A NEW LEARNING DISABILITY NURSING FRAMEWORK

In the first of a series of articles, Gwen Moulster and colleagues describe how an eclectic framework for learning disability nursing practice was developed.

Abstract

This article, the first in a series of three on developing a framework for learning disability nursing practice, discusses how a bespoke nursing model was devised from elements of other models. As the article makes clear, such frameworks must keep up with evolving needs, practices, policies and laws in the learning disability nursing field. The framework, devised by nurses from the Haringey Learning Disabilities Partnership, in London, is reflective, person centred, evidence based and outcome focused.

Keywords

Framework for nursing practice, person-centred care

As people live longer and the number of people with learning disabilities rises (Royal College of Nursing (RCN) 2010, 2011), the role of learning disability nurses is changing. Growing awareness of the needs of people with learning disabilities has led to developments in practice and policy that affect nurses in many areas of their work.

Learning disability nurses require a good knowledge of what is required of them under law and they should see that the law is followed. Their safeguarding role has been formally recognised (Department of Health (DH) 2000a, Safeguarding Vulnerable Groups Act 2006, Jenkins and Davies 2011) and, since 2007, they have been legally required to assess mental capacity and to act in the best interest of each person assessed (Mental Capacity Act 2005), although health services still struggle to assess capacity consistently (Mencap 2007, 2012).

Learning disability nurses have a duty to assess and manage risk, and to support others to do so (National Patient Safety Agency 2004, 2011), and they have an important role in supporting, teaching and advising healthcare colleagues to ensure that best-interest decisions are made.

The Disability Discrimination Act 2005 introduced the concept of reasonable adjustments, which has been reinforced by the Equality Act 2010. Meanwhile, Turner and Robinson (2011) have shown that generic health staff require guidance and support from learning disability nurses, who in turn must be skilled in developing accessible information and advocating appropriate reasonable adjustments.

Recent developments in health care include the introduction of an integrated model of care that emphasises the importance of each person’s experience, safety and health care at home (DH 2006, Shepperd et al 2008). Adoption of this model should increase the number of opportunities for more person-centred, nurse-led provision.

Brandon (2009) advocates a social model of care, in which staff who deliver care in the home should involve service users and their families in making decisions and planning care. Klotz (2004), meanwhile, argues that adoption of the medical model of care can lead to people with learning disabilities being seen as ‘less human’.

Gates (2006) advises that, in all nursing models and frameworks, the individual with learning disabilities must be central to care-planning processes, and that nurses must promote what is best for the individuals concerned.
If the social model of care is over-emphasised, however, too little attention may be paid to the importance of good health outcomes. This has been a cause for concern among learning disability nurses who trained under the 1982 syllabus (English National Board for Nurses, Midwives and Health Visitors 1982), some of whom lack confidence in their knowledge and skills when tackling complex health issues (Atkinson et al 2010, Wood and Thorley 2010).

Such traditional pre-registration nursing courses tended to be practical, while modern, degree-level pre-registration courses teach nurses to underpin their practice with evidence, and emphasise the importance of measuring health outcomes (Nursing and Midwifery Council (NMC) 2010) and working in outcome-focused environments (DH 2011). Nurses who trained before the introduction of the new curriculum need to embrace these changes (DH 2011).

Learning disability nurses also require a good understanding of public health. In a report on health inequalities, Emerson et al (2011) describe how people with learning disabilities 'fare particularly poorly' in receiving appropriate care and suggest that 'understanding the determinants of health inequalities helps identify potential solutions'.

According to Aggleton and Chalmers (2000), all nursing models should involve the following:

- Consideration of each individual who needs nursing care.
- Consideration of what has produced this need.
- Assessment of the individual's needs.
- Planning the individual's nursing care.
- Setting goals to meet the individual's needs.
- Implementing nursing care.
- Evaluating the quality of nursing care.
- Evaluating the nursing and health outcomes for each individual.

**Multidisciplinary partnership**

Haringey Learning Disabilities Partnership, London, is a multi-agency and multidisciplinary partnership between the London Borough of Haringey, The Whittington Hospital NHS Trust, also known as Whittington Health, and Barnet, Enfield and Haringey Mental Health Trust. The Partnership brings together health and social care staff to provide integrated services to people with learning disabilities. These staff also work with Haringey Learning Disabilities Partnership Board to implement recommendations laid out in Valuing People (DH 2001, 2009).

Learning disability nurses are seconded to the Partnership by Whittington Health. Until recently, these nurses worked to no single, specific nursing model, framework, or system, and the quality of the care they provided depended on the individual nurse's knowledge and skills. Not all interventions were evidence based and limited outcome measures had been put in place. As a result, the quality of nursing assessments, care plans and interventions was inconsistent. After a period of reflection and discussion, the nurses agreed that a nursing model combining elements from different models and frameworks with a reflective, person-centred, evidence-based and outcome-focused approach to care would ensure best practice.

The pace of change to services in Haringey is such that the appropriate model had to be adopted quickly. There are several nursing models and frameworks available, and identifying the best model for practice was difficult. The nurses decided, therefore, to study how frameworks with which they were already familiar would help them to provide effective care to people with complex and multifaceted needs. These models were devised by Roper et al (2000), Barker (2001), Orem (2001), Aldridge (2004), and McCormack and McCance (2006).

**Roper Logan Tierney Model**

The widely used Roper et al (2000) model of nursing provided a suitable basis for the assessment and planning of care, particularly in light of the poor health outcomes experienced by people with learning disabilities. Most of the nurses were familiar with the activities of daily living that underpin this model, which also involves comprehensive assessments of physical healthcare needs. However, Barrett et al (2009) suggested that the medical orientation of this model may narrow the nurse's focus.

**Tidal Model**

The learning disability nurses in Haringey support people who have mental health problems as well as learning disabilities, and the person-centred approach they have adopted has much in common with the recovery model adopted in mental health services. For this reason, Barker's (2001) Tidal Model, which emphasises the empowerment of people to lead their own forms of recovery rather than following professional direction, was considered as a possible approach.

The involvement of people in the planning and implementation of their own care is advocated by the Department of Health (2008) Care Programme Approach (CPA). The CPA is being adopted more widely in learning disability services (Higgins et al 2006), with some learning disability nurses helping clients to chair their own CPA meetings and take responsibility for their mental health. According to Norman and Ryrie (2004), however, the Tidal Model requires people to provide detailed accounts of their histories and to communicate their ideas.
of what would aid their recovery. Most people who have learning disabilities would struggle to achieve this level of self-awareness and lack the memory or ability to communicate detailed thoughts and ideas.

**Self-Care Model** Orem’s (2001) model of self-care emphasises the importance of learned behaviours of self-care to maintain health and wellbeing, and to support people to become more independent. This model can be effective with some people with learning disabilities, particularly in community based settings, and was deemed appropriate to developments in Haringey. However, Kozier et al (1998) suggest it is unsuitable for people with profound disabilities as they require considerable support with self-care.

**Ecology of Health Model** Aldridge’s model (2004) was formulated for learning disability practice. Jukes and Aldridge (2007) followed this by describing a person-centred and holistic model and its implementation within contemporary learning disability practice and policy. Aldridge’s model can be used to help learning disability nurses gain a holistic view of a person (Barr 2005), although Jenkins et al (2006) say that it emphasises physical health problems. The holistic nature of Aldridge’s model has been influential and provided the framework for the Haringey Partnership.

**Person-Centred Nursing Model** Manley et al (2011) highlighted the value of using McCormack and McCance’s (2006) framework for person-centred nursing. The nurses wanted to adopt elements of this framework, partly because it takes into account the context in which care is delivered, which is particularly useful to nurses working in community settings, partly because it takes into account how the personal attributes of nurses can influence care delivery, and partly because it allows staff to formulate and measure person-centred outcomes.

**Other frameworks**

The institutional model of nursing influences care provision in smaller, community based settings. Mansell (2006), in discussing the move from institutional to community settings, concludes that there is a need for ‘a renewed focus’ to ensure better ‘quality of life… and a change in the role of staff’ to ensure effective care for people with learning disabilities, especially those with complex needs.

People with learning disabilities should be fully involved and have choices in all aspects of their care. In some instances, this involvement is achieved through imaginative and creative approaches, and by encouraging and supporting family carers and advocates to contribute. Ensuring this involvement is a principle of person-centred care and of the best-interest approach to issues of capacity and inclusion. The Mental Capacity Act 2005 and the British Psychological Society’s (2007) guidance state that the families, carers or other people involved in the care of people with learning disabilities should be involved in decisions about best interest. This person-centred strategy is also part of the NHS Plan (DH 2000b).

Adopting such a strategy when working with people with learning disabilities is likely to ensure better collaboration and commitment to goals (Robertson et al 2005, Sanderson et al 2006). However, some people with learning disabilities may not change their behaviour even if they are aware of its effect on their health (Falvo 2011).

Manley et al (2011) and Braynion (2011) say that nurses should lead person-centred care. Nurses’ assessments should involve overviews of service users, their lives, and what has been, is and may be important to them. For example, many people with learning disabilities lose their ties with families, friends and staff, sometimes with little or no warning (Read 2005). Identification of significant historical events such as these can inform the assessment and planning process.

In their work on person-centred planning, Moulster et al (2006) discuss the benefits of working with circles of support. They suggest the use of several tools, such as maps, paths and essential lifestyle planning tools (Falvo et al 1994), to help people with learning disabilities plan, and make choices about, all aspects of their lives. In using these tools, staff should take into account service users’ histories to find out what they want in the future.

Northway (2006) suggests that, by contributing to research, nurses can improve the evidence bases for care. Learning disability nurses should be able to refer to a sound evidence base although evidence-based practice has been characterised as a ‘one-size-fits-all’ approach (Grinnell and Unrau 2011), but Porter-O’Grady (2010) says that individualised care requires a sound evidence base.

Benner (2001) describes the importance of learning through experience and how nurses develop expertise by taking part in day-to-day activities. Reflective practice is a way for nurses to turn ‘experience into meaningful learning’ (RCN 2009) and is advocated by the NMC (2004) as an important part of the commitment to lifelong learning.

Several models of reflection have been written for, or adopted by, nurses. Gibbs (1988), for example, has developed a simple reflective cycle that is widely used in nurse education, and Driscoll’s (2000) Reflective Cycle is a straightforward tool for
reflective practice (van Ooijen 2003). It should be noted, however, that Quinn (2000) and Johns (2009) have criticised cyclical models, such as that of Gibbs (1988), for being too prescriptive, and Johns (2009) has devised a more holistic method of reflection.

Conclusion

As this overview demonstrates, several nursing models and frameworks can be adapted for use in practice. To encourage learning disability nurses to practise in a person-centred, evidence-based, outcome-focused, reflective manner, the authors adopted elements of models devised by Orem (2001), Aldridge (2004), McCormack and McCance (2006), Gibbs (1988), and Jukes and Aldridge (2007). The result is the Moulster and Griffiths Learning Disabilities Nursing Framework.

According to the Disability Discrimination Act 2005 and Equality Act 2010, service providers are obliged to make the information they provide to clients accessible and understandable. Supporting information and care plans associated with the Moulster and Griffiths framework, therefore, are available in easy-read formats.