforms were needed to help them to identify nurses, had in fact had no difficulty identifying nurses who did not wear uniforms (Hawkey & Clarke 1990, 30). Clients also believe that uniforms instill confidence in the observer, with clients feeling 'safer' with uniformed nurses (Sparrow 1991, 119). However this is not necessarily always true: in 1994 a woman wearing a nurse's uniform walked into a British hospital and was handed a newborn child, purely because she was wearing a 'nurses uniform'. She then left the hospital, undetected for some period of time, with the neonate (Castledine 1994, 784).

Other beliefs by clients as to why nurses should wear uniforms include clients believing that nursing uniforms are an indication of knowledge, status, and hierarchical identification (Sparrow 1991, 118). However, they believe this is significant to the profession of nursing itself and not necessarily to themselves as clients, which Sparrow (1991) argues is an important indicator that a large proportion of clients look at nurses collectively believing they all have identical knowledge and skills (Sparrow 1991, 119). Finally, some clients believe nurses wore uniforms to protect themselves from infection and to 'keep clean' (Sparrow 1991, 120). However a study performed by Hawkey & Clarke (1990) found no difference in the microbial rates between uniforms and personal clothes after microbial testing (Hawkey & Clarke 1990, 30). In her study, Sparrow (1991) found that nurses were in fact more likely to wash their hands and wear aprons if they were wearing their own clothes as there was an increased concern attached to ruining their own clothes (Sparrow 1991, 120).

Conversely, there are also many reasons why clients would prefer it if nurses did not wear uniforms. Some clients feel that there is a distinct segregation between themselves and nurses in uniforms (Brennan, Scully, Tarbuck & Young 1995, 36). By wearing a uniform a nurse may appear more detached and less able to relate to a client (Brennan, Scully, Tarbuck & Young 1995, 36). As
one 92-year-old lady explained to me: 'I do like your less formal uniform, it makes you seem so much friendlier'. It has also been noted that some clients view nursing uniforms as a 'rigid, authoritarian, traditionalist regime', which once again places emphasis on the differences between staff and clients' and divides power (Livingston 1995, 390). This can be particularly detrimental in such settings as the psychiatric ward where clients are already feeling particularly powerless (Newnes 1981, 28). However, it has been argued that in some psychiatric situations when nurses have not worn uniforms, clients have become confused and disorientated and this has subsequently increased their levels of anxiety (Newnes 1980, 28). But Newnes (1980) continues to argue that this evidence is merely 'anecdotal' and that his study produced results that indicate personal clothes in fact reduce anxiety (Newnes 1980, 30).

There are several other reasons why clients feel that uniforms inhibit their care. When nurses wore uniforms clients felt their role was a passive one where by they had to 'lie back and let the nurse make me better', that the nurse had control and 'authority' (Hawkey & Clarke 1990, p.31; Punton 1985, 42). However when nurses were not wearing uniforms the clients felt more independent and more able to deal situations themselves without the need to seek permission (Sparrow 1991, 120). Roles thus become less defined and more equal (Sparrow 1991, 120). Clients also felt that when nurses didn't wear uniforms they were more obliged to introduce themselves and ask permission to access a client's body which once again made their relationship more equal (Brennan, Scully, Tarbuck & Young 1995, 36). Some older clients suggested that uniforms bought back bad memories of their experiences in the war, yet others felt that the defining of roles was important and decreased their confusion (Sparrow 1991, 119; Mangum, Garrison, Lind & Gill-Hilton 1997, 39). Younger clients tended to feel more comfortable and more able to relate to nurses out of uniform (Smith 1990, 34). Finally, some clients have suggested that night nurses are 'ghost like' in appearance creeping around in their white dresses, stating they found this to be unsettling (Smith 1990, 32).

What essentially needs to be derived from all of this information is whether or not uniforms inhibit or enhance the therapeutic relationship between clients and nurses (Smith 1990, 32). This is a significant consideration as nurses play a pivotal role in assisting clients to achieve their 'therapeutic objectives', which enable them to return to their pre-morbid health status (Smith 1990, 35). This question was addressed in a study conducted by Brennan, Scully, Tarbuck & Young in 1995. This study concluded that 82% of clients surveyed felt that by taking away uniforms that they could relate better to the nurses who were working with them and caring for them and that 77% of clients felt this made them more 'equal' with nurses. 83% of clients believed it took away the 'them and us' effect (Brennan, Scully, Tarbuck & Young 1995, 36). Nurses who did not wear uniforms were also perceived to be both friendlier and more approachable than those who wore a uniform which meant clients were more likely to 'self advocate' (Livingston 1995, 390; Brennan, Scully, Tarbuck & Young 1995, 37). 78% of clients felt they could develop a better relationship with a nonuniformed nurse. Finally, and of note, 61% of the clients surveyed felt that nurses still appeared professional even when they did not wear a uniform (Brennan, Scully, Tarbuck & Young 1995, 36).

So, with out doubt nursing uniforms are forms of nonverbal communication (Meade 1980, 147). It is suggested that clients do take in their visual impressions of a nurse, namely their uniform, and interpret them in a way that can influence their relationship with that nurse (Mangum, Garrison, Lind & Gill-Hilton 1997, 40). Perceptions have been derived from historical interpretation and subsequent construction of stereotypes (Heywood-Jones 1980, 105-108). It is argued that by wearing a uniform a nurse takes on predetermined expectations about his or her behavior and
attitudes - this can be very limiting for both the nurse and the client (Meade 1980, 147). By taking away, or at least modifying, uniforms many nurses, clients and myself believe that barriers will be brought down between clients and nurses (Smith 1990, 34: Brennan, Scully, Tarbuck & Young, 1995, 38). This has the potential to increase equality with in this therapeutic relationship as well as allowing for increased self-advocacy on the part of the client (Brennan, Scully, Tarbuck & Young 1995, 38). Consequently when it comes to first impressions, nursing uniforms are significant to not only nurses, nursing as a profession but also to clients (Mangum, Garrison, Lind & Gill-Hilton 1997, 40).
References


The Corner Youth Health Centre: a critical evaluation of its role in supporting child health in the community

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Abstract

The definition of child health can be ambiguous. The meaning of 'child' can be viewed in many different ways, and therefore difficulty is encompassed when trying to pinpoint what a child is. A broad definition of 'child' defines a child as being between the age of infancy and puberty (Moore, 1997:222). As the age of puberty differs between people, therefore so does the definition of child. It should also be noted that a person is always somebody's child, at any age (Moore, 1997:222). The definition of health, adopted by the World Health Organisation (WHO) is "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" (WHO, 1974:1, cited in McMurray, 1999:7). It should also be noted that health is not a static entity, but rather that it is ever changing. Health is also the extent to which people define themselves as healthy: health is relative (McMurray, 1999:7).

The phrase 'primary health care' is used by some as a general slogan agitating for the improvement of the whole health system, while others use it to describe particular activities (Fry, 1992:1). Possibly the simplest definition of primary health care is "Both the point of first contact with the health care system and the philosophy for delivery of that care." (Knight, 1998:147). Another definition of primary health care given by Fry is that "primary health care... aims to focus on the health system's first level of contact on protecting and promoting the health of defined communities, and on addressing their individual and collective health problems at an early stage." (Fry, 1992:3). Whichever definition of primary health care is chosen, it is important to understand that it constitutes the first level of a continuing health care process which is essential, and which aims to bring health care as close as possible to where people live and work. In a primary health care system, the level of care should be of a high standard, and therefore problems can be dealt with where they begin (Wass, 1994:9). One of the many primary-level services is that of the community health center: for example, The Corner Youth Health Centre.

The Corner Youth Health Centre is the result of research, planning and community involvement to provide a service that is accessible as well as appropriate for young people in the northern area of Tasmania (Hingston, Personal Communication, 2000). The Corner is located on the corner of Brisbane and Wellington streets and has been in operation, as a 'one-stop-shop for health', since October 1998, using the primary health care approach. Although the service has been in operation for only a short period of time, Talitha Hingston, a drug and alcohol counsellor at The Corner, states that there are on average 200 people who access the Corner each month (Hingston, Personal Communication, 2000).
The Corner is open from 9:00am to 3:00pm Monday to Friday and is primarily targeted towards the age bracket of twelve to twenty-four. The Corner is a community organisation that is managed by the Corner council, but the staff are government employees. The staff at The Corner consists of one drug worker, two drug and alcohol counsellors, one social worker and three nurses. In addition, a doctor is available on Tuesday, Wednesday and Thursday mornings from 9am to 12noon. Other services are available on a casual basis from community organisations such as Oakrise and 'Hassles'. Referrals to other services are also given when needed (Hingston, Personal Communication, 2000).

The Corner covers a wide range of youth services, issues and information, from pregnancy testing to a needle exchange program to helping people find employment. The Corner has specialist expertise in the areas of youth health (with services provided by a youth health team), illicit drugs, drug and alcohol abuse, complementary health and general medicine. However, the main services demanded by clients are that of pregnancy testing, needle exchange, general counselling and drug counselling.

The Corner Youth Health Centre has a core philosophy, mission and set of goals that underpin all areas of the centre. The philosophy of The Corner states that "All youth have the right to quality health services that address the needs of young people" (Hingston, Personal Communication, 2000). As Cooke (1992:4) states, the rights of children and adolescents to appropriate levels of health care must be considered. The mission of The Corner is "To maintain, promote and enhance the health and wellbeing of young people aged 12-24 years in northern Tasmania" (Hingston, Personal Communication, 2000). The set of core goals that underpins The Corner Youth Health Centre includes: to work cooperatively with all agencies, organisations, groups and departments involved with young people; to develop, implement and evaluate an innovative Primary health care service delivery model for young people; to work collaboratively with young people to maximise health and minimise harm; and to advocate for improvement in youth health status and health service provision (Hingston, Personal Communication, 2000).

There are many aspects of The Corner that contribute to fulfilling their aim of supporting child health in the Launceston area. Some of these factors include the location, the variety of services offered, minimal or no cost services and the adolescent-friendly atmosphere of the centre. The Corner Youth Health Centre is located on the corner of Brisbane and Wellington Streets, a central location in the Launceston area. Mabey and Sorensen (1995:82), argue that each agency has to weigh up the advantages and disadvantages of the sites of location, according to the services that it wishes to offer, the area it is servicing and the young people's needs it is trying to meet. It is essential that young people's counselling services are easily accessible, as the majority of young people do not have their own transport (Mabey and Sorensen, 1995:82). This enables easy access to the centre for youth.

People in different social positions are subject to different influences, and therefore need different services to accommodate their needs (Plant and Plant, 1992:122). The variety of confidential services offered by The Corner Youth Health Centre, also contributes to its effectiveness. Pregnancy testing, needle exchange, counselling, medical services, general information, employment assistance, complementary medicine, and Link assessment (an innovative service for homeless youth to pay for medical prescriptions), are just some of the services offered at The Corner. Workers within the youth services are aware of the difficulties of young people in knowing
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exactly what services they need. It is often that youth require a combination of counselling, advice and information (Mabey and Sorensen, 1995:15). When questioned upon what requirements are needed for a youth health centre, youth often request that services be available under the one roof (Mabey and Sorensen, 1995:76). The Corner acts as a 'one-stop-shop for health' by offering an integrated, multidisciplinary service and by providing young people with access to a broad range of mainstream and alternative health services under the one roof (Hingston, Personal Communication, 2000).

The Corner offers youth a minimal cost centre for health. All services at the centre are free, except for pregnancy testing which attracts a small fee of $2.00. Once again this is an effective feature of The Corner as it allows youth the opportunity to access a wide variety of health services without having to pay the fees that would be asked at conventional adult-based health services. This was made possible due to many factors such as funding granted by the Innovative Health Services for Homeless Youth Program, sponsorships, volunteer work and the ability to utilise government service workers (Hingston, Personal Communication, 2000). Sponsorship is provided by local businesses, educational facilities and government departments (Hingston, Personal Communication, 2000).

The youth-friendly atmosphere of The Corner allows youth to feel at ease when accessing the centre (Hingston, Personal Communication, 2000). It is not only the atmosphere, but also the demeanor of the staff that allows The Corner to be an approachable place for youth. It is essential when working in a youth health centre, and in fact any community centre, that the counsellors and other staff exhibit empathy and approachability. There are three main qualities that an effective counsellor must have: empathy, congruence and unconditional positive regard (Byrne and Byrne, 1996:47). Research has shown that a patient's judgement of the personal qualities of a counsellor is a better indicator of outcome, than the training and theoretical background of the counsellor (Nuckols et al, 1994:82). This greatly contributes to the friendly atmosphere that one encounters when visiting The Corner, and to its success as a youth community centre.

Just as there are many aspects of The Corner Youth Health Centre that contribute to fulfilling the aim of supporting child and adolescent health, there are many aspects of the centre that counteract these contributions. These include restricted opening hours of the centre, concurrent rostering of doctors, lack of staff and lack of emergency counselling. The Corner Youth Health Centre currently operates from 9:00am to 3:00pm Monday to Friday. While this does provide adequate accessibility for some youth to the centre, it also excludes a large number. Youth who are either employed full time or at school would have to absent themselves from their occupations in order to access the centre.

Doctors are available for consultation between 9:00am and 12:00noon Tuesday, Wednesday and Thursday mornings (Hingston, Personal Communication, 2000). To further the benefits of having a general practitioner on site, it could be suggested that the hours of availability be varied over the three days to encompass both morning and afternoon consultations. Invariably there will be some youth wishing to seek medical advice from the practitioners at The Corner, but not able to make an appointment due to availability times of the doctors. In some respects this has a detrimental effect on The Corner's ability to support child and adolescent health in northern Tasmania.
The Corner Youth Health Centre: 
a critical evaluation of its role in supporting child health in the community  
D. O'Brien

Lack of staff at The Corner proves to be somewhat detrimental to the success of the centre. At present there is no support staff (eg. receptionists) to aid in the running of the centre. Therefore, specialised staff are required to attend to all reception duties as well as conducting their normal roles (Hingston, Personal Communication, 2000). Direct service work is emotionally and professionally demanding. Having to perform duties outside of their professional role can increase frustration and stress, thus proving detrimental to the provision of services (Burrows, 1994:103; Byrne and Byrne, 1996:209).

To consult a counsellor at The Corner an appointment must be made. Making and keeping appointments for counselling is an issue with young people. Young people are generally less able to wait for appointments. A drop-in service provides a taste of what counselling will be, allows people to be seen quickly in a crisis situation and often prevents more difficult situations from arising (Mabey and Sorensen, 1995:58). This does not cater for crisis counselling, and thus does not provide adequate support of youth in the community.

Evaluation is an important tool for helping to refine programs and give feedback on aspects of the program, while also assessing if the program resembles what was envisaged by the developers (Davies and Coggans, 1991:59). To fully achieve the goals set by the centre a number of factors need to be reviewed along with a number of changes made. The Corner was originally designed for homeless youth, and has now grown to incorporate all youth (Hingston, Personal Communication, 2000). While this is an admirable development it has been recognised that the original goals of the centre have not specifically been met. The Corner also recognises the need for improvement in a number of areas to achieve assigned goals. Some of these areas include increasing the number of staff (receptionist, coordinator etc.) at the centre, longer opening hours, developing further services for young people, upgrading of the building and consolidation and integration of services (Hingston, Personal Communication, 2000). While there are a number of changes that can be made to improve The Corner, some of which are listed above, it is also important to keep in mind the length of time the centre has been in operation. The Corner is a relatively new centre, having only been in operation since October 1998. With any project there is always improvements that can be made. It should be noted that while The Corner Youth Health Centre has only been in operation for a short amount of time, the many goals and aims of the centre are already being achieved.

The Corner Youth Health Centre practises a primary health care approach to youth health in the Launceston area. In the short period of time it has been in operation it has proved to be a popular and well frequented service. The centre covers a wide range of youth health issues allowing young people to access most services at the one location. The Corner addresses some of the clearly identified gaps in services for young people.
The Corner Youth Health Centre:
a critical evaluation of its role in supporting child health in the community

D. O'Brien

References


Byrne, D., Byrne, A., 1996, *Counselling Skills for Health Professionals*, Macmillan Education Australia Pty Ltd, South Melbourne.


Patient Profile: 'Scott Chopping'

Lisa Sydes & A. Towns, BN Students, Year 2
Tasmanian School of Nursing
Nuritinga Issue 3
June 2000

Introduction

This seminar traces a [hypothetical] patient through the identification of symptoms of diabetes, diagnosis and hospitalisation and finally his discharge and education. Parts 1 and 2 of the seminar should provide you with an idea of some of the symptoms associated with diabetes in addition to basic information in regard to the associated clinical diagnostic tests. Parts 3 and 4 are more nursing orientated and focus on the hospitalised care of the newly diagnosed diabetic and the post hospital education and information required by the patient.

Part 1 — Home Visit:

What are the main issues for Scott?

What data supports your choice of issues and why?

What actions would you take and why?

In the short conversation with Scott he has disclosed a number of symptoms and some personal and family history;

Symptoms: Excessive urination
           Increased thirst
           Increased hunger
           Weight loss

Medical history: Recent bout of the mumps

Personal history: Married with five children

Age: 42

Family history: Brother has been a diabetic from childhood
               Mother is being treated for varicose ulcers

The above data seems sparse at first glance but on closer review provides the nurse/health practitioner with a wealth of information. Excessive thirst (polydipsia), hunger (polyphagia) and urination (polyuria) are classic markers for diabetes (Phipps, Sands & Marek, 1999: 1133; Price & Wilson, 1997: 958). Scott's brother has been a diabetic since childhood and his mother is being treated for varicose ulcers that may be secondary to some form of diabetes (Price & Wilson, 1997: 962). Both of these factors suggest a genetic predisposition to diabetes. Scott also reported that he had suffered a recent bout of the mumps, a viral infection. Viruses have been identified as possible
triggers for beta cell (insulin producing cells) destruction in the pancreas in genetically predisposed individuals (Patel, 1999; McCance & Heuther, 1998). Scott's age, 42, in addition to his increased thirst, hunger and urination would suggest that he is suffering from type 2 diabetes, however as type 2 diabetes tends to develop as a result of a high fat diet, patients tend to be obese. Therefore, considering Scott's weight loss in addition to his recent viral infection, he is most likely suffering from type 1 diabetes.

Regardless of the above preliminary diagnosis there is one main nursing issue for Scott; it is crucial at this point that he seeks further medical advice. As both a friend and nurse there is little one can do at this time except ensure that Scott understands what is happening to him and appreciates the importance of seeing his doctor as soon as possible. The nurse may choose to make this appointment for him immediately thereby ensuring he does not fail to receive medical attention. The nurse may also wish to take a blood glucose reading if the equipment is available, but as a doctor and further testing will be required to confirm the diagnosis it is far more important that he/she ensures that Scott seeks a medical consultation.

Part 2 – Assessing the situation

Scott has now been assessed and is currently in hospital. The following findings are available:

*What do these results suggest and why?*

Results related to Scott Chopping

<table>
<thead>
<tr>
<th>TEST (Normal Limits)</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinalysis</td>
<td></td>
</tr>
<tr>
<td>pH</td>
<td>6.0</td>
</tr>
<tr>
<td>(4.6 – 8.0 average 6.0)</td>
<td>This is within normal limits</td>
</tr>
<tr>
<td>Specific Gravity</td>
<td>1.030</td>
</tr>
<tr>
<td>(1.005 – 1.030 usually 1.010 – 1.020)</td>
<td>This is a slightly elevated result. Pagana &amp; Pagana (1994: 224) state that a specific gravity over 1.025 is abnormally high. High specific gravity may indicate low fluid intake or excessive water loss (Fischbach, 1995: 317) both of these imbalances are consistent with Scott's symptoms as he reported feeling excessively thirsty and urinating frequently. High specific gravity may also be due to fever, vomiting, diarrhoea, increased ADH secretion, diabetes mellitus or to a range of medications (eg. IV Dextran or Albumin) (Fischbach, 1995; Pagana &amp; Pagana, 1994;</td>
</tr>
<tr>
<td>Test</td>
<td>Result</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Blood (Negative)</td>
<td>Negative</td>
</tr>
<tr>
<td>Glucose (Negative)</td>
<td>++++</td>
</tr>
<tr>
<td>Urobilinogen</td>
<td>Negative</td>
</tr>
<tr>
<td>Bilirubin (Negative)</td>
<td>Negative</td>
</tr>
<tr>
<td>Ketones (Negative)</td>
<td>Large amount</td>
</tr>
<tr>
<td>Biochemistry</td>
<td></td>
</tr>
<tr>
<td>Fasting Blood Sugar</td>
<td>16 mmol/L</td>
</tr>
<tr>
<td>Repeat Test</td>
<td>18.2 mmol/L</td>
</tr>
<tr>
<td>Glycosylated haemoglobin (%)</td>
<td>&gt;10 %</td>
</tr>
</tbody>
</table>
**Patient Profile: 'Scott Chopping'**

**L. Sydes & A. Towns**

<table>
<thead>
<tr>
<th><strong>(4 – 7%)</strong></th>
<th>haemoglobin derivatives. The quantity of the derivate HbA1c is directly proportional to the average blood glucose level that the red blood cell is exposed to during its 120-day life span. Thus in long term hyperglycaemia, HbA1c constitutes a higher percentage of total haemoglobin. Transient elevations in blood glucose have little or no effect on HbA1c levels (Kaplan, et. al., 1996). Scott's results are above normal a limit, which indicates long term hyperglycaemia, thus further compounding the diabetic diagnosis.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fasting plasma triglyceride</strong></td>
<td><strong>&gt;2.4 mmol/L</strong></td>
</tr>
<tr>
<td><strong>(40 160 mg/dL)</strong></td>
<td><strong>&gt;7.5 mmol/L</strong></td>
</tr>
<tr>
<td><strong>Fasting plasma cholesterol</strong></td>
<td>2.4 mmol/L = 212.4 mg/dL [conversion: mmol/L / 0.0113 = mg/dL] (Kaplan, et. al., 1995).</td>
</tr>
<tr>
<td><strong>(140 – 199 mg/dL)</strong></td>
<td>7.5 mmol/L = 663.7 mg/dL [conversion: mmol/L / 0.0113 = mg/dL] (Kaplan, et. al., 1995).</td>
</tr>
<tr>
<td>In the absence of insulin Scott is unable to utilise carbohydrates for fuel, instead his body begins to breakdown other compounds in order to gain energy. The resulting increased fat catabolism causes an increase in free fatty acids that, when combined with glycerol in the liver, form an increase in triglycerides, hence Scott's result displays a hypertriglyceridaemic state (Phipps, Sands &amp; Marek, 1999: 1132). Scott also has a dangerously high cholesterol level that may be secondary to the diabetes but may also may be a long-term unrelated condition (Fischbach, 1995). Scott's high cholesterol makes him susceptible to heart disease and atherosclerosis.</td>
<td></td>
</tr>
<tr>
<td><strong>Electrolytes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>K+</strong></td>
<td><strong>5.5 mEq/L</strong></td>
</tr>
<tr>
<td><strong>(3.5 – 5.0 mEq/L)</strong></td>
<td>Scott has increased Potassium levels most probably secondary to ketoacidosis (Fischbach, 1999: 131). Hyperkalaemia is defined as K+ above 5.5 mEq/L (Price &amp; Wilson, 1997; 269). Alterations in potassium balance are extremely dangerous, as potassium is a primary energy source for both</td>
</tr>
</tbody>
</table>

**Nuritinga Issue 3, June 2000**

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Pseudohyperkalaemia is very common. Pseudohyperkalaemia may be caused by increased exercise prior to blood sampling or by an excessively tight tourniquet whilst sampling (Price & Wilson, 1997: 269). Serum potassium levels may be high following ketoacidosis due to transcellular shifts, despite there being an actual net loss of potassium secondary to osmotic diuresis (Phipps, Sands & Marek, 1999: 1132).

Scott has a slightly decreased sodium level. Increased glucose levels above renal threshold cause glucose to stay in the filtrate. Glucose within the filtrate causes an osmotic diuresis and therefore increased water loss, in an effort to maintain equilibrium the sodium is drawn into the filtrate via osmosis and is lost in urine (Phipps, Sands & Marek, 1999: 1399).

The normal daily urine output is regulated by the kidney and usually ranges from 1 to 2 Litres/day. This is an abnormally high output most probably due to osmotic diuresis secondary to high glucose levels in the renal filtrate.

(Tables 1.0)

What is the significance of each of these results to Scott?

Scott's laboratory results confirm his diagnosis of diabetes. Glucose in the urine indicates that blood glucose levels have surpassed the renal threshold (180mg/dl), thus the glucose remains in the filtrate. The glucose in the filtrate attracts water, an osmotic diuresis occurs, hence Scott complains of polyuria. Polyuria is also evident in Scott's results; he has recorded a 24 hr urinary output of 2686ml, well above the normal range of 1 - 2 L (Phipps, Sands & Marek, 1998: 1399). The high specific gravity further compounds the notion of high fluid loss (Fischbach, 1995: 317).

The polyuria also results in a net loss of water and electrolytes, particularly potassium, magnesium and phosphorus, sodium and chloride. The loss of water and sodium manifests as polydipsia. Polyphagia begins as cells become starved of their fuel source. In type 1 diabetes, where insulin is not being produced, there is a resulting inability to catabolise glucose for energy, this results in rapid weight loss as experienced by Scott (Phipps, Sands & Marek, 1998: 1132). The reduced fasting blood sugar, (16mmol/L and 18.2 mmol/L) above 11.1 mmol/L, also indicates diabetes (Patel, 1999). The large amount of ketone's in Scott's urine is very concerning as he is at high risk of developing complications of ketoacidosis, eg. coma.
What other information do you require and why?

Before commencing treatment we require more information about Scott.

- A more detailed medical history including current medications. There are some medications that are contraindicated with insulin. We will need to know if Scott's current medications will cause further problem and if so, the medication/s will need to be altered prior to beginning insulin therapy. Though it may be hard to pinpoint, any information with respect to Scott's compliance to medications and drug therapy will be helpful as after discharge from hospital Scott will be required to take charge of his condition.
- A detailed family history, particularly in relation to his brother's diabetes would be useful in estimating Scott's prognosis.
- Any information pertaining to Scott's lifestyle, including his diet, current exercise habits, stressors and health practices will be useful in determining a care plan for Scott.

Part 3: Managing the problem

Scott will require ongoing assessment and management for diabetes. You are caring for him during this hospitalisation.

1. What assessment data will you need to manage his care adequately?

Diabetes can cause damage to blood vessels and nerves if it is undiagnosed or not controlled (Calder 1978:62-63). Therefore, it is crucial that Scott has ongoing assessment and management for his diabetes, so that he can lead a normal healthy lifestyle (Phipps, Sands & Marek 1999:1148). There are multiple responsibilities related to the nursing care of a patient with diabetes. These include an assessment by collecting the history and performing a physical examination (Phipps, Sands & Marek 1999:1148-9) & (Burrell, Gerlach & Bless 1997:1185-1187). This assessment would therefore be performed on Scott:

Assessment:

This includes things such as:

- History - current medical problems and their management, Inquire about the current diabetic management regimen including diet, medications and exercise in order to assess the aspects of management relevant to the current problem.
- Family History - any family members have diabetes?
- Past Medical History - A review of coexisting medical problems may reveal diseases, such as hypertension and obesity, which are contributing factors to patients with diabetes.
- General information about their understanding of diabetes, how they feel, what causes the most problems for them.
- Diet - Do you eat away from home a lot, who prepares the meals, what does your diet consist of, has their been a change in your weight recently.
- Exercise - How much exercise do you perform in your work and during your leisure activities, what type of exercise do you do
- level of education - concept of diabetes
Physical Examination:

- **Cardiovascular System**
  - Assess for the presence and quality of posterior and dorsalis pedis pulses and assess the blood pressure

- **Musculoskeletal System**
  - Assess for foot deformities (bunions, ingrown toenails, and amputation) and also assess for abnormal gait

- **Skin**
  - At the injection site
  - Assess for redness or swelling and assess for indication of tissue and tenderness

- **Feet and lower legs**
  - Assess for cleanliness and condition of toenails, assess for pressure points and ulcers, blisters and calluses and assess for hydration, warmth and oedema
  - Assess for moistness, discolouration

- **Eyes**
  - Examine the fundus

- **Neurologic**
  - Assess for the absence or presence of Achilles tendon reflex and also compare patient's perception of light touch, sharp point and vibration sensation on feet versus a proximal area of the body

2. **What nursing care will Scott require?**

Drawing conclusions from the above assessment, issues would be revealed and from this we would be able to see what nursing care Scott would require, such as foot or eye care. Prior to discharge, however, Scott will need to know the following basic knowledge and skills:

- The basic nature of his diabetes
- Insulin and its use
- Patient support to self-inject insulin
- Support him with his home blood glucose monitoring system
- Instruct him on frequency and timing of home blood glucose monitoring
- Essentials of food management
- Review his dietary intake
- Refer him to a dietitian
- Hypoglycemia, its prevention and treatment
- Complications

The nursing actions would therefore, be teaching Scott measures that would help him achieve control of blood glucose (diet, exercise and insulin) and teaching him to detect, prevent and treat hypoglycemic reactions and also addressing the above points (Phipps, Sands & Marek 1999:1179). The nursing care that he will require while in hospital will also include regular blood glucose monitoring and administration of insulin injections. He would also require daily inspection of his feet for cleanliness and condition of toenails, assess for pressure points and ulcers, blisters and calluses and assess for hydration, warmth and oedema.
feet etc, to prevent any long-term complications. A person from the Diabetes Centre should also be recommended to come and see him; therefore it would be the nurse's responsibility to book an appointment if needed.

3. **What is the significance of the assessment data to Scott's care?**

   The significance of the nursing assessment data for Scott's care is to:
   - Identify physical findings related to diabetes
   - Identify needed psychosocial interventions
   - Identify education needs
   - To avoid any complications

**Part 4 - Returning to the Community**

Scott is to go home and will require information about managing his diabetes.

1. **Outline what information you would include when addressing nutrition, exercise and medications with Scott?**

Diabetes management involves a balance between nutrition, exercise and medication (Phipps, Sands & Marek 1999:1133). When discussing these issues with Scott I would discuss the following information.

**NUTRITION:**

When discussing the issue of nutrition with Scott we would inform him that, diabetes is directly related to how the body uses food and that nutrition is thus an essential component of management for all people with diabetes (Lutz & Przytulski 1997:344). Therefore, it is important for all people with diabetes to watch what they eat. Their diet, just like insulin injections, is necessary to control diabetes.

When discussing the issue of nutrition with Scott, we would therefore tell him that healthy eating and a balanced diet is essential for him to be able to keep his blood sugar level as close to the normal range as possible. The healthy Food Pyramid is a good guide to food choice (Vener 1997:31). To help control his diabetes and provide adequate nutrition we would tell him that his meals should be:

- High in carbohydrate
- High in fibre
- Low in fat
- Low in sugar

**CARBOHYDRATES** - these provide the best source of energy for the body. When your body digests them they form glucose. Providing his body with regular supplies of glucose helps him to perform at peak level (Anderson 1981:86). We would therefore, advise Scott to include high amounts of carbohydrates in his diet. This can include foods such as bread, cereals, rice and fruit and vegetables that are the major sources of carbohydrates in the diet with milk supplying a smaller amount. Grains such as wheat, oats, rye, bread, vegetables, rice, seeds, lentils and peas and beans are also excellent carbohydrate foods (Vener 1997:31).
We would also tell Scott when addressing the issue of nutrition, that while sugar does not cause diabetes, sugary foods such as sugar, sweets, chocolate, jam, fizzy drinks are not encouraged. Also, fruit and milk should be in the diet each day but not too much as it could adversely affect the blood glucose level. Fruit is best eaten fresh and raw to ensure that fibre and vitamins remain rather than as juice. We would let him know that it is easier to control blood glucose levels if he distributes his intake of carbohydrate foods throughout the day into five or six small meals (Anderson 1981:86).

FIBRE - helps to control blood glucose levels. We would therefore recommend Scott to consume high fibre foods in his diet, as they are more filling and also help to control weight (Anderson 1981:90).

PROTEIN - is used by the body for growth and repair. It also provides energy. It is therefore important to tell Scott to choose protein rich foods. Protein foods, however, may contain fat and contribute to weight gain. We would therefore, recommend to Scott to choose protein foods that are low in fat, such as lean meat, poultry without the skin and pulses. He should remember to use low fat cooking methods with minimal added fat (Anderson 1981:86-7).

FATS - eating too much fat can affect overall diabetes control, may raise blood fats (cholesterol and triglycerides) as well as lead to weight gain. The golden rule is to use as little fat as possible when preparing or cooking food and to choose low fat alternatives where possible (Dietitians Association of Australia 1998:2). We would therefore discuss with Scott to reduce visible fat from his diet -
- reducing butter, margarine, oils, dripping, and cream. When you need to use fat choose small amounts of polyunsaturated or monounsaturated oils and margarines
- choosing low fat dietary products including milk, yoghurt, cheese and ice cream, choosing lean meat and trimming fat from meat and skin from chicken.

WHEN COOKING:
- Grill, bake, dry roast or barbecue.
- if he needs to fry foods, either stir fry in a small amount of oil or use non-stick pan and lightly coat with a cooking oil spray

REDUCE HIDDEN FATS BY LIMITING USE OF:
- processed meats and sausages
- take-away foods
- cakes, pastries, biscuits, chocolate
- full-cream dairy products
- gravies and creamy sauces
- salad dressings and mayonnaise
- nuts, seeds, olives

SNACKS - When commencing insulin some people may require a snack containing at least some carbohydrate foods. Supper is very important, including suitable choices of toast or bread thinly spread with margarine or butter, wholegrain cereal or biscuits. This is important for Scott to be told when informing him about nutrition, as Scott would have just commenced insulin therapy.

ALCOHOL - can interfere with diabetes control and can cause hypoglycemia if taken without food. He should avoid drinking alcohol on a daily basis and limiting himself to two drinks at one time is
endorsed. As well as mentioning this information to Scott, it would also be appropriate to mention to Scott to eat some carbohydrate foods while drinking alcohol to avoid hypoglycemia (Dietitians Association of Australia 1998:2).

*It is important that when grocery shopping, to read the ingredients on food that you are purchasing!!*

**EXERCISE:**

Exercise plays an important role in the management of diabetes (Lutz & Przytulski 1997:343). If you increase your activity you will feel healthier and find diabetes management is more effective (Carpenito 1997:445). Exercise requires energy and uses up extra kilojoules and so will help you achieve and maintain his ideal weight. Increased activity can also improve his body's response to insulin and may delay or prevent the need for medication. However, it is important not to strain or over exercise. These points would be appropriate to include when talking to Scott about exercise. It would also be appropriate to tell him to aim to include 20-30 minutes of enjoyable activity 4 or more times a week, such as walking, swimming, cycling which are good examples of healthy exercise (Burrell, Gerlach & Bless 1997:1155).

We would explain to him that by following a regular exercise program he can reduce the risk of developing long-term complications of diabetes and related health problems. For example, exercise or increased activity can reduce the amount of fats and cholesterol in the blood and decrease blood pressure.

It is important to tell Scott to inspect his feet daily and after exercise for any sign of open areas, blisters, swelling and if any of these signs are present they should be reported to the physician immediately. During exercise proper footwear is necessary to prevent the above points from occurring (Lutz & Przytulski 1997:343). It is also important to point out to Scott that in anticipation to exercise it is necessary to increase caloric intake or decrease insulin dose to avoid hypoglycemic reactions during or after exercise (Nathan & Lauerman 1997:128). It is important also not to exercise before consulting his physician.

**MEDICATION:**

Insulin is one type of medication that diabetics use and is the one that is significant to Scott's care. It is important for him to know that insulin is administered by a needle either subcutaneously or intravenously, but most commonly subcutaneously. It can be injected into the thighs, buttock abdomen and upper arm (Lutz & Przytulski 1997:344). The best place is where there are loose folds of skin that can be pinched up. The abdomen is the preferred general area, but it is important to change the place of the injection on the abdomen to avoid local damage such as toughening of the shin, hypertrophy etc (Lutz & Przytulski 1997:344).

It is also important for Scott to know that insulin has to be stored in the refrigerator (2-8 0C) away from the freezer or freezing coils. It should not be exposed to excessive heat and should never be frozen. He can keep insulin that he is using out of the refrigerator for up to one month (Phipps, Sands & Marek 1999:1158). This way he can avoid injecting cold insulin that may sting. Before storing his cloudy insulin in the refrigerator, shake the vials to resuspend any settled insulin. Vials of clear insulin do not need to be shaken before storage. Prior to use, his cloudy insulin should be
resuspended by gently inverting the vial or by rolling the vial between the palms of his hands. If he draws up more than the required amount of insulin, he should not squirt the excess into the vial. The insulin vial may become contaminated with syringe lubricant.

It is important for him to know that he should do not use any vial if - the clear soluble insulin turns cloudy, the expiry date has been reached as shown on the vial, the insulin has been frozen or exposed to extreme heat, lumps or flakes appear in the insulin, the insulin is discoloured or the deposits of insulin remain on the side of the vial after being shaken (Phipps, Sands & Marek 1999:1159).

It would also be advised to Scott that he should purchase a blood glucose monitor to be able to test his blood glucose level. He would also need to purchase a device that delivers insulin eg. - A Novopen 3 that is an insulin-delivering device.

How would you advise both Scott and his family to recognise abnormal blood glucose levels and what would you advise them to do when they observe the signs and symptoms of abnormal blood glucose levels?

The aim of diabetes treatment is to keep blood glucose levels within the normal range as much as possible (Martini 1998:623). If you have diabetes your body is no longer able to maintain this control. It is likely that diabetics will develop hyperglycemia and they are also subject to hypoglycemia (Kelleher 1988:18-19). These are abnormal blood glucose conditions and it is important that Scott and his family are able to recognise these.

HYPERGLYCEMIA - this relates to a high blood glucose level above 15 mmol/L and is caused by the pancreas not making enough insulin to meet the body's requirements (Anderson 1981:18). It can occur in any person with diabetes. We would advise Scott and his family to recognise abnormal blood glucose levels if Scott experiences any of the symptoms below:

- feeling tired and unwell
- increase urine output
- thirsty
- blurred vision

Hyperglycemia can be caused by:

- eating too much sugary or starchy food at one time
- being inactive, causing medication to work less effective
- omitting his dose of medication or if the dose is too low
- overweight
- have an illness or infection
- experiencing emotional stress
- drink too much alcohol

It is important to advise Scott and his family that if they observe any of the above signs and symptoms to check what Scott has eaten etc, to see whether a cause can be found. If Scott has a high blood glucose level and feeling unwell it is important to contact his doctor or diabetes nurse.
HYPOGLYCAEMIA - this often occurs 1 - 3 hours after a meal. It is a result of very low blood glucose levels, below 3mmol/L. Warning signs and symptoms that Scott and his family should be aware of include, Scott becoming:

- nervous
- irritable
- hungry
- headache
- weak, dizzy
- shaky
- skin becomes clammy, pale and sweaty (Nathan & Lauerman 1997:135).

If not treated speech can become slurred and Scott may appear confused and drowsy. If it is severe it can cause loss of consciousness (Nathan & Lauerman 1997:136). It is advised that if Scott experiences hypoglycemia and is conscious, he should eat or drink something with sugar in it, such as glucose tablets, sweetened orange juice, jelly beans. This should be followed by carbohydrate foods like a wholemeal sandwich or a piece of fruit. If however, he is unconscious, it is important that his family are advised not to try to give him fluids or foods. He will require a glucagon injection, which will increase their blood glucose level. If glucagon is unavailable they (his family etc) should take him to hospital immediately by ambulance. If however, he is awake but groggy, putting honey or cake icing around his mouth between the gums and cheeks will effectively arouse him. This is because the honey or what ever is used is absorbed through the oral mucosa (Phipps, Sands & Marek 1999:1160).

It is important for Scott and his family to be aware that hypoglycemia can occur if he is taking insulin and he:

- misses or delay meals and snacks
- drinks too much alcohol
- has a significant weight loss
- does strenuous activities without eating extra carbohydrates

If is therefore important that Scott is advised that he should carry around sweets such as glucose tablets or jelly beans and eat them at the first sign of hypoglycemia. The effect of hypoglycemia should be explained to Scott's relatives, friends and workmates, so they will know how to help him if he is unable to treat himself. They should know to give glucagon and to call an ambulance (Nathan 1997:140). Also if he becomes unconscious it is important that the family and relatives know to turn him on his side and check that he is breathing properly. They should not attempt to give anything by mouth. If glucagon is available (Scott should have an emergency glucagon kit) and one of his family members knows how to give a simple injection of a substance such as glucagon that can increase his blood glucose level, it is advised they do so with care and that they take Scott to hospital or seek medical assistance if he does not recover after 10 minutes (Phipps, Sands & Marek 1999:1161).

Now that Scott has diabetes there are some issues related to his ongoing health, which need to be discussed with him and his family.
What are the issues?

All people with diabetes should have access to ongoing care, ideally delivered by a multidisciplinary diabetes team, which aim at normalising the metabolic state to reduce the development of complications (Vener 1997:33). Access to information and education to assist the acquisition of skills to assist management of the disorder is critical. These are therefore, issues that need to be address to Scott. He needs to be aware of the different types of self-monitoring glucose devices and insulin devices, as blood glucose levels and insulin are an integral component of Scott's treatment plan for diabetes (Vener 1997:34). It is also necessary to address the long-term complications with Scott and tell him that a key goal of diabetes treatment is to prevent the complications, which can result from poorly controlled diabetes (Lutz & Przytulski 1997:340-1). Scott also needs to be aware of the services available to him.

He needs to be aware that careful oral hygiene is important for people with diabetes, to prevent teeth and gum infections, also foot care is essential, regular eye checks etc. Other issues could include insurance, work and legal obligations such as life insurance or Superannuation, Motor Vehicle Licences etc. As discussed above diet, exercise and medication would also be issues that need to be addressed.

What information would you give Scott and his family to manage them?

We would refer Scott and his family to the Diabetes Centre, as they would have the resources to provide him with a health care team and be able to talk to them about Scott's condition and management. They could then be referred to health professionals such as:

- diabetes nurse
- dietitian
- endocrinologist
- general practitioner
- ophthalmologist
- optometrist
- podiatrist
- physiotherapist

The above health professionals would be able to help Scott manage and treat his diabetes. We would also tell him to visit his GP for regular check-ups because annual checks are the most effective way of detecting the progress of complications and with prompt management a great deal can be done to prevent the damage from getting worse. It is important to tell Scott that he is not on his own and that there are people out there to help him manage his diabetes, so he can continue to life a healthy life.

Conclusion:

It can be concluded from the information presented that diabetes is a chronic condition where the body does not produce enough insulin or the cell's in the body do not respond to insulin as well as they should. People that develop diabetes should have a management plan worked out to keep a balance between diet, exercise and medication. The key to successful management of diabetes is to perform regular blood glucose testing. It provides information that can help people with diabetes to determine the effect of food, exercise and medication. Blood glucose results will allow people with
diabetes to keep their blood glucose levels within normal limits, to prevent hypoglycemia or hyperglycemia.

Diabetes can cause damage to blood vessels and nerves if it is undiagnosed or not controlled and therefore it is important that people with diabetes manage to control their diabetes. Assessment, including physiological and social data, is essential in identifying the client's educational and physical needs. Regular checks with a health care team are an essential tool in the avoidance any long-term complications that can develop as a result of diabetes.

References:


Calder, J., 1978, Diabetes: Basic Principles of Treatment, University of Western Australia Press, W.A.


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Patel, M., 1999, Diabetes 5th June 1999
http://members.aol.com/m4ynk/intro1.html

University of Sunderland, 3rd July 2000.


What do nursing students need to know about research?

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Abstract

The role of nurse as researcher has undergone large-scale transformation in recent nursing history (Beanland, et al. 1999). The transition to university-based study necessitated the development of research studies from both within nursing itself and in collaboration with other disciplines (Morse 1994). For the purposes of this assignment an essential taxonomy of research literacy has been developed showing the progression of knowledge and capabilities. Three levels of research literacy are examined, and are classed as: procedural, critical and participatory stages. A functional definition of each stage is provided in conjunction with desired outcomes. In addition to fundamental research literacy, it is proposed that there are more far-reaching concerns about student's research knowledge. An exploration of the rationale supporting future directions to enhance researcher behaviour beyond the student experience is presented.

The shift of education from hospital based training and colleges of advanced education instigated the links "between training and research" within nursing (Waters & Crook 1990:311). The birth of the 'discipline' of nursing within an academic framework has necessitated the ongoing development of a research base. To foster the growth of nursing in this new setting, the realisation of research literate nurses capable of developing and enacting critical enquiry has become essential. It is the dynamic nature of research within nursing which must be illuminated for nursing students (Beanland, et al. 1999).

As defined in this paper, procedural research literacy may be classed as that which enables students to 'consume' research, ie. locate, access and decode current information. The depth and breadth of nursing research should be explored, identifying the various sources, techniques and concerns of research. This may include: sharing of information, computer-aided literature searches, instigation of journal clubs, identification of abstracts and problem statements, articles and literature reviews, a working knowledge of research components and terminology, and may include the upgrading of nursing libraries (Beanland, et al. 1999; Firlit 1985; Roberts & Taylor 1998; Stokes 1981). It is this level of research competence that is desired in student and graduate nurses (Beanland, et al. 1999; Radjenovic & Chally 1998).

The development of what Russell has coined "constructive doubt" (in Germov 1998:319) belongs to the second stage of critical research literacy. It is in this area of learning that students are able to assimilate research findings and engage in critical and comparative thought to evaluate reliability and credibility (Radjenovic & Chally 1998). Methodological difference must be appraised, sources assessed for credibility, and validity tested.
The final stage of research literacy as proposed here is the adoption of the role of researcher, without disassociation from the role of nurse. In this context, 'research' is viewed as both a generalised nursing practice of information seeking behaviour, and developing research projects from identified problems. This move away from seeing the research process as something beyond the scope of normal practice is required to make the change from theoretical to practical usage of research (Roberts & Taylor 1998) Access to this level of knowledge allows practising nurses, both alone and in collaboration with others, to "carry out practice-related research" (Farrell 1997:26).

Discussion centred on the viability of nursing as a research-based, ergo 'justified', discipline has raised concern over "a looming nursing faculty shortage" (Anderson 1998:5). The implications for nursing faculty are the development of enterprising and original strategies for the teaching of all aspects of research literacy and exploration of 'academic' nursing as an alternative career pathway (Anderson 1998; Pond & Bradshaw 1996).

The development of professional standards has structurally sanctioned the role of nurse as researcher, as evidenced by the adoption of national competencies (Australian Nursing Council Inc. 1998). Research has become increasingly articulated in both nursing education outcome statements, clinical job descriptions and health policy (Beanland, et al. 1999; Farrell 1997; Prime Minister's Science and Engineering Council, 1994). The phenomenon of evidence-based practice has stemmed from concerns over the accountability and basis of current practice within the health care arena (Farrell 1997). The rationale for the introduction of evidence-based practice in nursing is the assertion that "good nursing care is dependent upon both individual clinical expertise and the best available research evidence" (Farrell 1997:4).

Nursing students actively developing research literacy must be made aware of the resistance towards research among many in the nursing community. Recognising that the relatively small amount of published clinical nursing research has compounded the lack of interest and perceived lack of relevance within the current nursing community (Roberts & Taylor 1998). Much of the research that has been available was created by the pioneers of the postgraduate nursing program (Beanland, et al. 1999), demonstrates a North American cultural bias (Lawler 1991 in McCoppin & Gardner 1994), and is by no measure representative of the entirety of nursing practice concerns (Roberts & Taylor 1998).

Concern has also been aroused regarding the clinical relevance of these studies following assertions that many of these studies were frequently conducted using theories "borrowed carte blanche from other disciplines" (Morse 1994:2). The apparent disparity between research findings and clinical applications are explained by this adoption from other research areas; and the problematic tradition of separating the roles of nurse and researcher (Lawler 1993; Morse 1994; Roberts & Taylor 1998; Pond & Bradshaw 1996).

Discussion of future directions in the foundations of nursing research have been generated by projected consequences that "borrowed knowledge and language will inevitably impact upon our knowledge base" (Lawler 1993:7). The outcomes of these discussions often indicate the need for development of unique theory foundations, which adequately reflect the complex and diverse environments of contemporary nursing, something one would think is only achievable by nurses themselves (Beanland, et al. 1999; Donaldson & Crowley 1978; Lawler 1993; Roberts & Taylor 1998).
The lack of research utilisation by 'real' nurses is a common theme in discussions of both education for, and application of nursing research (Kessenich 1996; Pond & Bradshaw 1996; Roberts & Taylor 1998; Stokes 1981). It is also one of the main factors which affects student research utilisation in practice and the graduate year; as student nurses are socialised out of study analysis, and do not implement their tentative skills into the clinical setting (Kessenich 1996; Roberts & Taylor 1998).

Preparing nursing students to face this environment is an essential part of research education. Assisting students to develop strategies to involve their research knowledges in the work place may not only lead to the individual continuing with research activities, but may create a more supportive environment for those unaccustomed to research. Undertakings may include such diverse activities as providing copies of conference papers, journals or world wide web listings; becoming involved with nursing school research competitions; monthly reports by staff nurses on relative research findings; or even attaching 'Did You Know?' style fact sheets on the inside of staff toilet doors (Pontious 1996).

The reported resistance to inquiry based knowledge among currently registered nurses cannot maintain the drive for professionalisation and evidence based practice requirements (Beanland, et al. 1999; Farrell 1997; Floyd 1996; Radjenovic & Chally 1998; Roberts & Taylor 1998). The frequency and manner in which practising nurses access research are limited by both self-perceptions and institutional constructs (Beanland, et al. 1999; Kessenich 1996; Roberts & Taylor 1998). Without the developments of explicit navigational skills, appropriate descriptive language and supportive environments, nurses are without the resources with which to approach research (Farrell 1997; Roberts & Taylor 1998).

Both practising and student nurses require developmental programs to enable them to access and/or create research resources relevant to their varying needs (Roberts & Taylor 1998; Stokes 1981). It has been identified, however, that current university curriculum is not adequate to enable students or practising nurses to internalise, and subsequently exhibit, research behaviours (Radjenovic & Chally 1998).

It has been argued that current research education within preregistration programs is not aligned with the desired 'consumership' role of beginning nurses (Floyd 1996). The reported emphasis on proposition and performance of the research process at a time when both students and graduates are trying "to make sense of things as a nurse, let alone a researcher" is problematic (James 1992:24; Floyd 1996).

In addition to this, some universities have enacted research curricula for staff nurses (Farrell 1997). The current undergraduate curriculum is inappropriate for the needs of this group, and the development of research utilisation programs for this specific group has been advocated (Floyd 1996). For these learners, it is imperative that the courses developed are particularly suited to the clinical environment; otherwise their content will not be transferred into practice (Beanland, et al. 1999; Roberts & Taylor 1998; Stokes 1981).

Familiarity with both research processes and creating supportive environments provides individuals with additional tools for decision-making, appropriate practice and development of the profession. The gathering of knowledge about research processes should not be singularly ascribed for nursing students; it is inherent in lifelong learning, and should be facilitated in the environments of all
practising nurses. Resistance to initiating or maintaining research behaviours must be overcome with adaptation in the ways we think about what it is to be both 'nurse' and 'researcher'. This broadening of the role of nurse and the fortification of thought may be the penultimate goal of nursing research programs. Perhaps within a larger context of nursing we need to become perpetual 'researchers', looking for alternative ways in which to think about our practice and the forces that motivate it.

References


Farrell, C. 1997, Getting up to Speed with Evidence-Based Practice, Australian & New Zealand College of Mental Health Nurses, Greenacres, South Australia.

Firlit, S. 1985, 'Nursing Theory and Nursing Practice: Separate or Linked?' in ed J. Kenney, Philosophical and Theoretical Perspectives for Advanced Nursing Practice, Jones & Bartlett, Sudbury, Massachusetts:311-320.


Film Review:
Theory of Flight, Universal, Pine Film, copyright 1998 Distant Horizon Ltd
Helen Bonham Carter, Kenneth Branagh

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Review

This is a commercially produced film, billed as "a romantic comedy". It may well be asked, why should it be reviewed in a nursing journal?

The film is the true story of a period of time in the life of a young woman suffering from motor neurone disease (MND).

Jane, a 25 year old woman with MND lives at home with her mother who is her full time carer. Her speech is failing and her mobility is limited to the use of an electric wheelchair. As it unfolds, the film touches on many issues of relevance to nurses, in a relatively involving way. Unlike a traditional educational film, these issues are not belaboured, but fit naturally as part of the story.

Issues that can be drawn out of this film include:

- Attitudes toward and assumptions made about a person who is disabled
- The concept that all people with disabilities have the same problems and require the same type of care
- Sexuality issues for disabled people
- Personal autonomy, and the rights of a disabled person to make choices and decisions
- Issues around being a full time carer
- Duty of care and legal responsibilities.

This film is an excellent tool for illustration and discussion of the above and many other issues. In addition it is an excellent opportunity for students to see the impact of illness and disability on the everyday life of a young woman. Students are encouraged to read narrative accounts of patients' experiences of illness. This film is a graphic rendition of such a narrative.

Be warned, the language is also somewhat graphic.

Nuritinga Issue 3, June 2000
I am Pedro's Back

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Nuritinga Issue 3
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Background

Sharyn graduated with a BN from the TSON in December 1998. She wrote this poem as part of her coursework in Health Care Where People Live and Work (CNA 125). It has been recommended for publication because it shows a high level of genuine empathy with the patient/client, expressed in a creative way.

Poem

I am Pedro's back
I had two crushed discs
I had these discs removed.
now
I have a fusion of my lumbar 4 and 5 and sacrum 1
I had a Brandican's cage and bone chips inserted
I now sport a 15 cm vertical scar
I have changed Pedro's life completely.

he used to
Be the sole breadwinner
Go fishing
Go bushwalking
Play cricket
Romp with the kids

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Sleep all night
Have a great sex life
Enjoy gardening
Mow the lawns
Maintain the cottage
Attend school functions
Eat well
Drive the car
Chop the wood
Walk the dog
Service the car
Cart the chook pellets
Visit friends
Shower himself
Cook for pleasure
Work at the Pulp Mill on shift
Prime the creek pump
Not take pills
Feel mentally stable
Expect a future
Dream of building his dream home.
now
I have taken control of Petro's life
I dictate when and how he can do things
I restrict his environment, my favourite place is the bed

I introduced him to pain killers, muscle relaxants and anti-depressants

I forced him into the world of hospitals, doctors and nurses

I claim his leisure, to time now spent reading and watching TV

I disturb his sleep with my pain and fill his mind with 'maybes' until we are both exhausted

I give him that edge, to growl at the kids and nit pick his wife

I own his resentment of able bodies and fallen dreams

I demand him mourn for my being

I swallow up his self esteem and question his manhood

I allow others to intrude on his privacy for my sole benefit

I hold the key to his future pay packet now

I have become his sense of self, without any answers.