

The aim of this essay is to identify public health issue related to the health needs of a patient who is being cared for in the community. These health problems will be explored and discussed from a case study of a patient who is clinically obese and also diagnosed with Parkinson's disease. The case study will involve investigating the relevant Government policies relating to the long-term condition of the patient and how it is managed in a community setting. It will also look at the role of a nurse and the implications it has on the inter-professional team in supporting the patient by ensuring that knowledge of his condition is developed to a point where he is empowered to take responsibility for its management and foremost work in partnership with the health and social care providers.

“Health is the extent to which an individual or group is able on the one hand to realise aspirations and satisfy needs and on the other hand to change or cope with the environment. Health is therefore seen as a resource for everyday life not the object of living: it is a positive concept emphasising social and personal resources as well as physical capabilities”. (WHO 1984)

National Institute of Clinical Excellence (NICE 2005) define health needs assessment as “a systematic method for reviewing health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce health inequalities”.

Public health can be defined as “the science art of preventing disease, prolonging life and promoting health through the organised efforts of the society” (Department of Health 1998). Whereas health promotion is identified as “the process of enabling people to exert control over and to improve their health”.(World Health Organisation 1986). Health promotion involves decisions and choices that affect other people, which require judgements to be made about whether particular courses of action are right or wrong. There are no definitive ways to behave. It is not something that is done on or to people, it is done with people either as individuals or as a group. Both of these principles are important to encourage the population as a whole to play a part in their health.

It is well documented that there has been a change in attitudes and working practices towards people with health conditions and health issues over the last decade. In an effort to move away from sole reliance on medical intervention and by giving the opportunity for individuals to have a better understanding of health issues, results show that with the support of the

health professionals and the concordance of the individual taking the initiatives to stay healthy it can benefit health.

The changes in attitude and working practices have originated from the Government's national policies. These policies set the national standards and guidelines to follow. The patient self-management programmes were first advocated in saving lives:

Our Healthier Nation (Department of Health 1999), the NHS Plan was introduced in 2000 followed by The Expert Patient: a new approach to chronic Disease self-management (DoH 2001). Other documentation followed such as "Self Care – A Real Choice" (DoH 2005) which was highlighted in the NHS plan and is the key building block for patient centred health service. All these policies have contributed to the White Paper "Our Care" and "Supporting People with long term conditions to self-care" (DoH 2006). This strategic plan has identified that; people want more control over their own health and care, with support from community based services to maintain health, well being and independence. This appears to be the direction in which health and social care are to follow and put into practice to accommodate the modern world.

The author was fortunate enough to have been allocated a placement in a community hospital and observed the multi disciplinary team involvement in the health and social needs of a patient. The public health issue of obesity was the underlying problem and contributed to other health issues. This led to the case study of a patient and how his health needs were addressed in accordance with the White Paper "Supporting people with long term conditions to self care". Exploring into past and current life experience and the impact they have on his health and well being. Also including the impact it has on the family and the support needed to address these issues. The patient is a 12 years old boy who lives with his parents at home. Unfortunately his grandfather passed away couple of months ago which could be a psychological factor. The patient's ongoing medical history is that he has ischaemic heart disease and osteoarthritis in his knees and hips. His major health concern and one that is the basis for this public health essay is that he is clinically obese. He attended an outpatients clinic after his motor functioning had noticeably deteriorated and he showed signs of tremors especially on movement. A diagnosis of Parkinson's disease was made. Parkinson's disease is a chronic (persistent) neurological condition that affects the way the brain coordinates body movements, including walking, talking and writing (Parkinson's Disease Society 2007). To promote effective management of Donald's long term condition and the burden it has on his

well-being we have to objectively target his obesity as this is a public health issue that is on the increase. The family felt that the main issue at present is his decreased mobility, especially, getting to the toilet in time and being unable to transfer from wheelchair to bed.

This has led to the patient being confined to his bed where he now lacks confidence and motivation to deal with his mobility. When we looked at his health problems we can see issues emerging that could indicate the cause of his obesity. Factors that include his life style, behavioural, anxiety and depression all which might have been derived from the loss of his grandfather and his recent diagnosis of Parkinson's. It could be a combination of them all that has contributed to his weight gain and is probably the main issue to focus on in aiming to improve his health.

Obesity is a growing concern; its prevalence has increased rapidly over the past two decades in developed countries (Foresight 2007). The Government and the primary care's main priority are the prevention and management of obesity, which has been prepared by the National Institute of Clinical Excellence (NICE). These recommendations are based on the best available evidence of effectiveness, including cost effectiveness. The guidance supports the implementation of the "Choosing Health" White Paper and the existing national service frameworks (NSFs) in an effort to improve the care provided to adults with obesity, particularly in primary care.

When working with people to prevent or manage overweight and obesity, health professionals should follow the usual principles of person centred care. Patients' needs and preferences should be taken into account when health professionals give advice, treatment and care. People should have the opportunity to make informed decisions about their care and treatment in partnership with their health professionals.

Good communication between health professionals and patients is essential. It should be supported by evidence-based written information tailored to the patients' needs. Advice, treatment, care and the information patients are given should be non-discriminatory and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities and for people who do not speak or read English.

Mike was prescribed some medication on a trial basis to be reviewed if Mike develops any side effects. Further appointment was made to review Mike's progress and it was found that

since his treatment began he noticed a marked improvement in his functioning. His mother also bears witness to the fact that his tremors had disappeared. Stabilising Mike's Parkinson's is an important factor, giving him the opportunity to focus on his obesity. A referral was also made to the community physiotherapists to tackle his decreased mobility. The physiotherapist assessment and input is necessary to assist Mike to gain confidence and promote independence to enhance his quality of life. More importantly the main aim is to restore some mobility in order for Mike to attend future rehabilitation programmes in his community. The author was fortunate to witness and participate in the programme. A local Parkinson's disease group was held at a social club facilitated by a physiotherapist from the community hospital. The aim of the group is to provide an access to social needs giving the individuals a chance to share experiences on conditions and problems as it has been found that patients are expert in their own illness or disease. This gives the patients the opportunity to recognise and act upon ways of dealing with attacks or exacerbations of their disease in a more positive manner. The group also built upon improving strength, balance and circulation in the form of an exercise programme specially developed for the individual and their condition. The valuable knowledge of both patients and clinical professionals has a common goal whereby patients can be given greater control over their lives.

Self management programmes can be specifically designed to reduce the severity of symptoms and improve confidence, resourcefulness and self efficacy. There is evidence to suggest that this programmes work. Random controlled trails carried out by Montgomery (1994) found tailored information and recommendations for diet and exercise made an increased improvement in daily activities and self efficacy about controlling the symptoms and managing the disease. The study concluded there was a marked reduction in visits to General practitioners and hospitals.

Diet is a crucial factor contributing to Mike's obesity and the role of the community nurse involves an initial assessment where the nursing care plan is developed. Orem's (2001) model is widely used in rehabilitation, this enables the nurse to structure a holistic assessment of Mike's needs, goals and plan appropriate interventions to meet those needs and goals. In addition the assessment needs to include and involve Mike's willingness and ability to change. The nurse need to have the ability to explain the reasons for the advice on weight management, setting realistic goals and making Mike and his family aware of the benefits of diet and thus promoting better health. Explaining a healthy diet reduces the need for medical

intervention and supporting relieves further problems and the unnecessary stress on the family care. The nurse would advice in this situation smaller portions of foods in take and increase fruits and vegetables consumption and monitor Mike's weight on a monthly basis. The nurse will give further support as necessary for this to be achieved as outline by Green and O'Kane (2002). It is equally important to add physical activity into the plan, these two elements need addressing. Living with long term conditions for individuals affected and their families can often mean physical, psychological difficulties, socio-economic problems, reduced quality of life and sometimes social exclusion. Therefore the role of the nurse is to look at ways to help and give support to Mike and his mother to achieve the best outcome possible.

The individual health assessment has been designed to bring together information from many sources and incorporate into a consistent single record. Health and social care use this integrated contract to assess and document a person with complex needs. Multiple chronic conditions and acute exacerbation use or need two or more health and social care service. The main purpose of this document is to promote working in partnership and improve communication. It reduces information being repeated and helps to co-ordinate individual care and requirements.

The key role of the nurse requires knowledge and understanding of issues and policies to support their patient; however this role requires a detailed knowledge of inter-professional workers. It also requires a high level of communication skills, diplomacy and assertiveness. Rehabilitation nurses also need to have knowledge of service delivery systems to enable them to carry out this role.

In conclusion, the role of the nurse and health professionals is built on the developing equal partnerships with the people they work with so that the public health targets for people like Mike, their families can be met effectively, efficiently and in a resourceful manner. Nurses and health professionals need to practice in a sensitive and non-discriminatory manner to enable people to fulfil their needs and aspirations in self-care.

The author has learnt a great deal of knowledge not only from this assignment but also being involved and witnessing the process in action in a community setting. From the literature extracted there is evidence to suggest that self care incentives will take time to be fully implemented. Individuals and multi-professional team have to promote health awareness and

create an expectation that patient expect in a central component in the delivery of care to people with chronic diseases. They also need to build on a continuing professional development program, a core course that will promote health professionals' knowledge and understanding about the benefits for them as well as for patients of self-management programmes.

In addition they need to establish a national coordinating and training resources to enable health, social services and voluntary sector professionals to keep up to date with developments in provision of self management, patients should also have the opportunity to take part in developing professional education programmes.

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