The ROYAL MARSDEN
NHS Foundation Trust

The context of nursing

Sample chapter

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Chapter 1

The context of nursing

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The Royal Marsden Manual of Clinical Nursing Procedures: Professional Edition, Tenth Edition. Edited by Sara Lister, Justine Hofland and Hayley Grafton.

Overview

This introductory chapter presents an overview of the current context of nursing as well as outlining the purpose of the book and providing details of how it is structured. It also includes an explanation of the system used to grade the evidence that supports the clinical procedures.

Background

The first edition of *The Royal Marsden Manual of Clinical Nursing Procedures* was produced in the early 1980s as a core procedure manual for safe nursing practice within The Royal Marsden NHS Hospital, the world's first cancer hospital. Implicit behind that first edition was the drive to ensure that patients received the very best care, including clinical procedures carried out with professional expertise combined with an attitude of respect and compassion. This vision is still at the forefront of nursing in The Royal Marsden today, reflected in two of the themes of The Royal Marsden's *Nursing Strategy 2016–2018* (Royal Marsden NHS Foundation Trust 2015) (Box 1.1).

Context of nursing

It is argued that the role of the nurse is as essential in responding to the healthcare needs of society today as it was over 30 years ago. In the current NHS England *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff* (NHS England 2016) it is stated that:

> Though the world has changed, our values haven't. As nursing, midwifery and care staff we know that compassionate care delivered with courage, commitment and skill is our highest priority. It is the rock on which our efforts to promote health and well-being, support the vulnerable, care for the sick and look after the dying is built. (NHS England 2016, p.5)

However, in 2020 the context of nursing is different in many ways from that in 1984, when the very first manual was published. In this chapter, two specific influences are identified: political and professional.

Box 1.1 Themes of The Royal Marsden's *Nursing Strategy 2016–2018*

1 Delivering safe, effective and harm-free care
2 Providing a positive experience of care that exceeds expectations

Political context

Nurses are the largest group of employees in the NHS, so the context of nursing in the 21st century is shaped by the situation in the NHS. The aforementioned *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff* (NHS England 2016) (Figure 1.1) was based on the NHS's *Five Year Forward View* (NHS England 2014), which highlighted the changes taking place in society:

- changes in personal health needs and preferences as we live longer with increasingly complex and more long-term conditions, as well as a need to take increased responsibility for our own wellbeing
- changes in technology and developments in medical research with opportunities arising from these advances that need to be embraced to further enhance treatment and care
- reductions in funding provision because of the global recession that began in 2008.

Unwarranted variation

One of the core principles of the NHS when it was founded 70 years ago was that it should 'meets the needs of everyone' (NHS Liverpool Heart and Chest Hospital 2018, p.1; see also NHS England 2018a). This has continued to guide the development of the NHS; however, as identified in the *Five Year Forward View* (NHS

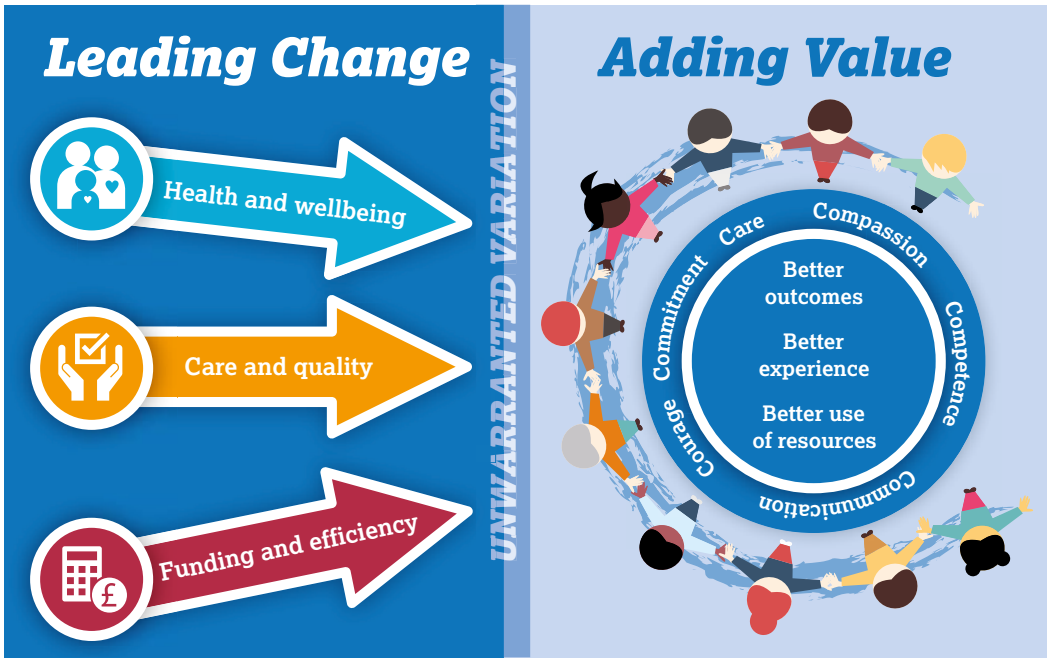

Figure 1.1 *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff. Source*: Reproduced from NHS England (2016) with permission of the NHS.

Box 1.2 Unwarranted variation: turning intention into action

- Taking a closer look at what we do: for example, benchmarking our procedures against the evidence-based procedures in *The Royal Marsden Manual of Clinical Nursing Procedures*.
- Uncovering activities that we need to change, add or take away.
- Challenging established practice because we understand that service can be delivered in a better way: for example, using the online version of *The Royal Marsden Manual of Clinical Nursing Procedures* to upload and disseminate agreed examples of good practice across an organization.
- Striving for high-value care: for example, reviewing equipment and the medication involved in procedures, or exploring whether procedures are being carried out by the most appropriate member of the team.

Source: Adapted from NHS England (2018b, p.11) with permission of the NHS.

England 2014), changes in society are contributing to three distinct gaps that, if they are not addressed, will impact the long-term provision of healthcare and increase inequalities:

- *Health and wellbeing*: a focus on prevention is needed or the inequalities in health will continue to grow and the budget for healthcare will need to be spent on avoidable illness and not on the development of new treatments.
- *Care and quality*: health needs will go unmet unless we reshape care, harness technology and address variations in quality and safety (NHS England 2018b, p.8).
- *Funding and efficiency*: without efficiencies, a shortage of resources will hinder care services and progress (NHS England 2018b, p.8).

An implicit part of the role of nursing is therefore to be an integral part of closing these gaps, whether at a strategic, national level or locally at the bedside or in the outpatient department. It is suggested that the impact of these gaps is exaggerated because of 'unwarranted variations', which is 'a term used to describe inequalities that cannot be justified by variations in geography, demography or infrastructure' (NHS England 2018b, p.9). At a local level, nurses can be involved in challenging unwarranted variations in the ways shown in Box 1.2.

NHS Long Term Plan

The NHS Long Term Plan (NHS England 2019) sets out a new service model for the 21st century. This responds to 'concern – about funding, staffing, increasing inequalities and pressures from a growing and ageing population' and optimistically holds 'the possibilities for continuing medical advance and better outcomes of care' (NHS England 2019, p.6).

The plans set out have various implications for nursing. The key chapters of the NHS Long Term Plan with direct relevance to nursing practice in an acute setting are set out in Table 1.1 with reference to the chapters in this manual that might be of specific significance to nurses who are involved in implementing new ways of working.

Professional context

There are many factors influencing the professional context of nursing in 2020. The two highlighted here are patient safety and quality of care, and new roles required to respond to the increasing demand for services.

Patient safety and quality of care

Core to nursing, wherever it takes place, is the commitment to caring for individuals and keeping them safe, so wherever the procedures are used, they are to be carried out within the framework of the Nursing and Midwifery Council's *Code* (NMC 2018a).

One of the original purposes of *The Royal Marsden Manual of Clinical Nursing Procedures* was to promote patient safety through standardized and evidence-based approaches to care. Patient safety is an essential part of nursing care that aims to prevent avoidable errors and patient harm. The Royal College of Nursing (RCN) (2019) highlights four key factors that are important in patient safety:

1. *Developing a culture of safety*: this involves promoting attitudes and behaviours that encourage staff to learn from preventable incidents, which will make it less likely that the incident will happen again. Organizations fostering a proactive approach to patient safety should be open, just and informed, and reporting and learning from error should be the norm (Carthy and Clarke 2009).
2. *Designing for reliability*: this involves making healthcare more reliable – that is, taking a standard approach to patient care, agreeing to ways of working based on research and evidence where it is available, and agreeing at an organizational level to apply that knowledge to practice.
3. *Taking a systemic approach to work*: the system of work – which includes equipment, devices, medication and information systems – makes a considerable difference to quality and safety. Changes to the design of physical things can make a big difference to how well people work. For example, the interfaces of devices, control panels, packaging and lighting levels can improve the speed, accuracy and reliability of a procedure.
4. *Human factors*: this refers to the way teams work together and the culture that influences how they act. The discipline of human factors can be defined as enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organization of human behaviour and abilities, and application of that knowledge in clinical settings (Clinical Human Factors Group 2019). To paraphrase Ives and Hillier (2015), *nurses* within healthcare are *one of* healthcare's greatest sources of strength and the science of human factors and ergonomics is about providing a system which allows them to work to the very best of their ability *to provide safe, high-quality care for patients*.

Adapted by the RCN, the consultancy Leadership Management and Quality's Human Factors Model (Figure 1.2) illustrates the interaction between the *direct factors* (dexterity (mental or physical), awareness/memory, distraction/concentration and decision – in the orange circle) that impact performance and therefore the patient experience and the *potential factors* (stress, fatigue, safety culture, communication, teamwork, leadership and work environment – in the teal circle), which have the potential to make the situation either better or worse. The *interventions* or *managing* factors (green circle) manage the effect of the potential factors and improve the direct factors (RCN 2019). The interventions or managing factors are many, both at the organizational and the individual levels. The *Royal Marsden Manual of Clinical Nursing Procedures* has a role at the organizational level, providing standardized procedures on which training can be based, and at the individual level, supporting the development of problem prevention and problem solving through the acquisition of knowledge associated with clinical processes.

Professional competency

The development of clinical competency is an integral part of delivering safe care; the Nursing and Midwifery Code states that nurses must:

- have the knowledge and skills for safe and effective practice without direct supervision
- keep their knowledge and skills up to date throughout their working life
- recognize and work within the limits of their competence (NMC 2018a).

Table 1.1 The NHS Long Term Plan (NHS England 2019) and *The Royal Marsden Manual of Clinical Nursing Procedures*

New ways of working identified in the NHS Long Term Plan with direct relevance to nursing practice	Relevant chapter(s) in *The Royal Marsden Manual*	Related content in *The Royal Marsden Manual*
Chapter 1: A New Service Model for the 21st Century		
Personalized health budget and self-care	Chapter 5: Communication, psychological wellbeing and safeguarding	Information giving and decision making.
Same-day emergency care and clinical standards for critical illness	Chapter 12: Respiratory care, CPR and blood transfusion Chapter 13: Diagnostic tests Chapter 17: Vascular access devices: insertion and management	Nursing procedures for emergency care, e.g. CPR.
Improved discharge	Chapter 3: Discharge care and planning	Processes and procedures for arranging discharge with Social Services.
Chapter 3: Further Progress on Care Quality and Outcomes		
Whole chapter	All chapters	The foundation of this textbook is to provide evidence-based procedures and to underpin rationale for the day-to-day procedures used by nurses in the acute setting with the aim of promoting quality care for the best outcome. This is discussed in more detail in the section below.
Chapter 4: NHS Staff Will Get the Backing They Need		
Workforce changes, including increased flexibility and access to professional development to help manage the pressures of working in the NHS	Chapter 19: Self-care and wellbeing	This chapter specifically considers strategies to help nurses cope with the pressures of working in the NHS.
Chapter 5: Upgrading Technology and Digitally Enabling the NHS		
Whole chapter	n/a	This theme is not specifically addressed; however, references are made where appropriate to digital support for procedures, plus the online version of the manual is continually being enhanced.

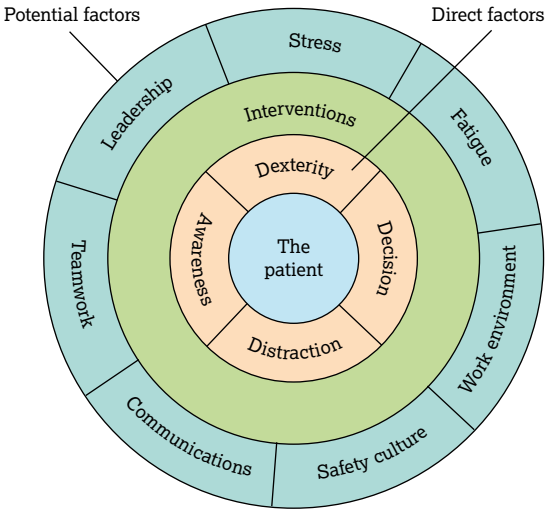

Figure 1.2 The Human Factors Model. *Source*: Adapted from RCN (2019) with permission of the Royal College of Nursing.

The Nursing and Midwifery Council (NMC) 'has a duty to review the standards of proficiency it sets for the professions it registers on a regular basis to ensure that standards remain contemporary and fit for purpose in order to protect the public' (NMC 2018b, p.3). In fulfilling this duty, it published *Future Nurse: Standards of Proficiency for Registered Nurses* (NMC 2018b) (Figure 1.3). This document details the knowledge and skills that all registered nurses must demonstrate when caring for people of all ages and across all care settings, reflecting what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. These proficiencies have a legal standing, fulfilling Article 5(2) of the Nursing and Midwifery Order 2001, which requires the NMC to establish standards of proficiency necessary for nurses to be admitted to each part of the register and for safe and effective practice under that part of the register (NMC 2018b). The proficiencies are designed to apply across all fields of nursing practice (adult, child, mental health and learning disabilities), 'because registered nurses must be able to meet the person-centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges' (NMC 2018b, p.60).

Figure 1.3 *Future Nurse: Standards of Proficiency for Registered Nurses. Source*: Reproduced from NMC (2018b) with permission of the Nursing and Midwifery Council.

Box 1.3 The seven platforms of Standards of Proficiency for Registered Nurses

1 Being an accountable professional
2 Promoting health and preventing ill health
3 Assessing needs and planning care
4 Providing and evaluating care
5 Leading and managing nursing care and working in teams
6 Improving safety and quality of care
7 Co-ordinating care

The proficiencies are grouped around seven platforms (Box 1.3). These reflect what the nursing profession expects a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career (NMC 2018b).

In addition, there are two annexes that describe what registered nurses should be able to demonstrate they can do at the point of registration in order to provide safe nursing care. Annex A specifies the communication and relationship management skills required, and Annex B specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely (NMC 2018b).

Many of the chapters in this edition of *The Royal Marsden Manual of Clinical Nursing Procedures* map onto the NMC proficiencies in Annex B of the Standards of Proficiency for Registered Nurses (NMC 2018b); these are detailed in the Appendix in this edition of the manual. The manual provides theory and exploration of anatomy and physiology related to nursing procedures, recognizing that competence is not just about knowing how to do something but also about understanding the rationale for doing it and the impact it may have on the patient.

The revision of the standards for nursing also has implications for the education and training of nurses – specifically, ensuring they are prepared for the future roles they will be fulfilling (Figure 1.4).

New roles

The changes in demand for healthcare and the limited resources (particularly staff) available to provide it have prompted government, employers and the profession to consider new roles. These new roles could potentially provide a faster route to solving staffing problems and offer career development opportunities that could also help to improve retention. These include expanding physician associate and advanced nurse practitioner roles and the new nursing associate roles (King's Fund 2018).

Nursing associates

The report *Raising the Bar: Shape of Caring – A Review of the Future Education and Training of Registered Nurses and Care Assistants* (Health Education England 2015), led by Lord Willis, made recommendations for the education of nurses and care assistants. One of the key areas it identified was the skills gap between care assistants and registered nurses (NMC 2018c). The nursing associate role, announced by Ben Gummer, Health Minister, in 2015, was developed to address this gap:

> The new nursing support role is expected to work alongside healthcare support workers and fully qualified nurses to deliver hands on care, ensuring patients continue to get the compassionate care they deserve. Nursing associates will support nurses to spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions about patient care. (Department of Health and Social Care 2015)

The NMC is the regulator for these new roles and has set out standards of knowledge and skills expected of a nursing associate for safe and effective practice (NMC 2018c). The Standards of Proficiency are structured in a similar way to those for registered nurses and are based around six platforms (Box 1.4).

The procedures that it is expected a nursing associate will be able to undertake competently on registration are defined in Annex B of the Standards of Proficiency, which states: 'Nursing associates

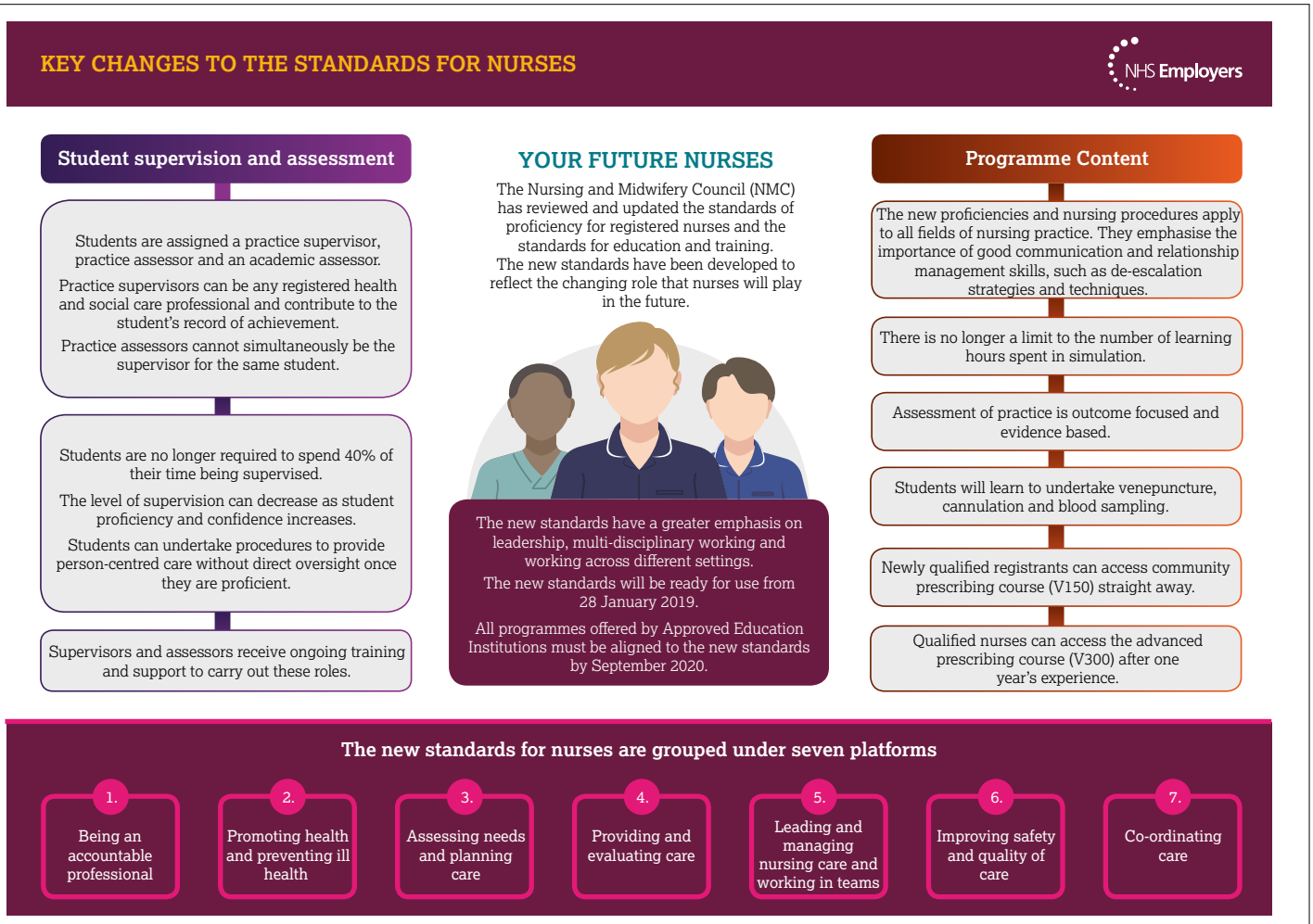

Figure 1.4 Summary of key changes to the standards for nurses. *Source*: Reproduced from NHS Employers (2018) with permission of the NHS.

Box 1.4 Standards of Proficiency for Nursing Associates

- Platform 1: Being an accountable professional
- Platform 2: Promoting health and preventing ill health
- Platform 3: Provide and monitor care
- Platform 4: Working in teams
- Platform 5: Improving safety and quality of care
- Platform 6: Contributing to integrated care

are expected to apply evidence-based best practice across all procedures. The ability to carry out these procedures, safely, effectively, with sensitivity and compassion is crucial to the provision of person-centred care' (NMC 2018c, p.15). It is hoped that this manual will be a resource for nursing associates in helping them to develop the understanding necessary to apply evidence-based practice to all the procedures they undertake. The procedures specified in Annex B of the Standards of Proficiency for Nursing Associates are mapped against the chapters in this manual in the Appendix.

Advanced nurse practitioners

'New solutions are required to deliver healthcare to meet the changing needs of the population. This will need new ways of working, new roles and new behaviours' (NHS England 2017, p.1). Advanced clinical practice roles are seen as an essential part of these solutions (Nuffield Trust 2016). A multi-professional advanced clinical practice framework has been developed to define advanced clinical practice and set out the core capabilities expected across professions and care settings to foster the development of these new roles in a consistent way to ensure safety, quality and effectiveness (NHS England 2017) (see Box 1.5).

Box 1.5 Definition of advanced clinical practice

Advanced clinical practice is defined as follows:

Clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterized by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes. (NHS England 2017, p.7)

Source: NHS England (2017). Reproduced with permission of the NHS.

Developing new roles and taking responsibility for new procedures have obvious risks attached and, although every individual nurse is accountable for their own actions, every healthcare organization has to assume vicarious liability for the care, treatment and procedures that take place. An organization will have expectations of all of its nurses in respect of keeping patients, themselves and the environment safe. There are obvious ethical and moral reasons for this: 'Nurses have a moral obligation to protect those we serve and to provide the best care we have available' (Wilson 2005, p.118). Clinical governance has therefore become an integral part of day-to-day nursing work; for this reason, the clinical governance implications of the areas of practice have been integrated into each chapter of this edition of the manual.

Evidence-based practice

The moral obligation described above extends to the evidence upon which we base our practice. Nursing now exists in a healthcare arena that routinely uses evidence to support decisions, and nurses must justify their rationales for practice. Whereas, historically, nursing and specifically clinical procedures were based on rituals rather than research (Ford and Walsh 1994, Walsh and Ford 1989), over the past 30 years evidence-based practice (EBP) has formed an integral part of practice, education, management, strategy and policy in healthcare. As Draper (2018) states, 'as the global demand for healthcare services increases exponentially, it has never been more important to demonstrate clinical effectiveness to achieve the best outcomes … while ensuring value for money" (p.2480). Research has played a key role in identifying the specific interventions that lead to the best outcomes, or, in other words, identifying the evidence to underpin clinical practice – that is, evidence-based practice.

What is evidence-based practice?

EBP was first described by David Sackett, a pioneer in introducing EBP in UK healthcare, as follows:

> [EBP is] the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patients. The practice of evidence-based medicine [or nursing] means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett et al. 1996, p.72)

A hierarchy of evidence (Box 1.6) has been developed to provide an indication of the strength of the evidence and therefore, by implication, its usefulness for evidence-based and evidence-informed decision making and clinical practice (Draper 2018, Ingham-Broomfield 2016).

Glover et al. (2006) present for nursing research a hierarchy of evidence as a pyramid (Figure 1.5), with the seventh level or base of the pyramid being ideas, opinions, anecdotes and editorials. Other sources (e.g. Ingham-Broomfield 2016) have created similar pyramids, and it must be noted that the pyramids vary slightly between authors, organizations and professions.

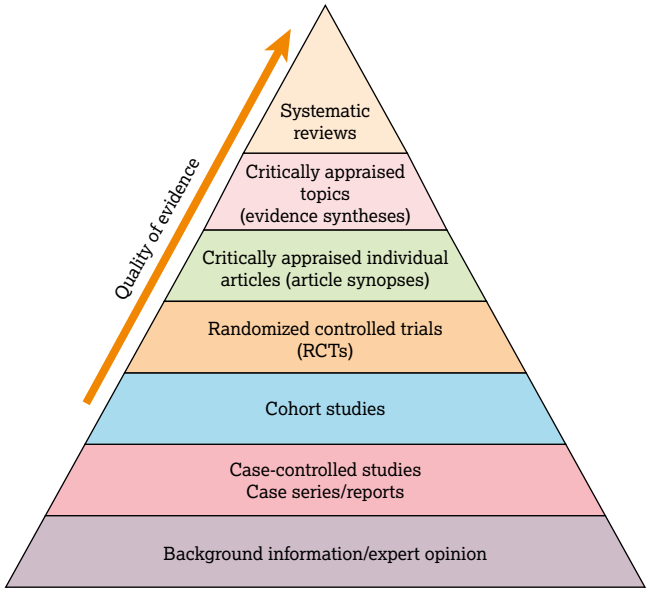

Figure 1.5 Hierarchy of evidence pyramid for nursing. *Source*: Adapted from Glover et al. (2006) with permission of Lei Wang.

These hierarchies assume that the most robust evidence is that derived from systematic reviews and meta-analyses of large-scale randomized controlled studies (Draper 2018, Greenhalgh 2014, Ingham-Broomfield 2016). However, they provide no means of including qualitative research studies (Greenhalgh 2014) or those seeking to answer questions about patients' experiences or concerns (Del Mar et al. 2013). Draper (2018) therefore proposes that typologies of evidence are a more appropriate way of defining the quality of evidence. Petticrew and Roberts (2003) propose the following features to be used in evaluating evidence: effectiveness, service delivery, salience, safety, acceptability, cost-effectiveness, appropriateness and satisfaction. Glasby et al. (2007) propose a different approach suggesting three different types of evidence: theoretical, empirical and experiential (Box 1.7).

This typology is reflective of the seminal work of Carper (1978), who delineated four different forms of knowing encompassed in clinical expertise in nursing. These are:

- empirical evidence
- aesthetic evidence
- ethical evidence
- personal evidence.

The issue of determining which evidence is acceptable in practice is evident throughout this manual, where clinical expertise

Box 1.6 The traditional hierarchy of evidence

1 Systematic reviews and meta-analyses
2 Randomized controlled trials with definitive results (i.e. confidence intervals that do not overlap the threshold, clinically significant effect)
3 Randomized controlled trials with non-definitive results (i.e. a suggested clinical significant effect but with confidence intervals overlapping)
4 Cohort studies
5 Case-control studies
6 Cross-sectional surveys
7 Case reports

Source: Adapted from Greenhalgh (2014, p.41).

Box 1.7 A typology of evidence to inform practice

- *Theoretical evidence*: ideas, concepts and models used to describe an intervention, and explain how and why it works.
- *Empirical evidence*: information about the actual use of the intervention, its effectiveness and outcomes when it is used.
- *Experiential evidence*: information about people's experiences of the intervention or service.

Source: Adapted from Glasby et al. (2007, p.434).

and guidelines inform the actions and rationales of the procedures. Indeed, these other types of evidence are highly important as long as we can still apply scrutiny to their use.

Porter (2010) describes a wider empirical base upon which nurses make decisions and argues for nurses to take into account and be transparent about other forms of knowledge, such as ethical, personal and aesthetic knowing, echoing Carper (1978). By doing this, and through acknowledging limitations to these less empirical forms of knowledge, nurses can justify their use of them to some extent. Furthermore, in response to Paley's (2006) critique of EBP as a failure to holistically assess a situation, nursing needs to guard against cherry picking (i.e. ensuring that EBP is not brandished ubiquitously and indiscriminately) and know when judicious use of, for example, experiential knowledge (as a form of personal knowing) might be more appropriate.

Evidence-based nursing (EBN) and EBP are differentiated by Scott and McSherry (2009) in that EBN involves additional elements in its implementation. EBN is regarded as an ongoing process by which evidence is integrated into practice and clinical expertise is critically evaluated against patient involvement and optimal care (Scott and McSherry 2009). For nurses to implement EBN, four key requirements are required (Scott and McSherry 2009):

1 to be aware of what EBN means
2 to know what constitutes evidence
3 to understand how EBN differs from evidence-based medicine and EBP
4 to understand the process of engaging with and applying the evidence.

We contextualize our information and decisions to deliver best practice for patients; that is, the ability to use research evidence and clinical expertise, together with the preferences and circumstances of the patient, is essential to arrive at the best possible decision for a specific patient (Guyatt et al. 2004).

Knowledge can be gained that is both *propositional* – that is, from research – and *non-propositional* – that is, implicit knowledge derived from practice (Rycroft-Malone et al. 2004). In more tangible, practical terms, evidence can be drawn from a number of different sources, and this pluralistic approach needs to be set in the context of the complex clinical environment in which nurses work in today's NHS (Pearson et al. 2011, Rycroft-Malone et al. 2004). Rycroft-Malone et al. (2004) proposed that the evidence that informs clinical nursing practice can be considered as arising from four main sources:

1 research
2 clinical experience, expertise and tradition
3 patients, clients and carers
4 the local context and environment (Pearson et al. 2011, Rycroft-Malone et al. 2004).

These four sources have all informed the evidence base that is integral to this manual, which acknowledges that 'in reality practitioners draw on multiple sources of knowledge in the course of their practice and interaction with patients' (Rycroft-Malone et al. 2004, p.88).

Evidence-based practice and *The Royal Marsden Manual of Clinical Nursing Procedures*

The evidence that informs clinical nursing procedures is integral to *The Royal Marsden Manual of Clinical Nursing Procedures*. It is critically discussed in the sections within each chapter on 'related theory' and 'evidence-based approaches'. In these sections, the source of evidence (reflecting the sources described by Rycroft-Malone et al. 2004) is indicated in the rationale that supports the steps in procedures. In previous editions, the level on the research hierarchy was also included, in an attempt to represent the robustness of the evidence. In this edition, that nomenclature has been dropped for two reasons: because the hierarchy does not include qualitative studies, some of which are significant in informing nursing practice, and because the hierarchy does not recognize the quality of a study, just the methodological approach.

Box 1.8 Examples of sources

- Clinical experience and guidelines (Dougherty 2008, **E**)
- Patient (Diamond 1998, **P**)
- Context (NMC 2018a, **C**)
- Research (Stevenson et al. 2017, **R**)

The following key is used to indicate the sources of evidence:

- Clinical experience (**E**)
  Encompasses expert practical know-how, gained through working with others and reflecting on best practice.
  Example: (Dougherty 2008, **E**). This is drawn from the following article that gives an expert clinical opinion: Dougherty, L. (2008) Obtaining peripheral vascular access. In: Dougherty, L. & Lamb, J. (eds) *Intravenous Therapy in Nursing Practice*, 2nd edn. Oxford: Blackwell.
- Patient (**P**)
  Gained through expert patient feedback and extensive experience of working with patients.
  Example: (Diamond 1998, **P**). This was gained from a personal account of care written by a patient: Diamond, J. (1998) *C: Because Cowards Get Cancer Too*. London: Vermilion.
- Context (**C**)
  Can include audit and performance data, social and professional networks, local and national policy, guidelines from professional bodies (e.g. the RCN) and manufacturers' recommendations.
  Example: (NMC 2018a, **C**). This reference is: NMC (2018a) *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates*. London: Nursing and Midwifery Council.
- Research (**R**)
  Evidence gained through research.
  Example: (Stevenson et al. 2017, **R**). Stevenson, J.C., Emerson, L. & Millings, A. (2017) The relationship between adult attachment orientation and mindfulness: A systematic review and meta-analysis. *Mindfulness*, 8, 1438–1455.

In the text, the source will be represented as shown in Box 1.8. If there is no written evidence to support clinical experience or there are no guidelines to justify undertaking a procedure, the text will be referenced as an '**E**' but will not be preceded by an author's name. Through this process, it is hoped that the reader will be aware of the source of the evidence upon which the care of patients is based and continue to critically evaluate their practice, engaging in research and audit where there are gaps or where best practice is not confirmed.

Structure of the manual

The chapters have been organized into five broad sections that represent – as far as possible – the needs of a patient along their care pathway. The first section, 'Managing the patient journey', presents the generic information that a nurse needs for every patient who enters the acute care environment. The second section, 'Supporting patients with human functioning', relates to the support a patient may require with normal human functions such as elimination, nutrition and respiration, and includes procedures relevant to those areas. The third section, 'Supporting patients through the diagnostic process', relates to all aspects of supporting a patient through the diagnostic process, from simple procedures

such as taking a temperature to preparing a patient for complex procedures such as a liver biopsy. The fourth section, 'Supporting patients through treatment', includes procedures related to specific types of treatment or therapies a patient is receiving. An additional final section and chapter has been added focusing on the wellbeing and self-care of the nurse. This has been included for two reasons. Firstly, the new NMC Standards of Proficiency for Registered Nurses state that self-care is a professional responsibility: 'in order to respond to the impact and demands of professional nursing practice, [nurses] must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support' (NMC 2018b, p.3). Secondly, there is a common tendency for nurses and other care workers to become 'invisible patients' because their own needs are often ignored or pushed to the bottom of the list (Sheridan 2016). The health and wellbeing of those who care for patients is being recognized as one of the most important aspects of enabling them to care safely (Sign Up to Safety 2019). The final chapter is included to provide accessible strategies that any nurse or care worker can put into practice.

Structure of the chapters

The structure of the chapters is consistent throughout the manual. The core of each chapter is the procedures or guidelines. The other sections provide supporting information so that the procedure can be carried out with understanding of the clinical, technical, physiological, psychological and professional knowledge and evidence from which it has been developed. In each chapter there are the following elements:

- *Overview*: as the chapters are large and have considerable content, each one begins with an overview to guide the reader, informing them of the scope and the constituent sections of the chapter.
- *Definition*: each section begins with a definition of the terms and an explanation of the aspects of care, with any technical or difficult concepts explained.
- *Anatomy and physiology*: if it is necessary to understand the anatomy or physiology of a part of the body to perform a procedure, then the chapter or section includes a discussion of the related anatomy and physiology. If appropriate, this is illustrated with diagrams so the context of the procedure can be fully understood by the reader (e.g. electrical functioning of the heart to explain how electrocardiography works).
- *Related theory*: if it is necessary to understand theoretical principles in order to understand a procedure, then these are included (e.g. theory of communication).
- *Evidence-based approaches*: these sections provide background information and present the research and expert opinion in the relevant area. If appropriate, the indications and contraindications are included, as are any principles of care.
- *Clinical governance*: these sections outline any professional guidance, law or other national policy that may be relevant to the procedures. If relevant, this also includes any professional competences or qualifications required in order to perform the procedures. Any risk management considerations are also included in these sections, including principles of harm-free care.
- *Pre-procedural considerations:* when carrying out any procedure, there are certain actions that may need to be completed, or equipment prepared, or medication given, before the procedure begins. These are made explicit under this heading.
- *Procedure:* each chapter includes the current procedures that are used in the acute hospital setting. They have been drawn from the daily nursing practice at The Royal Marsden NHS Foundation Trust. Only procedures about which the authors have knowledge and expertise are included. Each procedure gives detailed, step-by-step actions, supported by rationales. Where available, the known evidence underpinning these rationales is indicated.
- *Problem solving and resolution*: if relevant, each procedure is followed by a table of potential problems that may be encountered while carrying out the procedure as well as suggestions as to the cause, prevention and any action that may help to resolve the problem.
- *Post-procedural considerations*: care for the patient does not end with the procedure. This section details any documentation the nurse may need to complete, education and information that needs to be given to the patient, and ongoing observations or referrals to other members of the multiprofessional team that may be required.
- *Complications*: any ongoing problems or potential complications associated with the procedure are discussed in a final section. Evidence-based suggestions for resolution are also included.
- *Illustrations*: colour illustrations have been used to demonstrate the steps of some procedures. These will enable the nurse to see in greater detail, for example, the correct position of the hands or the angle of a needle.
- *Websites and references*: many of the chapters have a list of related websites that can be consulted for further information. All of the chapters end with a reference list. Only texts from the past 10 years have been included, unless they are seminal texts.

Finally

This book is intended as a reference and a resource, not as a replacement for practice-based education. None of the procedures in this book should be undertaken without prior instruction and subsequent supervision from an appropriately qualified and experienced professional. We hope that *The Royal Marsden Manual of Clinical Nursing Procedures* will continue to be a resource to help nurses deliver high-quality care that maximizes the wellbeing and improves the health outcomes of patients in acute hospital settings.

To paraphrase the quote from *Leading Change, Adding Value* (NHS England 2016, p.5) near the beginning of this chapter, compassionate care delivered with courage, commitment and skill is our highest priority as nurses. This is made more explicit in Commitment 4 of *Leading Change, Adding Value* (NHS England 2016, p.21), which highlights the importance of putting the person at the centre of care (Box 1.9).

It is important to remember that even if a procedure is very familiar to us and we are very confident in carrying it out, it may be new to the patient, so time must be taken to explain it and gain consent, even if this is only verbal consent: 'the views of the person [receiving the treatment] should also be taken into account when choosing which treatment is most likely to be successful for an individual' (NMC 2018a, p.38). The diverse range of technical procedures to which patients may be subjected should act as a

Box 1.9 Commitment 4: We will focus on individuals experiencing high value care

We will ensure that individuals are always supported to influence and direct their own healthcare decisions, so that they are confident that 'no decision is taken about me without me'.

Care planning should involve the development of a personalized plan for each individual who is entering, leaving or transitioning care environments whether within a hospital, in their own home, care home or rehabilitation unit.

We need to encourage people to take more responsibility for their health by focusing on personalized care planning, self-management and behaviour change.

Source: Adapted from NHS England (2016) with permission of the NHS.

reminder not to lose sight of the unique person undergoing such procedures and the importance of individualized patient assessment in achieving this.

When a nurse
Encounters another
What occurs is never a neutral event
A pulse taken
Words exchanged
A touch
A healing moment
Two persons
Are never the same

(Anon. in Dossey et al. 2005)

Nurses have a central role to play in helping patients to manage the demands of the procedures described in this manual. It must not be forgotten that for the patient, the clinical procedure is part of a larger picture, which encompasses an appreciation of their unique experience of the reason they have needed nursing care in the first place.

References

Carper, B. (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), 13–23.

Carthy, J. & Clarke, J. (2009) *The 'How to Guide' for Implementing Human Factors in Healthcare*. Patient Safety First. Available at: https://chfg.org/how-to-guide-to-human-factors-volume-1

Clinical Human Factors Group (2019) *What Are Clinical Human Factors?* Available at: https://chfg.org/what-are-clinical-human-factors

Del Mar, C., Hoffman, T. & Glasziou, P. (2013) Information needs, asking questions, and some basics of research studies. In: Hoffman, T., Bennett, S. & Del Mar, C. (eds) *Evidence Based Practice across the Health Professions*, 2nd edn. Chatswood, Sydney: Churchill Livingstone / Elsevier, pp. 16–37.

Department of Health and Social Care (2015) *Nursing Associate Role Offers New Route into Nursing*. Available at: https://www.gov.uk/government/news/nursing-associate-role-offers-new-route-into-nursing

Diamond, J. (1998) *C: Because Cowards Get Cancer Too*. London: Vermilion.

Dossey, B.M., Keegan, L. & Guzzetta, C.E. (2005) *Holistic Nursing: A Handbook for Practice*, 4th edn. Sudbury, MA: Jones & Bartlett.

Dougherty, L. (2008) Obtaining peripheral vascular access. In: Dougherty, L. & Lamb, J. (eds) *Intravenous Therapy in Nursing Practice*, 2nd edn. Oxford: Blackwell.

Draper, J. (2018) Healthcare education research: The case for rethinking hierarchies of evidence (editorial). *Journal of Advanced Nursing*, 74, 2480–2483.

Ford, P. & Walsh, M. (1994) *New Rituals for Old: Nursing through the Looking Glass*. Oxford: Butterworth-Heinemann.

Glasby, J., Walshe, K. & Harvey, G. (2007) Making evidence fit for purpose in decision-making: A case-study of the hospital discharge of older people. *Evidence & Policy*, 3(3), 425–437.

Glover, J., Izzo, D., Odato, K. & Wang, L. (2006) *EBM Pyramid*. Hanover, NH / New Haven, CT: Dartmouth University / Yale University.

Greenhalgh, T. (2014) *How to Read a Paper: The Basics of Evidence Based Medicine*, 5th edn. London: BMJ Books.

Guyatt, G., Cook, D. & Haynes, B. (2004) Evidence based medicine has come a long way. *BMJ*, 329(7473), 990–991.

Health Education England (2015) *Raising the Bar: Shape of Caring – A Review of the Future Education and Training of Registered Nurses and Care Assistants*. Available at: https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

Ingham-Broomfield, R. (2016) A nurses' guide to the hierarchy of research designs and evidence. *Australian Journal of Advanced Nursing*, 33(3), 38–43.

Ives, C. & Hillier, S. (2015) *Human Factors in Healthcare: Common Terms*. Clinical Human Factors Group. Available at: http://s753619566.websitehome.co.uk/wp-content/uploads/2018/06/chfg-human-factors-common-terms.pdf

King's Fund (2018) *Examining the Evidence for New Roles in Health and Social Care*. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Examining%20the%20evidence%20for%20new%20roles%20in%20health%20and%20care.pdf

NHS Employers (2018) *Key Changes to the Standards for Nurses*. Available at: https://www.nhsemployers.org/-/media/Employers/Publications/Workforce-Supply/Key_Changes_to_the_standards_for_nurses.pdf

NHS England (2014) *NHS England: Five Year Forward View*. London: NHS England.

NHS England (2016) *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf

NHS England (2017) *Multi-professional Framework for Advanced Clinical Practice in England*. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

NHS England (2018a) *About the NHS*. Available at: https://www.nhs.uk/using-the-nhs/about-the-nhs/principles-and-values

NHS England (2018b) *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff – A Learning Tool to Support All Nursing, Midwifery and Care Staff to Identify and Address Unwarranted Variation in Practice*. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/05/lcav-e-learning-tool-v1.pdf

NHS England (2019) *NHS Long Term Plan*. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

NHS Liverpool Heart and Chest Hospital (2018) *70 NHS Facts*. Available at: https://www.lhch.nhs.uk/media/5967/nhs70-facts.pdf

NMC (Nursing and Midwifery Council) (2018a) *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates*. Available at: https://www.nmc.org.uk/standards/code

NMC (2018b) *Future Nurse: Standards of Proficiency for Registered Nurses*. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf

NMC (2018c) *Standards of Proficiency for Nursing Associates*. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/print-friendly-nursing-associates-proficiency-standards.pdf

Nuffield Trust (2016) *Reshaping the Workforce to Deliver the Care Patients Need*. Available at: https://www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

Paley, J. (2006) Evidence and expertise. *Nursing Enquiry*, 13(2), 82–93.

Pearson, A., Field, J. & Jordan, Z. (2011) *Evidence-Based Clinical Practice in Nursing and Health Care: Assimilating Research, Experience, and Expertise*. Oxford: Wiley-Blackwell.

Petticrew, M. & Roberts, H. (2003) Evidence, hierarchies and typologies: Horses for courses. *Journal of Epidemiology & Community Health*, 57(7), 527–529.

Porter, S. (2010) Fundamental patterns of knowing in nursing: The challenge of evidence-based practice. *ANS Advances in Nursing Science*, 33(1), 3–14.

RCN (Royal College of Nursing) (2019) *Patient Safety and Human Factors*. Available at: https://www.rcn.org.uk/clinical-topics/patient-safety-and-human-factors

Royal Marsden NHS *Foundation Trust (2015) Nursing Strategy 2016–2018*. Available at: https://shared-d7-royalmarsden-publicne-live.s3.amazonaws.com/files_trust/s3fs-public/nursing-strategy-2016-18.pdf

Rycroft-Malone, J., Seers, K., Titchen, A., et al. (2004) What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, 47(1), 81–90.

Sackett, D.L., Rosenberg, W.M., Gray, J.A., et al. (1996) Evidence based medicine: What it is and what it isn't. *BMJ*, 312(7023), 71–72.

Scott, K. & McSherry, R. (2009) Evidence-based nursing: Clarifying the concepts for nurses in practice. *Journal of Clinical Nursing*, 18(8), 1085–1095.

Sheridan, C.B. (2016) *The Mindful Nurse: Using the Power of Mindfulness and Compassion to Help You Thrive in Your Work*. Galway: Rivertime Press.

Sign Up to Safety (2019) *Did You Know that Nearly Everyone's Job Affects the Safety of Patients?* Available at: https://www.signuptosafety.org.uk/nearly-everyones-job-affects-safety

Stevenson, J.C., Emerson, L. & Millings, A. (2017) The relationship between adult attachment orientation and mindfulness: A systematic review and meta-analysis. *Mindfulness*, 8, 1438–1455.

Walsh, M. & Ford, P. (1989) *Nursing Rituals, Research and Rational Actions*. Oxford: Heinemann Nursing.

Wilson, C. (2005) Said another way: My definition of nursing. *Nursing Forum*, 40(3), 116–118.