ECG Rhythms ...... Without the Blues!

Over the coming weeks we will examine a number of common ECG rhythm disturbances, how to recognise them and their significance.

Acute Renal Failure
Causes and management of acute renal failure

Acute Left Ventricular Failure
Heart Failure is described as an inability of the heart to deliver blood at a rate commensurate with the requirements of metabolising tissues despite normal filling pressures.

DUBLIN 2006 Irish Nurse Magazine Healthcare Exhibition
4th & 5th OCTOBER 2006: RDS - IRELAND further details inside
Remedica is an innovative and dynamic medical education publisher with a strong and growing range of guides and textbooks for nurses, students and doctors. A number of our books are prescribed or recommended reading at universities and colleges in the UK, Europe and the USA.

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Update on the Modernisation and Redesign of Services and Facilities at Randolph Wemyss Memorial Hospital

An extended range of community services and improved in-patient facilities will be available for the local population on completion of a refurbishment project at Randolph Wemyss Memorial Hospital in Buckhaven which is estimated to cost approximately £4.5 million.

Building work will start mid-September 2006 and is expected to be completed by the end of November 2007. To ensure that the disruption is kept to a minimum during the course of the refurbishment ward patients will be moved temporarily to Cameron Hospital. Full discussions on this have been held with staff and relatives of patients and they are satisfied with the arrangements being put in place. Patients moving to Cameron will be looked after by nursing staff from Randolph Wemyss, who will also use this opportunity to develop their existing skills in other areas.

Dr Les Bisset, Project Lead and Clinical Director of the Kirkcaldy and Levenmouth Community Health Partnership (CHP) who manage this site said “This is an exciting time for the CHP and for local services at Randolph Wemyss. At last we can take forward what was agreed in the consultation in 2002 and provide a local community facility that will meet the modern needs of the Health Service.

Randolph Wemyss is almost 100 years old and it was built at a time when health provision was very different. This large investment will allow a facility that is much valued by the local people, to meet their needs both now and in the future.”

The range of services provided from Randolph Wemyss after the refurbishment include -

- A 16-bed Continuing Care in-patient unit for older people (including respite);
- 15 day places for rehabilitation of older people;
- Adult physiotherapy, occupational therapy and speech and language therapy;
- New Podiatry suite;
- Paediatric physiotherapy, paediatric occupational therapy and speech and language therapy;
- Health Visitors, Smoking Cessation Services and groups, Community Learning Disability Team and Maggie’s Outreach Facility;
- Well woman and family planning;
- Clinical psychology and psychology groups;
- Community dental services;
- Community Information Point (6 voluntary agencies);
- Men’s health clinics;
- Learning disability service;
- Clinical outpatients clinics.

These services will enable the whole community to have access to core primary care and community services in their local area. The development offers improved quality and capacity, improved access and experience, and will promote new ways of working. Plans of the development are on display in the main reception area.

Eating healthier foods will improve male fertility

Studies from around the globe are pointing towards diet as one of the major contributing factors when it comes to male fertility. Eating properly and focusing on certain healthy foods can help increase male fertility.

Decreasing male fertility rates over the past few decades have given rise to a new problem: troubles conceiving. Typically, when a couple is having problems getting pregnant, the man’s fertility and sperm count are the first things called into question. It’s a known fact that sperm count has decreased drastically over the last 20-30 years.

There are a number of foods that males should eat, and avoid eating, in order to provide the right conditions for sperm production. Stress is also another big factor.”

Your body needs certain nutrients to produce sperm. Foods rich in zinc are a good place to start, which is why oysters, which are very rich in zinc, are often associated with a boosted sex drive.

Other essential nutrients include selenium, lycopene, folic acid, water, and a number of vitamins. A good place to start is to eliminate refined foods such as sugars and white flour.

Quitting smoking is also very important not only for healthy sperm counts, but for overall health. Trying to include more vegetables that are considered ‘leafy greens’ is always a good idea. Good examples of foods that will give a boost to sperm production include, but are not limited to: spinach, spirulina (seaweed), barley, lamb, asparagus, pumpkin seeds, flaxseed oil, oysters, and poultry.
Further Education Colleges welcome more nurses onto complementary therapy courses

British consumers spend over £130 million on herbal remedies, aromatherapy and other alternative treatments each year and it is predicted that this figure will rise and that the market will be worth £200 million by 2008. One in two Britons has visited an alternative health practitioner such as an osteopath, aromatherapist or acupuncturist and the industry as a whole is estimated to be worth £1.6 billion.

All this has meant a huge growth in job opportunities in the field of complementary therapy with many people seeking to get the appropriate qualifications along with recognition by the relevant professional body. It has also meant that the general public is more likely to expect some degree of knowledge of these therapies from their traditional healthcare providers – pharmacists, GPs and nurses.

Over the last few years many general practices have embraced these developments and responded to demand by providing some complementary therapies, with some GPs and primary health care teams trained in at least one complementary therapy.

Research published in 2004 by Developing Patient Partnerships revealed that 71% of people would like to discuss complementary medicine with their GP or pharmacist and 63% thought it should be available on the national health. But 85% of GPs felt they didn’t have enough knowledge and information on the safety and efficacy of complementary medicine.

Nurses frequently incorporate therapies such as massage, aromatherapy and reflexology into their practices and as a consequence much of the responsibility for improving the knowledge of a healthcare team and dealing with patients in this field is falling on their shoulders.

Moira Frizzell, Head of Faculty for Child Education, Health & Social Care at Stevenson College Edinburgh, says: “More and more of the places on our complementary healthcare courses are being taken up by nurses who not only have an interest in this area but who also see the demand for it from their patients on a day-to-day basis and are seeking to fulfil that demand. Many studies report high levels of satisfaction amongst users of complementary therapies with many using it to relax and promote well being. Most users will use complementary medicines and therapies alongside traditional orthodox medical care.”

To meet the increasing demand, both from the general public and healthcare practitioners, further education colleges across Scotland have been introducing new courses covering a range of complementary therapies. Of the 46 Scottish FE colleges, three offer access or introductory courses and 11 offer courses at HNC and HND level, but many others offer individual courses in some of the better known therapies such as reflexology, aromatherapy and massage.

Stevenson College in Edinburgh is one such college which now offers a range of five courses, three of which are brand new for the autumn term: Swedish Massage, Aromatherapy and Reflexology all of which are available at VTCT Level 3 Certificate on a part-time or evening basis. Stevenson also offers an evening course in Homeopathy and a Level 3 VTCT Diploma in Holistic Therapies which is available as a one year full-time or a two year part-time course and includes aromatherapy, full body and advanced massage and reflexology.

There are still places on the 10 week evening homeopathy course, starting September. More courses will run again in January 2007. For more information on these or any other courses at Stevenson, please contact their Student Advice Centre on 0131 535 4700 or email info@stevenson.ac.uk Alternatively, contact your nearest FE college to see what courses and places are available.
Public Involvement in Learning Disabilities Unit

The need for public involvement and consultation was emphasised by NHS Fife Board members in their debate on the proposal for the development of a Forensic Unit for Learning Disabilities at their recent meeting.

Susan Manion, General Manager, Dunfermline and West Fife CHP, said, “There will be a full programme of public involvement and consultation including meetings with local residents and their representatives. Details will be available shortly. The results of the responses will then be collated and put to the Board”.

George Brechin, Chief Executive, NHS Fife said, “Board members took a decision to support in principle the recommendations that such a service be created. They were also clear in their direction to staff that public engagement and consultation was absolutely necessary and the results of that process had to be reported to the Board before it could take a final decision on the proposed unit”.

The process will consist of information events, briefing notes and include meetings with local residents, community groups, individuals, MSPs, clinicians, the Dunfermline and West Fife Community Health Partnership and Fife Council. This will need to be completed and the results fed back to the Board before any decision will be taken on having the unit at Lynebank Hospital, Dunfermline.

An NHS Project Team from Fife, Lothians, Borders and For the Valley had concluded that a single unit was the route forward and that Lynebank should be the only recommended location, based on the availability of expert specialist staff, existing facilities, land availability and location.

Grow your own mushrooms

If you’ve spent the summer encouraging kids to grow their own vegetables, there’s no reason to stop now the season’s over. You can move onto other things such as mushrooms.

Encouraging children to grow their own mushrooms is a great way to kick-start their five-a-day diet. Mushrooms are stacked full of vitamins and minerals, including potassium to lower blood pressure and the antioxidant selenium. And one serving of mushrooms also provides about 20 to 40 percent of the daily value of copper, a mineral reputed to have cardioprotective properties.

You don’t need acres of land - or even a garden - to produce a ready supply of delicious fresh-tasting white cap mushrooms. Mushroom-growing kits are designed to grow indoors and one box provides everything you need for perfect crop. All you have to add is water. Not only will you save on your grocery bill, kids will love discovering and harvesting the ‘magical’ crop. Follow the easy-to-understand instructions and mushrooms will start to appear in just over a fortnight.

The kits should provide three ‘flushes’ of mushrooms, after which the spent compost can be used in the garden as an excellent soil improver. Keep the mushrooms in a paper bag in the fridge, and add them raw to salads or as a filling in a delicious healthy omelette. There are three easy steps to follow and hey presto – you have mushrooms.

Handy tip - When harvesting mushrooms, carefully twist them upwards so you don’t disturb the compost and immature mushrooms.

Did you know?

14 raw white cap mushrooms typically contain:
10 kcals, 1.4g protein, 0.3g fat, 0.3g carbohydrate 0.9g fibre
For more details visit www.unwins-seeds.co.uk
Choose Life- World Suicide Prevention Week 4 – 10 September

Suicide prevention is everyone’s business. Part of NHS Fife’s local plan is to raise awareness of helpline numbers that can be of use to people if they are in distress or contemplating suicide.

If you need to talk to someone or know someone who might be at risk contact Childline on 0800 1111 or the Samaritans on 08457 909090, their website is on www.samaritans.org. Breathing Space helps people talk through their problems before they reach crisis level and their number is 0800 838587.

Fife has 40-60 suicides each year and their effects can be profound and lifelong – on families, friends, colleagues, and in the wider community. For this reason, Fife like every other area in Scotland, has a local plan called ‘Choose Life’ which aims to reduce suicide and its impact on people’s lives.

Dr Margaret Hannah, Consultant in Public Health, said “Suicide is still a major public health issue in Fife. Rates in Fife and Scotland are almost double the rates in England. We have a particular problem with young men where it is the commonest reason for death in men aged between 15 and 44. Fife’s Choose Life action plan has set up new services and extended the range of others to improve responses to people in mental distress and families affected by the tragedy of suicide”.

She continued, “Efforts to reduce suicide have to operate at local as well as national and regional levels. Agencies in Fife include Cornerstone, Penumbra, Cruse, Samaritans, Fife Families Support, LINK, Fife Men, KASP; Contact the Elderly and TODAY as well as Fife Council, Fife Constabulary and NHS Fife. They have shown great commitment to reducing the numbers of suicides and incidents but there is still more we want to do”. Choose Life in Fife aims to respond more effectively to people in need of help as well as to help people cope better with the aftermath of what is a devastating event. World Suicide Week highlights the subject. The Choose Life Group’s key areas for action include early prevention and intervention, long term work to support recovery, priority groups and training. Projects range from working with young people who self harm, befriending schemes for older people living alone, vulnerable youngsters and training for people in the community who might come across people at risk.

The Scottish Association for Mental Health has a booklet called “After a Suicide” which can be downloaded from their website on www.samh.org.uk.
Exercise essential to reduce diabetes risk

Physically active people who have a large waist are less likely to develop Type 2 diabetes than those with the same waistline who are physically inactive. Research, published in the journal Diabetic Medicine, found the same pattern was seen among the lower waist size groups, with those who exercised regularly having a lower chance of developing Type 2 diabetes than those who did not.

The study of 1,812 people by the National Public Health Institute in Finland also shows that the physically inactive with a large waist had a five and a half times greater risk of developing the condition than physically active people with small waists. However, those in the same large waist group who exercised regularly lowered their risk to four and a half times.

People who do 30 minutes of moderate to intense physical activity five a week have a reduced risk of developing Impaired Glucose Tolerance (IGT); an early indication that glucose is not being processed efficiently in the body, and Type 2 diabetes, than those who do no physical activity.

Simon O’Neill, Director of Care and Policy at Diabetes UK said ‘We already know that physical activity plays a huge part in the prevention of Type 2 diabetes. Although this research demonstrates that physical activity reduces your risk irrespective of your waist size, a smaller waist reduces your risk further. Your waist should measure less than 31.5 inches for women, 37 inches for white and black men, and 35 inches for South Asian men. This can be achieved through a healthy, balanced diet, along side regular physical activity.’

Katja Borodulin, who led the study said ‘Previous studies looking at the risk of developing Type 2 diabetes across the categories of physical activity and obesity have not focused on abdominal obesity. Our study provides new evidence of the joint associations of abdominal obesity and physical activity with the risk of Impaired Glucose Tolerance and Type 2 diabetes in apparently healthy individuals. However, these joint associations still remain unclear and will require further research.’

There are currently 2.1 million people with diabetes in the UK and a further 750,000 people who have the condition but do not yet know it. Undiagnosed diabetes leaves people at greater risk of developing diabetic complications such as blindness, heart disease, kidney failure and lower limb amputations. Early diagnosis helps to significantly reduce the risk of developing complications.

Healthy boost for Renal Unit

Maybole woman Margaret Thomson celebrated her 60th birthday with a party and a bumper cheque for almost £1,300.

Kindhearted Margaret asked friends and family for donations to the Kidney Patient Support Group at Crosshouse Hospital instead of personal gifts. The money was raised in memory of her late husband Norman, who died of kidney failure four years ago.

Mrs Thomson held her birthday party in Maybole Town Hall on 28 July with live music and entertainment. A number of other fundraising events took place at the party, including a raffle and the added attraction of local man Bobby Green having a sponsored full body wax!

Staff Nurse Shirley Blair commented: “The donation of £1,300 to the renal unit from Mrs Thomson is greatly appreciated and will be used to benefit all patients within the John Lynch Renal Unit.”
Living life to the full – helping you to help yourself

NHS Ayrshire & Arran, in partnership with James Watt College and Kilmarnock College, are running courses to help people cope with mental health problems like anxiety or depression.

Many of us will experience problems with stress or low moods at some point in our life, either personally or indirectly. However, not everyone knows how to cope with such situations. The ‘Living Life to the Full’ course aims to help people not only understand the causes of low mood and stress, and how they can impact on our everyday lives but also how to manage them.

Subjects covered include:
• Discovering why we feel the way we do
• Establishing problem-solving skills
• Relationships
• Keeping fit through fun activities
• Tips on how to avoid stress
• Tips on how to sleep better
• The power of positive thinking
• Healthy living

The course runs as a series of eight sessions, each lasting two hours, and is available at James Watt College or Kilmarnock College:

Kilmarnock College : Thursday 21 September 2006 : 7 – 9pm
James Watt College (Kilwinning Campus) from Monday 25 September 2006 : 6 – 8pm

Sharon Hackney, Project Manager – Doing Well by People with Depression comments: “The course will be useful for anyone who has experienced difficulties such as stress, anxiety or depression. We want to help them to help themselves. The course offers key practical problem-solving and other life skills, and is available to everyone in the local community.”

The course costs £50. However, you should contact the colleges to find out if you are eligible for financial help.

If you would like to enrol on the course, or would like to find out more, contact James Watt College on 0800 085 8200, or Kilmarnock College on 0800 389 6817. Or you can visit the Living Life to the Full website on www.livinglifetothefull.com

Stepping out to support Alzheimer Scotland - Memory Walks 2006

Have fun taking part in a sponsored memory walk on or around Sunday 24th September to celebrate World Alzheimer’s Day.

Get a team of family and friends or work colleagues and organise your own memory walk, or contact Alzheimer Scotland to see if one is being organised near you!

Memory Walks can be of any length, in town or country and anyone can take part. Have a great day out, perhaps remembering someone close to you who has dementia and support Alzheimer Scotland.

Alzheimer Scotland is Scotland's leading dementia charity and provides care, understanding and support for people with dementia, their carers and families.

For further information and a free fundraising pack call the events hotline on 0845 2600 789, or email mlawrance@alzscot.org or check out the website at www.alzscot.org

Memory Walks 2006 Planned Walks

These are the walks already arranged; you can join in with any of these or arrange your own with friends, family and colleagues. Check out www.pathstohealth.org.uk for lots of ideas!

Leading specialist palliative and neurological care provider, Sue Ryder Care, is to review and evaluate key elements of the NHS End of Life Care programme.

The project, to be conducted by the Sue Ryder Care Centre for Palliative Care and End of Life Studies at the University of Nottingham, will be the first national evaluation of its kind. It will provide an up to date snapshot of progress and signpost areas where care can be improved in the future.

The NHS End of Life Care Programme aims to address variations in care practices between Cancer and other long-term conditions by developing greater awareness among staff of patients’ and carers’ needs and initiating activities that enhance the co-ordination and quality of care services, including improving patient choice.

Professor Jane Seymour, Chair of the Sue Ryder Care Centre will be leading the research. She commented: “We are pleased to have been asked to evaluate this important programme, and look forward to working with colleagues across the UK. Better care for people in need of palliative and end of life care is a crucially important issue, and we hope that by providing information to the NHS about the structure, process and outcomes of this initiative, we can contribute to the shaping of policy and practice aimed at improving care for all.”

Claire Henry, National End of Life Care Programme Director, commented: “The academic expertise and nationally recognised organisations in this partnership will gather evidence and produce an evaluation which will help to increase the knowledge of staff and improve systems to the benefit of all patients wherever they live at the end of their lives”

www.scottishirishhealthcare.com
Ayrshire Maternity Unit welcomes its first new arrivals

At 10am on Wednesday 23 August 2006 the new state-of-the-art Ayrshire Maternity Unit at Crosshouse Hospital opened its doors to expectant mums.

The staff at the new unit had a busy opening day, welcoming the babies who were transferred from the Neonatal Unit at Ayrshire Central. They then prepared for some other special deliveries - the first babies born at Ayrshire Maternity Unit at Crosshouse Hospital, and the last baby born at Ayrshire Central Hospital.

Susan Welsh and partner Ian Gale, from Irvine, got a bit of a shock when baby Seth arrived just over three weeks early. Seth weighed in at a 5lb 9oz at 20 minutes past midnight on 24 August, the day before mum Susan’s 30th birthday! The proud parents of the first baby were presented with an engraved silver quaich by Miss Angela Cunningham, Senior nurse/midwife manager, NHS Ayrshire & Arran, and Dr Clive Baird, Susan’s Consultant Obstetrician.

Shortly afterwards, at 1.30am, Master Aidan Strachan weighed in at 8lb – the first baby to be born in the Ayrshire Maternity Unit’s relaxing new birthing pool. Aidan is a third child from mum Lee-Anne and dad Alan, of New Farm Loch, and a brother for Payton, three, and Jordan, 10.

The last baby born at Ayrshire Central Hospital was to first-time parents Jacquelyn and Neil Leckie, also from Irvine. Baby Kaiden weighed in at a healthy 7lb 9oz at 4.24pm on 23 August and mum and baby were then transferred to the new unit. They were also presented with an engraved silver quaich to mark the special occasion.

Miss Angela Cunningham, Senior nurse/midwife manager, NHS Ayrshire & Arran, commented: “The design of the new unit fulfils our aim of ensuring women and their babies have a seamless journey through our maternity services. We would like to wish our new mums and indeed mums to be a safe and happy time in our new unit.”

Representatives from Ayrshire Hospitals Ltd, the consortium who designed and built the new unit, also presented £100 in Mothercare vouchers and a silver photo frame to the first baby.

Mr Donny McKinnon, Chairman of Ayrshire Hospitals Limited, added: “The new unit will provide mums with an improved environment with greater integration between labour suite and the Neonatal Unit. The stunning new unit opened for mums, on time and on budget, well on time for the first baby to be born!”

Dr Allan Gunning, Chief Operating Executive, NHS Ayrshire & Arran, commented: “The opening of the Ayrshire Maternity Unit marks a true milestone for NHS Ayrshire & Arran. The new building will enable us to build on the excellent standards of care our doctors and midwives have provided over the years at Ayrshire Central.”
fit and well

But what if something goes wrong

We are presently helping a number of Nurses both young and elderly. If you know someone who you think needs our help contact:

**Margaret Sturgeon**
15 Camp Road
Motherwell ML1 2RQ
Telephone: 01698 252034

Visit our website for more details
www.bfns.org.uk

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www.livingwithstress.co.uk/courses.asp or contact
Living With Stress Ltd, Tel: 0870 737 0707

* 4th & 5th October 2006
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ECG rhythm recognition in Cardiac Arrest, Adult and Paediatric CPR guidelines,
Do not attempt resuscitation guidelines

Check website for further details or Tel. +44 (0)1292 284800 Email: strathayrltd@btclick.com

* 17th – 18th October 2006
  **ACTION FOR EQUITY CONFERENCE**
Four Seasons Hotel, Carlingford, Co Louth
A two-day conference organised by The Institute of Public Health in Ireland. A full programme and registration details available online shortly. The aim of this event is to stimulate debate and secure action on equity in health. This will be achieved by:
  • Defining equity in health
  • Identifying effective action
  • Deciding on policies and approaches to improve equity
  • Committing to action and accountability
A rich mix of plenary presentations, discussions, workshops, debate, drama and opportunities for networking. Speakers include:
  • Mary Black, Health Action Zone Co-ordinator, North & West Belfast Health Action Zone
  • Gro Harlem Brundtland, Director, American Programme Bureau; Former Norwegian Prime Minister and Director General, WHO
  • Niall Crowley, Director, Equality Authority, Ireland
  • David Gordon, Director, Townsend Centre for International Poverty Research

* October 19-20
  **Common Ground: Playing Your Part in a Developing World**
A two-day exhibition/workshop series on Thursday and Friday, 19 and 20 October 2006, to be held in the Silver Springs Conference Centre, Silver Springs Hotel, Tivoli, Cork.

The NGO sector, missionary organisations, youth organisations, third-level institutions offering courses in Development Studies, as well as community-based organisations, will be represented. The event will also afford an opportunity for dialogue and networking between these organisations.

Further information: Jeremy Meehan, Director of Education, Bóthar. Tel. 021-487 8693 E-mail: jmeehan@indigo.ie

* 22nd October- 25th October 2006
  **ISQua 23rd International Conference** London
www.isqua.org.au

* 25th - 27th October 2006
  **NHSRU. 5th International Conference**
Practice to Policy: Global Perspectives in Nursing
Hamilton, Ontario, Canada
• 8 November 2006
Inaugural All-Ireland Health Intelligence Conference - With its partners, Ireland and Northern Ireland’s Population Health Observatory (INIsPHO) is pleased to announce this seminal event in the 2006 calendar.

As we are all aware, big changes are occurring in the health services and the health intelligence function on the island, both North and South. At this conference you will:

* Hear about the progress being made by the key health information and intelligence agencies on the island, and their plans for the future
* Examine some of the health information and intelligence innovations that have occurred recently, and discuss them with their developers
* Meet like-minded colleagues and discuss how to best work together and contribute to the future direction of health information and intelligence function on the island.

Enquiries should be directed to: Cynthia McMahon, Institute of Public Health in Ireland
Tel: +353 (0)1 478 6300
Email: cynthia.mcmahon@publichealth.ie

Leah Friend, Institute of Public Health in Ireland
Tel: +44 (0)28 90648494
Email: leah.friend@publichealth.ie

• 8th, 9th and 10th November 2006
7th Annual Interdisciplinary Research Conference of the School of Nursing & Midwifery Studies
"Transforming Healthcare through Research, Education and Technology"

If you require any further information about our Annual Interdisciplinary Research Conference please contact: Jeni Ryan, Administrative Officer - Events Trinity College School of Nursing and Midwifery Studies, 24 D’Olier Street, Dublin 2, Ireland
Tel: +353 1 608 3860 Fax: +353 1 6083001

Managing Myeloma - Medical Treatments and Nursing Implications
Education Day for Haematology Nurses

• 10 November 2006
Hilton Hotel, Dublin Airport, Dublin
One day education meeting designed especially for nurses caring for those with myeloma. The day provides a comprehensive overview of the latest in disease management and clinical research in myeloma. Chair: Mary Kelly, CNS, Tullamore General Hospital
Programme sessions, themes and workshops: Myeloma - An overview; diagnosis, staging and related disorders, Current treatments and management, new guidelines, management of relapse, New treatments, developments in the field Nursing implications, Breakout Sessions, Patient Perspective Fees: £30 (Euro 45)

For further information, application, registration and booking forms, please apply to the event organiser:
Kirsty Jamieson, IMF (UK) Lower Ground Floor, 37 York Place, Edinburgh EH1 3HP Tel: 0131 557 3332
Email: kirsty@myeloma.org.uk
Website: http://www.myeloma.org.uk

• Various Dates
Fundraising events in support of Croí (West of Ireland Cardiology Foundation)

Croí, the West of Ireland Cardiology Foundation is a registered charity and relies solely on voluntary sponsorship and donations. Check out www.croi.ie for more information.
I am a nurse and midwife practicing in Scotland and have raised £80,000 for a maternity hospital in Malawi. This was achievable through the selling of a recipe book which I put together and obtained sponsorship from the Royal Bank of Scotland for printing costs. I visited Malawi and am continuing to raise money through a calendar this Christmas and a second book next year. The success of my project has been primarily through net working and spreading the word of the problems in Malawi and what we can do no matter how small, in our developing world.

Linda McDonald RN .RM

Life continues to be demanding and fruitful. The difficulty is keeping Malawi business as an interest and not allowing it to take over my life. Fortunately my husband reminds me every now and then!

August 2006.

This is a busy month for Iain and I while the Edinburgh festival is on. We provide bed and breakfast for visitors which we really enjoy and of course the demands of night duty in the hospital continue.

Information and recipes are being gathered, art work is progressing and deadlines for the end of September are being made for the production of a Mums recipe calendar due out on 1st October for Christmas.

I found out a while ago that there was medical equipment stored in the old Eastern General Hospital in Edinburgh and had been for some time. The hospital land was going to be sold and used for development, which has become a familiar story all over the country.

The unwanted N.H.S equipment had been collected by A.L.S.O.members, around Scotland (Advanced Life Support in Obstetrics). Included in this equipment was an operating table which I knew Bottom Hospital desperately needed .

I also found out through the Scottish Executive, that there was a depot in Glasgow with tons of medical equipment all gathered by individuals throughout Scotland, waiting to be shipped to Malawi. The only obstacle holding all this back was of course money and time to organise the process.

I spoke to Professor Brian Kelly who manages the depot and all that is involved with getting a container to Malawi. I told him that Mums Recipes had the money to ship the equipment. He was of course delighted. Brian had for some time been trying to get funding without success.

So a date was set for transporting the equipment from Edinburgh to join all the equipment in Glasgow. I even received a delivery of supplies from a medical practice in Spain! Nine friends and their children met on Thursday 3rd August and helped load the truck. My husband Iain and I continued on to Glasgow and to meet Brian.
Malawi

It was an amazing set up. Brian is retired but now works as a volunteer through the Lord Provost's Office. He works tirelessly, efficiently and with vast amounts of knowledge and contacts to make the transporting of equipment as smooth and as official as possible.

The depot is enormous and was extremely organised. Everything boxed, labelled and listed.

Brian has a marvellous group of volunteers who were going to come in at the weekend and after work to get everything ready for Thursday 10th when the container arrived. It takes at least four hours to load a container.

The equipment was going to different hospitals in Malawi including Bottom Hospital. Within the shipment were specially designed chairs for disabled children destined for an orphanage. Instruments, paracetamol, disposable gloves, computers, hospital beds, a transportable incubator, were amongst the boxes, the list was endless.

I think what struck lain and I most that day, was the continuous commitment Brian has. This applies to all the wonderful people on his team who help him. It also brought home to us that there are a lot of people doing a lot of hard work in all sorts of ways whom in general are not known about.

We had a lovely retired couple staying with us recently, whom we had met in a café, as you do, in Lilongwe, Malawi when we were on our trip. They were on their way home to America after spending eight years in the ministry and came for a visit to Edinburgh.

They taught me a lovely African saying ‘Pong ono, Pong’ono ndi mtolo’ which means little by little makes a bundle.

This surely applies to our experience in Glasgow and to the many other people I know and those I don’t know who in there own way are contributing to help others.

Linda Mcdonald R.N. RM.

Beef & Guiness Casserole

(Serves 6-8)

Given to me by my sister Julie, brought back from Canada. Very Irish though. The kitchen smells wonderful while it cooks! Fabulous served with ‘Braised Red Cabbage’ and ‘Mustard Mash’ – recipes in ‘Salads and Vegetables’ section.

Ingredients:

- 700g/1lb braising steak, sliced
- 1 tbsp plain flour
- 1 tbsp oil
- 2 onions, sliced
- 225g/8oz carrot, sliced
- 2 sticks celery, sliced
- 225g/8oz ready to eat prunes
- 300ml/1/2pt beef stock
- 300ml/1/2pt Guinness
- 2 tbsp tomato purée
- red pepper, chopped
- salt and pepper

Method:

1. Heat oven to 160°C/Gas Mark 3.
2. Toss beef in flour.
3. Heat oil in pan and brown steak.
4. Add onion, carrot and celery.
5. Stir in prunes, stock, purée and Guinness, season and bring to the boil.
6. Bake for 1 hour 45 minutes.
7. Add pepper.
8. Cook for 15 minutes.

Freezes well.
Acute Renal Failure

The human kidney constitutes only 1% of body mass yet renal blood flow equates to approx. 20% of the resting cardiac output. I.e. typically 1200mls of blood per minute The functional unit of the kidney is the nephron.

The main functions of the kidney are:

- Excretion of waste products such as urea & creatinine
- Selective reabsorption to control electrolyte balance
- Water balance
- Acid - base control (along with buffers and respiratory system)
- Endocrine functions:
  - Erythropoietin (essential for red blood cell production)
  - Renin

Acute Renal Failure refers to the sudden failure of the kidney to produce urine of sufficient quality to prevent a rise in the level of nitrogenous metabolites, urea and creatinine and other waste products in the blood, to maintain normal electrolyte and fluid balance. The diagnosis is made from a rapidly rising urea and creatinine and a reduction in urine production over a period of hours or days.

Causes of acute renal failure.

Causes are classified as below:

**Pre Renal:** occurs as a result of renal hypoperfusion which usually responds well to rehydration

**Renal:** in critically ill patients other insults such as infection, hypoxia, drugs etc may convert a simple problem of poor perfusion into one of acute tubular necrosis where there is structural damage to the renal parenchyma. The patient may not die from renal failure although this may be present at the time of death. There is a high mortality in patients who develop ARF in the context of other severe illness.

**Post Renal** (obstructive) The most common cause of obstructive uropathy in men is prostate

**Clinical Signs and symptoms:**

Oliguria and anuria: ARF is normally associated with oliguria (24 hour urine volume less than 400 mls) and possibly anuria (24 hour urine volume less than 100 mls) although it can occur with a wide range of urine output.

Uraemia: failure to eliminate the waste products of protein metabolism leads to a symptomatic serum rise of waste products normally found in the urine.

Electrolyte disturbances e.g. hyperkalaemia

Metabolic acidosis

Fluid overload

Other: GI disturbances, hiccoughs / itching skin, thirst, dry mouth, candida infections, confusion, convulsions and coma

**Hyperkalaemia:** the normal serum level of potassium is 3.5 - 5 mmols /L. Potassium levels may elevate in acute renal failure mainly due to reduced renal excretion. The effects of hyperkalaemia can be dangerous and myocardial irritability and possible cardiac arrest can be seen.

ECG monitoring is a necessity. The main ECG signs of hyperkalaemia tend to be:

- Peaking of the T wave
- Widening of the QRS complex
- Possible cardiac arrest rhythms

**Normal ECG complexes:**

**ECG with hyperkalaemia**
Management of Acute Renal Failure

Acute Renal Failure is a medical emergency. Renal function may be reversible in a large number of cases and so prompt assessment and treatment is essential to maximize the chances of recovery. The underlying cause of the ARF should be identified and treated as soon as possible.

Closely screen at risk patients: It is essential that nurses identify at risk patients, such as those with pre-existing renal disease or receiving nephrotoxic drugs and also patients where there may be a reversible cause such as haemorrhage.

Ultrasound examination and abdominal x-ray are important to exclude obstruction.

Urinary ‘dipstick’ testing may also be useful in determining the nature of the ARF.

Fluid status: It is important to distinguish pre renal failure from established renal failure by establishing the fluid status of the patient. A number of observations may help:

- Jugular Venous Pressure (JVP) is often raised in fluid overload. Lying and standing Blood Pressure: a marked postural fall is a good sign of hypovolaemia.
- Lungs: the presence of crepitations due to pulmonary oedema may indicate fluid overload.
- Central Venous Pressure (CVP) A central line may be inserted as this is often a good indicator of fluid status. Low readings are often seen in hypovolaemia and higher readings in fluid overload.
- Chest x-ray: the presence of cardiomegaly and pulmonary oedema may indicate fluid overload.
- General observations e.g. dry tongue, poor perfusion

If dehydration is suspected an intravenous fluid challenge e.g. 250mls of colloid is given while the patient is closely observed for signs of overload.

If the blood pressure is low despite correcting fluid status, intravenous Inotropic drugs such as dobutamine may be considered. This is usually commenced at a rate of 2.5 – 5 micrograms per KG per minute and titrated to BP response.

Dopamine intravenous infusion at a rate of 2 micrograms per KG per minute may improve renal perfusion although its effectiveness remains controversial. Care should be taken when administering Dopamine via peripheral lines as infiltration may lead to local tissue necrosis.

If fluid overload is suspected consider diuretic as this may increase amount of fluid loss but will not necessarily improve renal function.

A strictly accurate fluid balance must be kept and it may be necessary to impose a fluid restriction that takes account of any insensible loss e.g. sweating.

Nutritional support is very important and may require enteral feeding. Adequate calories must be provided to minimize the breakdown of body protein that can lead to further rises in urea and creatinine.

Managing hyperkalaemia:

Firstly ensure the accuracy of result as it may be abnormal due to sample haemolysis. Remember that correcting the potassium ultimately depends on restoring homeostasis. It is important to identify and discontinue any contributing medication.

Measures to temporarily reduce potassium:

- Hypertonic (50ml 50%) glucose and 15u Actrapid IV over 15 minutes – may reduce K+ by 1 mmol in 1 hour and lasts 2 hours. Remember that intravenous hypertonic glucose may be irritant to veins and a vein that ensures good flow should be selected for cannulation.
- Calcium Gluconate 20% 10 mls IV – the ECG normalizes rapidly although the effect may be relatively short lived.
- Exchange resins – Resonium 15 grams four times daily oral or rectally. Simple laxatives may be equally effective in increasing gastrointestinal loss of potassium.
- Consider haemodialysis particularly if hyperkalaemia is refractory to treatment or if there is pulmonary oedema and a severe or worsening metabolic acidosis.

Observations:

Strictly accurate 24 hour fluid balance
- Daily weight: if possible. This offers a good indication of fluid status
- 1 - 2 hourly vital signs
- CVP recording
- ECG monitoring and daily 12 lead biochemistry & haematology

Infection: patients are particularly vulnerable to infections from their invasive lines and urinary catheters. Meticulous hand washing is essential whenever dealing with these.

Anaemia: reduced production of erythropoietin and dilution may reduce the red blood cell count.

Most Nurses will encounter patients with Acute Renal Failure throughout their career. It is a medical emergency that requires prompt assessment and intervention if the patient is to survive.

For training courses in Renal Disease and other clinical skills visit www.cb-training.com

Further reading:

- Brady HR, Singer CG. Acute Renal Failure. Lancet 1995; 346: 1533-40
Acute Heart Failure

Acute Left Ventricular Failure [LVF]

Heart Failure is described as an inability of the heart to deliver blood at a rate commensurate with the requirements of metabolising tissues despite normal filling pressures.

CARDIAC HAEMODYNAMICS:

Cardiac Output (CO) is the volume of blood ejected by the ventricles in one minute. This will normally be 5 – 7 litres although in LVF this will be reduced. Cardiac Index is often used as relates CO to body mass.

There are a number of factors that determine cardiac output:

Preload: the more the myocardium is stretched in the diastolic phase the greater the force of contraction in the systolic phase. However this is true to a point as the hearts performance will decline if myocardial stretch is excessive.

Afterload: is the resistance the ventricles must overcome in order to move blood into the pulmonary artery and aorta. Systemic Vascular Resistance (SVR) reflects left ventricular afterload and is greater than Pulmonary Vascular Resistance (PVR) that reflects right ventricular afterload.

Contractility: refers to the muscular pumping ability of the ventricles.

Acute LVF may be caused or exacerbated by the following conditions:

- Ischaemic Heart Disease / Myocardial Infarction
- Hypertension
- Aortic Stenosis
- Pathophysiology
- Volume overload
- Drugs e.g. beta blockers, cocaine
- Infection e.g. Myocarditis

In LVF the cardiac output is reduced e.g. secondary to an acute Myocardial Infarction. Failure of the ventricles to eject blood results in increased intracardiac pressures and pulmonary capillary pressure.

CLINICAL PRESENTATION

- Fatigue / reduced exercise tolerance
- Dyspnoea
- Frank pulmonary oedema
- Paroxysmal nocturnal dyspnoea
- Cough
- Crepitations - after coughing
- Hypoxia & cyanosis
- Sweating
- Tachycardia

Chest x-ray appearances:

The chest x-ray will typically demonstrate:

- Cardiomegaly i.e. an enlarged heart
- Pulmonary oedema: the lungs will appear whiter often with a typical ‘bats wing’ distribution of oedema
- Dilated pulmonary capillaries and upper lobe diversion
MANAGEMENT OF ACUTE LVF

Immediate management consists of:

Morphine IV as required – this will help allay the terror and anxiety but may also reduce preload and afterload

Drug therapy:

Diuretics: help by reducing circulatory volume and thereby reducing preload. An intravenous loop diuretic such as Frusemide is administered in the first instance

Venodilators: an intravenous infusion of Gliceryl Trinitrate may be useful in reducing preload and afterload and may also improve coronary blood flow. Caution must be exercised in patients who are hypotensive

Inotropic drugs: these drugs are used to increase myocardial contractility and output. They are often classified according to their activity at alpha and beta receptors.

Drugs with mainly alpha activity will -
increase afterload
increase blood pressure
slow pulse rate

Drugs with mainly beta activity will -
reduce afterload
increase pulse rate and cardiac output

Dobutamine (Dobutrex)
Exerts its effects on beta1 and beta 2 receptors and thereby Increases myocardial contractility and output. It has no renal (dopaminergic) effects.

The standard dose is 2.5 - 20 micrograms per KG per minute by continuous intravenous infusion

Dobutamine does exert chronotropic effects and it may increase myocardial oxygen consumption and aggravate angina

Side effects include:
ventricular arrhythmias
tachycardia
hypokalaemia
angina

Dopamine
Exerts its effects on dopaminergic, beta1 and beta2 receptors. At low dose (0.5 - 2 mcgs/KG/min) it has mainly dopaminergic effects ~ increased renal blood flow and diuresis. Higher doses result in vasoconstriction and contractility, afterload and systemic Blood Pressure all increase

Dopamine can be very irritant to tissue and the infusion site should be regularly inspected for signs of local site necrosis ~ midline administration may be preferable

ACE inhibitors e.g. Ramipril may be used in the long term management of heart failure. These drugs work by preventing angiotensin II formation.

Possible side effects include:
Hypotension
Renal deterioration
Cough
Rash
Taste disturbance
ECG Rhythms

“ECG Rhythms ...........
Without the Blues!”

Welcome to the first in this series of ECG rhythm recognition. Over the coming weeks we will examine a number of common ECG rhythm disturbances, how to recognise them and their significance. We begin this series with a review of normal ECG rhythms.

NORMAL HEART RHYTHMS

Heart muscle contracts in response to electrical activity spreading across it. (depolarisation) This electrical activity is carried across the heart by the electrical conducting system. This is a specialised collection of cells and structures that are involved in initiating and conducting the electrical impulses. An ECG is a recording of these impulses.

Let’s now look at the names of the various blips and squiggles that make up a normal ECG complex.

The first wave of the normal ECG is called the P wave, normally a small upwardly humped wave - it represents depolarisation of both atria. Having travelled across the atria impulses enter the atrioventricular node (AV node) where they are slowed to allow ventricular filling.

The straight line that follows the P wave comprises part of the PR interval, the time from the initiation of the impulse in the SA node to the moment of ventricular depolarisation. A normal PR interval, measured from the start of the P wave to the start of the QRS complex, is 0.12 – 0.20 secs. (3 to 5 wee squares on ECG paper!)

Impulses then travel through the Bundle of His to the right and left bundle branches and are released into the ventricles via the purkinje fibres. Subsequent depolarisation of the ventricles gives rise to the larger QRS complex. The QRS complex is followed by the ST segment and the T wave, the latter representing ventricular repolarisation.

If all that happens as it should you will see something looking like this ☛

Systematic guide to ECG rhythm interpretation.

It is best to approach your ECG rhythm recognition in a very systematic way. We’d recommend that you apply the following every time – you’ll soon be doing it without thinking!

Step 1: If the rhythm doesn’t look right check your patient!

Step 2: Is the rhythm regular or irregular (i.e. are the QRS complexes coming in regularly)

Step 3: What is the heart rate (to calculate this quickly count the number of big squares between any two consecutive QRS complexes into 300)

Step 4: Can you identify P waves

Step 5: Can you identify QRS complexes & T waves

Step 6: What is the ratio of P waves to QRS complexes

Step 7: What is the PR interval

Step 8: Anything else you notice that shouldn’t be there
The normal heart rhythm is called sinus rhythm:

What to look for on the ECG:

The rhythm will be regular
The rate will be between 60 and 100
There will be P waves and QRS complexes
The P to QRS ratio is 1 : 1
The PR interval is normal

Look for these features in this example of sinus rhythm:

![ECG example of sinus rhythm](image)

Sinus tachycardia may be seen in:

- Exercise
- Anxiety, pain, fear
- Hypotension
- Over active thyroid
- Drug effect e.g. atropine
- Stimulants e.g. caffeine

Example of sinus tachycardia:

![ECG example of sinus tachycardia](image)

You may come across a rhythm that looks very much like sinus rhythm except for a slight variability in the regularity of the QRS complexes. This is called sinus arrhythmia. This is often due to transient vagal stimulation that occurs due to a breathing effect and in such cases is not generally significant.

For more information on ECG Training visit [www.cb-training.com](http://www.cb-training.com) To register for our new online 12-lead ECG Training programme see our advert.

When sinus rhythm is present at a rate of less than 60 we call it **sinus bradycardia**.

Sinus bradycardia may be seen in:

- Normal finding in fit, athletic individuals
- Increased vagal tone e.g. during vomiting
- Drug effect e.g. beta blockers
- Hypothermia
- Under active thyroid
- Myocardial Infarction
- Raised intracranial pressure
- Electrolyte disorders

Example of sinus bradycardia:

![ECG example of sinus bradycardia](image)

Conversely when sinus rhythm is present at a rate of over 100 it is called **sinus tachycardia**.
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- The ECG in:
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  - ST elevation MI
  - Non-ST elevation MI
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Supported by an educational grant from Welch Allyn
Accredited by Glasgow Caledonian University
Supporting the Patients Association
Supporting the British Heart Foundation
Personality Disorder (PD) is a term that has provoked fundamental controversy in the mental health world. To many it is characterised by a sense of stigma, alienation and confusion. The debate continues between clinicians and personality theorists as to whether personality is best assessed on a categorical or dimensional basis, and to whether or not it is therefore appropriate to consider someone as ‘disordered’. Regardless of this debate, it remains a reality that there are many people who, due to personality predispositions combined with traumatic experiences suffer from chronic and severe mental health and social adjustment problems. Most people with personality disorder also meet diagnostic criteria for other forms of mental disorder (Lenzenweger & Clarkin, 2005) commonly including affective disorders and substance misuse. Historically, such people have often found themselves to be ‘revolving door’ patients who are in regular contact with mental health services. They often find that their needs are not catered for by services in the statutory sector, and that they can be excluded from services once a PD diagnosis has been established. Their difficulties are often compounded by the fact that there is an enduring perception that people with personality disorder can be a risk to the public, but the evidence to date suggests that commonly they are at risk to themselves through self-harm, neglect, and impulsive and suicidal behaviours.

A sea-change in the position of people with PD disorder has recently come in to play as a result of the Mental Health (Care and Treatment) (Scotland) Act (2003). Scotland’s milestone mental health act now formally recognises ‘personality disorder’ however caused or manifested as a formal mental disorder. The Act is radical in that it gives service users with a PD diagnoses the same right of access to services and therapies as those with other mental disorders such as schizophrenia, depression, or learning disabilities. Coupled with the implementation of the Act, there have been a host of multi-agency working groups and conferences throughout Scotland set up over the past three years to consider the impact of the new legislation upon the development and improvement of standards of care for this group. Key issues that have been identified to date include the need to promote changing attitudes, training and support, early intervention, monitoring and evaluation, networking and sharing good practice, mapping existing services, research and ring fenced resources for people with a diagnosis of PD.

**What is ‘personality disorder’?**

Where does the line lie with regards to considering personality as ‘disordered’? Personality is best described and classified in terms of dimensions or traits, for example the degree of introversion versus extroversion, neuroticism vs stability, agreeableness vs antagonism, conscientiousness vs lack of self-discipline, and openness to experience vs rigidly. It is widely accepted that personality disorders are variations or exaggerations of normal personality characteristics that are associated with suffering or difficulties in coping. For clinicians, the classification of PD is a contentious issue. The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV, APA 1994) takes a categorical approach to PD, outlining the criteria that need to be met for a diagnosis of 10 recognised personality disorders that are grouped into three clusters: Cluster A (the odd/eccentric cluster) considers paranoid, schizoid, and schizotypal PDs; cluster B (the dramatic/erratic cluster) considers antisocial, borderline, histrionic, and narcissistic PDs and cluster C (the fearful/ anxious clusters) considers avoidant, dependent, and obsessive-compulsive PDs (see table 1). There is currently no particular validity to this clustering, and in practice many clinicians often experience that there is overlap between the criteria for some categories and it is relatively common for individuals to meet the criteria for more than one category of PD. A recent report by the British Psychological Society (Alwin et al, 2006) emphasizes the importance of recognizing that ‘these are categories of disorder, not types of people’, a theme emphasized in recent service-user research (Ramon, Castillo, & Morant, 2001).

<table>
<thead>
<tr>
<th>Table 1: The DSM-IV Personality ‘Disorders’</th>
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<tbody>
<tr>
<td><strong>Cluster A</strong></td>
</tr>
<tr>
<td>(odd/eccentric)</td>
</tr>
<tr>
<td>Paranoic</td>
</tr>
<tr>
<td>Distrusting and suspicious</td>
</tr>
<tr>
<td>interpretation of the motives of others</td>
</tr>
<tr>
<td>Schizoid</td>
</tr>
<tr>
<td>Social detachments and restricted</td>
</tr>
<tr>
<td>emotional expression</td>
</tr>
<tr>
<td>Schizotypal</td>
</tr>
<tr>
<td>Social discomfort, cognitive distortions,</td>
</tr>
<tr>
<td>behavioural eccentricities.</td>
</tr>
<tr>
<td>Narcissistic</td>
</tr>
<tr>
<td>Grandiosity, need for admiration, lack of</td>
</tr>
<tr>
<td>empathy</td>
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www.scottishirishhealthcare.com 23
How common are personality disorders?

To inform the development of services or strategies for people with PD in Scotland, it is necessary to consider the prevalence of PD in different settings and in different populations. Studies on the prevalence of PD are relatively scarce, and those that have been conducted to date are not without methodological concerns. There are a number of reasons for the lack of robust research including lack of training around diagnosis, avoidance of perceived stigmatisation, or rejection of the diagnosis secondary to therapeutic nihilism. Research conducted over the past 20 years or so in the western world would suggest a lifetime prevalence of any single PD within the community to be between 6.7% and 33.1% with a median around 12.9% (Mattia & Zimmerman, 2001). In psychiatric settings, the prevalence of PDs are thought to be higher still, estimated to be between 30-50% (Casey, 2000). Prison samples show the highest prevalence rates, with recent English studies indicating that around 64-78% of male prisoners and 50% of female prisoners meeting criteria (Singleton et al, 1998). Such figures indicate that while PD has been a much-maligned group in terms of service provision to date, that this is not in concordance with the epidemiological rate.

What causes personality disorder?

It is generally accepted that PD is the result of a complex interplay of biological, social, and psychological factors and this literature was recently reviewed by the British Psychological Society’s working group on PD (Alwin et al, 2006). Traumatic experiences in early life such as abuse and neglect are highly represented in this service user group. However, research is required to understand why some individuals develop personality difficulties, and how their experiences and genetic inheritance may differ from other individuals who may have had similar neglectful or traumatic experiences who do not go onto develop PD. Understanding what protects some people from developing PD has an important role in preventing vulnerable people from developing PD in the future.

Can therapy be offered for people with personality disorder?

Historically, there has been a great deal of therapeutic nihilism around PD, with a tendency to assume that people with PD are ‘untreatable’. Psychological therapies seem to have the most efficacy, and reviews of the effectiveness of psychological interventions with PD have been carried out in recent years (Bateman and Tyrer, 2004; Warren et al, 2003; Woods and Richards 2002). The general quality of the literature around therapeutic interventions for PD falls short of gold standard research and most studies to date have significant methodological problems. There is no standard therapy for PD, and more high quality research is urgently required. To date, the largest body of the literature has examined interventions with borderline personality disorder. These studies have provided some encouraging evidence that some patients with personality disorder may respond to treatment. For example, there is some evidence for the use of dialectical behaviour therapy (Linehan et al, 1991), for partial hospitalisation (Bateman and Fonagy, 1999) and for psychodynamic psychotherapy (Roth, 2005). The therapies used often have different therapeutic goals (see table 2). However, there is considerable consensus that effective treatment needs to consider the uniqueness of the person and is tailored towards their needs in an integrative manner.

In general terms, interventions for people with PD should be delivered with consideration to the ‘What Works’ criteria (Roth, 2005) and be acceptable to the service user. It is now considered that interventions for people with PD must be:

a) Needs led
b) Protocol driven
c) Evidence based
d) Derived from ‘best practice’
e) Clinically effective
f) Aimed at restoring self respect
g) Aimed at reducing the risk to the service user and to others to manageable proportions.

The impact on Service Development

There has been considerable development in the provision for people with PD in England and Wales, spurred on by publications rejecting PD as a “diagnosis of exclusion” from services (NIMHE, 2003a,b). As part of the recent developments in England, a number of pilot services for people with PD have been set up and are currently being rigorously evaluated. A number of working parties in Scotland have recently been considering these projects in both forensic and community settings, in order to see what lessons can be learned in terms of the development of Scottish Services. What is clear, is that there is a need for the development of specialist PD teams act as a bridge between mental health services and people with PD. It has been recognised that people with PD often have complex needs that penetrate the spheres of employment, housing, criminal justice matters, mental and physical health needs, and social integration. As a result of this, skilled workers from a variety of health and social service agencies are required to develop a high level of interdisciplinary and multi-agency working to meet their needs (NIMHE, 2003b).

<table>
<thead>
<tr>
<th>Psychological Therapy</th>
<th>Aims</th>
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<tbody>
<tr>
<td>Cognitive Behavioural Therapy</td>
<td>To alter dysfunctional core beliefs</td>
</tr>
<tr>
<td></td>
<td>To change behaviour</td>
</tr>
<tr>
<td>Dialectical Behaviour Therapy</td>
<td>To reduce self-harm and eventually to achieve transcendence</td>
</tr>
<tr>
<td>Cognitive Analytic Therapy</td>
<td>To achieve greater self-understanding</td>
</tr>
<tr>
<td>Dynamic Psychotherapy</td>
<td>To increase reflective capacity, and emotional and interpersonal understanding</td>
</tr>
<tr>
<td>Therapeutic Community</td>
<td>To effect attitudinal and behavioural change</td>
</tr>
</tbody>
</table>

Table 2 : Aims of Psychological Treatments for Personality Disorder (from Bateman and Tyrer, 2004)
In order to respond to this, staff will need to be equipped with the skills to work with these client groups, particularly to promote effective engagement. To date, few professions have given much weight to the needs of PD service users as part of their core training. Over the next few years, educational establishments responsible for the training of health and social care staff will rise to the challenge in developing such core training. For instance, the Department of Psychology at Glasgow Caledonian University is currently considering these very issues as part of their teaching and research programmes. A number of staff have a keen interest in personality disorder research. Their taught postgraduate programmes in psychology and mental health and forensic psychology put emphasis on the development of the kind of skills required for mental health professionals from a variety of backgrounds for effective working with personality disorder. The curriculae of these programmes focus upon the skills of risk assessment, working with co-morbidity, developing therapeutic approaches, and engaging service users in research that can inform service development. It is hoped that training developments in England will soon be mirrored in Scotland.

Conclusion
Historically, there has been a tendency to assume ‘untreatability’ in relation to PD. Despite these challenges, a philosophical change has been recognised in terms of the new Scottish Mental Health Act. It is recognised that personality disorder is a short-hand term for a set of complex and enduring mental needs that requires some sophistication on the part of service providers in order to meet these needs. Key to high quality service provision will be the development of staff training.

References

Treatment, 10, 378-388.
Diabetic Emergencies

by Dr Jane Nally, Mr David Cochrane and Dr Bill Young. Diabetes Education and Training Unit, Glasgow Caledonian University, Glasgow G4 0BA.

The number of people who have been diagnosed with diabetes is increasing. Currently about 3.5% of the population have diabetes and this figure is predicted to double in the next 10 years. More worrying is the estimate that there may be half as many again who have undiagnosed diabetes. In the UK, the prevalence within some minority groups is considerably higher, e.g. the prevalence in people over 55 with a Pakistani background is around 35% meaning that in some inner city areas levels of diabetes may be reaching epidemic proportions even today. With diabetes affecting such large numbers it is reasonable to assume that the number of diabetic emergencies will increase and Health Care Professionals and carers should be competent to identify such emergencies and to deal with them.

Diabetic emergencies usually relate to inadequate glycaemic control leading to plasma glucose concentrations critically falling (hypoglycaemia) or rising (hyperglycaemia). Plasma glucose levels can fall to dangerous levels within minutes, whereas increases tend to happen over hours or a day. Either situation may lead to unconsciousness and each is life threatening. Consequently it is vital to be able to establish the cause of the emergency.

Hypoglycaemic events occur most commonly in those people with diabetes who require insulin, however such events are also possible in people who take those oral hypoglycaemics that release insulin from the pancreas – the sulphonylureas and meglitinides. Some newer drugs that are likely to be licensed in the UK soon can also lead to hypoglycaemia - for example the incretin hormone Exenatide and the DPP-IV inhibitors sitagliptin and vildagliptin. Symptoms of hypoglycaemia may be experienced when the plasma glucose concentration falls below 4 mmol/l. The brain is liable to suffer from energy starvation if plasma glucose concentration falls below 2.5 mmol/l with the danger of coma and death if prompt action is not taken. Many parents of children with type 1 diabetes and many elderly people express fears about night time ‘hypos’, brought on by glucose/insulin imbalance. In addition, hypoglycaemia may be precipitated by exercise, alcohol or vomiting.

Figure 1 illustrates characteristic features of hypoglycaemia. Patients are often aware of the onset of hypoglycaemia but this awareness may be lost if the patient has had diabetes for some time, if they have had repeated hypoglycaemic events, if they have neuropathy, if they use very intensive insulin regimes or if they switch to human insulin from porcine or bovine forms. Hypoglycaemia should be treated by administration of glucose in the form of a drink or food with a high sugar content. This may be self administered or given by a carer depending on the severity of the blood glucose fall. This should be followed by complex carbohydrates to maintain blood glucose levels until the next meal. Less commonly, trained personnel may administer intra-muscular glucagon. Intravenous administration of glucose or glucagon by a Health Care Professional may be required in severe cases.

The other side of the coin is hyperglycaemia and the associated problem of ketoacidosis. Under conditions of starvation the human body can utilise fats as an energy source – the process of ketosis. In the absence of insulin, this process becomes pathological and ketoacidosis occurs, accompanied by dehydration, hyperglycaemia and ketonuria. In diabetes, ketoacidosis can therefore be described as a stage of uncontrolled catabolism associated with insulin deficiency and hyperglycaemia. There are, however, occasions when an excess of counter-regulatory hormones (cortisol, oestrogen, growth hormone, catecholamines) rather than a lack of insulin, can lead to this dangerous condition. ☢️
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Introducing Visio - the ultimate meter for parents with diabetes. Finally you can have all the best features packed into one system so wherever your patients’ needs the Visio is always the best choice.

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This becomes particularly important during illness such as a myocardial infarction, during and following surgery, after trauma, during infection or with stress or emotional disturbance. At these times it is extremely important that blood glucose be measured more frequently, perhaps every four hours or even more often. Figure 2 illustrates the characteristic features of ketoacidosis. A smell of acetone on the breath and “gasping” respiration distinguish the effects of hyperglycaemia from those of hypoglycaemia, where there is no smell of acetone and respiration is “shallow”.

Guidelines for hyperglycaemia have typically suggested that when plasma glucose concentrations are higher than 13 mmol/L and the patient is vomiting, then ketonuria will be expected. Recent studies have, however, suggested that some individuals can suffer from ketoacidosis despite normal blood glucose, suggesting that any patient with diabetes who becomes unwell should be checked, not only for hyperglycaemia but by testing blood gases and ketone levels in blood and urine. (De & Child, Practical Diabetes Int., 2001, 18, 239-240).

The management of ketoacidosis involves the rapid administration of insulin and the replacement of lost fluids and electrolytes. The urgent need to restore the acid-base balance must be stressed as a relatively small deviations from the normal pH of the body may be life threatening. High blood glucose levels are less dangerous than the acidosis and will stabilise faster than ketone levels. Insulin should not be stopped when blood glucose approaches normal if acidosis is still present and at this stage glucose may have to be administered until pH and ketone levels return to normal. It is not usually necessary to administer bicarbonate. In all cases of ketoacidosis the underlying cause should be determined and advice given to the patient to avoid a recurrence.

In most cases, it is relatively straightforward to determine the nature of the emergency. Co-existing morbidities may, however, cloud the picture and it is important that the key features of hypoglycaemia and hyperglycaemia are identified so that rapid reversal is achieved. Speed is of the essence in diabetic emergencies.
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“Life’s an itch - eczema and me”

National Eczema Week 16 – 23 September 2006

Healthcare professionals are being asked to look beyond the skin in their consultations with eczema patients.

National Eczema Week (16-22 September) is raising awareness of eczema as a physical and an emotional condition. Healthcare professionals’ recognition of the psychological impact of eczema is vital to improving management of the condition and patient care.

“Life’s an itch – eczema and me”, this year’s National Eczema Week sees the introduction of a new patient booklet ‘Mind over eczema,’ which provides information and advice on coping with the psychologically distressing aspects of living with eczema. It communicates the wider issues associated with eczema and helps sufferers identify with and manage emotions they may be feeling.

Consultant clinical psychologist Penny Titman, from Great Ormond Street Hospital, said: “Although eczema is often not considered as a serious medical problem, it has a marked impact on quality of life and can result in psychological difficulties for sufferers and their carers.

“The sensation of itching caused by eczema can make babies and children more irritable and this directly affects their behaviour,” Dr Titman continued. “It may also affect their ability to concentrate and learn at school and many children may experience teasing or bullying because of their appearance which can have an impact on their self esteem.”

In the 2005 ISOLATE (International Study of Life with Atopic Eczema) study, figures show that 71% of sufferers worry about their appearance, 29% have been bullied or teased because of their eczema, 24% have difficulty forming a relationship and 38% feel there is no release from eczema.

National Eczema Society Chief Executive Margaret Cox explains: “Eczema is on the increase affecting one in five children and one in 12 adults making it more important than ever to communicate that eczema is far more than a skin complaint, it can affect a person’s relationships, self esteem, career and can even lead to depression.

“We need greater recognition of the deeper impact eczema can have on a person’s life to help improve the medical advice and understanding that patients receive.”

As the only charity dedicated to the needs of people with eczema and their carers, The National Eczema Society offers professional membership to the healthcare profession which gives detailed information, support, a dedicated help line and access to a wide variety of printed information to improve understanding of the condition.

Dr Penny Titman added: “Caring for a child with eczema can be very stressful and it can have a psychological impact on parents of children with chronic eczema. In addition to having to manage the time consuming skin-care routine required, parents also have to manage the impact of the eczema on their child. However help is available and it’s important that people living with eczema – and healthcare professionals - recognise that support, advice and guidance is available through the National Eczema Society.”

To mark its awareness week, the Society has produced a new booklet on the psychological impact of eczema called “Mind over eczema”, which is available free during National Eczema Week by calling the Society’s patient helpline 0870 241 3604 or emailing helpline@eczema.org.

For further information about the National Eczema Society’s professional membership scheme, call the Society on 0207 561 8230 email: professional@eczema.org or visit: www.eczema.org
Case Study

Tania Carson (35), Surrey

“I hate waking up in the morning not knowing what I’m going to look like.”

Having suffered from eczema since she was nine months old, Tania Carson is no stranger to the emotional battle that comes with it. For years she ignored the fact that her eczema was making her ill until she realised it was taking over her life and she needed help.

“Because of my eczema I lost my natural confident nature which made me unable to stand up for myself. I became a victim of bullying all through school and into my adult years at work - just because I was an easy target.

“I was very good at keeping my feelings to myself and hoping the bad stuff would go away. I never discussed it with my family, but then they never discussed it with me. My eczema was almost taboo - it was like we were all trying to pretend it wasn’t happening. I was cocooned in my own sore, red skin. I realise now that I should have opened up to my family rather than keeping my feelings bottled up inside.

“Deep down I knew one day it would all catch up with me, and when it did it almost destroyed me. I’d hit rock bottom due to the break up of a relationship and I had been subjected to bullying at work. My whole world crumbled, so on the verge of a mental breakdown I decided it was time to get help.

“For the first six months of going to the therapy sessions I found myself avoiding the subject of my eczema, I didn’t believe that my skin could be the cause of all my problems. I had bottled it up for decades and just didn’t have the emotional strength to accept it.

“But therapy helped me to confront the issue head on and after a holiday under the advice of my therapist, it was time to open up and release the feelings that had been bubbling away for years. In the first session I remember I was having a ‘black’ day and I cried for 90% of the session, but gradually as the weeks passed, the emotional pain grew less and less and I was able to talk more openly and confidently about my condition.”

Despite overcoming her ‘eczema demons’, Tania’s condition still has a huge impact on her life.

“Every morning I wake up and wonder what I’m going to look like. There are three Tanias. On a good day, when my skin is clear, I can go up to people and look them in the eye with confidence. On an average day, when my skin is dry and flaky, I can get on with things, but am aware of my skin. On bad days, when my skin has flared up, I feel insecure, I cover myself up and try to avoid other people. I hate not knowing who I’ll be.

“I really want children, but fear they would be atopic too. It would be awful to watch my own child suffer the same way I did. It’s taken me 30 years to learn that eczema affects sufferers mentally as well as physically, so at least if my children do have eczema, I am in the best position to help them come to terms with it.”

Case Study

Tina Gibbins and Lily-Marie

Five-year-old Lily-Marie Gibbins has been told she sparkles like a mermaid and is the envy of her classmates. Yet her mum Tina (34) had dreaded the day her daughter started school.

Tina has managed Lily-Marie’s severe eczema since she was a baby. She has nursed her daughter through the exhausting baby and toddler years and prepared her for the transition to an independent child managing her own condition at school.

Living with her child’s eczema has at times taken its toll on Tina who admits to feeling helpless, desperate and alone. “The hardest part is not being able to make the itching stop. When you become a parent you expect to be able to make your child’s world safe, happy and comfortable. For parents whose child has severe eczema, that world is suddenly turned upside down.”

Lily-Marie first showed signs of eczema when she was four months old. “The hardest part of looking after a child with eczema is having to watch them scratch. It can be difficult to find diversions for Lily-Marie and without them, she just tears at her skin. She once scratched so much that she took a chunk out of her ankle and couldn’t wear shoes for weeks. Yet people still say ‘it’s only eczema’.

“Twelve months ago all I wanted was the peace of mind that my daughter would be like any other child when she started school and not just “the child with eczema”. She is a child and she does have eczema but while it takes a lot of managing and keeping on top of, to look around Lily-Marie, at the friends she has and the things she does, she really is like any other child.

“Knowing that is the best management technique we could ask for.”
Continence

Killing the ‘A’ Dragons
by Ian Holland, Information Officer, Continence Foundation

A woman is visiting her GP. Although she has been there many times before, she is ill at ease on this occasion. After exchanging a few pleasantries, she steelies herself for a moment, then tells him that she is leaking whenever she coughs or lifts her shopping or picks up her grandchildren. She has had the problem for years, she tells him, but it has become much worse during the last few months. The doctor leans back in his chair. “Well,” he says, “You’re 50, you’ve had three children – what do you expect?”

Happily, most GPs are far more enlightened. But if the above scenario is extreme, it is by no means unique. My charity’s Helpline receives calls from distraught or depressed women telling similar tales at least once a month. And how many other people give up hope entirely after equally dismissive reactions from other health care professionals – people we never hear from?

Incontinence is not a subject foremost in the mind of many non-specialists. But there are three reasons why all nurses owe it to their patients to become more knowledgeable and proactive about incontinence: the number of people affected (see box copy); the effect the condition has on their quality of life; and the reticence they display in presenting with their symptoms.

“A miserable and lonely condition”
That was how one woman described her condition to me. The trouble with today’s society, still, is that incontinence is a taboo subject. People with a bladder or bowel problem often feel stigmatised, ashamed and unable to talk openly about their symptoms. For a combination of these reasons, an estimated 42% of women wait up to 15 years from the onset of their condition before seeking professional help.1 Many women keep it a secret from their husbands. One caller to our Helpline said that whereas some husbands and wives might have a cuddle if they meet up in the kitchen or pass by on the stairs, she just wanted to reject the contact because she felt “dirty in myself.”

Research shows that incontinence can have a dramatic impact on the mental, emotional and physical well? being of those people affected. A recent study2 found that 8% of women and 6.2% of men with clinically significant symptoms said they were ‘a lot of bother’, and 3.2% of women and 2.2% of men with clinically significant symptoms said their incontinence was ‘socially disabling’ and had ‘a lot of impact on social life, relationships, feelings and quality of life’.

Many non-specialist nurses may never be faced with any but the most overt cases of incontinence and infer - reasonably enough - that the vast majority of their day-to-day patients do not have a problem. But that is an ‘A Dragon’. A friend introduced this bit of market-speak to me a few years ago. The ‘A’ is for ‘assumptions’, and the trouble with them is that, like dragons, they can be dangerous if left to roam free.

Just because patients are reticent about the subject, this does not mean that they do not have a condition. It would be from the inhibiting factors of shame and embarrassment already touched upon, many people have ‘A Dragons’ of their own. Some assume that nothing can be done, and never investigate the possibilities open to them. A considerable number of women (and some GPs) think it is an inevitable consequence of childbirth or ageing. There is also a widespread misapprehension that any treatment will involve drastic surgery.

This is a great pity, because the symptoms can always be alleviated - and often cured - with appropriate treatment. A 70-80% cure or improvement rate of suitable cases in primary care has been reported.1 And many treatments exist to deal with bladder and bowel problems. These usually involve conservative measures in the first instance. Examples include pelvic floor exercises, lifestyle changes such as reducing caffeine intake, and techniques to retrain the bladder. However, a variety of medicines and minor surgical procedures are available if other alternatives are not successful.

Why Nobody is Incontinent
Given all the ‘A Dragons’ stopping people from presenting with incontinence, the onus is on all nurses to take the lead in identifying patients with bladder or bowel problems. An excellent way to achieve this is by instigating pro? active questioning about symptoms of at? risk groups, such as school age children, pregnant women, recent mothers, menopausal women, older people and their carers, and people with disabilities. This should entail not only positive ‘screening’, but interventions to raise the subject during unrelated consultations.

Sensitivity is required in these instances and it is best to use words and phrases the patient is comfortable with, while avoiding emotive terms such as incontinence. Many people associate that word with a total loss of control. One caller to our Helpline was indignant that the word had been applied to her. “I’m not incontinent,” she said. “I just leak a little.” People often respond more positively to questions couched in terms of ‘leaking’, ‘damp pants’, or ‘occasional wetness’.

Creating a welcoming environment in a surgery or ward can encourage people to broach the subject. Displaying informational materials, such as posters, or having a small supply of patient leaflets placed where copies can be discreetly picked up, can coax many people into seeking a nurse’s advice. These materials show that the nurse is aware of the condition, and create an ambience in which patients feel more able to raise the issue of their condition.

In terms of the actions you take after identifying a person with a continence problem, you should have an agreed care pathway for onward referrals.

Patients presenting with incontinence should be offered an initial assessment by a suitably trained individual, without which even the simplest treatments should not be started. This assessment is in addition to the usual general patient assessment in respect of mental health, mobility and underlying conditions and might not be conducted at a single consultation. One option is to refer patients with continence problems to a specialist continence service for initial assessment and treatment.

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Every September the Continence Foundation organises a publicity campaign. The campaign has two goals. First, to raise awareness of the professional help available to anyone who has a continence problem. Second, to combat the prejudice and misunderstanding that surrounds the subject of incontinence by promoting positive media coverage of the condition.

This year, Continence Awareness Week will tackle a wider topic than usual. Instead of focusing on a particular aspect of the condition, such as stress incontinence or overactive bladder syndrome, its theme will be bladder and bowel problems as a whole. The secondary purpose of this campaign will be to encourage people who last investigated treatment and management options a number of years ago - perhaps unsuccessfully - to try again in light of recent advances in these areas.

As usual, we are launching a colourful and informative leaflet for the public during Awareness Week. Called ‘Bladder or Bowel Problems?’, the leaflet explains - in general terms - the most common types of continence problem, and outlines the latest treatments, medicines, surgical options and products available. It tells how to request more detailed information from the Foundation free of charge, and gives the contact details of our Helpline, which is run by continence nurse specialists. Finally, it describes how to get professional help from UK NHS Continence Advisory Services (the Foundation can provide details of all Services via its national database).

Our 1,300+ Campaign Supporters receive a free supply of leaflets in our Campaign Pack. The Pack also contains A4-sized posters giving our Helpline number. In addition, the posters have a label-sized space where appropriate local contact details can be added. Other items in the Pack include self-adhesive ‘toilet stickers’ and some multi-coloured balloons featuring our ‘megaphone bladder’ campaign logo.

Our supporters distribute and display these materials within their own communities (GP surgeries, wards, pharmacies, libraries, shopping centres, etc), so that they come to the attention of members of the public. The Campaign Pack also contains press releases and useful information for supporters who wish to organise local events during Awareness Week, such as information stands or special ‘drop in’ clinics.

Prevalence – how big is the problem in Scotland and Ireland?

Urinary Incontinence

A recent study conducted in France, Germany, the UK and Spain revealed remarkably consistent prevalence figures for female urinary incontinence in women aged 18 or older: 44%, 41% and 42% respectively for the first three named (Spain had a lower prevalence of 23%, but this was possibly due to cultural factors).

By reference to the 2001 census, which reported the female population of Scotland aged 20 or older to be 2,031,270, a prevalence of 42% equates to 853,133 women. Applying the same percentage to the Northern Ireland census return in 2001 yields a figure of 260,247 women aged 20 or older, while comparison with population data from the Republic of Ireland’s Central Statistics Office for women aged 20 or older in 2002 reveals a figure of 594,249 - giving an all-Ireland total of 854,496.

Male prevalence is less well researched, but in 2000 a study conducted in the UK found that 28.5% of men aged 40 or older have clinically significant symptoms of one or more bladder problems. Applying this percentage to the relevant population sources used above, this means that 318,078 men are affected in Scotland, 93,485 in Northern Ireland, and 173,310 in the Republic of Ireland – an all-Ireland total of 664,873.

Faecal Incontinence

Few studies have been made compared to urinary incontinence. However, a report from the Royal College of Physicians3 found that 0.4% of men and women aged from 15-64 were affected by faecal incontinence, rising to 4% in the 65-84 age range and increasing to 15% in men and women of age 85 or older. Again referring to the population sources used above, this is equivalent to 55,313 people in Scotland, 15,858 in Northern Ireland, and at least 32,425 people in the Republic of Ireland (separate population figures for people aged 85 or older not available) – an all-Ireland total of 48,283. It should be noted for these figures that faecal incontinence is grossly under-reported.

Box Copy References:


Urinary Incontinence in Children

by Anne Weaver RGN - Helpline and Clinical Assistant ERIC
Penny Dobson Msc, RGN, CQSW - Director ERIC

Introduction
There is a general expectation that children will be toilet trained between the ages of two and four years and dry at night before starting school. However, for many, this does not happen and wetting accidents continue beyond this age. For others, wetting might start again at a later stage. In the UK it is estimated that over 500,000 children between the ages of five and 16 experience bedwetting (nocturnal enuresis) and over 125,000 wet in the daytime. The true figures could be higher as parents are sometimes reluctant to talk about the situation, fearing blame or judgement.

The effects on children and their families are often under-estimated. Children with continence problems often miss out on school trips and sleepovers and memories of social exclusion can affect self-esteem into adult life (Hagglof et al 1997). Changing sheets and underwear; extra washing, and coping away from home can increase pressure and one third of parents admit to punishing their children (Butler et al 2005).

The primary health care professional is ideally placed to give early support and advice. This can reduce the duration of the problem and help to improve the lives of children and their families.

Bedwetting (Nocturnal enuresis)
Nocturnal enuresis is defined as "an involuntary voiding of urine during sleep, with a severity of at least twice a week, in children aged five years or older, in the absence of congenital or acquired defects of the nervous system" (American Psychiatric Association, 1995). The International Children's Continence Society (Neveus et al 2006) has agreed a definition based upon the "leakage of urine while sleeping", regardless of the presence or absence of daytime symptoms, such as urgency or frequency.

Causes
There are three identified causes that form the basis for assessment and treatment, known as the Three Systems approach (Butler and Holland 2000).

System 1: Low nocturnal vasopressin levels.
Studies show that some children who wet the bed lack an adequate circadian rhythm of vasopressin (AVP) that regulates urine production during sleep. This results in an amount of urine that exceeds bladder capacity, thus increasing the risk of wetting.

Indications are: - wetting happens early in the night; large patches and dilute urine.

System 2: Bladder over-activity and low voided volume.
This can cause wetting when the detrusor muscle contracts, causing the bladder to empty before it is full.

Indications are: - daytime urgency or frequency; smaller patches sometimes more than once a night and waking after wetting.

System 3: Lack of arousal from sleep.
Some children are not aware of the signal from bladder to brain to wake up and 'hold on'. This is outside conscious control.

Indications are: - child sleeps through wetting.

Other factors include:-
- Genetic predisposition - 70% of sufferers have a parent or sibling who wet the bed as a child (Bakwin 1971)
- Stress - Anxieties or change can "trigger" bedwetting in children who were previously dry (secondary nocturnal enuresis).

Assessment
Early intervention is preferable, as it is probably only those children with mild symptoms who will spontaneously "grow out of it" (Yeung 2006). An assessment
Incontinence

based on the Three Systems (see above) is the key to offering appropriate treatment options for the individual child and family. Enuresis clinics usually see children around the age of seven. It is important to identify the pattern of the wetting, explore the attitudes of the child and parents and arrange a medical examination, including a routine urine test, to exclude any underlying health problem. Charts can be useful to record accurate baseline information and can be an incentive to the child, but should focus on behaviour the child does have control over e.g. drinking good levels of fluid, rather than dry nights.

**General advice to help all children from the age of five**

- Drink six to eight cups of water-based fluid at regular intervals throughout the day.
- Establish a regular routine for going to the toilet.
- Ensure the bladder is fully emptied.
- Have a smaller drink before bed.
- Go to the toilet last thing before settling down to sleep.
- Monitor types of drinks as some may increase urinary output e.g. fizzy drinks.
- Ensure the toilet is accessible with a soft night-light.
- Discontinue using night-time absorbent pants and use suitable bedding protection.
- Provide families with details of ERIC for support and resources.

**Treatment options**

It is important that treatment is acceptable to the child and family.

**Enuresis alarm (consider for systems 1 and 3)**

- Alerts the child when urine hits sensor
- Designed to help child to wake up and "hold on"
- Successful in 65-70% of children (Forsyth & Butler 1989)
- Requires well motivated child and family support
- Most suitable for children over seven
- Sometimes suitable from five years depending on the child’s understanding of the alarm system.

**Medication**

*Desmopressin (consider for system 1)*

- Analogue of the natural vasopressin, in tablet or melt form.
- Licensed for children over five years.
- Has around 70% success rate (Caione et al 1997).
- Treatment should be assessed at three-month intervals.
- Limit fluid intake for two hours before and eight hours after taking it.

*Oxybutynin (consider for system 2)*

- Anticholinergic medication that reduces over-active bladder contractions and increases bladder capacity.
- Licensed for children from five years (little research to confirm its effectiveness at this age).

**Bladder training (consider for systems 1, 2 and 3)**

- Regular toilet routine.
- Encourage complete emptying of bladder.
- Six to eight water-based drinks spread over the day (see general advice).

**Daytime Wetting**

Daytime wetting, or urinary incontinence, is defined as the “leakage of urine in children over the age of five years which occurs at least once per week and where there is an organic cause” (Hjalmas 1992).

**Causes**

Younger children may be engrossed in play and leave it too late before going to the toilet. Wetting may also be triggered by a change in routine or mild illness.

In the over fives, the organic cause can be a neurological or urological abnormality, such as the urethral valves or sphincter incompetence, or it can be functional with no underlying anatomical or neurological problem. Functional daytime wetting is almost always urge incontinence due to an over-active bladder (Hjalmas 1992). Urinary tract infection and constipation are also factors to consider.

**Assessment**

This will include a routine urine test and an ultrasound of the bladder and kidneys in the over fives. Questions should also be asked about the pattern of the wetting accidents, history of urinary tract infections and any related emotional factors. A record chart is useful to provide baseline information and to monitor progress.

**Treatment**

If there is no evidence of a urinary tract infection, or signs of other abnormalities, the advice is:-

- drink at least six to eight cups of water-based fluid per day spread out over the day
- take time to empty the bladder fully
- establish a regular toileting routine use a prompt such as “1-2-3 do I need a wee” or a vibrating wristwatch as a reminder
- check the accessibility to drinking water and school toilets
- teach pelvic floor awareness for older children.

**Further treatment**

It can take time for daytime wetting to resolve. In persistent cases, consider a referral to a paediatric urologist or nephrologist for further investigations, including urodynamics tests and cystometry, to assess bladder function. Some children benefit from combining the general treatment strategies with anticholinergic medication such as oxybutynin to increase bladder capacity (see previous).

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References:
1. Pusey P et al. Feeding is infants with increased energy requirements. Irish Paediatric Association Meeting, May 1996.
4. SMA High Energy is a milk-based and therefore not suitable for babies with lactose or milk intolerance or galactosemia.
5. SMA High Energy is a milk-based formula for the dietary management of infants and young children with modestly elevated energy requirements as identified by a doctor or dietitian. It is suitable for use in infants and young children up to eighteen months of age, either as the sole source of nutrition or in conjunction with solid foods as advised by a doctor or dietitian. It is not recommended for use in infants under twelve months of age. SMA High Energy is not intended for use with infants premature, below term, for infants of low birth weight or for infants of very low birth weight. However, SMA High Energy may be used, under medical supervision, after these babies are discharged from hospital.

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Previous exhibitors views -

I would like to thank you once again for a wonderful recruiting experience while attending the Irish Nurse Nursing and Healthcare Exhibition in Dublin. As always, your commitment to your customer was obvious and very much appreciated. The entire team made themselves available to our needs and I feel this type of customer service is a reflection of a truly professional organisation.

The overall event was a success for our organisation as we felt the quality of candidates was excellent and of the working category which is essential to our product. We were able to meet several candidates that expressed interest in our service and now it is up to us to complete the process. The facilities at the Royal Dublin Showground were very good and the logistics for set-up were problem free.

Barry Brown, Assignment America

The Irish Nurse Recruitment Fair in Dublin provided us with an opportunity to maintain our profile in the nursing sector and network with our clients.

Gerry Donohoe, Alliance Nurses Agency

The Irish Nurse Recruitment Fair was well organised and the staff were extremely friendly and helpful.

Mary Brosnan, National Maternity Hospital, Dublin

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SEMINARS

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For more information contact Mark Renshaw at KCI-UK on 01865 840 695 or visit www.kci-medical.com.

Managing Acromegaly in the community: A shared car approach new document for health professionals

Ipsen Limited, the UK subsidiary of the Ipsen Group, has launched an updated information resource for health professionals entitled ‘Managing acromegaly in the community: a shared care approach’ to facilitate the management of patients in primary care.

The resource, developed by a panel of endocrine and practice nurses and endorsed by the Endocrine Nurse Committee of the Society for Endocrinology, outlines a best practice approach to managing people with acromegaly in the community and is based on evidence and clinical experience. It also provides guidance on a shared-care approach to patient management to ensure continuity of care and improved patient outcome.

Acromegaly is a rare condition in adults caused by the prolonged, excess release of growth hormone (GH) from the pituitary gland and affects approximately 2,000 – 2,500 people in the UK. There are many different symptoms of acromegaly ranging from enlargement of the hands, feet and head, protrusion of the jaw and joint stiffness to high blood pressure and impaired glucose tolerance.

Long-acting somatostatin analogues are the first-line treatment for people with acromegaly who require medical treatment. To improve adherence to treatment and quality of life, long-acting somatostatin analogues are now routinely administered in the community as part of a shared-care agreement between secondary and primary care. This resource will be a useful tool for health professionals involved in the management of people with acromegaly in the community.

Copies of the resource can be obtained from: Medical Information Department, Ipsen Ltd, 190 Bath Road, Slough, Berkshire, SL1 3XE. t: 01753 627777 e: medical.information.uk@ipsen.com

Ipsen is an innovator in the production of peptides and proteins, and in controlled-release technology. The company is supporting Somatuline®-Autogel® by providing services and educational resources for health professionals and patients.

Hammersmith Hospital installs the Dräger Medical Ponta architectural system because of its greater flexibility

The General ICU at Hammersmith Hospital has recently taken delivery of Dräger Medical Ponta architectural beam system for its new intensive care unit. The Ponta beam system is explicitly designed to enable development of a comprehensive adult or neonatal intensive care workplace, an ICU, intermediate care or recovery rooms. It provides Hammersmith General ICU with a very flexible solution as it is designed explicitly to support critical care workflows, and yet is easily adapted to suit the ever changing patient requirements.

The decision to opt for the Ponta beam system as opposed to a “pendant” style system was made by Lisa Walters, Head Nurse of the General Intensive Care unit, following comprehensive research on architectural systems at a number of ICU’s across London, and in collaboration with the nursing and medical staff.

Ponta’s equipment carrier can be moved lengthways along the supply beam and rotated on the swivel arm to optimise bedside access. The system’s flexibility means that the hospital can adapt its day-to-day work processes to the general needs of the ICU and the specific requirements of individual patients. The “hidden difference” in the design of the Ponta – no cables or hoses around the patient’s head – helps to create a calming environment, making the hospital stay a more positive and soothing experience not only for the patient, but also their family and friends.

NEW DATA FOR RISPERDAL® CONSTA™

Data presented this week at the British Association of Psychopharmacology annual meeting showed a 64.1% reduction in hospital admissions when patients with schizophrenia were switched to risperdone long-acting injection (Risperdal® Consta™) from their existing medicaton.

Data were collected for 12 months prior to the commencement of Risperdal Consta and 12 months post commencement of Risperdal® Consta™ for 100 patients with a diagnosis of schizophrenia. 33 of the patients were inpatients and 67 were outpatients at the commencement of Risperdal® Consta™

Study author, Professor Keith Lloyd, Professor of Psychological Medicine at Swansea University said, “The results represent impressive findings given that this was a chronic population and adherence to oral medication had generally been poor.”

Risperdal Consta is the only long-acting atypical antipsychotic licensed for the treatment of schizophrenia.

BAYER DIAGNOSTICS HELP TO REMOVE THE DOUBT FROM hCG TESTING IN DERBY

Pregnancy testing at Derby City Hospital, Derbyshire Royal Infirmary and many of the city’s GP practices, is currently being standardised on the Bayer Diagnostics Clinitek Status® Urine Chemistry Analyzer.

The Clinitek Status® was chosen as it is a meter-read system that takes away the subjectivity associated with visually read pregnancy tests. This is particularly important in a hospital environment where clinicians must avoid carrying out certain procedures on patients who may be pregnant. In Derby, hCG testing is now routinely undertaken in heavy use departments such as gynaecology and A&E as well as in light use units including X-ray and surgical and medical assessments.

Staff reaction has been very favourable – the system is easy to use and provides an automated reading facility for both MultiStix® urine test strips and Clinitek hCG cassettes. With a 200 test memory and the ability to print out results and download data to computer, the Clinitek® Status provides a detailed audit trail for near patient urinalysis.

For more information please contact
Theresa Shapland, +44 (01635) 666265, theresa.shapland.ts@bayer.co.uk
NATURAL RELIEF FOR THE GREATEST CAUSE OF DISABILITY IN THE UK

Osteoarthritis affects an estimated 8 million people1 in the UK. But now there is no need to either suffer the pain of arthritis or to put up with the risk of side effects from taking powerful non-steroidal, anti-inflammatory (NSAID) or COX-2 inhibitor drugs. New clinical evidence has shown that a natural product — glucosamine — is effective in relieving pain associated with most forms of osteoarthritis.

Derived entirely from natural sources Oxst from Goldshield is a premium glucosamine sulphate supplement designed specifically to promote joint health and reduce the pain associated with arthritis. Glucosamine is naturally produced in the body from a sugar (glucose) and an amino acid (Glutamine) to form an integral constituent in the structure of cartilage, tendons and ligaments, which are consistently being regenerated in the body. Supplemented with glucosamine is considered to be highly beneficial in helping to protect the joints and giving relief from the pain associated with osteoarthritis and sports damage6.

Flexeze is also available from pharmacies at £15.22 for 60 tablets (820mg glucosamine and 200mg chondroitin plus vitamin C and calcium) or on prescription from your doctor.

1. http://www.arc.org.uk
2. http://www.bbc.co.uk
3. As reviewed in the New England Journal of Medicine;
   43:1772-1779, 2001; The Lancet
4. A randomised double-blind study, involving 212 patients, has shown a reduction in joint changes for patients treated with glucosamine for 3 years compared to placebo — Regenstein JF, Genetly P, Rolland LC, Lee RL, Lappere E, Brugere G et al. Long-term effects of glucosamine sulphate on osteoarthritis progression: a randomised, placebo-controlled clinical trial. /Hid
   1.25mg/day on two occasions daily for 8 weeks. The treatment was effective in reducing pain, inflammation and stiffness. Results were also significant in improving mobility and allowing greater participation in daily activities. The treatment was well tolerated by patients.

VARIOP MODULAR OPERATING THEATRE – NOW DIRECT FROM MAQUET

With immediate effect, Maquet Ltd based in Sunderland, Tyne and Wear, will be directly responsible for the sale, installation and support of the company’s VARIOP modular operating theatre in the UK.

Working with Maquet in Germany, where the VARIOP is manufactured, Maquet Ltd will also undertake site surveys, assist in planning surgical departments and offer a comprehensive theatre design service.

Maquet in the UK will also project manage the VARIOP modular theatres from initial site preparation through to final handover. A dedicated VARIOP team has been formed to bring together the engineering and clinical expertise essential for such projects. It will be backed by Maquet’s experience of installing more than 2200 VARIOP modular operating theatres over the last 30 years.

Architects, contractors and trusts will now have direct access to this experience and the specialist skills necessary to take a project through from planning and design to handover.

For more information on VARIOP modular operating theatres, contact: Maquet Ltd Tel: 0191 519 6200 e-mail: sales@maquet.co.uk

IPSEN LAUNCHES DECAPEPTYL® SR 11.25mg IN PRECOCIOUS PUBERTY

Ipsen Limited, the UK subsidiary of the Ipsen Group, has launched Decapeptyl® SR 11.25mg (triptorelin), a gonadotrophin releasing hormone (GnRH) analogue, for the treatment of central precocious puberty (CMP) in boys before eight years in girls and nine years in boys). Decapeptyl® SR 11.25mg is the only three month formulation with this licensed indication.

Precocious puberty, which occurs more frequently in girls than in boys, is generally defined as the appearance of secondary sex characteristics before the age of eight years in girls and nine years in boys. Secondary sex characteristics include breast development in girls, genital enlargement in boys, and the appearance of pubic hair.

Precocious puberty has important and diverse consequences for the affected children and their families and its impact can be physical and psychological. The indication for the treatment of precocious puberty may be either psychosocial, behavioural or auxological, or a combination of both. It may be important to regress or arrest the signs of puberty that may be distressing to a young child and to decrease the rate of bone maturation.

The primary aim of treatment is the suppression of gonadotrophin secretion and therefore of gonadal sex steroid secretion i.e. lowering the levels of oestrogen, testosterone and progesterone in the body. In a trial of 84 children (54 girls and 10 boys) with central precocious puberty, Decapeptyl 11.25mg was administered as a three-month depot injection for 12 months. The main efficacy criterion LH £ 3 I/U/L was met in 85% of patients at month 3, 97% at month 6 and 96% at month 12. Serum FSH and sex steroids were also significantly reduced, while pubertal development regressed in most patients.

The dosage of Decapeptyl® SR 11.25mg is one intramuscular injection repeated every three months.

Treatment should be stopped around the physiological age of puberty in boys and girls and should not be continued in girls with bone maturation of more than 12 years3. Treatment should cease in boys with a bone maturation of 13-14 years.

Decapeptyl® SR 11.25mg costs £2074.

REVOLUTIONARY HAND HYGIENE RANGE LAUNCHED BY LEADING UK HEALTHCARE COMPANY........

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This non-alcohol based range is available in 50ml tottle, 300ml & 500ml bottles and 800ml pouches for wall mounted dispensers. Vernon-Carus have a fully certified dispenser survey and fitting service that makes the change over to AZOIC™ easy and straightforward.

The active ingredient in all the AZOIC™ products is G-Cide™ a revolutionary new disinfectant which is safe and very effective in the fight against healthcare associated infection. For more information on AZOIC™ and G-Cide™ please contact Amanda Smith on 01772 299969 or email: azoric@vernon-carus.co.uk

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VITALOGRAPH SUPPORTS NEW HEALTH AWARENESS CAMPAIGN

The British Lung Foundation and Vitalograph are delighted to support a new initiative - a health awareness campaign focusing on truck driver’s health. The Health Challenge Campaign is being managed by a trade magazine, Commercial Motor and has several sponsors such as Shell, Iveco, Renault Trucks and Truckfest.

The campaign was highlighted at the SED Annual Show held in Corby Northamptonshire where professional nurses carried out lung tests using the popular Vitalograph Alpha spirometer. This is a 12 month long campaign and a fantastic opportunity for the BLF and Vitalograph to be highlighting the importance.

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Email: Elizabeth.Lcox@sesahs.health.nsw.gov.au
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Please include brief CV with names and contact numbers of two professional referees (no written references please) and applicant’s telephone contact.

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Further details may be obtained from Mrs Sandie Gracia, Clinical Nurse Manager - Alocations on Tel: 00-350-72266 ext .

For an application pack please contact the HR Department, Gibraltar Health Authority, St Bernard’s Hospital, Gibraltar, on (Tel: 00-350-46194) (Fax: 00-350-43864) (e.mail lizanne.wink@gha.gi)

Applications must reach the Human Resources Manager at the above address not later than Monday 25th September 2006.

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This programme has both February and September intake of students.

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Further Education Colleges welcome more nurses onto complementary therapy courses

British consumers spend over £130 million on herbal remedies, aromatherapy and other alternative treatments each year and it is predicted that this figure will rise and that the market will be worth £200 million by 2008. One in two Britons has visited an alternative health practitioner such as an osteopath, aromatherapist or acupuncturist and the industry as a whole is estimated to be worth £1.6 billion.

All this has meant a huge growth in job opportunities in the field of complementary therapy with many people seeking to get the appropriate qualifications along with recognition by the relevant professional body. It has also meant that the general public is more likely to expect some degree of knowledge of these therapies from their traditional healthcare providers – pharmacists, GPs and nurses.

Over the last few years many general practices have embraced these developments and responded to demand by providing some complementary therapies, with some GPs and primary health care teams trained in at least one complementary therapy.

Research published in 2004 by Developing Patient Partnerships revealed that 71% of people would like to discuss complementary medicine with their GP or pharmacist and 63% thought it should be available on the national health. But 85% of GPs felt they didn’t have enough knowledge and information on the safety and efficacy of complementary medicine.

Nurses frequently incorporate therapies such as massage, aromatherapy and reflexology into their practices and as a consequence much of the responsibility for improving the knowledge of a healthcare team and dealing with patients in this field is falling on their shoulders.

Moira Frizzell, Head of Faculty for Child Education, Health & Social Care at Stevenson College Edinburgh, says: “More and more of the places on our complementary healthcare courses are being taken up by nurses who not only have an interest in this area but who also see the demand for it from their patients on a day-to-day basis and are seeking to fulfil that demand. Many studies report high levels of satisfaction amongst users of complementary therapies with many using it to relax and promote well being. Most users will use complementary medicines and therapies alongside traditional orthodox medical care.”

To meet the increasing demand, both from the general public and healthcare practitioners, further education colleges across Scotland have been introducing new courses covering a range of complementary therapies. Of the 46 Scottish FE colleges, three offer access or introductory courses and 11 offer courses at HNC and HND level, but many others offer individual courses in some of the better known therapies such as reflexology, aromatherapy and massage.

Stevenson College in Edinburgh is one such college which now offers a range of five courses, three of which are brand new for the autumn term: Swedish Massage, Aromatherapy and Reflexology all of which are available at VTCT Level 3 Certificate on a part-time or evening basis. Stevenson also offers an evening course in Homeopathy and a Level 3 VTCT Diploma in Holistic Therapies which is available as a one year full-time or a two year part-time course and includes aromatherapy, full body and advanced massage and reflexology.

There are still places on the 10 week evening homeopathy course, starting September. More courses will run again in January 2007. For more information on these or any other courses at Stevenson, please contact their Student Advice Centre on 0131 535 4700 or email info@stevenson.ac.uk. Alternatively, contact your nearest
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