Health promotion opportunities related to a person or group of people taking into account the legal, ethical and policy context

Rebecca Wynne
Faculty of Education, Health and Community
School of Nursing and Allied Health
Liverpool John Moores University

Abstract

Health promotion in nursing is the process of supporting people to increase control over, and to improve their own health. The World Health Organization (WHO) (1946) defined health "*As a complete state of physical, mental, social and emotional well-being, not merely the absence of disease*". It moves beyond a focus of individual behaviour to a wide range of social and environmental interventions (WHO 2015). Health promotion is "*About improving the health status of individuals and the population as a whole"* (Evans, Coutsaftiki and Fathers 2014). Thinking like a health promoter enables nurses to integrate the principles of effective health promotion which is a fundamental aspect of nursing care (Piper 2009).

Keywords

Health Promotion; Drug Addiction; Infection Control

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The Nursing and Midwifery Council (NMC) (2010) has set out standards for pre-registration nurse education which it considers necessary for safe and effective practice in relation to health promotion and public health. These standards involve *"…support and promote the health*, *wellbeing, rights and dignity of people…" (NMC 2010, p.23).* Nurses must also *"…understand public health principles and practice in order to recognise and respond to the causes and social determinants of health, illness and health inequalities"* (NMC 2010, p.18).

For the purpose of this article three health promotion issues most relevant to this practice experience will be discussed. The legal, ethical and policy context in relation to these issues will be explored. The actual name of any patient/s or the trust will not be disclosed, this is to maintain confidentiality and consent was gained following the NMC (2015) *Code of Professional Conduct*.

Background

This practice experience was a four week placement situated in the Hepatology/liver clinic located within a government owned acute trust in the North West of England, this includes a specialist nurse led outpatient clinic for the treatment of viral hepatitis and chronic liver diseases often caused by substance misuse. This organisation is regulated and inspected by the Care Quality Commission (2015) who ensures that the organisation is meeting quality standards when caring for individuals. The Health and Social care Act 2001 also placed a legal duty on NHS organisations to ensure they involve and consult patients and the public in the planning and development of their services (Reed 2011).

Numerous health promotion and public health issues were identified during this placement including: health education, the reduction and prevention of health risks, empowerment, advocacy and health policy development (Raingruber 2014). However, in relation to this practice experience and specific client group the three health promotion issues which will be explored are: drug addiction, infection control in relation to hepatitis C and lastly undernourishment.

Drug Addiction

Drug addiction is when an individual becomes physically or psychologically dependent on illegal or prescribed drugs, which then forms a central part of their daily life (Hanson, Venturelli and Fleckenstein 2012). The WHO (2008) defines drug misuse as "*The use of substances for purposes not consistent with legal, medical or pharmaceutical guidelines".* In December 2010, the Government published its *Drug Strategy* which sets out the Government's approach to address and tackle drug and alcohol dependence, both of which are the main causes of social harm, including crime, family breakdown and poverty (Department of Health (DH) 2010). In terms of regional differences, the North West of England had the highest prevalence of opiate and/or crack cocaine use at 10.83 per 1000 of the population aged 15 to 64 (Health and Social Care Information Centre 2013).

During this practice experience patients required nursing care and treatment for chronic complications of intravenous drug use including: liver disease, hepatitis infections and occasionally referrals to psychopathologists (Ford, Bammer and Becker 2009). However, it was noted that although patients were fully aware of the health related risks

and complications of substance misuse they continued to actively use drugs. The DH (2011) states that around 5,800 hospital admissions were due to complications or diseases caused by substance misuse. This contributes largely to NHS costs; annually around £500 million is spent on treatment for class A substance misuse in England and Wales. This research indicated nurses often experienced difficulties when caring for patients who misuse drugs as they considered these patients to be dangerous and problematic. Many nurses were also found to have negative attitudes towards this patient group, often influenced by many stigmas and their own health beliefs (Natan, Beyil, and Neta 2009).

However, justice in healthcare refers to fairness and entitlement, (Gallagher and Hodge 2012) therefore, National Institute for Health and Clinical Excellence (NICE) (2007) guidelines states individuals who misuse drugs should receive the same care, respect and privacy as any other person. The DH (2006) published '*Our Health, Our Care, Our Say,'* which is aimed to promote health and social care to work together and offer easier access to other services, for example, extending community services and outreach teams who provide community prescribing for this specific client group (Reed 2011). It is therefore essential that individuals who misuse drugs have access to services which can offer a holistic approach, advice and support best suited to their current lifestyle and the lifestyle changes they wish to make. For example, highlighting the importance of key worker support which could then be followed up with a referral to detox or rehabilitation centres, group work and peer support may help in the process of their lifestyle change. In March 2012, the Home Office published '*Putting Full Recovery First'*, outlining their

roadmap for creating a new treatment system based on commitments made in the Drug Strategy.

However, nurses need to be mindful that many individuals who misuse drugs do not wish to change their lifestyle. It is therefore vital nurses respect patient autonomy and confidentiality, as well as supporting individuals to care for themselves to improve their own health (NMC 2015). Empowering patients is an important element in patient autonomy and encourages patients to engage as active partners in their health (Barello et al. 2014). For those individuals who do not wish to seek help or change their lifestyle, it is essential that they too receive education and advice on how drug addiction can impact on their health. They should also receive health promotion information on the safe use of drugs, for example, community organisations providing a needle exchange service, offering advice and support on safe intravenous drug use as well as hepatitis and HIV screening. Moreover, it is a nurse's duty of care to act as an advocate, helping individual's access relevant health and social care, information and support (NMC 2015). Therefore, active drug users should receive information on where to access services within their community, as well as up to date information on the treatments available to them should they wish to change their lifestyle.

Infection control

Patients who attended clinic for follow-up appointments were either active or recovering drug users, who had, unfortunately contracted hepatitis via intravenous drug use. There are five main hepatitis viruses, referred to as types A, B, C, D and E. However, literature suggests types B and C lead to chronic liver disease in millions of people and together

are the most common causes of liver cirrhosis or liver cancer as a result (WHO 2015). Hepatitis C is a blood borne virus which infects the cells in the liver. This causes inflammation, swelling and tenderness. It can be transmitted via blood products, having unprotected sex with infectious partners, needle stick injuries in healthcare settings or infants being born to a mother who is infected (CDC 2014). However, the most common route of hepatitis C in England is through sharing contaminated needles or using drug paraphernalia used by other infected drug users (Rassool 2009).

Public Health England (PHE) (2014) published '*Hepatitis C in the UK: 2014 report,'* which suggests intravenous drug use continues to be an important risk factor for viral hepatitis C infection in the UK. Around 350,000 to 500,000 people die each year from hepatitis C related liver diseases (WHO 2014), and in England around 160,000 people are infected with hepatitis C (NICE 2012). PHE (2014) states tackling hepatitis C is consistent with the strong national focus on improving and protecting health and on improving the health of the poorest first, in this way, life expectancy can be increased. Confronting this infection and the premature mortality in which it results has to be a fundamental part of any programme to reduce health inequalities and to improve public health overall.

Many opportunities exist to prevent hepatitis infections in public health settings such as, sexually transmitted disease clinics and substance misuse treatment centres (Buffington and Jones 2007). However, research suggests this may not always be effective as healthcare professionals do not always ask their patients about the possible risk factors

of hepatitis during assessments. Even if such risk factors were discussed healthcare professionals feel a patient may not always admit to the fact he/she has been exposed to or is at risk of contracting the virus (Papatheodoridis and Hatzakis 2012).

Although NICE (2012) states 160,000 people in the UK are infected with hepatitis C, recent literature from PHE (2014) suggests around 214,000 people now have hepatitis C in the UK, of which only 3% actually start treatment each year. PHE (2014) continues to state that they will redouble their efforts to prevent, raise awareness, test and treat people with viral hepatitis. Furthermore, encouraging patients to play a more active role in their healthcare can increase their knowledge and therefore enable them to manage their health better (Coulter 2011).

Undernourishment

Hunger or undernourishment occurs when an individual's calorie intake is below the minimum dietary requirement (Swain 2013). Although undernourishment may not endanger life immediately, it does however lead to a reduced physical and mental health status (Strike et al. 2012). Any individual experiencing ill health may be at risk of undernourishment. However, drug users are often found to be at an increased risk of this. The reason why is unclear. Nevertheless there have been links to a wide-range of lifestyle factors such as, chaotic lifestyle choices, limited finances and inadequate storage of nutrition in damaged livers due to hepatitis C or HIV viruses (Tang et al. 2011).

Therefore, the importance of recording patient's height and weight during each clinical appointment was noted; this was to ensure that nurses had adequate evidence whether their patients had lost or gained weight. The reason for this was a variety of patients being treated for hepatitis had medication prescribed based on their weight. Although no special diet is required in the treatment of hepatitis, patients are generally known to lose weight (Lewis et al. 2014). Patients who are at a high risk of malnutrition should be reviewed on a regular basis and referred to a dietician who can offer further nutritional assessments and provide advice and support around the importance of healthy nutrition (NICE 2013).

Legislation

We can accept both legally and ethically that patients have the right of autonomy and that they should be fully involved within their healthcare. However, some form of legal system and legislation is necessary for public health and society to prosper (Avery 2013). This legislation in relation to this specific client group includes: The Human Rights Act 1998 which is a UK law meaning public organisations must treat everyone equally with fairness, dignity and respect; The Misuse of Drugs Act 1971 which again is a UK law defining a series of offences including, unlawful supply, intent to supply, import and export as well as unlawful production of drugs; The Public Health (Control of Disease) Act 1984 which was set out to prevent the spread of infectious diseases, and lastly the Data Protection Act 1998 which, is a law designed to protect personal and confidential data either stored on a computer system or within paper records (GOV.UK 2014).

Conclusion

Health promotion is the shared responsibility of the nurse, who is required to understand factors affecting health and health beliefs, as well as the individual, who has to take responsibility of his/her own health by adopting healthier lifestyle choices. However, this is not always the case. Patients who are fully aware of the health related risks of substance misuse continue to lead a lifestyle which may put their health at further risk. Therefore, health promotion is not just the responsibility of the healthcare professional. Health promotion is the process of empowering individuals to take control over, and to improve, their own health. This enables individuals to reach a state of complete physical, mental and social well-being (WHO, 1986).

I have used the Gibbs (1988) model of reflection to reflect on my learning outcomes. This has helped me to identify that although individuals have the right of autonomy they may not always make the right lifestyle choice when it involves their own health. It is therefore essential that nurses familiarize themselves with the principles of health promotion, public health and nursing ethics, representing a personal and professional commitment to equality and diversity, while also demonstrating a none judgemental attitude towards patients within their care (NMC 2015).

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