US nurse’s experience is a warning for us all

Lynda Arnold’s lecture highlighted the lack of education, clear guidelines and policies to protect every health worker, patient and their families. The RCN has started its campaign against needlestick injuries. In Scotland, the Scottish Executive set up a working group on needlestick injuries in March. I am the RCN safety representative on this group. The group’s remit is to ‘review the available data and information on preventing needlestick injuries, make recommendations on good practice and specifically consider the value of safety devices and make recommendations on their possible use in the NHS’. The review will be based on risk assessment and take account of current practice and procedures, and cost and benefit to the NHS of current and alternative practices. Recommendations to the health minister should be practical and achievable, and take account of current and planned health and safety laws.

American nurse Lynda Arnold, who became HIV positive following a needlestick injury, spoke at the recent RCN Congress (News April 12). Her lecture brought home the importance of the use of gloves and good practice, but also the need to report all incidents, and the need for policies being in place and available to all staff. If, as suggested, 60 per cent of needlestick injuries are not reported how are we going to prevent further trauma?

Another nurse bravely told of her experience and of the need for follow-up care and blood tests. But the desire to stay involved with patient care remains paramount. Peer support has to be evident – there can be nothing worse than to suffer an injury and be treated like a leper. Accidents happen and if we treat nurses in this way how will we react to patients?

Patient’s wishes are paramount in resuscitation

My partner had a heart attack 18 months ago and he found it really distressing to be observed by his loved ones at his most vulnerable – you cannot get more vulnerable than lying bare chested and intubated on a resuscitation trolley.

RCN Congress passed a resolution on developing guidelines on witnessing resuscitation, but the debate centred around the needs and wishes of the relatives. I would add that the wishes of the patient should be paramount and it should be noted that not everyone would want their family to be present. While I realise the difficulty of obtaining such information, it is essential that the patient’s perspective is considered in any guidelines.

Who has the right to judge another’s life?

Why is it that if anyone dares to criticise initiatives that lead to health workers snooping into their patients’ private lives, they are accused of condoning acts such as domestic violence (Letters April 5)? It’s much like the accusation that anyone who believes in free speech must be a racist.

It worries me that a new generation of professionals will be trained to believe that they have the right to judge the dynamics of someone’s private life and will spend most of their time telling (sorry, advising) people how to behave towards one another rather than providing health care.

Not so long ago I was shocked by an NVQ assignment a healthcare assistant was doing on ‘elder abuse’ and how to look for signs of it. (Sound familiar?) I suppose anyone like me who objects to this will be accused of condoning violence towards elderly people. This type of emotional blackmail is being used to stifle debate and should be challenged strongly.

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All students suffer the same hardships

Having read Charlotte Clark’s letter concerning degree students and their financial hardship (Letters April 5), I feel compelled to respond with facts about the diploma course.

We might get our uniform free, but we can only claim travel expenses while on placement, and then only if the distance travelled exceeds our normal journey to college. I know students who travel over